

Palliative Care Journal Watch

A partnership between Pallium Canada and several Divisions of Palliative Care and Medicine across Canada and Internationally:

McMaster University, University of Calgary, University of Alberta, Queens University, University of Toronto, McGill University, University of Manitoba, Hadassah-Hebrew University Medical Center



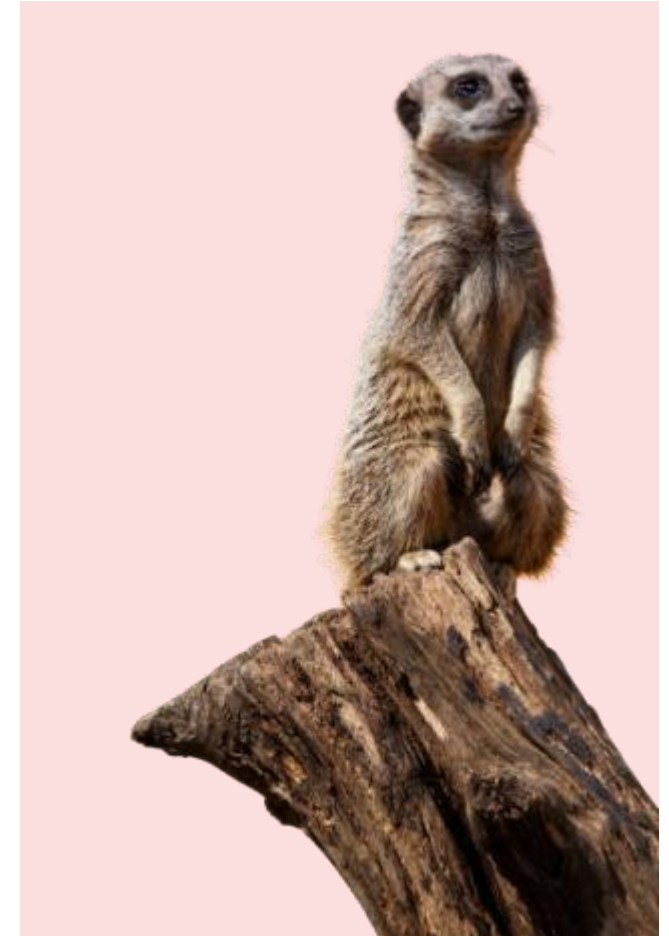
Hosts: Dr. Leonie Herx and Dr. Sharon Watanabe

Guest Panelists: Dr. Aynharan Sinnarajah, Dr. Jean Mathews and Dr. Anna Voeuk

Date: September 16th, 2024

Welcome to the Palliative Care Journal Watch!

- Keeps you up to date on the latest peer-reviewed palliative care literature.
- Led by palliative care experts from several divisions of palliative care/medicine across Canada and internationally.
 - McMaster University
 - Queen's University
 - McGill University
 - University of Toronto
 - University of Manitoba
 - University of Calgary
 - University of Alberta
 - Hadassah-Hebrew University Medical Center in Israel.
- We regularly monitor over 30 journals and highlight articles that challenge us to think differently about a topic or confirm our current practices.



The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.



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What to expect from today's session

- We will present and discuss our featured selections and provide a list of honourable mentions.
- Please submit questions through the Q&A function.
- This session is being recorded and will be shared with registrants within the next week.
- This 1 credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **8 Mainpro+ credits** (each 1-hour session is worth 1 Mainpro+ credit).

Introductions

Hosts:

Dr. Leonie Herx, MD, PhD, CCFP(PC), FCFP

Section Chief, Pediatric Palliative Medicine, Alberta Health Services - Calgary Zone

Director, Rotary Flames House, Children's Hospice & Palliative Care Services
Clinical Professor, Cumming School of Medicine, University of Calgary

Dr. Sharon Watanabe, MD, FRCPC

Director, Department of Symptom Control and Palliative Care
Cross Cancer Institute, Edmonton Zone, Alberta Health Services
Professor, Division of Palliative Care Medicine
Department of Oncology, Faculty of Medicine and Dentistry
University of Alberta

Guest Panelists:

Dr. Aynharan Sinnarajah, MD CCFP(PC) MPH

Chair, Dr. Gillian Gilchrist Palliative Care Research, Division of Palliative Care, Queen's University and Lakeridge Health, ON, Canada

