Specialist Palliative Care Treatment and Hematological Malignancy

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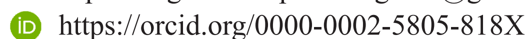
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Palliative care is comprehensive and holistic specialized medical treatment for patients suffering from terminal illness like cancer and for their family. Though does not require either a terminal diagnosis or nearness to death; the term "Palliative care" is generally incorrectly used for terminal care or hospice care.[1] Many review articles suggest cancer patients may have following benefits by early integration of palliative care: 1) reduction in symptom due to disease burden, 2) improvement in quality-of-life and improve emotional state, 3) better-quality of survival and 4) improves care givers outcome; this also applies to those receiving active cancer care treatment. Although there are evidences for many unmet palliative care needs in hematologic cancer patients, these patients are very rarely referred for palliative care as compared to patients with solid tumors.[1-3] This discrepancy suggests a necessity for more education and additional efforts by hematology oncologist to adapt palliative care services in order to meet the needs of patients with hematologic malignancies.[4]

The main aim of palliative care is to improve quality-of-life of both the patient suffering from terminal illness and their family. Palliative care approach includes multidisciplinary team for symptom control, emotional support, and assist in decision making related to treatment for patients having life limiting illness and for care givers. It emphasizes on reduction of suffering of patients and carers throughout their disease trajectory, no matter the diagnosis or the stage of disease. "Palliative care" describes a philosophy of care and does not refer to a specific place or a specific stage of disease.[4] The World Health Organization (WHO)[4] defines palliative care as "an approach that improves the quality-of-life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual." It emphasizes a holistic and comprehensive approach for prevention and treatment of the complications of the illness and its treatment and it applies equally to patients with solid tumors and hematologic malignancies. Early palliative care should be offered in the progression of any prolonged fatal ailment, and these principles can be administered along with curative treatments meant to prolong life.[3] Apart from this, a study by Manitta et al suggests that patients with hematological cancers are less likely than patients with other cancer to avail palliative treatment and those who avail the palliative care are more likely to have it at a later stage in their illness.[3]

Role of Palliative care specialist in oncology

Back et al,[5] focus on three main things for primary palliative care in patients with advanced non-small-cell lung cancer in randomized controlled trial: (1) symptoms management, (2) patients' engagement in activity to facilitate emotional adjustment with illness, accepting the illness and for treatment planning, and (3) filling the gap between the clinicians and the patient, helping the clinicians to interpret for the patient, and the patient for the oncologist.[5,6] The article also suggests that palliative care services have unique characteristic from oncology care services, and the importance of both the clinicians is complementary in the care of patients with advanced cancer.[7] A survey on Hematology/Oncology Fellows' Training in Palliative Care by Buss et al shows trainees of oncology are not adequately trained in areas like management of refractory pain, imparting additional support to the conception that specialist from palliative care is specially skilled having proficiency in complex pain management and counselling beyond that which a typical hematologist/ oncologist provides.[8]

Who can provide palliative care?

Primary clinicians who treat patients with cancer can provide "primary palliative care", or "generalist palliative care" independent of specialist palliative care. Primary palliative care may include all supportive care interventions like management of chemotherapy induced nausea & vomiting,

management of infection, cancer related pain, or discussions about prognosis and understanding of prognosis.[4] Involvement of specialist palliative care in the care of patients with hematologic malignancies dose not necessitate to change the primary palliative care which is already being delivered by the hematologist-oncologists. But specialists palliative care is most beneficial in decreasing high symptom load, for management of complicated symptoms and in challenging conditions with significant ambiguity in prognostication and a comparatively poor prognosis. In patients with high symptom burden and poor prognosis, these specialists can: (1) provide additional proficiency and enable optimum symptom management, (2) provide effective communication, (3) help in facilitation of effective adjustment with disease, accepting, and scheduling treatment goals for patients having a lot of uncertainties and (4) they act as a communicating link between the clinicians and the patient, especially in circumstances where the patients do not open and converse about their doubts, worries and distresses with the primary treating oncologist.[4]

When is Palliative care required in patients with hematological malignancy? [4,9-11]

- Patients with hematologic malignancies experience physical and psychological symptom including pain, mucositis, dyspnea, fatigue, nausea, constipation, and diarrhea, that are equivalent to or greater than that of patients with advanced solid tumors.
- In hematological malignancy, the symptoms load is significantly greater in (1) patients who are on ongoing therapy, (2) those who have poor functional state, (3) in hospitalized patients, and (4) patients with advanced stage of disease. [9-11]
- Following patients with hematological malignancies require specialist palliative care.[4]
  - Patients having high symptom burden or intractable symptoms,
  - In patients for transplantation of allogeneic stem cell.
  - Patients having considerable emotional distress.
  - Those who have difficulty in managing or adjusting along with their disease.
  - Patients having complicated family and social challenges.
  - Those who have significant persistent misapprehension about their disease state and prognosis.
  - Patients with poor prognosis and life expectancy less than one year.

What are the fundamental clinical differences in palliative care approach for patients with hematological malignancy?

There are several reasons as mentioned below, palliative care approach is different in patient with hematological malignancy than solid tumor as suggested by Webb et al in 'Caring for patients with hematological malignancy.'[12]

- Hematological cancers generally respond more to chemotherapy as compared to solid tumors, so usual prognostic evaluations such as functional status do not relate well to various situations in malignant hematology.
- Staging in hematology is different and is mainly based on molecular/genetic features; where ‘advanced disease’ does not mean that it is not curable.
- Hematopoietic stem cell transplantation (HSCT) can differ considerably in both intensity and expected outcomes. Hence, palliative care approaches for this population must be customized accordingly.
- High concentrated or new therapies are common in hematologic malignancies and warrant distinctive methods to combined palliative care that are free of prognosis.
- Evaluating and controlling psychological distress is an area of unmet need in hematologic malignancies presents an opportunity for palliative care incorporation.
- Integrated palliative care at the time of hospital admission for HSCT improves outcomes in patients.
- Hematologists are more hostile with their treatments as compared to solid tumor oncologists and may often misinterpret palliative care as a substitute for hospice or end-of-life care.
- Hematologists frequently treat their patients aggressively near the end-of-life so that they may attain better results and hence struggle to anticipate who will benefit and who will not.
- Transfusion support can have noteworthy benefits of palliative care for several patients with fatal hematological malignancies but may hinder end-of-life care.
- Quality measures indicate that end-of-life outcomes become worse in patients with hematological malignancies, emphasizing a boundless necessity for integration of palliative care and hospice in this population.

Conclusion

There are many patients who have considerable requirements of palliative care services as many problems have not been answered on “how to

effectively incorporate specialist palliative care services in hematology malignancy to meet those requirements."

Patients with hematological malignancy suffer from considerable physical and psychological symptoms that are equivalent to those who have advanced or metastatic nonhematological malignancies at all points in the course of their illness impacting their quality of life and sufferings. Integration of palliative care in the early stages forms the baseline from where the discussion about goals of care, quality of life and advance care planning can be initiated, and this is possible with the active involvement of hematologists.

Appropriate screening of symptoms at all stages of the disease progression starting from diagnosis to remission, will enable earlier intervention and improved support, including palliative care, for patients and caregivers thus impacting the outcome and quality of life simultaneously.

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