The role of palliative and best supportive care in bladder cancer

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Conflicts of interest

Type of affiliation / financial interest	Name of commercial company
Receipt of grants/research supports	Roche (unrestricted research grant)
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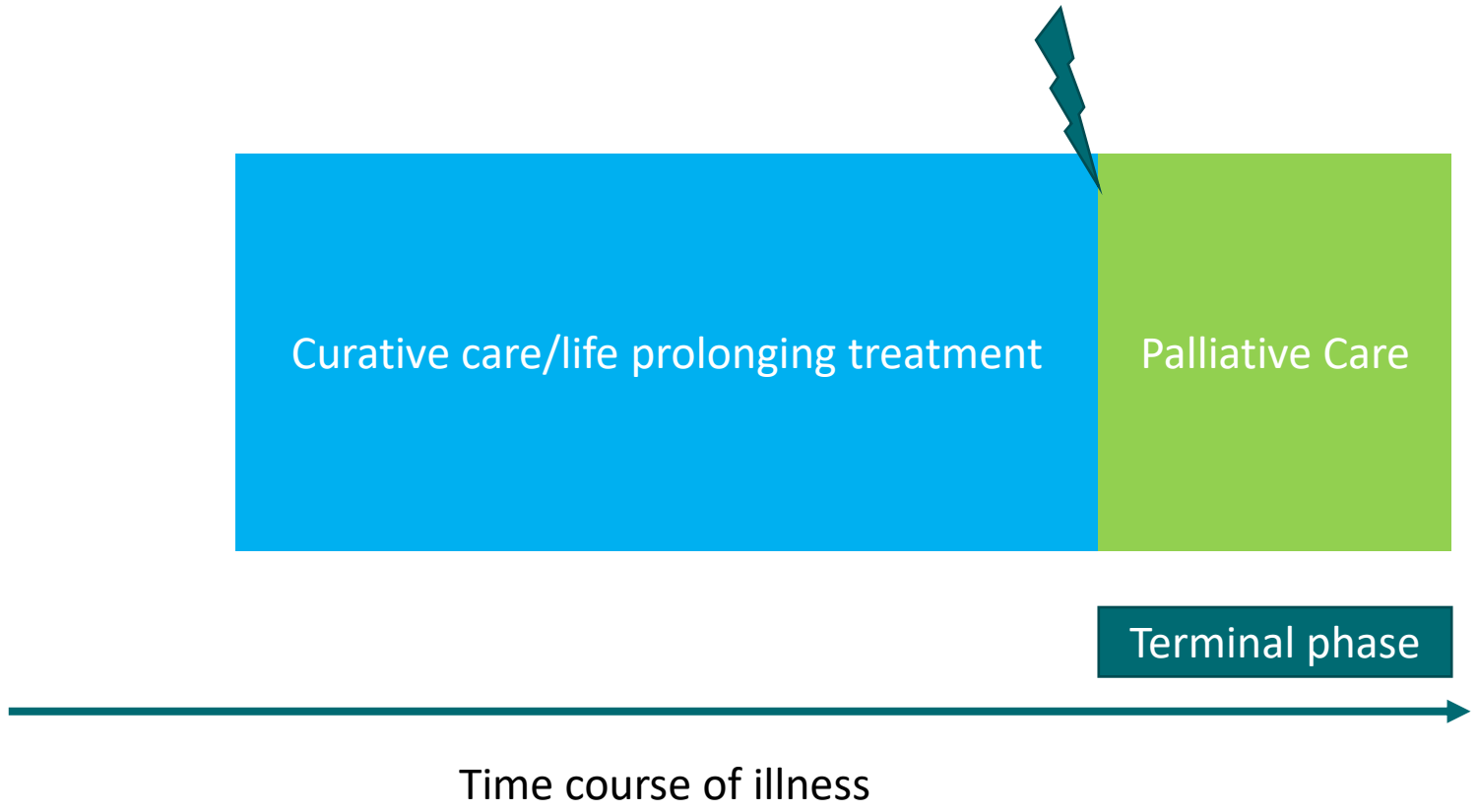
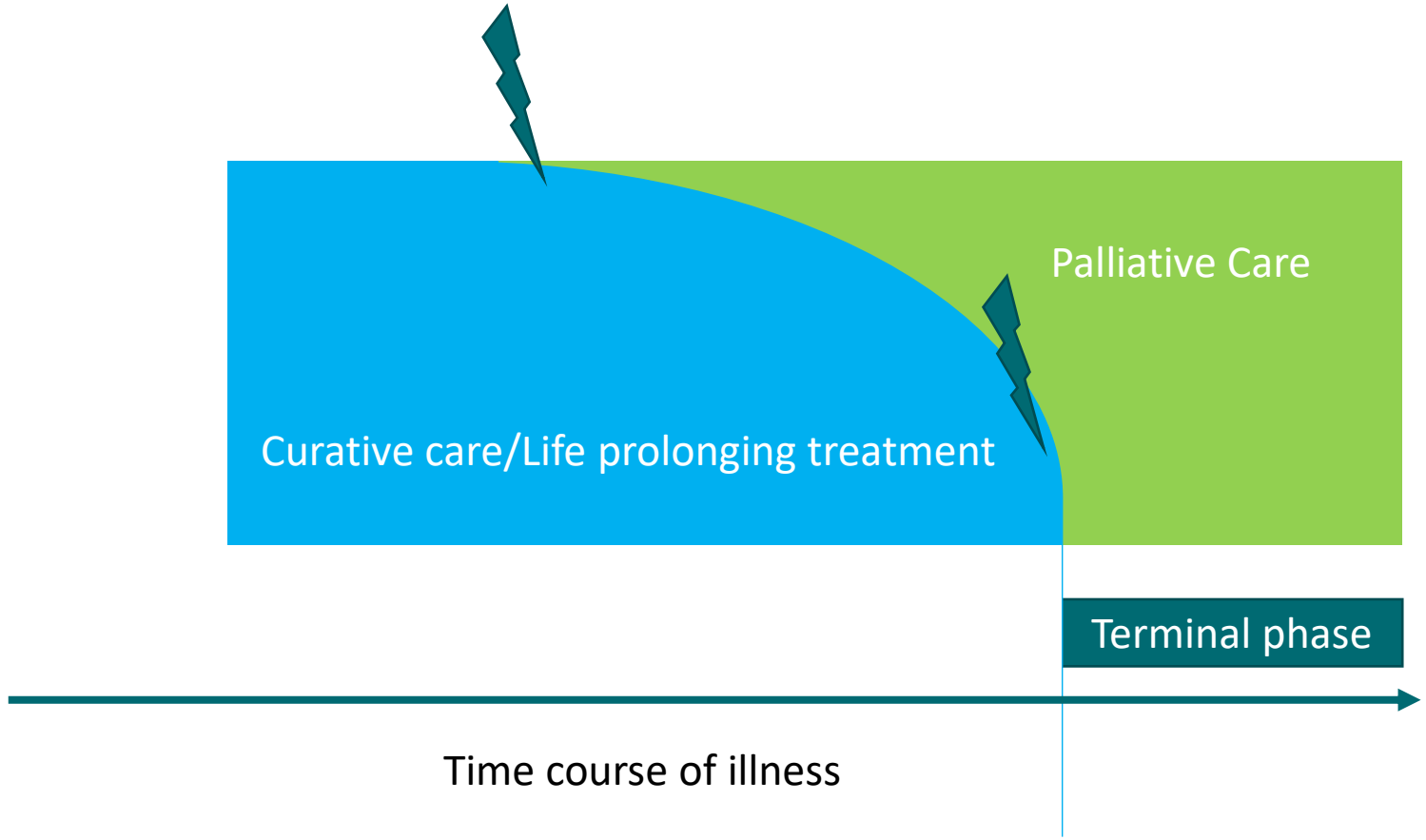
Stock shareholder	None
Other support (please specify):	Speaker’s bureau: Merck, Bayer, Janssen, Ipsen, Teva