Dr. Jean Mathews, MBBS, MD

Assistant Professor, Division of Palliative Medicine, Queen's University, Kingston, ON, Canada

Dr. Anna Voeuk, MD, MPH, CCFP(PC), FCFP, DTM&H

Assistant Clinical Professor, Division of Palliative Care Medicine
University of Alberta, Edmonton, AB, Canada

Disclosures

Pallium Canada

- Not-for-profit.
- Funded by:
 - Health Canada (through contribution agreements 2001-2007, 2013-2018), Patrick Gillin Family Trust (2013-2016), Li Ka Shing Foundation (2019 to current), CMA (2019 to 2022), Boehringer Ingelheim (dissemination of LEAP Lung courses 2019 to current).
 - Partnerships with some provincial bodies.
 - Revenues from LEAP course registration fees and licenses, sales of Pallium Palliative Pocketbook.

This ECHO program has received financial support from:

- Health Canada in the form of a contribution program.

Disclosures of Hosts/Guest Panelists:

- Dr. José Pereira: Scientific Advisor, Pallium Canada.
- Dr. Leonie Herx: No conflicts of interest to declare.
- Dr. Sharon Watanabe: No conflicts of interest to declare.
- Dr. Aynharan Sinnarajah: No conflicts of interest to declare.
- Dr. Jean Mathews: No conflicts of interest to declare.
- Dr. Anna Voeuk: No conflicts of interest to declare.

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content.

Featured articles

1. Mooney-Doyle K, Ventura Castellon E, Lindley LC. **Factors Associated With Transitions to Adult Care Among Adolescents and Young Adults With Medical Complexity.** Am J Hosp Palliat Care. 2024 Mar;41(3):245-252. doi: 10.1177/10499091231177053. Epub 2023 May 18. PMID: 37199720. <https://pubmed.ncbi.nlm.nih.gov/37199720/>
2. Cheon S, Tam J, Herx L, Nowak J, Goldie C, Kain D, Iqbal M, Sinnarajah A, Mathews J. **Care Coordination Between Family Physicians and Palliative Care Physicians for Patients With Cancer: Results of a Quality Improvement Initiative.** JCO Oncol Pract. 2024 Mar 13:OP2300560. doi: 10.1200/OP.23.00560. Epub ahead of print. PMID: 38478801. <https://pubmed.ncbi.nlm.nih.gov/38478801/>
3. Davis MP. **Novel therapies for nausea and vomiting in advanced illness and supportive cancer care.** Palliat Care Soc Pract. 2024 Jun 6;18:26323524241257701. doi: 10.1177/26323524241257701. PMID: 38855566; PMCID: PMC11159532. <https://pubmed.ncbi.nlm.nih.gov/38855566/>
4. Greer JA, Post KE, Chabria R, Aribindi S, Brennan N, Eche-Ugwu IJ, Halpenny B, Fox E, Lo S, Waldman LP, Pintro K, Rabideau DJ, Pirl WF, Cooley ME, Temel JS. **Randomized Controlled Trial of a Nurse-Led Brief Behavioral Intervention for Dyspnea in Patients With Advanced Lung Cancer.** J Clin Oncol. 2024 Aug 1:JCO2400048. doi: 10.1200/JCO.24.00048. Epub ahead of print. PMID: 39088766. <https://pubmed.ncbi.nlm.nih.gov/39088766/>

Factors Associated With Transitions to Adult Care Among Adolescents and Young Adults With Medical Complexity.

Article Reference:

Mooney-Doyle K, Ventura Castellon E, Lindley LC. Factors Associated With Transitions to Adult Care Among Adolescents and Young Adults With Medical Complexity. Am J Hosp Palliat Care. 2024 Mar;41(3):245-252. doi: 10.1177/10499091231177053. Epub 2023 May 18. PMID: 37199720.

Selected by: Aynharan Sinnarajah

Presented by: Aynharan Sinnarajah

Summary of Key Points:

- Adolescents with Medical Complexity (AMC) are living longer due to advances in healthcare and technology, and are expected to transition to adult healthcare
- Current transition care systems and policies may not reflect the needs of AMC and their families or the impact of social determinants of health
- Goal: Describe the relationship between social determinants of health and high-quality transition care

Methods used:

- Retrospective cohort study using 2019-2020 National Survey of Children's Health data
- Restricted to adolescents aged 12-17 years with medically complex health conditions
- Weighted to composition of each state (so, n=479 adolescents à 444,915 children (weighted))
- Main outcome: Any support for transition to adult health care, created from 3 survey components (Time alone with provider without adult during last visit; Provider actively worked with adolescent to manage care transition to adult provider; Provider discussed shift to adult health providers with adolescent)
- 6 categories of Independent variables based on social determinants of health framework: Economic stability, Neighborhood/physical environment, education, food, community, health care system
- Weighted logistic regression analysis for any support for transition. Also, separate regressions for each outcome component.

