The Interface Between Medical Oncology and Supportive and Palliative Cancer Care

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Traditionally, medical oncology has focused on the active period of diagnosis, treatment and follow-up of cancer patients, and palliative medicine, the pre-terminal and end-of-life phases. Palliative medicine physicians have particular expertise in communication and symptom control, especially, for example, with pain management. Medical oncologists also have need of excellent communication skills and knowledge of supportive care issues, such as the management of emesis, bone marrow suppression, mucositis, neuropathy, and symptoms created by treatment. This article examines the interface between medical oncology and supportive and palliative care to emphasize how each can benefit from the others.

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Medical oncologists have special expertise in prescribing and monitoring systemic anticancer treatment. Frequently, this can be in the adjuvant or curative setting, but many patients under their care will have incurable cancer. Due to the increasing array of disease-modifying medicines, for many patients, cancer is now a chronic illness. The medical oncologist plays a vital role in supporting patients throughout. Prescribing anticancer medicines is arguably the easy part of cancer care. Events after a cancer diagnosis can present some of the biggest challenges a patient has to face. In addition to the physical problems, patients and their families are burdened with psychological, emotional, spiritual, and social difficulties. Many will experience significant symptoms and side effects during their illness. To ensure optimal clinical care medical oncologists must have an extensive range of supportive care skills that reach beyond just choosing the best cytotoxic drugs. These include expertise in identification, assessment, and management of the physical and psychological consequences of cancer and its treatment. It is this aspect which is the interface between medical oncology and supportive and palliative care.

EARLY INTEGRATION OF MEDICAL ONCOLOGY AND SUPPORTIVE AND PALLIATIVE CARE BENEFITS PATIENTS

There can sometimes be confusion regarding what is meant by medical oncology, supportive care and palliative care. In incurable disease, a common perception is of a blinkered focus on maximal active intervention to control cancer and prolong survival using treatments that are often toxic and expensive. Conversely, palliative care (from the Latin palliare, to cloak), which aims to alleviate the symptoms of disease rather than strive to cure or control disease, is frequently perceived as appropriate only for the short period of terminal care. It is seen as a “passive” attitude to cancer control using minimal intervention and as comparatively inexpensive. Traditionally, when no further medical oncology treatments are available, depending on the facilities and expertise available, terminal care may be transferred to a multidisciplinary palliative care team. This old paradigm is now recognized as outdated (Figure 1). 3–4 Supportive and palliative care has to be used alongside oncological therapy to alleviate the side effects and enable maximal drug delivery (Figure 2) and alleviate symptoms. In addition, a number of patients have incurable disease at diagnosis and they are likely to benefit from greater integration and collaboration between specialties earlier in the cancer journey. This can have a synergistic and more holistic effect on patient care. A recent study found that among patients with metastatic...
lung cancer randomized to palliative care alongside oncological treatment or oncological treatment alone, those who received concurrent palliative care had better quality of life and mood but also lived longer despite less “aggressive” treatment (11.6 v 8.9 months). In the incurable setting, especially where life expectancy is short (eg, unresectable cancer of the pancreas), communication between medical oncology and palliative care physicians should be seamless. The medical oncologist must be honest with the patient regarding treatment expectations and the introduction of the palliative care team should take place at the earliest opportunity.

**MEDICAL ONCOLOGISTS NEED TO UNDERSTAND SYMPTOM CONTROL DURING ALL PHASES OF ACTIVE TREATMENT**

Within medical oncology there is a trend towards becoming tumor site super-specialized due to the complexity of treatment. With that comes the risk of being unskilled in important areas such as symptom control. All medical oncologists, in addition to requiring cancer symptom management skills, need to be proficient in treatment-related side effects like emesis, pain, mucositis, diarrhea, and myelosuppression. When delivering adjuvant chemotherapy, some side effects can be dose-limiting and require supportive care to enable patients to receive the full dose of potentially life-saving treatment. Often medical oncologists do this very well but there can be some symptoms that are difficult to treat and liaising with colleagues with supportive or palliative care expertise can be invaluable to enable continued treatment. A key aspect of supportive and palliative care is the ability to fully elucidate the potential multifaceted causes underlying a specific symptom; medical oncologists should also possess these skills. One example is nausea and emesis. Although 5-hydroxytryptamine 3 (5HT3) antagonists have revolutionized delivery of many highly emetogenic chemotherapy regimens,
some patients still have significant symptoms. This may occur due to different factors such as underlying anxiety (so anxiolytics may be helpful), gastric stasis (relieved with prokinetics), or excess gastric acid production (treated with H2 antagonists or proton pump inhibitors). Another circumstance can be bone pain, arthralgia, or myalgia induced by granulocyte colony-stimulating factors or taxane chemotherapy. This can be severe and debilitating, especially in younger patients. In order to maintain dose intensity, appropriate analgesia is required. Sometimes this goes beyond the traditional mild opioid-based analgesics, and drugs for neuropathic pain like gabapentin may be more appropriate.6,7

