Published in final edited form as:

Curr Oncol Rep. 2011 August ; 13(4): 252–254. doi:10.1007/s11912-011-0168-x.

How Important is Palliative Care?

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Rating

Of importance.

Introduction

How important is palliative care? An integrative approach which embraces the administration of both antineoplastic therapy and palliative care is encouraged—but has only sparingly been tested. Yet the rationale for such an integrative approach remains strong: the multidimensional needs of the cancer patient seem best addressed by multidisciplinary teams that incorporate the expertise of both cancer and palliative care specialists. This rationale prompted Temel and others to conduct a randomized, controlled study to examine the effects of concurrent palliative care in patients who were receiving antineoplastic therapy for metastatic non–small cell lung cancer.

Aims

To assess whether antineoplastic therapy alone (standard therapy arm) compared to the combination of antineoplastic therapy and palliative care (early palliative therapy arm) leads to better quality of life in newly diagnosed patients with metastatic non–small cell lung cancer. The primary outcome of this study was a change in previously validated physical and functional well-being questionnaire scores from baseline to 12 weeks after study entry. Secondary end points included assessment of depression, aggressiveness of treatment at the end of life, and survival.

Methods

This trial randomly assigned patients with metastatic non–small cell lung cancer to one of two study arms as summarized above. Patients who were assigned to the early palliative therapy arm met with a member of the palliative care study team within 3 weeks of enrollment and continued to meet at least monthly until death; the study protocol did not specify type of prescribed antineoplastic therapy or frequency of routine visits with the oncologist. Patients assigned to the standard therapy arm, which included only antineoplastic therapy, were allowed to meet with the palliative care team, but these patients had to initiate this request themselves.

Disclosure

No potential conflict of interest relevant to this article was reported.

Patients completed the study questionnaires at approximately 12 weeks either at the clinic or via mail. The electronic medical record was used to gather other patient data, including indicators of aggressiveness of care and death.

Results

One hundred and fifty-one patients participated, 74 in the standard therapy arm and 77 in the early palliative therapy arm. Patients who received early palliative therapy manifested better quality of life (scores of 98 vs 91.5; $P=0.03$), lower rates of depressive symptoms (16% vs 38%; $P=0.01$), lower rates of aggressive care at the end of life (33% vs 54%; $P=0.05$), and improved survival (11.6 vs 8.9 months; $P=0.02$).

Discussion

This clinical trial incorporates several features of a well-designed study: a prospective trial design, a randomization process, well-balanced study arms, a thoughtfully conceived standard therapy arm, which allowed patients to request and receive a palliative care consult if they chose to, and careful medical record–based follow-up, which, of course, is critical to the reliable assessment of outcomes. Thus, these favorable reported outcomes with early palliative care—better quality of life, less depression, less aggressive care, and better survival—appear plausible within the context of this rigorous study design. Although the latter observation is surprising, previous studies had already suggested that palliative care might improve survival [1]. The prospective study design employed by Temel and others serves to add further plausibility to the concept that palliative care can do much more than just assuage end-of-life symptoms.

Comments

In patients with metastatic non–small cell lung cancer, bevacizumab prolongs survival by approximately 2 months, cetuximab by 1.2 months, and, most notable of all, palliative care by 2.7 months [2, 3]. When first reported, the survival advantage derived from the latter drew much attention. Von Gunten described this observation as “precedent-setting for all of us in the palliative field,” and stated further that palliative care “should not be considered a last resort...” [4]. Referring to the Temel study, a website went on to report, “Here’s a study that probably surprised many folks, but it shouldn’t have” [5]. Although it might be tempting to conclude that palliative care truly does prolong life for patients with metastatic non–small cell lung cancer, several aspects of the current study by Temel and others warrant caution when counseling patients about this presumed benefit, as advised by the authors themselves.

First, the fact that this study represents a single-institution effort; that patients, families, and health care providers were not blinded to study assignment; and that survival was a secondary, but not primary end point all leave open the possibility that the palliative care intervention itself perhaps might not have accounted for this observed difference in survival after all. Other potential causal factors range all the way from inadvertent biases that might have favored patients within the palliative therapy study arm to a spurious observation generated by chance alone. Although we as health care providers truly hope that the powerfully positive effects of palliative care might also confer a survival advantage, other potential causative factors need also be considered when interpreting these trial results.

Second, although a very minor point, this study did not report or control for time from cancer diagnosis to study enrollment. All patients had to have had a recent diagnosis of metastatic non–small cell lung cancer, but they were allowed 8 weeks from cancer diagnosis

to study enrollment. Admittedly, randomization would likely ensure that study arms remain balanced with respect to this interval. However, a notable comparative shortening or lengthening of this 2-month interval in one arm might conceivably reduce any observed survival advantage to statistical non-significance. Hence, confirmation of findings with another prospective study would be of value.

Finally, despite careful descriptions of the palliative care intervention, it remains unclear which component(s) of palliative care was/were responsible for this ostensible survival advantage. We learned that “patients who were assigned to early palliative care met with a member of the palliative care team, which consisted of board-certified palliative care physicians and advanced-practice nurses, within 3 weeks after enrollment and at least monthly thereafter...” and that “specific attention was paid to assessing physical and psychosocial symptoms, establishing goals of care, assisting with decision-making regarding treatment, and coordinating care on the basis of the individual needs of the patient.” But what exactly is palliative care? What truly made the difference here? Was it the pain medications, or was it some other more humanistic aspect of palliative care that led to this survival advantage? The absence of a comparable arm that offered a similar degree of attention to patients and family members but without a specific “palliative care” component makes it difficult to discern exactly what aspect of this intervention might have accounted for the observed survival advantage. A clearer understanding of the mechanistic rationale for how palliative care might lead to a prolongation of life and perhaps even a future study design that focuses on the most plausible, survival-enhancing aspect of this intervention might provide even greater acceptance of the conclusion that palliative care helps lung cancer patients live longer.

For now, as we counsel cancer patients about the importance of palliative care, it might be best to describe the important impact of this intervention on controlling symptoms and on improving quality of life. It might also be important to allude to the possibility of a survival advantage. Over time and as more research is conducted in this area, we will be able to counsel patients on all the benefits of palliative care with greater certainty.

Acknowledgments

This work was funded by 5K24CA131099-03.

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