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Selected by: Aynharan Sinnarajah

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Key Results/Findings:

- 66% in special education. 42% missed more than 11 days of school. 62% received food assistance. 17% experienced hunger. 53% had ≥ 2 ACEs (adverse childhood experiences)
- Less than a third (27.6%) of adolescents with medical complexity (AMC) received any support from providers in their transition to adult care.
- Receiving special education was negatively related to any transition support, while those who experienced hunger had greater odds of having any support for the transition to adult care.
- Factors negatively associated with providers actively managing the transition included AMC in: 0-199% Poverty level, parent with a college degree, and aggravated parents.

Discussion:

- AMC and their families navigate complex environments with significant influence from social determinants of health
- Important subset have problems paying bills, require food assistance and experience food insecurity. Also, half report parental aggravation, live in unsupportive neighborhoods and 2 or more ACEs. These compound stress on AMC transition.
- Parent-provider relationships and expectations are important, as provider assumptions may impact transition support. E.g. Parents with high education had less support (?assume parents know already). High aggravated parents get less support (?providers engage less, or parents with high expectations)
- Incorporate screening for social determinants and parent/family health into AMC care

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Additional Comments:

- Not a common area of experience for adult palliative care physicians. To be aware, when taking over an AMC coming to adult palliative care services.
- The role of expectations and assumptions between AMC, parents, and healthcare professionals in shaping successful transition experiences. Improving communication and building trusting relationships is important.
- The need for standardized approaches to transition conversations and processes, as recommended by existing guidelines (e.g. Got Transition (<https://www.gottransition.org/six-core-elements/>), Together for Short Lives), to help address barriers and promote more equitable transition care
- The impact of social determinants of health, particularly financial stability, on the transition of AMC to adult healthcare. The findings suggest that poverty can negatively affect the level of support and management provided by healthcare providers during this transition, highlighting the need for further research in this area

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Selected by: Aynharan Sinnarajah

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Strengths:

- Use of a nationally representative dataset to examine the relationship between social determinants of health and transition to adult care among adolescents with medical complexity
- Comprehensive examination of a wide range of social determinants of health
- Analysis of both overall transition support and the specific components of transition support

Limitations:

- Used administrative secondary data, which was not originally intended for the specific research question
- Cross-sectional nature of the survey did not allow for causal conclusions to be drawn
- Reporting bias as self-reported by respondents (over past 12 months)

Why is this article important?

- Important for adult palliative care teams, as we are likely to see AMC adolescents transitioning to adult services.
- Highlights the complex social and environmental factors that influence this critical transition period for AMC
- Inform efforts to improve the equity and quality of transition care

Discussion

Care Coordination Between Family Physicians and Palliative Care Physicians for Patients With Cancer: Results of a Quality Improvement Initiative

Article Reference:

Cheon S, Tam J, Herx L, Nowak J, Goldie C, Kain D, Iqbal M, Sinnarajah A, Mathews J. Care Coordination Between Family Physicians and Palliative Care Physicians for Patients With Cancer: Results of a Quality Improvement Initiative. JCO Oncol Pract. 2024 Mar 13:OP2300560. doi: 10.1200/OP.23.00560. Epub ahead of print. PMID: 38478801

Selected by: Sharon Watanabe

Presented by: Jean Mathews

Summary of key points:

- Patients with cancer are followed by multiple specialists and value the involvement of their family physicians to coordinate their care
- Yet, patients receiving treatments at cancer centres often lose contact with their family physicians.
- Oncologists directly refer patients to palliative care physicians (PCPs), limiting family physicians' (FPs) ability to provide timely primary palliative care and remain involved as the Patient's Medical Home.