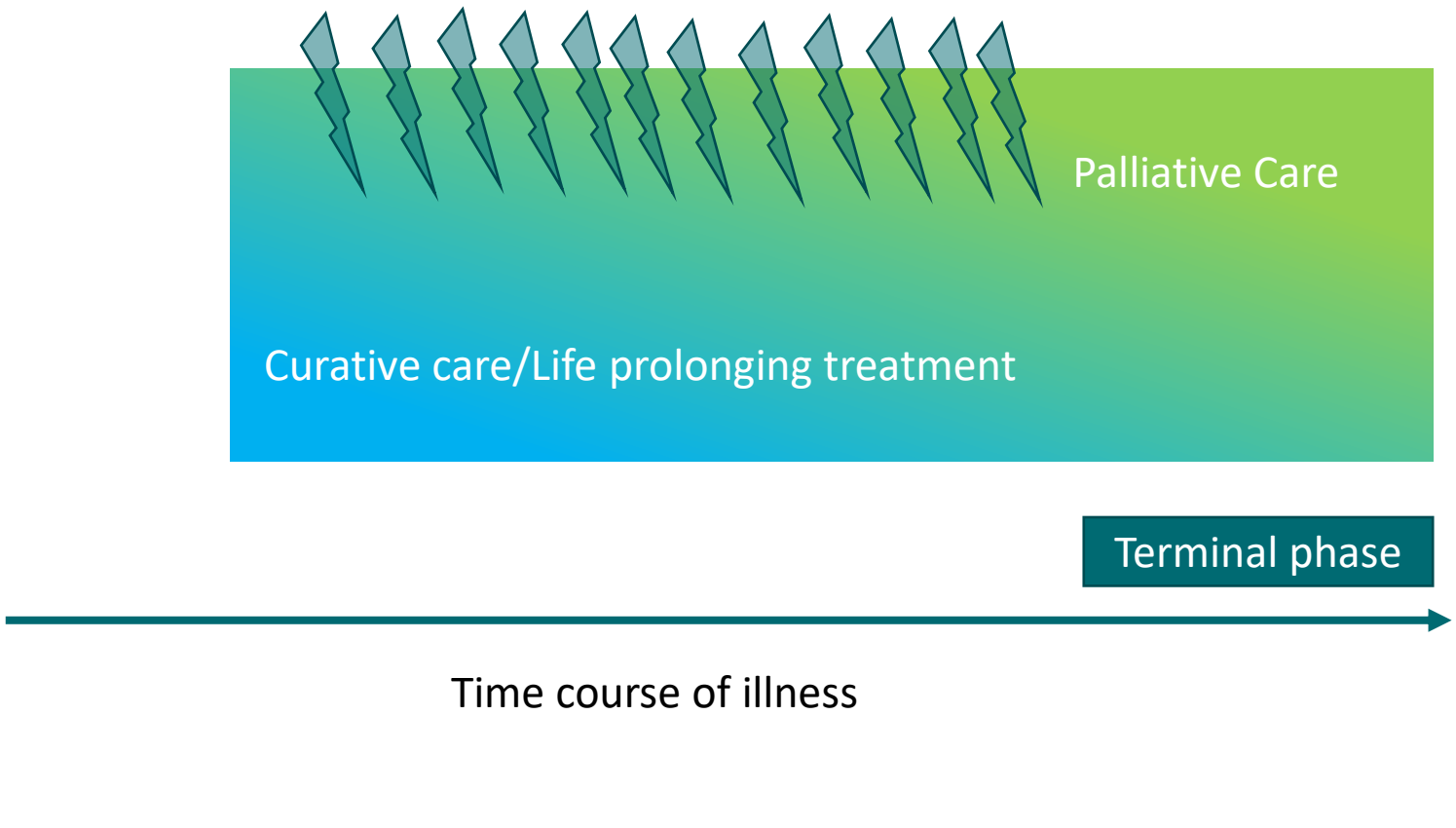
Traditional Model



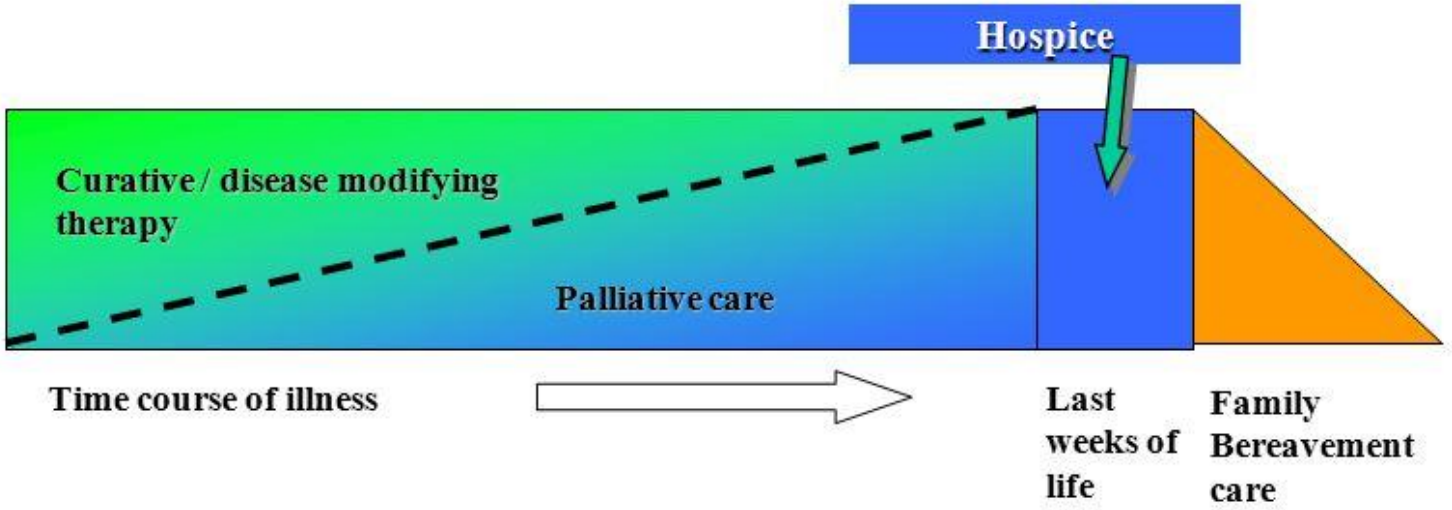
Introduction Model



Integrative Palliative Care Model



Hospice/Palliative Care Interface



Integrated Palliative Care Model

Modified From Emanuel, von Gunten, Ferris. Plenary 3:EPEC series and reproduced in Kinzbrunner. Palliative Care Perspectives, Chapter 1 in Kuebler, Davis, Moore Palliative Practices, An Interdisciplinary Approach, 2005, p. 22.

VITAS®

Early Palliative Care

- Decrease symptoms of advanced disease
- Increase QoL
- Increase Life (?)

JAMA Oncology | Original Investigation

Association of Early Palliative Care Use With Survival and Place of Death Among Patients With Advanced Lung Cancer Receiving Care in the Veterans Health Administration

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Supplemental content

IMPORTANCE Palliative care is a patient-centered approach associated with improvements in quality of life; however, results regarding its association with a survival benefit have been mixed, which may be a factor in its underuse.

OBJECTIVE To assess whether early palliative care is associated with a survival benefit among patients with advanced lung cancer.

DESIGN, SETTING, AND PARTICIPANTS This retrospective population-based cohort study was conducted among patients with lung cancer who were diagnosed with cancer between January 1, 2007, and December 31, 2013, with follow-up until January 23, 2017. Participants comprised 23 154 patients with advanced lung cancer (stage IIIB and stage IV) who received care in the Veterans Affairs health care system. Data were analyzed from February 15, 2019, to April 28, 2019.

EXPOSURE Palliative care defined as a specialist-delivered palliative care encounter received after lung cancer diagnosis.

MAIN OUTCOMES AND MEASURES The primary outcome was survival. The association between palliative care and place of death was also examined. Propensity score and time-varying covariate methods were used to calculate Cox proportional hazards and to perform regression modeling.

RESULTS Of the 23 154 patients enrolled in the study, 57% received palliative care. The mean (SD) age of participants was 68 (9.5) years, and 98% of participants were men. An examination of the timing of palliative care receipt relative to cancer diagnosis found that palliative care received 0 to 30 days after diagnosis was associated with decreases in survival (adjusted hazard ratio [aHR], 2.13; 95% CI, 1.97-2.30), palliative care received 31 to 365 days after diagnosis was associated with increases in survival (aHR, 0.47; 95% CI, 0.45-0.49), and palliative care received more than 365 days after diagnosis was associated with no difference in survival (aHR, 1.00; 95% CI, 0.94-1.07) compared with nonreceipt of palliative care. Receipt of palliative care was also associated with a reduced risk of death in an acute care setting (adjusted odds ratio, 0.57; 95% CI, 0.52-0.64) compared with nonreceipt of palliative care.

CONCLUSIONS AND RELEVANCE The results suggest that palliative care was associated with a survival benefit among patients with advanced lung cancer. Palliative care should be considered a complementary approach to disease-modifying therapy in patients with advanced lung cancer.