SURVIVORSHIP AND SYMPTOM MANAGEMENT BEYOND CHEMOTHERAPY

For many patients, cancer treatment does not end with chemotherapy or radiotherapy. For example, women with hormone-responsive breast cancer also undergo at least 5 years of adjuvant anti-estrogen treatment with medicines such as tamoxifen or aromatase inhibitors. The latter, are increasingly recognized as associated with arthralgia,8 and for some women it can be so severe that they choose to discontinue their treatment with medicines such as tamoxifen or aromatase inhibitors. The latter, are increasingly recognized as associated with arthralgia,8 and for some women it can be so severe that they choose to discontinue their treatment9 with potential adverse effects on survival. Many oncologists will be aware that anti-inflammatory medications are recommended10 but have only limited efficacy. In our center, supportive and palliative care input for this adjuvant patient population improved arthralgia and enabled them to continue their prescribed course of treatment.

Oncologists focus on treating or curing cancer. However, with the development of treatments that significantly prolong life, we now recognize that there are some less favorable consequences of successful treatment. There are more survivors who, although cured of their cancer, are significantly disabled by long-term side effects such as fatigue or peripheral neuropathy.11–15 Many oncologists and patients regard these side effects as inevitable and untreatable. Effective collaboration with colleagues in palliative medicine can optimize management of these debilitating symptoms and enhance quality of life. For example, we have established a referral service for peripheral neuropathy that is jointly run by a medical oncologist, a palliative medicine physician, and an anesthesiologist/pain medicine specialist. This combination has enabled successful treatment of neuropathic pain using various interventions that would normally be beyond the expertise of traditional medical oncology training alone, such as the use of ketamine and novel agents.16,17 Our model of integration of supportive and palliative care and medical oncology also facilitates the conduct of well-designed research studies examining important symptom control areas. This has the potential to benefit a wide spectrum of patients.

CANCER SURVEILLANCE AND FOLLOW-UP

Apart from the physical consequences following cancer treatment, there can be significant psychological sequelae. One of the most prominent is fear of recurrence. Paradoxically this is not often brought up by either the patient or oncologist at follow-up consultations. It is not unusual for patients to overestimate their risk of recurrence, especially as their lives may have been dominated by arduous chemotherapy for several months. In appropriate circumstances, like adjuvant chemotherapy for stage II colon cancer (5-year survival may be in the region of 80%), it is especially important that the oncologist reinforces the positive outlook after chemotherapy.

Where possible, cancer surveillance may include monitoring serum tumor markers such as carcinoembryonic antigen (CEA), prostate-specific antigen, or CA125. These tests can be a mixed blessing: on one hand a normal result may be reassuring; however, because no test has 100% specificity or sensitivity, there may be false positives (a raised CEA due to smoking not colorectal cancer recurrence) or false negatives (not all colorectal tumors produce CEA). Understandably, many patients get fixated on their tumor marker results to the extent that minor increases (which an oncologist would view as stable disease) can cause significant psychological distress. Medical oncologists can pre-empt this by educating and managing patient expectations. It is important that they are also able to recognize psychological distress that may require intervention.18,19

WHEN CANCER RELAPSES—GETTING THE BALANCE RIGHT

When cancer relapses, medical oncologists must break bad news to patients. However, even for those with incurable disease, survival may be in terms of many months or years and effective management of their cancer and symptoms is vital. Sometimes, the optimal chemotherapy cannot be used due to side effects from previous treatment. However, one example of successful close collaboration between palliative care and medical oncology that enabled continued anticancer treatment was a woman with stage III ovarian cancer. She had relapsed carboplatin-sensitive disease, but painful peripheral neuropathy precluded repeat treatment. Carefully chosen analgesia reversed her neuropathic pain to the extent that she was later able to receive more carboplatin and had further disease remission.20

When considering different therapeutic options, the medical oncologist has to consider both the impact of
treatment on patient survival and quality of life (ideally with improvements in both). There can be cultural differences in the treatment approach by both physician and patient; in the United States many oncologists prescribe chemotherapy continuously until disease progression, intolerable drug toxicity, or death. Traditionally in Europe treatment tends to be given in intermittent batches, partly to allow recovery from drug toxicities and arguably to reduce the economic impact on government-provided healthcare. The differing impact on survival and quality of life remains a subject of debate and research.

Patients' treatment attitudes also vary between individuals and change according to disease stage and symptoms. Understandably, fear can be a driving force and many find it difficult to live with the knowledge that there is cancer present but do nothing about it. When offered a treatment, patients may wholeheartedly engage in a proactive approach and take comfort from the feeling they are “doing something” or “fighting” their cancer. Others find it more helpful to adopt an accepting approach and try to live with their cancer rather than fight it.

