STUDY REPORTS THAT EARLY PALLIATIVE CARE EXTENDS LENGTH AND QUALITY OF LIFE IN PATIENTS WITH METASTATIC NON-SMALL-CELL LUNG CANCER

In *NEJM* last week, researchers from Massachusetts General reported on their three-year study of concurrent palliative and curative treatment for patients with terminal diagnoses of non-small-cell lung cancer. Patients enrolled in the study were randomly assigned to get either oncology treatment alone, or oncology in conjunction with palliative care.

In an article on the study, *The New York Times* said, “Those getting palliative care from the start … reported less depression and happier lives as measured on scales for pain, nausea, mobility, worry and other problems. Moreover, even though substantially fewer of them opted for aggressive chemotherapy as their illnesses worsened and many more left orders that they not be resuscitated in a crisis, they typically lived almost three months longer than the group getting standard care, who lived a median of nine months.”

Dr. Gail Cooney, past president of the American Academy of Hospice and Palliative Medicine (AAHPM), is an advanced ovarian cancer patient who received concurrent palliative and curative treatment for her disease. *The Wall Street Journal* cites her as saying that she believes that palliative care helps patients “access more difficult treatment regimens” which help them live longer.

Dr. R. Sean Morrison, president of AAHPM, called the study “of critical importance,” and said, “It’s first concrete evidence of what a lot of us have seen in our practices — when you control pain and other symptoms, people not only feel better, they live longer.”

The authors of the report say that one of the major advantages of the study is that participants were not just referrals to a palliative care center, but were recruited in order to obtain a representative sample. Dr. Atul Gawanda, Harvard Medical Center surgeon and author, said, “The field was crying out for a randomized trial.”

Another benefit of the study may be the altered use of health care by advanced cancer patients. The authors noted that significantly more palliative care patients had documented preferences for resuscitation. They also chose less aggressive end-of-life care, including longer hospice stays and reduced chemotherapy. The article says, “Given the trends toward aggressive and costly care near the end of life among patients with cancer, timely introduction of palliative care may serve to mitigate unnecessary and burdensome personal and societal costs.”
An accompanying *NEJM* editorial, “Palliative Care – A Shifting Paradigm,” notes, “Palliative care is provided both within the Medicare hospice benefit (hospice palliative care) and outside it (nonhospice palliative care).” The *NEJM* editorial says that, though palliative care services are increasingly available in US hospitals, the actual use of physicians using palliative care “for their patients remains low.” “The results of this study show,” says the *NEJM* editorial, “that palliative care is appropriate and potentially beneficial when it is introduced at the time of diagnosis of a serious or life-limiting illness — at the same time as all other appropriate and beneficial medical therapies are initiated.”

Dr. Diane E. Meier, director of the Center to Advance Palliative Care, said, “It shows that palliative care is the opposite of all that rhetoric about ‘death panels’ It’s not about killing Granny; it’s about keeping Granny alive as long as possible — with the best quality of life.”


**ORGANIZATION ISSUES GUIDELINES FOR EVALUATION OF SUICIDAL TENDENCIES IN ELDERLY MALE HOSPICE PATIENTS**

Staff members at West Virginia’s Hospice Care recently reviewed the charts of five completed suicides among their patients in the last 10 years. All were elderly men (ages 64-78), retired, with a mean hospice stay of 50 days. All five were alone when they used a firearm to kill themselves. The article briefly summarizes each of the cases, then describes the organization’s recommendations.

According to the authors, none of these suicides were expected. They note that anywhere from one-third to four-fifths of all suicide attempts are impulsive. One cited study reported that less than 10 minutes passed from the thought of suicide to the actual attempt in nearly half the patients.

The article recommends “a need for heightened awareness of suicide risk in terminally ill men with a history of military service, especially as they reach a point in their illness when they are no longer able to care for themselves in their own home.” Other factors which may have played a role include “autonomy as a strong theme in the face of ongoing losses,” the opportunity to be alone, and access to a firearm.

The authors recommend establishing an annual staff education program on suicide prevention. Staff are also encouraged to:

* Develop a checklist for use in identifying patients at risk for suicide.
* Implement a protocol for following high-risk patients. Include inquiries about firearms in
the home, “meticulous attention to symptoms,” “enhanced continuity of care by staff,” and
possible consultation by a psychiatric nurse specialist.
* Identify a cleaning agency that can respond promptly to the site of a firearm suicide.
* Provide prompt and ongoing debriefing and support services to employees, and specifically
tailored bereavement services to families.
* Establish “a baseline for completed suicides in hospice patients by national and/or regional
tracking to include pertinent demographics, risk profile data, and mode of executing the act.”