Sullivan et al. JAMA Oncology, 2019;5512: 1702-1709

Early Palliative Care RCTs

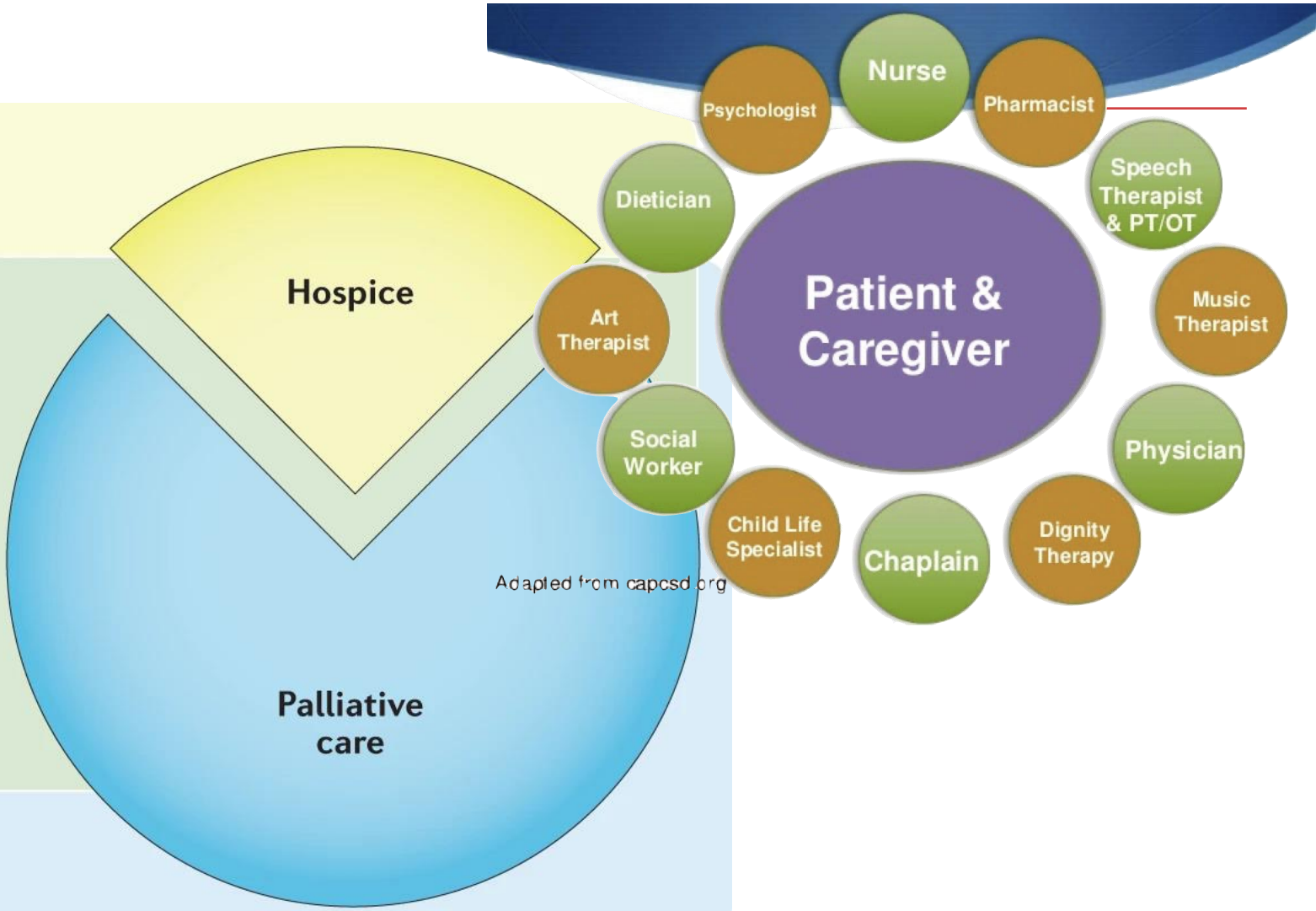
Study (country, year)	Design and comparison	Cohort	Key finding
Zimmermann et al.[110](Canada, 2014)	Cluster-randomization of medical oncology clinics; early palliative care team consultation and regular follow-up monitoring versus standard oncological care	Patients with advanced cancer (22% lung, 30% GI, 17% GU, 16% breast, 15% Gyn) 228 intervention; 233 control	85% completed at least one follow-up survey; at 4 months, **Better QoL** (FACIT-sp,QUAL-E)
Bakitas et al.[111] (USA, 2015)	Randomized control trial, 1:1 block randomization by cancer type and enrolment site; early versus delayed concurrent palliative care and standard oncological care	Advanced cancer (46% lung, 24% GI, 11% breast, 10% other, 8% GU, 5% haematological) 104 early; 103 delayed	53% of the cohort died, **15% fewer intervention patients died at 1 year (*P* = 0.038), median survival was 18.3 and 11.8 months for intervention and control groups,** respectively (NS); no difference in resource use
Maltoni et al.[112] (Italy, 2016)	Multicentre randomized trial, 1:1 block randomization by centre, no blinding; early versus on-demand palliative care	Newly diagnosed metastatic or locally advanced inoperable pancreatic cancer at 21 centres 97 early; 89 on-demand	77% of participants died and there **was no difference in survival** (38% in the intervention group and 32% in the control group); **significantly improved QoL**
