Palliative Haematology

or....
Goals of Care when Cure is not an Option....
Let’s Challenge the Title....
Some Background

• Palliative Care developed on a background of dissatisfaction in End of Life Care in oncology patients in the 60s and 70s

• Oncologists were more concerned about finding the best regimen to cure patients with

• Palliative Care recognized as a sub-specialty in UK in 1987 and in USA in 2006
Who Needs Palliative Care?

• Palliative Care has been extended beyond the realm of cancer

• The WHO defines palliative care as an approach that:
  
  – Improves the quality of life of patients and their families facing the problems associated with life-threatening illness
  
  – Prevents and relieves suffering
  
  – Identifies and prevents pain and other problems, physical, psychosocial and spiritual
Note that patients eligible for Palliative Care do NOT necessarily have to be suffering from incurable malignancy...
The Haematologist and Palliative Care

• What does the Haematologist do:
  – Manages Haematological Malignancies
  – Manages Pre- and Post-BM Transplant Patients
  – Manages Non-Malignant Haematological Disorders
  – Manages Laboratory Issues and reports BMs/BFs
• What Malignancies do we deal with?
  – Acute Myeloid and Lymphoblastic Leukaemias
  – Chronic Myeloid and Chronic Lymphocytic Leukaemias
  – High-Grade Lymphomas
  – Low-Grade Lymphomas
  – Multiple Myeloma
  – Some Rare Disease Rx as Cancer
• What are the Overall Survival Rates for these Disorders?

  – AML 30% 5 year Survival  ALL  30% 5 Year Survival

  – CML 95% 5 year Survival  CLL  60% 5 year Survival

  – High-Grade Lymphomas (Commonest Hodgkin’s & DLBCL)
    • Depends on Whether B- or T- Cell
    • With B-Cell can be anything from 50-80% 5 Year Survival

  – Low-Grade Lymphomas (Commonest Follicular Lymphoma)
    • Depends on Whether B- or T- Cell
    • With B-Cell can be anything from 50-90% 5 Year Survival

  – Multiple Myeloma  5 Year Survival
    • 50% 5 Year Survival
Survival in AML

Overall Survival

Time (years)

Favorable, n = 153
Intermediate, n = 627
Unknown, n = 120
Unfavorable, n = 440
Log-rank p-value < .01
• But let’s not forget that Palliative Care is not only for those ‘Beyond’ curative therapeutic options.

• More therapeutic options are one of the reasons overall and disease-free survival rates increase.

• There are more and more survivors scarred by treatment and these would have benefited from palliative care input.
Studies on Palliative Care in Haematology

• Palliative care was originally intended for patients with Non-Haematological Malignancies

• Looking at survival data, a number of Haematology patients succumb to disease

• Few studies have assessed Palliative Care in Haematology patients
My Impression
(Personal/Self Observation)

• Haematologists tend to NOT discuss Palliative Options with patients after several lines of therapy....why ?
  – Do we feel that Palliative Care equates with failure of treatment ?
  – Do we feel the need to try newer drugs developed (‘leave no stone unturned’) ?
  – Do we equate failure to initiate some active therapy as a failure towards our patients ?
  – Are we afraid to talk about death (Cultural/Religious)?

• Is this my impression or is it really true ?
"You’ve got six months, but with aggressive treatment we can help make that seem much longer."

"Hospice is only for patients who are very close to death, I’m not sure you qualify."

HOSPICE MYTHS
What the Literature Says

• Blood 2013: Thomas W. LeBlanc et al.: Palliative Care for Patients with Hematologic Malignancies: A Profile of Patients with Blood Cancers Referred to the Choice Hospice Network

• Blood 2016: R. Draliuk et al.: Integrating Care in Outpatient Hematology Clinic Increases Patient Satisfaction, Adherence to Care and Decrease Hospital Admissions

Both the 2013 and 2018 Reviews Note:

- Patients with HMs are referred late
- They appear to be more seriously ill
- They appear to have worse physical function
- They have shorter length of stay compared to NHMs
Mr JB

- 50 year old gentleman diagnosed with MM in 2014. Ineligible for Autograft due to Psychiatric/Psychological issues
- Treated with Cy-Bor-Dex 1st Line
- Progressive Disease at 4/12 therapy
- Swapped to Len-Dex
- Treated with Len-Dex and Len Maintenance for 1 Year
- Progressive Disease in 2014/15
- Treated with Pom-Dex and Pom Maintenance for 1 year
- progressed in 2017/18
- Treated with Daratumumab + Dex
- Escalated Daratumumab Therapy since Progressing on Daratumumab
- Admitted with Acute Subdural
- Discussed with Palliative Care
- Patient Passed away within 2-3 Days
What can we learn from this case...

- The patient had been in and out of hospital several times during his disease.
- He may have benefited from hospital-based and community-based palliative care earlier.
Learning Points

• We Haematologists should be educated to recognize when to refer to Palliative Care earlier

• We need to debunk the myth that palliative Care is only for those who are going to die of disease

• We Haematologists should Receive more training in Palliative Care

• We should incorporate Palliative Care in our MDT Pathways to provide a Holistic Approach
...but can the Local Hospital and Community-Based Palliative Services accommodate our ever increasing number of patients?