Perhaps the most important and valuable effect of a successful medical oncology consultation is the management of fear. More often than not, this has nothing to do with anticancer drugs. Effective communication skills are the key, and there are useful lessons that can be learned from palliative medicine in this regard. For many, simply being able to express their fears and have them acknowledged can be very therapeutic and transform a situation that previously appeared overwhelming, to one that seems manageable. The skilful oncologist will elicit patient concerns and where appropriate gently correct misconceptions and gain an understanding of how that patient wants to spend the time they have left and which therapeutic approach (if any) is best for them.

THE TIME TO STOP ONCOLOGICAL TREATMENT

Some cancers have many treatments available and therefore during their illness patients may have undergone several different chemotherapy regimens. Oncologists must honestly appraise the value of any further treatment. It is their duty of care to accurately communicate the balance of survival benefit, potential toxicity, or time spent in hospital rather than at home with family. As the number of lines of treatment increases, the likelihood of tumor response decreases. The time to decide not to proceed with further treatment must inevitably come. This can be a difficult period for the patient who has focused on anticancer treatment as a source of hope and does not want to “give up” (or there is pressure from family to “keep fighting”). However, for others, it may come as a relief and they finally have “permission not to fight anymore.” In the United States particularly there is a positive “can do” culture, but just because it is possible to instigate another anticancer treatment, does not mean we should.

Less commonly acknowledged is the fact that oncologists are human too and for reasons they may or may not be aware of, it may be difficult for them to stop a patient’s treatment. Most doctors are adept problem solvers. There may be an underlying need to always be able to “do” something; to still offer hope; to avoid a sense of failure, disappointment, or even grief; or perhaps most crucially, to avoid talking about and facing death. Therefore a strong, mature and open self-awareness is imperative to being a complete and effective oncologist.

THE TERMINAL PHASE OF ILLNESS

When further anticancer treatment is deemed inappropriate, the focus shifts to palliative care. Where services allow, this is traditionally when care of the patient may transfer from the medical oncologist to a multidisciplinary palliative care team that generally consists of physicians, registered nurses, nursing assistants, physiotherapists, social workers, occupational therapists, and chaplains. Their focus is to optimize physical and psychological comfort with care based either in an appropriate institution or the home. The patient may be relieved to be away from the bustle and energy of a hospital environment. Conversely or simultaneously it also can arouse feelings of being abandoned by their medical oncologist. Sometimes, this is unavoidable, but where possible at least the lines of communication should be kept open, and when possible medical oncologists should visit their prior patients in their new environment.

Sometimes the medical oncologist may be responsible for terminal care. Patients have many complex needs. One study showed the median number of symptoms per patient was 11 (range, 1–27), the most prevalent of which was pain. Research has shown there is room for improvement regarding oncologists’ ability to manage pain. However, even for those who manage this well, it is also important they are aware of their own limitations and involve a palliative care physician in a timely fashion. This may provide other methods of pain relief using more specialist drugs such as ketamine; anesthetic intervention techniques like intrathecal infusions and nerve blocks; or complementary methods such as acupuncture and relaxation therapy. It should also be emphasized that discussions and training should be in two directions, ie, it is also important that palliative care specialists know the potential value of active palliation for tumor shrinkage (irradiation of a painful spinal metastases) versus medical oncologists who think that any analgesic beyond paracetemol...
(acetaminophen) should be sorted out by palliative care physicians.

Whichever multidisciplinary team is responsible for care of the dying, it is vital that they have the skills to ensure the dignity and comfort of a dying patient and their family. In the United Kingdom, in order to transfer the best quality for care of the dying from the hospice movement into other clinical areas, the Liverpool Care Pathway is gaining momentum. This is an integrated care pathway with symptom management prompts that can be used at the bedside in hospitals, in care homes, and in patients’ homes. An important prerequisite of use is the acknowledgement that the patient is likely to die within days.

RESEARCH

Traditionally, medical oncology has been an academic specialty with many clinicians dividing time between patient care and research. Most of this research has focused on cancer biology or new anticancer treatments. Health economics is becoming ever more important, and robust research to evaluate the true benefit of third- and forth-line oncological treatments is relevant if controversial. Another key research area is where patients should be managed and by whom. In the United Kingdom, the hospice movement is largely supported by charity rather than government funding. This raises the possibility that early palliative care input, if successful, not only provides good patient care but may actually save government money. Research in palliative care has been contentious. Some believe it is unethical because this population is too vulnerable or should not be burdened with research. We have found this not to be the case and patients are keen to be involved. It is vitally important to encourage research into areas including symptom interventions and the value of emotional support to produce an evidence base for best practice and improve patient care. Moreover, given the increasing survivorship issues and interest among medical oncologists regarding long-term side effects, there is clearly an exciting potential to bridge the gap between medical oncology supportive care and palliative care.

REFERENCES