Vanbutsele et al.[113](Belgium, 2018)	Randomized controlled trial, 1:1 block randomization by treating department; early, systematic palliative care versus usual multidisciplinary standard oncological care	Advanced solid malignancy (38% GI, 17% lung, 10% head and neck, 9% GU, 8% breast, 8% melanoma) 92 early systemic; 94 usual	**QoL was significantly improved** (EORTC QLQ C30, MQOL. 65% of participants had died and there was **no significant difference in median overall survival** (312 days for intervention and 343 days for control, *P* = 0.97)
Temel et al.[114] (USA, 2017)	Randomized trial, 1:1 randomization stratified by cancer type; early palliative care versus usual oncological care	Incurable cancer (55% lung and 45% non-colorectal GI)	At 12 weeks, quality of life was not significantly improved ; at 24 weeks, **quality of life was improved overall** .

Adapted from Hugar et al. Nat Reviews Urology 2021

- Affirm life and regard dying as a normal process
- Neither hasten nor postpone death

- Determine patients' values and preferences
- Establish care plans in accordance with values and preferences
- Facilitate autonomy, knowledge and choice
- Facilitate communication between patient and caregivers
- Treat both the patient and their family or caregivers
- Provide relief from pain and other distressing symptoms
- Integrate psychological, spiritual and social aspects of care
- Coordinate care between medical teams and facilities

- Integrate with life-prolonging treatment
- Offer support system to help patients live as actively as possible



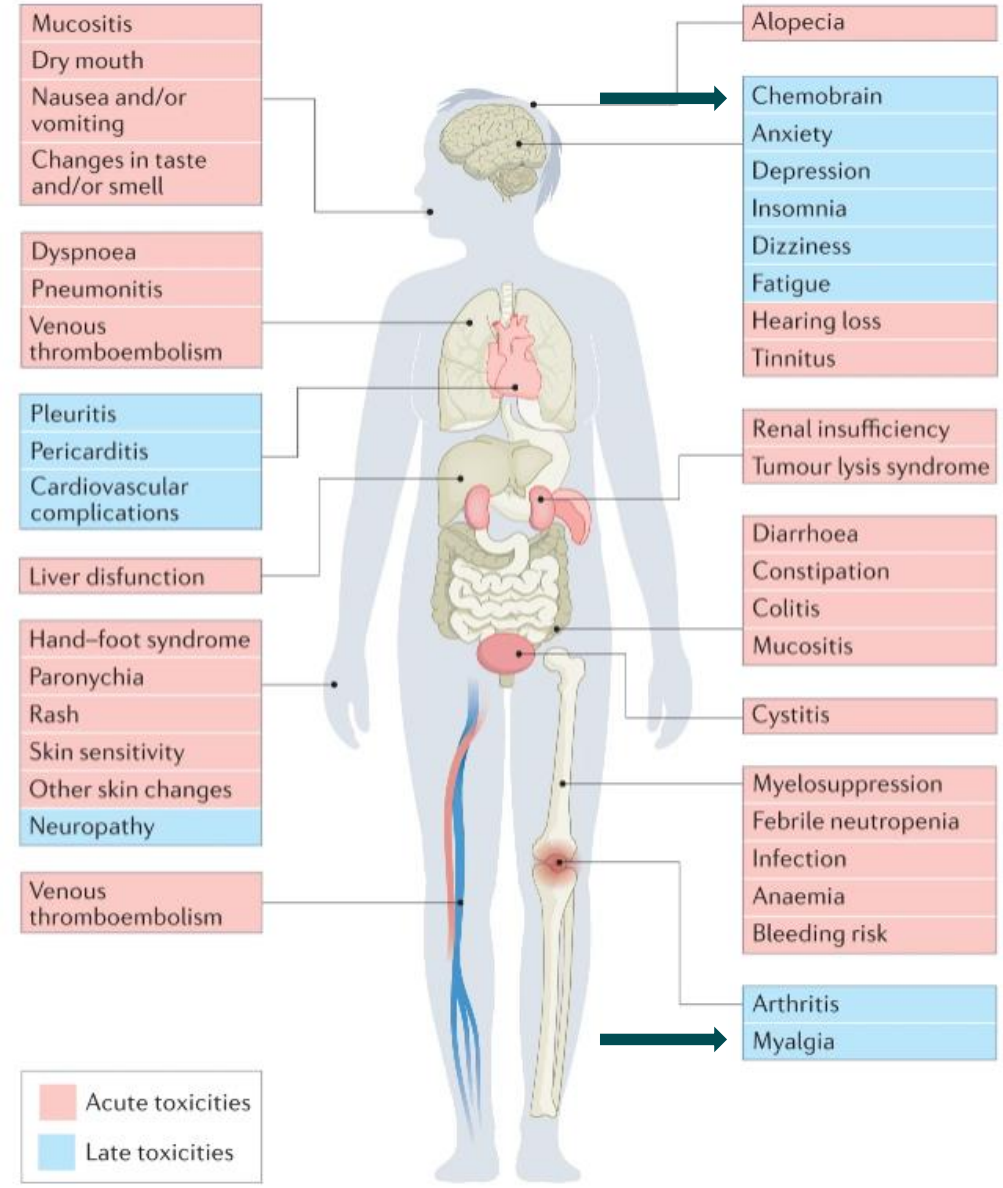
Adapted from Hugar et al. Nat Reviews Urology 2021

