In 2010, Temel et al\(^1\) demonstrated improved outcomes, including longer survival, in patients with metastatic non–small-cell lung cancer receiving palliative care along with usual oncology treatment. A provisional opinion published in 2012 by the American Society of Clinical Oncology further supported early palliative care for any cancer patient with advanced disease or high symptom burden.\(^2\) The Center to Advance Palliative Care, the American Cancer Society, and other national organizations have been instrumental in the advancement of the education, research, and literature base for supportive and palliative care in cancer settings. They have led the charge to support patient and family quality of life and align care with patient goals. Study results have demonstrated improved costs of care while maintaining quality, leading to significant advances in the penetration and growth of palliative care programs nationwide.\(^3\)\(^-\)\(^6\)

However, more than a decade after the Institute of Medicine first studied the quality of cancer care, the obstacles to provision of quality palliative care for patients with cancer remain formidable.\(^7\) Patients frequently do not receive adequate symptom control or management of treatment-related side effects, and decisions about care often are not patient-centered or rooted in the most recent scientific evidence.\(^7\) In Dying in America, the Institute of Medicine’s 2014 consensus report on care of the dying, a committee of experts found that improving the quality and availability of medical and social services for patients and their families could not only enhance quality of life through the end of life, but may also contribute to a more sustainable care system.\(^8\)

In this issue of *Cancer Control*, we present topics on palliative care that highlight the progress made to support the well-being of patients with cancer and the challenges to continued integration and advancement of the field of palliative care in oncology.

Dr Ramchandran and colleagues review the compelling case for palliative care integration, the barriers to progress, and summarize key lessons gleaned from randomized controlled trials in palliative care integration in both the inpatient and outpatient oncology settings. Employing a case-study approach, they discuss means to integrate palliative care into oncology care and offer guidance for sustainability of integration. Among the strategies for scalable integration, the importance of quality measures and metric development is emphasized.

Dr Kamal and associates provide insight into quality improvement for palliative care achieved through collaborations that examine how care is delivered and may be improved. Their article describes endeavors to enhance the provision of quality palliative care at regional and national levels through cooperative efforts within an expansive group of community and academic palliative care providers. The development of the innovative, evidence-based Quality Data Collection Tool and its utilization are described as means to generate quality improvement projects aligned with national quality measurement initiatives. Such projects are an impetus for identifying and addressing troubling symptoms associated with serious illness, such as those frequently encountered in patients with cancer.

The management of symptoms in cancer is updated in Dr Prommer’s article on state-of-the-art palliative pharmacotherapy. The treatment of prevalent symptoms that compromise the well-being of patients and their caregivers throughout the course of cancer care is emphasized, with particular focus on those that engender distress as disease progression occurs. Symptom mechanisms, means of assessment, and management approaches utilizing both medication-based treatments and nonpharmacological therapies are described.

In a second article, Dr Prommer reviews the pharmacological management of cancer pain. The World Health Organization analgesic ladder for the management of cancer pain of varying intensity is described, with detail provided on use of specific agents among the familiar “tried and true gold-standard” medications and more recently available agents. The additional value of adjuvants and interventional pain modalities is represented along with approaches to medication conversions and management of common opioid side effects. The epidemiology of malignant pain and the understanding of opioid responsiveness in the context of opioid receptor interactions are elucidated together with approaches to opioid-resistant pain.

Given the use of opioids for cancer pain, Dr Bell and coauthors explore the basis of opioid analgesic responsiveness with a review of clinical studies that have assessed the connections between the effects of opioids and the genetic variants in the many genes.
that govern their actions. The evidence is examined for associations between specific genetic variants and modulation of opioid response with variability in treatment results. Despite the challenges identified and the need for prospective studies comparing pharmacogenetic-guided opioid treatment to standard practice, the authors’ suggestion of the potential use of genotyping to achieve more effective therapy in cancer-related pain palliation is compelling.

Dame Cicely Saunders, the founder of the modern hospice movement, emphasized the need for palliative care to manage “total pain”: The spiritual, psychological, social, and emotional elements that together with physical distress can cause intolerable suffering. Drs Maltoni and Setola review the controversial topic of palliative sedation for relief of refractory physical symptoms. Their article focuses on the application of proportionate palliative sedation at the end of life, consistent with national and international guidelines, as an ethical modality without effect on survival.

The multifaceted understanding and management of total pain in cancer goes beyond relief of physical suffering and necessitates the integration of psychosocial care. Drs Jacobsen and Lee review progress in this area, describing the application of standards, key clinical practice guidelines, and quality monitoring. They describe the effect of such monitoring on quality in psychosocial care. Models are provided to demonstrate efforts to enhance provision of psychosocial care by implementing such standards and guidelines in community settings.

Dr Bakitas and colleagues discuss the limitations to access and the dissemination of comprehensive palliative care for patients with cancer living in rural settings. They have gathered empirical evidence, largely focused on patients with cancer, and describe the present state in rural palliative care research and practice. The article reveals a dearth of research in this arena and a paucity of rural palliative care services, resulting in limited care. However, the successful initiatives described demonstrate opportunities to establish palliative care practice services and standards specific to rural settings.

Dr Rabow and associates describe other areas of importance in community-based palliative care in their article about outpatient oncological palliative care. Recognizing the fundamental but minority role played by hospital palliative care in the context of the totality of palliative care required in oncology is pivotal. The article describes the current state in oncology palliative care and highlights vanguard elements in outpatient oncology palliative care, including the setting and timing of palliative care integration into outpatient oncology, quality and measurement, research, electronic and technical innovations, finances, and the relationship between primary and specialty palliative care.

Specialty palliative care distinguishes the activity of specialty-trained providers managing complex refractory symptoms, existential and psychosocial distress, medical futility, and advanced communications. However, specialty palliative care in oncology also encompasses expert palliative care that may be provided to special populations of patients with cancer who have unique needs. The particular challenges of these groups and their care are described in the articles on palliative care in adolescent and young adult patients with cancer by Dr Donovan and coauthors and palliative care of older patients with cancer by Dr Balducci and associates.

The article by Donovan and colleagues highlights the limited provision of palliative care and research studies on palliative care in adolescent and young adult patients with cancer. Gaps in care with high potential for distress and opportunities for earlier inclusion of palliative care are also identified. The article features guidelines supporting the integration of palliative care, the options for advance care planning, and challenges to implementation in this patient population.

Balducci et al focus on palliative care for older patients with cancer and provide a comprehensive overview of the effects of advancing age. They emphasize specialized palliative care concerns pertaining to this expanding population, a group also frequently affected by nononcological medical issues. The priorities elucidated include setting goals, prevention and management of treatment complications, management of cancer-related symptoms, and management of older survivors of cancer.

Survival prediction principles and recent literature on prognostication are reviewed by Dr Hui in the context of examining clinician prediction of survival in patients with advanced cancer. With emphases on prognostication as a process, the evolution of prognostic factors over time, the variability in prognostic accuracy, and the overriding principle of unpredictability of the exact time of death, Dr Hui highlights the uncertainty in survival prediction. Yet, use of existing validated prognostic models and factors still enable clinicians to provide approximated time frames. These can facilitate clinical decision making in the present, and the future holds promise for multiple opportunities in prognostication research.

We have compiled this compendium of topics in palliative care in oncology in the hopes of advancing our understanding and adoption of palliative care in cancer. Our goal is partnership to enhance patient and caregiver quality of life throughout the cancer continuum. We are gratified with the progress made and motivated by the opportunities that remain.
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