Palliative Care in Chronic Obstructive Pulmonary Disease: The Case for Early Integration

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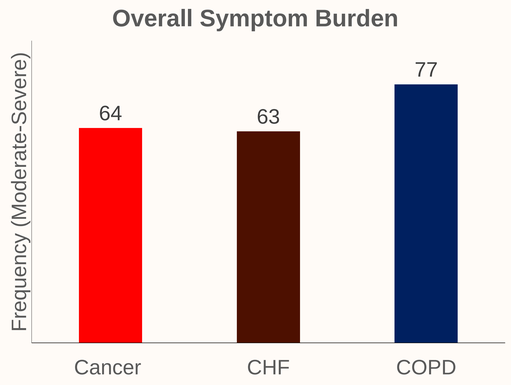
ABSTRACT

Chronic obstructive pulmonary disease (COPD) is the only major worldwide cause of mortality increasing in prevalence. Furthermore, COPD is currently incurable, with oxygen being the only therapy shown to have a mortality benefit. Compared to patients with cancer, patients with COPD experience similar levels of pain, breathlessness, fatigue, depression, anxiety, and have a worse quality of life, but have comparatively little access to palliative care . When these patients do receive palliative care, they tend to be referred later than do patients with cancer. Many disease-, patient-, and provider-related factors contribute to this phenomenon, including COPD's unpredictable course, misperceptions of palliative care among patients and physicians, and lack of advance care planning (ACP) discussions outside of crisis situations. An integrated palliative care approach would introduce palliative treatments alongside, rather than at the exclusion of, disease-modifying interventions. This approach has the potential to address many of the barriers to palliative care in these patients.

BACKGROUND

1. **COPD is a common disease**
   - Age-standardized rate in Canada as of 2013 was 4.0%
   - Estimated to account for over 6 million deaths worldwide per year by 2020

2. **There is significant symptom burden in COPD**

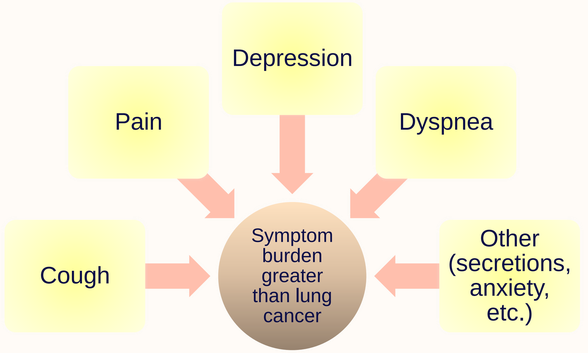


BARRIERS TO PALLIATIVE CARE

- Ongoing perception that palliative care is offered when no other options are available
- Chronic disease course, with gradual decline punctuated by acute worsening, any of which may be fatal
- Patients may be unaware of the progressive and terminal nature of COPD
- Perception that death in an older person may be "expected" and therefore less "deserving" of palliative care
- Many patients have not engaged in ACP discussions with their physicians at all
- Patients and physicians identify outpatient settings as preferable for ACP discussions
- Myth that discussing advanced-care planning will diminish patient's hope, despite research showing that these discussions reduce anxiety
- Many different physicians may be involved, including a respirologist, internist, family doctor, and palliative care specialist

SYMPTOM BURDEN

- Dyspnea is most common, often debilitating despite maximal therapy
- Cough can deprive patients of sleep
- Pain is often under-recognized
- Depression and anxiety (often related to functional/social consequences of disease) more common than in lung cancer
- Upper airway secretions distressful for patients (and family)
- **Overall effect on functioning and quality of life greater than in lung cancer**

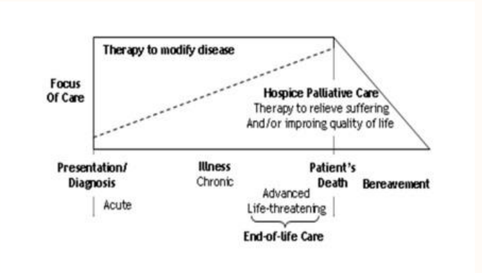


INTEGRATING PALLIATIVE CARE

Early integration leads to better patient outcomes

•Temel et al. (2010) randomized lung cancer patients to usual care or integrated model with early palliative care involvement

•Patients receiving early palliative care: improved quality of life, reduced depression, and **improved survival**



Several factors are important to a successful integration

•Increased education at preclinical and clinical level

•Removing the either/or dichotomy between palliative and curative care at a policy level (where applicable)

•Dispelling the myth of palliative care being synonymous with death (for patients and healthcare professionals)

•All healthcare providers should have a basic knowledge of essential palliative care competencies

REFERENCES/CONTACT

1.Pantilat SZ, O'Riordan DL, Dibble SL, Landefeld CS. Longitudinal assessment of symptom severity among hospitalized elders diagnosed with cancer, heart failure, and chronic obstructive pulmonary disease. J Hosp Med. 2012 Sep;7(7):567-72.
2.Jackson VA, Jacobsen J, Greer JA, Pirl WF, Temel JS, Back AL. The cultivation of prognostic awareness through the provision of early palliative care in the ambulatory setting: A communication guide. J Palliat Med. 2013 Aug;16(8):894-900.
3.Gott M, Gardiner C, Small N, Payne S, Seamark D, Barnes S, et al. Barriers to advance care planning in chronic obstructive pulmonary disease. Palliat Med. 2009 Oct;23(7):642-8.
4.Gardiner C, Gott M, Payne S, Small N, Barnes S, Halpin D, et al. Exploring the care needs of patients with advanced COPD: An overview of the literature. Respir Med. 2010 Feb;104(2):159-65.
5.Knauft E, Nielsen EL, Engelberg RA, Patrick DL, Curtis JR. Barriers and facilitators to end-of-life care communication for patients with COPD. Chest. 2005 Jun;127(6):2188-96.
6.Mahtani-Chugani V, Gonzalez-Castro I, de Ormijana-Hernandez AS, Martin-Fernandez R, de la Vega EF. How to provide care for patients suffering from terminal non-oncological diseases: Barriers to a palliative care approach. Palliat Med. 2010 Dec;24(8):787-95.
7.Au DH, Udris EM, Engelberg RA, Diehr PH, Bryson CL, Reinke LF, et al. A randomized trial to improve communication about end-of-life care among patients with COPD. Chest. 2012 Mar;141(3):726-35.
8.Strand JJ, Kamdar MM, Carey EC. Top 10 things palliative care clinicians wished everyone knew about palliative care. Mayo Clin Proc. 2013 Aug;88(8):859-65.
9.Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010 Aug 19;363(8):733-42.
10.Gardiner C, Cobb M, Gott M, Ingleton C. Barriers to providing palliative care for older people in acute hospitals. Age Ageing. 2011 Mar;40(2):233-8.
11.Hardin KA, Meyers F, Louie S. Integrating palliative care in severe chronic obstructive lung disease. COPD. 2008 Aug;5(4):207-20.
12.Von Roenn JH, Voltz R, Serrie A. Barriers and approaches to the successful integration of palliative care and oncology practice. J Natl Compr Canc Netw. 2013 Mar;11 Suppl 1:S11-6.

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