Palliative care in bladder cancer

- 4% (2008-2013, university of Pittsburgh)
- After cystectomy: 9.9% (2014-2019, Atlanta GA)

Palliative care in Bladder Cancer: Medical Oncologist

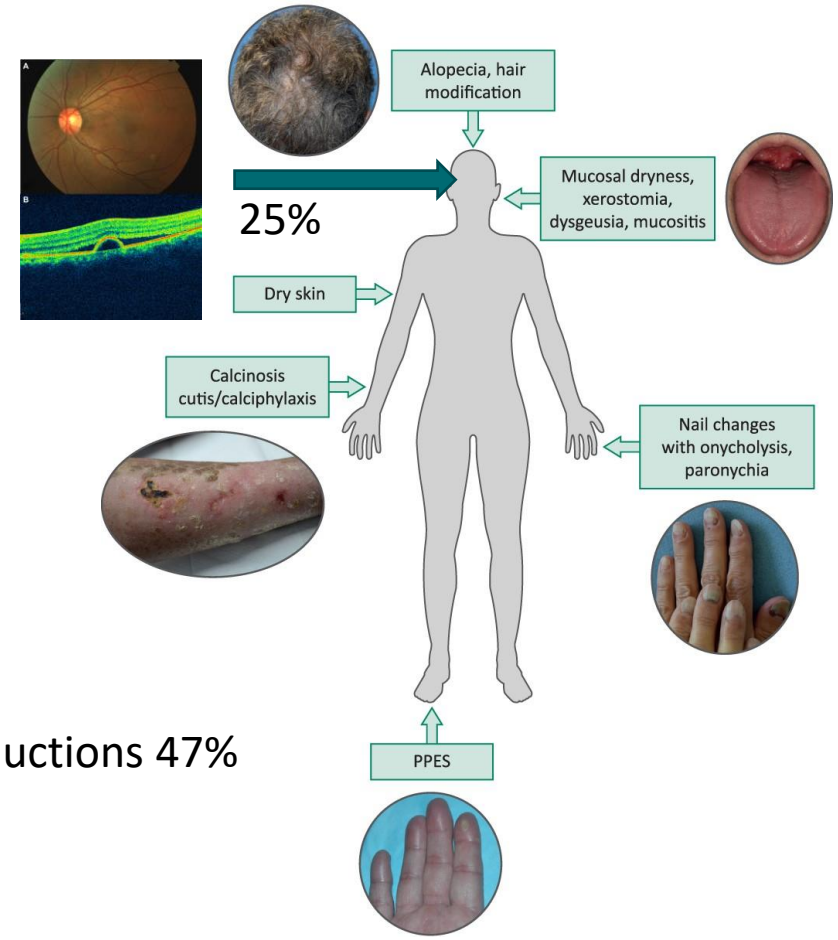
- (Neo-)Adjuvant treatments:
  - More than cure rate/OS benefit
  - Longterm QoL data is lacking for cytostatic chemotherapy regimens.
  - DFS benefit allowed if less toxic (IO)?



Nature Reviews Clinical Oncology, October 2022

Palliative care in Bladder Cancer: Medical Oncologist

- Metastatic setting:
  - AE grades not always capture QoL of patients (eg erdafatinib)
  - Importance of PROMs in trials AND daily clinic



AEs leading to interruption 95% and dose reductions 47%

Adapted from Lacouture et al. The Oncologist, feb 2021

Palliative care in Bladder Cancer: Medical Oncologist

- "No new safety signals reported"