**RESEARCH & RESOURCE NOTES**

* A scientific advisory panel to the FDA voted 8-to-6 to allow expanded use of Eli Lilly’s
Cymbalta for lower back pain. Cymbalta has earlier been approved for major depression,
diabetic nerve pain, generalized anxiety disorder and fibromyalgia. If approved by the FDA,
Cymbalta would compete in the lower back pain arena with “Tylenol, aspirin and other anti-
inflammatory drugs, and opioids like codeine and morphine.” Its use could increase Cymbalta’s

* Researchers at Memorial Sloan-Kettering Cancer Center report that the “desire for
hastened death” in patients with advanced AIDS was lessened if the patients were
diagnosed as depressed and responded to treatment for depression. Those who did not
respond to treatment for depression reported little change in their desire for a hastened
death. The lead author said, “Successful treatment for depression appears to substantially decrease
desire for hastened death in patients with advanced AIDS.” (Obesity, Fitness & Wellness Week, 8/28;
Psychosomatics, 2010;51(2):98-105)

* A recent study from Beth Israel Deaconess Medical Center reports that primary care
practitioners (PCPs) treat “approximately 52% of chronic pain patients, pain physicians
treat 2%, chiropractors treat 40%, and acupuncturists treat 7%.” Long-acting opioids such
as methadone, anti-depressants or anticonvulsants are prescribed 50-100% more often by
pain physicians than by PCPs. Twenty-nine percent of PCPs and 16% of pain physicians
reported “prescribing opioids less often than they deem appropriate because of regulatory
oversight concerns.” PCPs are less likely than others to be confident of their ability to
manage musculoskeletal and neuropathic pain, and least likely to favor mandatory pain
education for all PCPs. (Obesity, Fitness & Wellness Week, 8/28; Southern Medical Journal,
2010;103(8):738-47)

* Growth House is offering several modules relating to spiritual training and assessment for
end-of-life and palliative care. All materials are free and may be downloaded from the link below.
(Growth House Website, www.growthhouse.org/spirit/)

* “A Problem Solving Intervention for Hospice Caregivers: A Pilot Study,” in the current
Journal of Palliative Medicine, describes a “structured, cognitive–behavioral intervention
that provides people with problem-solving coping skills to help them face major negative
life events and daily challenges.” Caregivers who enrolled in the study reported a higher quality
of life, less anxiety, an increase in positive esteem, a decrease of the average lack of value of family support, financial impact, impact on scheduling, and health. They also reported “high levels of satisfaction with the intervention.” (Journal of Palliative Medicine, 2010,13(8):937-938, www.liebertonline.com/doi/pdf/10.1089/jpm.2010.0022)

PUBLIC POLICY NOTES

* New York Governor David A. Paterson (D) recently signed a new law which will require patients to be offered information about “options for end-of-life care including hospice, aggressive pain management, palliative sedation, and other palliative care” at the time they are diagnosed with a terminal condition. Patients who do not want the information are not required to receive it, and those who lack the capacity to understand it will have it offered to a proxy or a family member. (New York Assembly Health Committee Press Release, 8/16; Crain’s Health Pulse, 8/17)

* Medscape Today reports that the FDA recently told Medscape Medical News that the risk evaluation and mitigation strategies (REMS) for opioids are on schedule for approval in 2011, and that roll-out and implementation will follow. The approval had originally been scheduled for this summer, but an advisory committee voted against the agency’s plan, resulting in reevaluation and delay. (Medscape Today, 8/13, www.medscape.com/viewarticle/726875)

* Ruben Betancourt’s case (see HNN, 5/17, 6/1, 7/13) will not be decided in the courts after all – the state appellate court has ruled the case moot due to the Betancourt’s death. But the court called on the legislature to clarify who has the authority to withdraw care at end of life. Trinitas Medical Center ignored Betancourt’s daughter’s wishes and took him off dialysis and classified him as DNR. The lower court had ruled that the daughter had the right to make decisions for her father and that the hospital could not contradict those wishes. Trinitas appealed. (The Star-Ledger, 8/17, blog.nj.com/njv_editorial_page/2010/08/nj_court_rightly_urges_legisla.html)

OTHER NOTES

* An editor of the Journal of Palliative Medicine asks, “When Will ‘Usual Care’ in Advanced Illness Be ‘Palliative Care’?” She writes that 20 years ago hospital-based palliative care programs began “describing their positive outcomes,” and other “persuasive” studies were calling for change 15 years ago. “With all the work, effort, money, and evidence to promote quality care for patients with life-limiting illnesses, I am still provoked by the large number of patients who do not receive palliative care consultation,” she says. “As a middle-aged person, I am fearful that I will not benefit from these services as my last days approach. Perhaps we don’t need any more descriptions of the value of palliative care consultation; perhaps we need more evidence from interventions that change the proportion of those who get palliative care compared to those who don’t.” (Journal of Palliative Medicine, 2010,13(8):934-935, www.liebertonline.com/doi/pdf/10.1089/jpm.2010.9801)

* Kate Wells, reporter for Iowa Public Radio, recently presented a short segment on the “communication barriers and information gaps that surround hospice care in Iowa.” The
* Janice Brown's experiences when her mother was dying led her to start an ambassador program for The Visiting Nurses Association and Hospice of Southern California in Claremont.” The purpose of the program is to “help get the word out about end-of-life issues and hospice care,” and the ambassadors are mostly already volunteering with the hospice. They are asked to “simply keep an ear open and if they come across a situation where a person may be comfortable, then talk.” Informational meetings are held every three months, and ambassadors attend to answer questions that participants may have.” (Inland Valley Daily Bulletin, 8/13, www.dailybulletin.com/news/ci_15768573)

* The No One Dies Alone program at Christiana Hospital in Delaware was established because a nurse practitioner had seen too many patients die alone, and the volunteer coordinator was still disappointed that she had not been present when her brother died. So nurse Shirley Brogley and manager Margarita Rodriguez-Duffy looked over the existing programs, and adapted the procedures from one in Oregon. Their program now has 25 volunteers who can be called at any time to sit with a dying patient at the end of life. (The News Journal, 8/17, www.delawareonline.com/article/20100817/LIFE/8170301)

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