Methods used:

- We implemented a quality improvement (QI) initiative aimed at systematically facilitating care coordination between FPs and PCPs.
- A coordination toolkit that includes an introductory letter and describes options for collaborative care was co-designed by PCPs and FPs.
- The toolkit was sent from the PCP to the FP whenever the clinic received a consultation request from an oncologist.
- Responses from FPs regarding their preferred level of engagement with PC determined further care planning in the clinic.
- We measured feasibility, response rate, and qualitative surveys of FPs about the usefulness of the intervention.

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Selected by: Sharon Watanabe

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Key Results/Findings:

- 214 new consultations were eligible over the 6-month implementation period.
- Feasibility for sending the toolkit was 90.0% and response rate for collaborative care preference from FPs was 86.0%, with median response time of 3-4 days.
- 78.9% of FPs indicated they would prefer ongoing consultative care by the PCP, while 18.6% indicated that PCP, or that the FP would provide primary PC after a one-time PCP consultation.
- Qualitative analysis revealed themes including appreciation for the intervention, FP ownership of their role as the Patient's Medical Home, barriers such as lack of time to practice PC and discomfort with complexity of care.

Discussion:

- We successfully implemented a QI initiative to improve care coordination between FPs and PC physicians for patients with cancer.
- It is now standard of care at our oncology palliative care clinic
- The coordination toolkit can protect the patient-FP primary PC relationship and optimize specialist PC resource utilization for complex patients

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Selected by: Sharon Watanabe

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Strengths:

- A major strength of this study is that we were able to achieve a response rate of >85% after sending a coordination toolkit to a busy FP and without any additional incentives.
- That FPs took the time to read through the toolkit and fax a response back to clarify care coordination is testament to the importance that FPs in our region place on their role as the Patient's Medical Home

Limitations:

- The response rate for the qualitative survey on the usefulness of the intervention was low at 34%. Therefore, there might be sampling bias
- As this is a QI initiative, the generalizability and effectiveness of such a toolkit in different health systems is not known.
- We did not systematically survey the patient perspective on care coordination between their FP and the PCP or measure downstream effects on patient outcomes and healthcare utilization

Discussion

Novel therapies for nausea and vomiting in advanced illness and supportive cancer care.

Article Reference:

Davis MP. Novel therapies for nausea and vomiting in advanced illness and supportive cancer care. Palliat Care Soc Pract. 2024 Jun 6;18:26323524241257701. doi: 10.1177/26323524241257701. PMID: 38855566; PMCID: PMC11159532.

Selected by: Leonie Herx & Anna Voeuk

Presented by: Anna Voeuk

Summary of key points:

- The prevalence of nausea and vomiting (N/V) in advanced cancer is ~ 40-60%.
- Serotonin (5HT3) receptor blockers are frequently used but have little proven benefit in treating nausea associated with advanced cancer.
- Mechanisms that generate nausea and vomiting are poorly understood
- Antiemetic recommendations are based on presumed causes of nausea and vomiting.

Summary of other key content:

Review of three medications that have antiemetic benefits, either in controlling chronic N/V (blonanserin, mirtazapine) or treating acute or breakthrough nausea [isopropyl alcohol (IPA)].

Blonanserin

- Atypical antipsychotic, with a high affinity for dopamine D2 and D3 receptors and serotonin receptor 5-HT2A, approved for treatment of schizophrenia in Japan, Korea, and China.
- One retrospective study reported blonanserin 20-40 mg TD to improve nausea not responding to prednisone and prochlorperazine. Other studies suggest possible decrease in risk of delirium.
- Advantages of blonanserin (TD): less risk of extrapyramidal symptoms; ideal if oral route is not possible; reduces risks of drug–drug interactions within the GI tract; lower risk of prolonging QTc interval than haloperidol; ?may not reduce seizure thresholds.
- May have a role in treating N/V in advanced cancer patients. Additional randomized trials using standard antiemetics as active controls needed before recommending it as an antiemetic.

Novel therapies for nausea and vomiting in advanced illness and supportive cancer care.

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Summary of other key content:

Mirtazapine

- Noradrenergic & specific serotonergic antidepressant that can treat symptoms other than depression.
- Reviewed 7 studies (mainly prospective, single-arm). Suggest benefits of mirtazapine on symptoms related to advanced cancer (nausea, depression, sleep, appetite). Few RCTs centered on GI symptoms (N/V, appetite), are negative. Suggests a robust placebo effect, which may affect observed mirtazapine benefits seen in single-arm prospective & retrospective studies.
- Established benefits as a prophylactic antiemetic in chemotherapy induced N/V(? substitute for olanzapine) compared to N/V in advanced cancer
- Improvement in N/V and pruritis associated with spinal morphine anesthesia; reduction in post-operative N/V and post-operative shivering; reduction upper GI symptoms in patients with functional bowel syndromes; improvement in pruritis associated with cancer and uremia.
- Mirtazapine's benefits in treating multiple cancer symptoms need to be explored in randomized trials.