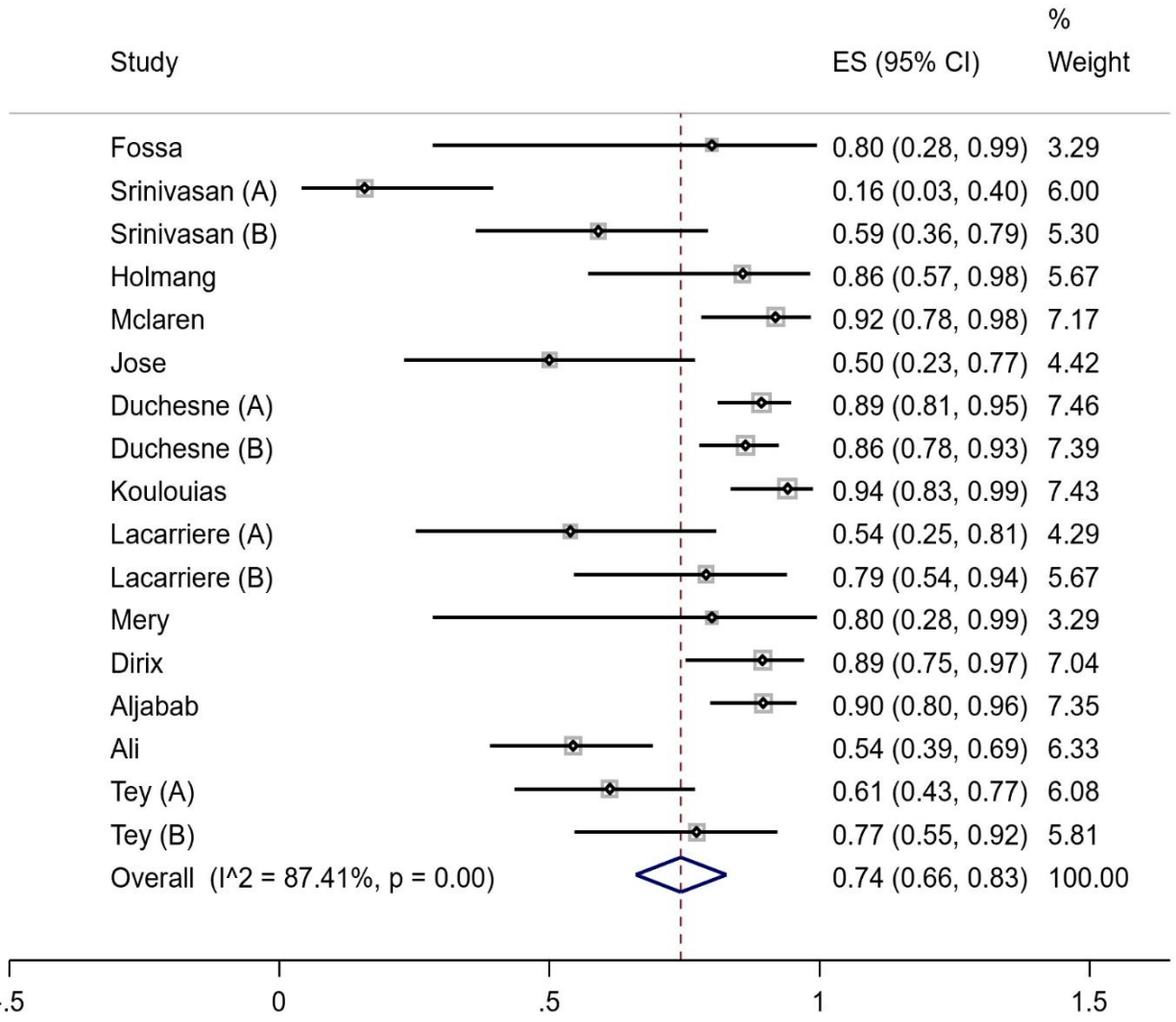
	Grade 1–2	Grade 3	Grade 4	Grade 5*
All treatment-emergent adverse events	29 (29%)	58 (57%)	6 (6%)	8 (8%)

Siefker-Radtke et al The Lancet Oncology, feb 2022

"You've got six months, but with aggressive treatment we can help make that seem much longer."

Severe or medically significant but not immediately life-threatening; hospitalization or prolongation of hospitalization indicated; disabling; limiting self care ADL.

Palliative care in Bladder Cancer: Radiotherapy



Pooled Response Rate of hematuria

74%

Pooled Response Rate of dysuria

58%

Pooled Response Rate of frequency symptoms

71%

Palliative radiotherapy for bladder cancer: a systematic review and meta-analysis. Tey et al. Acta Oncologica. Dec 2020

Palliative care in Bladder Cancer: Radiotherapy

CLINICAL INVESTIGATION | VOLUME 110, ISSUE 2, P412-424, JUNE 01, 2021

Clinical Outcomes of a Randomized Trial of Adaptive Plan-of-the-Day Treatment in Patients Receiving Ultra-hypofractionated Weekly Radiation Therapy for Bladder Cancer

Robert Huddart, PhD • Shaista Hafeez, PhD • Rebecca Lewis, BSc • Helen McNair, PhD • Isabelle Syndikus, MD • Ann Henry, MD • John Staffurth, FRCR • Monisha Dewan, MSc • Catalina Vassallo-Bonner • Syed Ali Moinuddin, MSc • Alison Birtle, MD • Gail Horan, FRCR • Yvonne Rimmer, MD • Ramachandran Venkitaraman, MD • Vincent Khoo, MD • Anita Mitra, FRCR • Simon Hughes, MD • Stephanie Gibbs, FRCR • Gaurav Kapur, MD • Angela Baker, M.Sc. • Vibeke Nordmark Hansen, PhD • Emma Patel, B.H.Sc. • Emma Hall, PhD • on behalf of all HYBRID Investigators [1] • Show less • Show footnotes

Open Access • Published: December 10, 2020 • DOI: https://doi.org/10.1016/j.ijrobp.2020.11.068 •

