

Being Critical of Critical Care Given to People With Metastatic Cancer: Get Palliative Care Involved

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What Did They Do and Why?

We know intensive care unit (ICU) use is common among patients with cancer. Up to 5% of patients with solid tumors and 15% of those with hematologic malignancies will spend time in an ICU.¹ It is certainly appropriate for a newly diagnosed person with treatable leukemia to do so, but it becomes less appropriate for someone with advanced disease whose main wish is to die at home. In the ICU, in-hospital, 3-month, and 1-year mortality rates are not much different between patients with cancer and the general population, although progressive cancer, fungal infection, and organ failure predicted worse survival.²

In this issue of *JNCCN*, Loh et al examined ICU admissions of patients with metastatic cancer in 2010 to determine whether inpatient palliative care (IPC) consultation had any effect on use of critical care therapies (CCTs), such as invasive mechanical ventilation, dialysis, tracheostomy, gastrostomy tube, and total parenteral nutrition. They used the California State Inpatient Databases to identify patients with metastatic cancer, and then further identified patients who used IPC by the palliative care ICD-9 diagnosis code V66.7, now Z51.5 in ICD-10-CM. Prior studies show that this method has a specificity of 95% to 99% and a sensitivity of 66% to 83%, so Loh et al may have missed about a third of the patients, but all patients with IPC consultations were included.

What Did They Find?

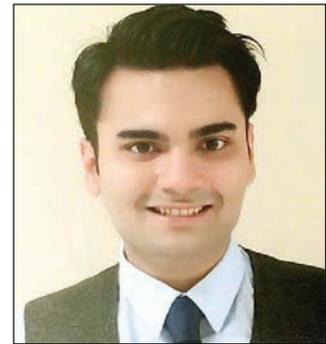
The first important finding was that use of IPC services during hospitalization of patients with metastatic cancer remained low, at 19.8% of admissions. Although no one knows the “right” number, >60% of admissions to a typical academic cancer unit are for symptom management,³ in which IPC could be helpful. The importance of symptom control was shown in a randomized controlled trial of 766 patients with metastatic cancer treated at Memorial Sloan Kettering Cancer Center.⁴ Those who reported symptoms using a patient-reported outcome measure had increased median survival of 6 months and an absolute increase in survival of 6 per 100 at 6 years.⁴

Second, Loh et al found that use of IPC varies by disease: lung, 28%; breast, 22%; genitourinary, 16%; and colorectal cancer, 13%. This is not surprising given that the early studies were performed in lung cancer.

Third, they found that IPC was strongly associated with a high risk of death. Patients who received IPC had an inpatient mortality rate of 63.9% compared with 29.8% in those not receiving IPC. We do not believe that this means IPC kills people or even allows them to die sooner, but rather that calling the palliative care team is a recognition of advanced disease. At least a quarter of all patients who received CCTs died in the hospital without any IPC services. Only 14% of people with metastatic lung cancer were DNR (do not resuscitate) on admission, suggesting that we are still delaying these tough discussions until near the end of life.

The fourth finding was that one could predict with reasonable accuracy which patients would receive an IPC consult. Those more likely to use IPC services were those with lung cancer, a high comorbidity score, DNR status on admission or within 24 hours, and infection, and those treated at a larger hospital (≥ 200 beds).

Finally, costs of care and length of stay were lower in those who received IPC. Counting survivors only, length of stay was shorter (14.3 vs 16 days; $P=.01$) and total costs were lower (\$42,775 vs \$52,387; $P<.01$). This effect was seen almost exclusively in breast cancer survivors, in whom the difference was \$26,350 versus \$60,861. Matching care to what is really wanted has been reported to save money, multiple times in almost every setting.⁵⁻⁸



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What Does This Mean?

Use of IPC is still low among patients with metastatic cancer admitted to the hospital, even in a state where nearly every hospital has IPC consult services. This is a population with known symptoms in need of control, and a median survival of 4.7 months was found in a similar population.³

What in This Study Should Affect Practices at NCI-Designated Cancer Centers?

Palliative care is recommended for every patient with advanced cancer within 8 weeks of diagnosis.⁹ For palliative care to make a difference in hospitalization and financial outcomes, consultation should start at least 3 months before death—otherwise one loses the opportunity to change patterns of care at the end of life.¹⁰ Further, if hospice or home-based palliative care is not in place, patients will end up in the emergency department and be admitted.

For oncologists, the message is, “don’t save the tough conversations until the last hospitalization.” Rather, progression of disease on CT or MRI scans should trigger the question, “would you like to discuss what this means?” In one series of 128 tape-recorded conversations after scan results, only 4 frank discussions of prognosis occurred, even after bad results were given.¹¹ We as oncologists know the game has changed in terms of prognosis and options, but our patients do not. We should make it a reflex to ask the question. And if hospice is foreseeable, we should bring it up and arrange a “hospice information visit”—even in the ICU.

Critical care practitioners should understand that experts have noted that joint management between intensive care and cancer specialists, on both admission and subsequent care, is key in successfully managing these patients.¹²

As physicians become accustomed to easy access to ICUs, it becomes difficult to consider caring for critically ill patients anywhere but in the ICU, even for patients at the end of life. This technological imperative drives not only admission to the ICU but also a culture of using technology liberally in the ICU regardless of a patient’s prognosis. We would add that bringing palliative care specialists into the team can help patients and families define what is medically possible, what their goals are, and how to achieve them.¹³

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