Keys to Supportive Care in Pancreatic Cancer: Early Palliative Care, Improved Communication

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Optimal supportive care for patients with pancreatic cancer is essential. Putting these interventions into practice requires that oncologists and oncology teams incorporate innovations at both the individual and the system level.

The article by Torgerson and Wiebe in this issue of ONCOLOGY provides an excellent guide to medical management of the supportive care issues involved in pancreatic cancer. If all patients with this complex illness were managed as carefully as described by these authors, I suspect that general quality of life would clearly improve. The question I will address in this commentary is, how could we improve the way these issues are managed in busy outpatient oncology clinics?

One method of addressing supportive care issues is to involve an integrated palliative care team from the time of diagnosis. Although this has not been reported specifically for pancreatic cancer, Temel and others have reported a variety of benefits that sprang from the early involvement of an interdisciplinary palliative care team for patients with metastatic non-small-cell lung cancer.[1] Notably, the palliative care consultation team worked physically within the oncology clinic, ensuring ongoing communication and collaboration, and saw patients frequently. The benefits of early palliative care delivered in this way included improved quality of life, reduced symptom burden, better mood, and increased survival. Follow-up analyses of this randomized study showed that patients on the palliative care intervention arm received slightly less intravenous chemotherapy[2] and had better prognostic awareness over the course of their illness.[3] Another key ingredient in helping our patients and their families hope for the best, prepare for the worst, and partner effectively with the oncology team is to improve clinicians’ communication skills. Patients and families clearly value what they hear from their oncologists, yet the communication they receive is often muddled. In one study of oncology fellows, for example, less than 20% used the word “cancer” in disclosing a cancer recurrence to a standardized patient.[4] Oncologists frequently overlook emotional cues, and in one large observational study, oncologists made empathic responses in only 11% of their visits with patients who had advanced cancers.[5] There is clear evidence, however, that communication skills can be improved with training. Fallowfield documented substantial improvements in a large randomized study of senior oncologists in the UK.[5] Back demonstrated even larger improvements in a pre/post study of US oncology fellows,[6] and recently Tulsky demonstrated improvements in oncologist empathy and subsequent patient trust after a CD-ROM-based training intervention.[5] The new frontier for this work is to involve oncology teams. Current practice patterns involve frequent handoffs between oncologists, advanced practice practitioners, nurses, social workers, nutritionists, chaplains, and others. The challenge is to create interprofessional communication that seems to the patient and family like a single continuous conversation, and for the team to create a channel for background communication that enables each professional to approach the patient and family in an up-to-the-minute way. Fallowfield has already reported early efforts in defining what is needed for teams.[7] Optimal supportive care for patients with pancreatic cancer is essential. Putting these interventions into practice requires that oncologists and oncology teams incorporate innovations at both the individual and the system level.

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