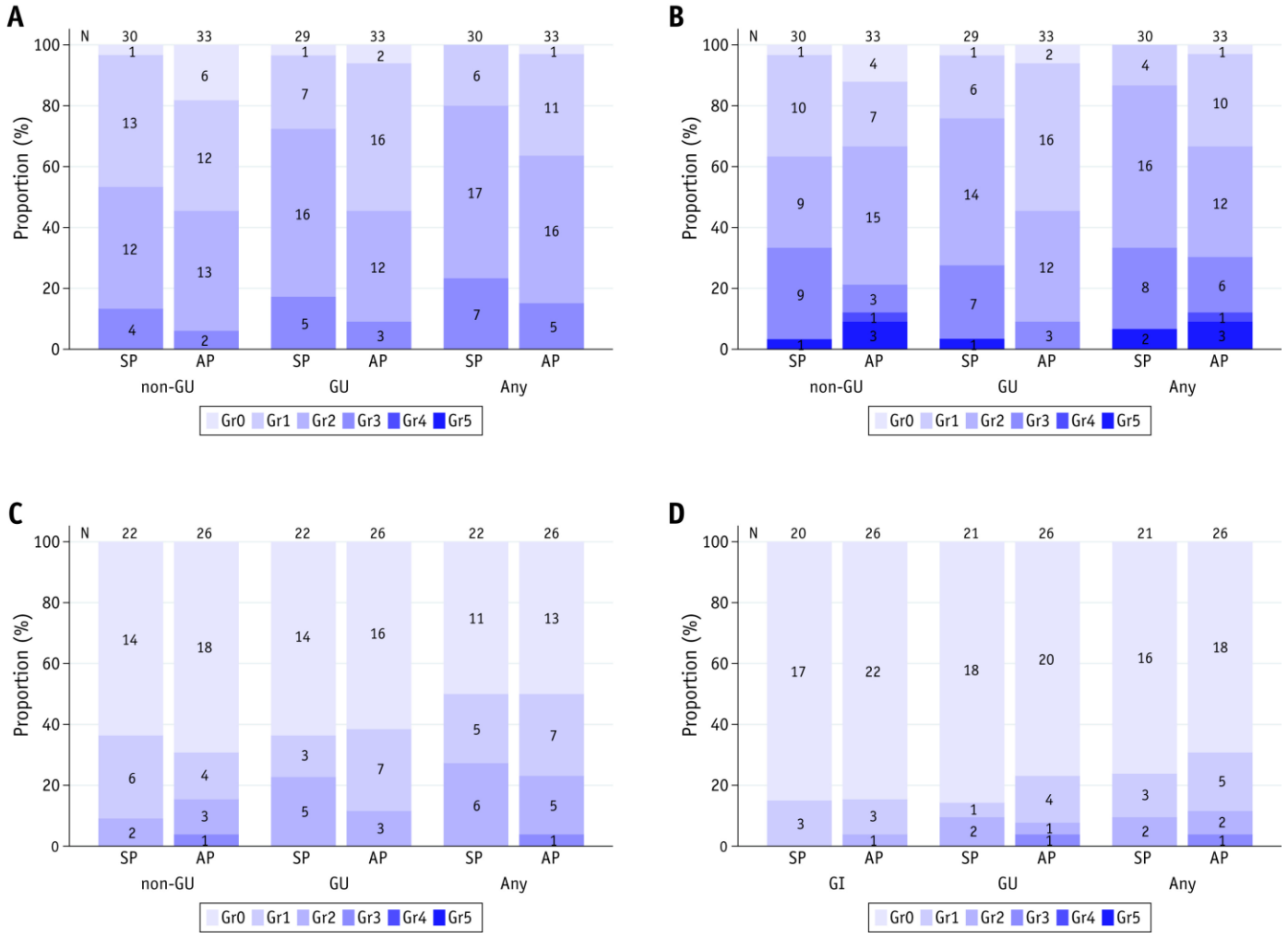
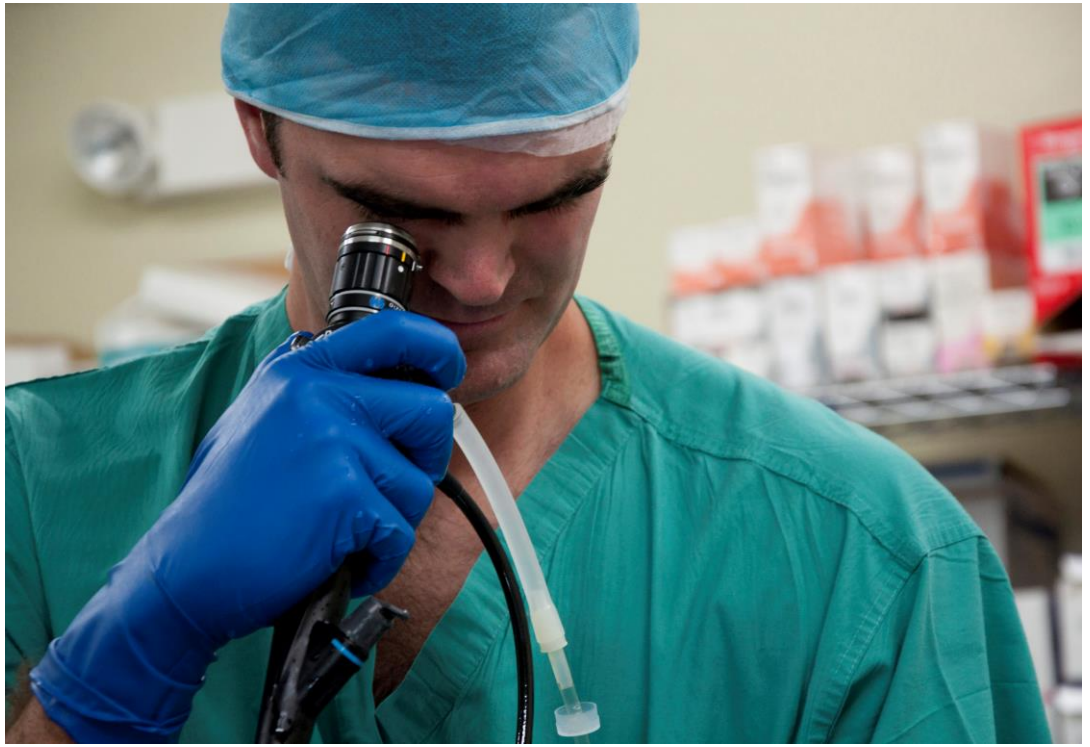


Fig. 2Stacked bar chart of the worst-grade acute toxicity, acute adverse event, late toxicity, and RTOG. Worst-grade (A) acute CTCAE toxicity, (B) acute CTCAE adverse event, (C) late CTCAE toxicity, and (D) RTOG. Adverse event refers to an event that was not present at baseline or was reported at a higher grade than at baseline, and toxicity refers to the subset of adverse events that were categorized as treatment related. *Abbreviation:* CTCAE = Common Terminology Criteria for Adverse Events; GI = gastrointestinal; GU = genitourinary; RTOG = Radiation Therapy Oncology Group.