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Presented by: Anna Voeuk

Summary of other key content:

Isopropyl alcohol (IPA)

- IPA explored in randomized trials in management of acute N/V in the emergency department (ED) and postoperative N/V. Other aromatherapy reported for breakthrough N/V from chemotherapy, but no IPA studies published.
- Randomized trials show that IPA (“prep pads”) in ED improved N/V, reduced use of rescue anti-emetics, and reduced overall costs; may have greater pain reduction as additional benefit; and rapid onset of improving nausea (2, 10, 30 min).
- Systematic review of the 3 mentioned randomized trials showed no difference in the number of individuals who vomited between the IPA and placebo groups, suggesting IPA was more effective in reducing nausea than preventing vomiting
- No data to suggest IPA prevents post-operative N/V; controversial whether IPA in post-op setting reduces need for anti-emetics (small, negative studies)
- Advantages to IPA over standard antiemetics: inexpensive, easy to administer, few drug adverse effects or drug–drug interactions, could be used as a bridge to treating acute nausea until standard antiemetics take effect, and can be self-administered as-needed at home if necessary.

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Selected by: Leonie Herx & Anna Voeuk

Presented by: Anna Voeuk

Additional Comments:

- Innovative ways to use currently existing therapies for management of N/V +/- other symptoms
- Overlap of symptoms
- Need for robust research and further studies to add to evidence base

Why is this article important?

It explores innovative therapies that can potentially be used to manage nausea and vomiting in certain circumstances, besides the usual/standard treatments for N/V

Strengths:

- Looks at medications already being used in palliative care setting (mirtazapine) or readily available and inexpensive (IPA) to help in the management of N/V and possibly other symptoms.

Limitations:

- Blonanserin not widely available and limited studies specifically related to N/V mentioned
- Generalizability in palliative care context

Discussion

Randomized Controlled Trial of a Nurse-Led Brief Behavioral Intervention for Dyspnea in Patients With Advanced Lung Cancer.

Article Reference:

Greer JA, Post KE, Chabria R, Aribindi S, Brennan N, Eche-Ugwu IJ, Halpenny B, Fox E, Lo S, Waldman LP, Pintro K, Rabideau DJ, Pirl WF, Cooley ME, Temel JS. Randomized Controlled Trial of a Nurse-Led Brief Behavioral Intervention for Dyspnea in Patients With Advanced Lung Cancer. *J Clin Oncol*. 2024 Aug 1;JCO2400048. doi: 10.1200/JCO.24.00048. Epub ahead of print. PMID: 39088766

Selected by: Aynharan Sinnarajah

Presented by: Aynharan Sinnarajah

Summary of key points:

- Dyspnea is a highly prevalent and distressing symptom in advanced lung cancer, affecting over 70% of patients
- Clinical guidelines (ASCO, ESMO) prioritize non-pharmacologic interventions as first-line therapy for dyspnea management
- Patients with advanced lung cancer face challenges with trial participation and supportive care engagement
- The research team previously conducted a pilot feasibility trial of a nurse-led behavioral intervention for dyspnea, which showed high acceptability and improved dyspnea

Methods used:

- Randomized controlled trial; May 2017 – Oct 2022
- Inclusion criteria: ECOG 0-2; Receiving oncology care; Advanced lung cancer (NSCLC, SCLC) or Mesothelioma; Receipt of oncology care, Modified Medical Research Council Dyspnea Scale (mMRCDS) ≥ 2 (0-4 scale; 2 = On level ground, I walk slower than people of my age, or I've to stop for breath when walking at my own pace; 3 = I stop for breath after walking 100 yards or few minutes; 4 = I am too breathless to leave house or when dressing/undressing)
- Efficacy of a nurse-led, two-session (30-45 mins each) behavioral intervention (in-person, phone, v)deo): Psychoeducation (dyspnea experience, symptom relationship, relaxation response), Breathing techniques, Postural position, Use of handheld fan; Review skills / problem-solve barriers
 - Nurse underwent comprehensive training with PI (Dr Greer), licensed clinical psychologist; Listened to 3 audio recordings of sessions
- Primary outcome: Patient-reported dyspnea (mMRCDS; Cancer Dyspnea Scale (CDS)) at 8 weeks
- Secondary outcomes: QoL, psychological symptoms, activity level (wrist actigraph device)
- Control group received usual oncology care
- Control group offered the intervention after the final 24-week assessment