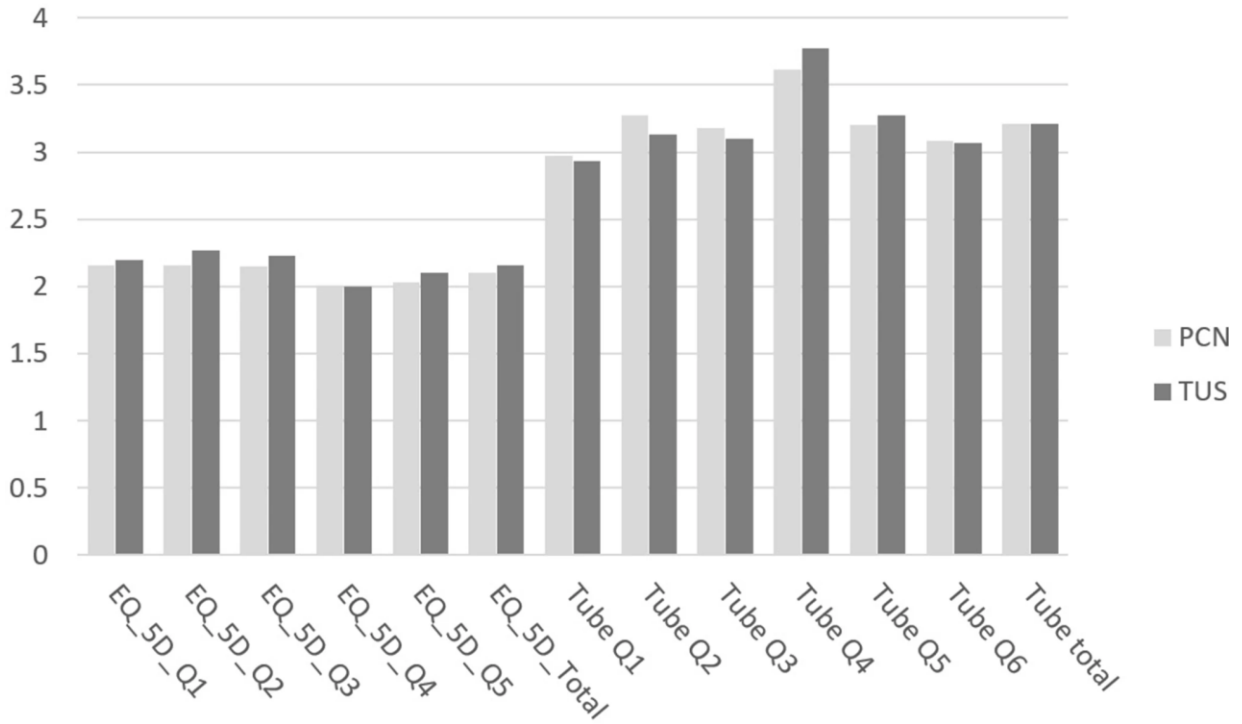
Palliative care in Bladder Cancer: Surgeon

- Urologist: myriad of palliative procedures
  - Ureteral stenting
  - Nephrostomy
  - Suprapubic cystostomy
  - Laser coagulation of the bladder
  - Palliative radical cystectomy



Palliative care in Bladder Cancer: Surgeon

- Nephrostomy vs ureteral stenting

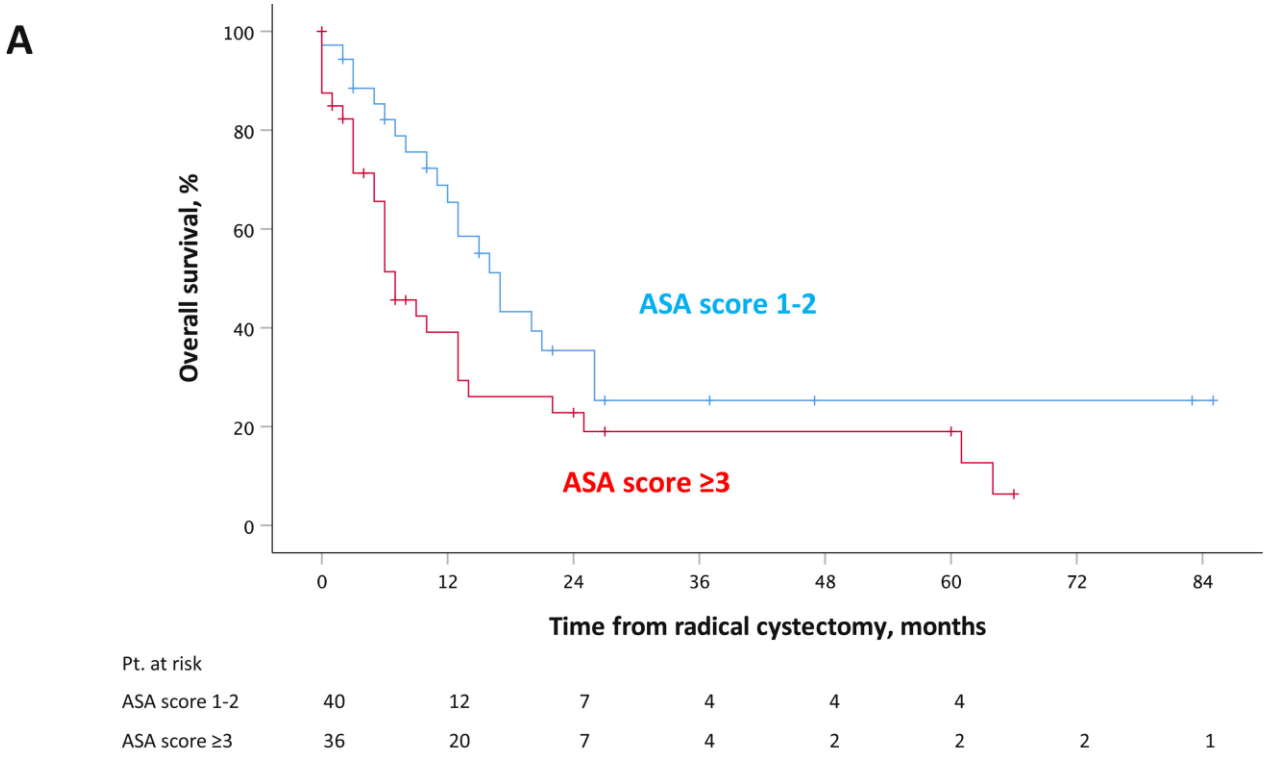


No QoL differences

Shvero et al. Supportive Care in Cancer, 2022

Palliative care in Bladder Cancer: Surgeon

- Palliative radical cystectomy : T4 lesions



No QoL data
OS very poor
High rate of early complications

Maisch et al. Urologic Oncology. June 2021

Palliative care in Bladder Cancer: Surgeon

- Potential curative procedures : MIBC
  - QoL aspects differ greatly between different treatment options:
    - no HRQoL differences **RARC** with extracorporeal urinary diversion vs ORC;
    - patients with a **neobladder** have better overall and physical HRQoL outcomes, but worse urinary outcomes in comparison with ileal conduit patients
    - bladder-preserving **radiochemotherapy** showed slightly better urinary and sexual but worse gastro-intestinal HRQoL outcomes in comparison with RC patients

Rammant et al. QoL Research, 2020

  - Concurrent palliative care post-surgery: improved fatigue, depression, quality of life, and posttraumatic growth.

Rabow et al. *Urol Oncol Semin Orig Investig* 2015

Conclusions

- Palliative care in bladder cancer is **underused**
- **Lack of good QoL data** of palliative procedures
- Palliative care principles (increase QoL and decrease symptoms) benefit bladder cancer patients even in **early stage of the disease**
- Palliative care should be **integrated** in bladder cancer care
- Identification of **lifegoals** will better select the right treatment for the right patient

Talk about (end-of)

life goals