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Selected by: Aynharan Sinnarajah

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Key Results/Findings:

- Approached 1,961 patients. 358 signed consent. N=247 at end (121 control vs 126 intervention).
- **Both groups improved!** But, nurse-led brief behavioral intervention improved patient-reported dyspnea on the mMRCDS (-0.33) and sense of dyspnea-related discomfort on the CDS subscale, as well as functional well-being on the FACT-L.
- No impact on overall quality of life, psychological symptoms, or physical activity level.
- Longitudinal analyses: Both groups had significantly improved dyspnea on the mMRCDS and CDS total scores from baseline to 24 weeks. Trajectories of these improvements did not differ.

Discussion:

- The intervention focused on teaching patients skills for managing acute episodes of dyspnea, such as pursed-lip breathing, postural positions, and use of a handheld fan.
- The intervention improved dyspnea-related functional disability and discomfort, but did not affect other domains of dyspnea or secondary outcomes like overall quality of life and psychological symptoms.
- Both the intervention and usual care groups showed improvements in dyspnea over time, which could be due to factors like advances in lung cancer therapies, regression to the mean, and the expectation of usual care participants to receive the intervention at the end of the study.

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Strengths:

- Rigorous randomized controlled trial (RCT) design
- Comprehensive assessment of multiple outcomes including dyspnea, quality of life, psychological symptoms, and physical activity
- High intervention fidelity with nurses addressing over 95% of the intervention protocol

Limitations:

- Limited generalizability due to a homogeneous sample from a specific clinical setting
- Higher attrition rate in the intervention group, which may have affected the ability to detect intervention effects over time.
 - Intervention: n=126 → 92 at 8 weeks → 68 at 24 weeks
 - Control: n=121 → 99 at 8 weeks → 79 at 24 weeks
- Intervention focused primarily on functional disability rather than the multidimensional nature of dyspnea
- Lack of systematic assessment of potential adverse events, which may have resulted in under documentation of participants' experiences

Randomized Controlled Trial of a Nurse-Led Brief Behavioral Intervention for Dyspnea in Patients With Advanced Lung Cancer.

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Additional Comments:

- Sample was relatively homogeneous, limiting generalizability to other settings and populations.
- Interestingly both groups improved over time! Is this from advances in lung cancer therapies? Regression to mean? Usual care knew they would get intervention at end?
- Higher attrition rate in the intervention group may have affected the ability to detect intervention effects over time.
- Intervention focused primarily on dyspnea-related functional disability rather than the full multidimensional nature of dyspnea. But balance with scale/acceptability of intervention burden
- Lack of systematic assessment of potential adverse events à under documentation of experiences.

Why is this article important?

- Potential to change practice because it demonstrates the efficacy of a scalable, nurse-led behavioral intervention for improving dyspnea
- Can be targeted at oncology nurses. Nurses do need a bit more time. In very busy oncology clinicians, might be still too much?
- Palliative care clinicians could also learn some of these skills (Table A1, Appendix. Nice list of all the techniques)

Discussion

Honourable Mentions

- Stevens J, Miranda R, Pype P, Eecloo K, Deliens L, De Vleminck A, Pardon K. **Complex advance care planning intervention in general practice (ACP-GP): a cluster-randomised controlled trial.** Br J Gen Pract. 2024 Jan 25;74(739):e78-e87. doi: 10.3399/BJGP.2023.0022. PMID: 38253546; PMCID: PMC10824347. <https://pubmed.ncbi.nlm.nih.gov/38253546/>
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Wrap-up

- Please fill out our feedback survey a link has been shared in the chat!
- A recording of this webinar and a copy of the slides will be e-mailed to registrants within the next week.
- To listen to this session and previous sessions, check out the **Palliative Care Journal Watch** podcast.



NOTE: recordings, slides and links to articles from all our sessions are available at www.echopalliative.com/palliative-care-journal-watch/.

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Thank You



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