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

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Hosts & Panelists: Dr. Jose Pereira, Dr. Leonie Herx, Dr. Sharon Watanabe, Dr. Aynharan Sinnarajah

Date: February 4, 2025

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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Project ECHO Palliative Care - Canada BY Pallium Canada

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

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Professor, Division of Palliative Care Medicine
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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

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.

Mitigating Potential Biases:

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

Featured articles

- Simon ST, Higginson IJ, Bausewein C, Jolley CJ, Bajwah S, Maddocks M, Wilharm C, Oluyase AO, Pralong A; BETTER-B Consortium. **Practice review: Pharmacological management of severe chronic breathlessness in adults with advanced life-limiting diseases.** Palliat Med. 2024 Dec;38(10):1079-1087. doi: 10.1177/02692163241270945. Epub 2024 Sep 12. PMID: 39264397. https://pubmed.ncbi.nlm.nih.gov/39264397/
- George LS, Duberstein PR, Keating NL, Bates B, Bhagianadh D, Lin H, Saraiya B, Goel S, Akincigil A. **Estimating oncologist variability in prescribing systemic cancer therapies to patients in the last 30 days of life.** Cancer. 2024 Nov 1;130(21):3757-3767. doi: 10.1002/cncr.35488. Epub 2024 Jul 30. PMID: 39077884. https://pubmed.ncbi.nlm.nih.gov/39077884/
- Han B, Jones CM, Einstein EB, Dowell D, Compton WM. **Prescription Opioid Use Disorder Among Adults Reporting Prescription Opioid Use With or Without Misuse in the United States**. J Clin Psychiatry. 2024 Jul 15;85(3):24m15258. doi: 10.4088/JCP.24m15258. PMID: 39028542; PMCID: PMC11338316. https://pubmed.ncbi.nlm.nih.gov/39028542/
    - Kolodny A, Bohler RM. **Screened Out - How a Survey Change Sheds Light on Iatrogenic Opioid Use Disorder.** N Engl J Med. 2024 Dec 12;391(23):2183-2184. doi: 10.1056/NEJMp2410911. Epub 2024 Nov 6. PMID: 39504517. https://pubmed.ncbi.nlm.nih.gov/39504517/
- Lykke C, Jurlander B, Ekholm O, Sjøgren P, Juhl GI, Kurita GP, Larsen S, Tønder N, Høyer LV, Eidemak I, Zwisler AD. **Identifying Palliative Care Needs in Patients With Heart Failure Using Patient Reported Outcomes**. J Pain Symptom Manage. 2024 Dec;68(6):561-572. doi: 10.1016/j.jpainsymman.2024.09.002. Epub 2024 Sep 11. PMID: 39270879. https://pubmed.ncbi.nlm.nih.gov/39270879/

Practice review: Pharmacological management of severe chronic breathlessness in adults with advanced life-limiting diseases

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Simon ST, Higginson IJ, Bausewein C, Jolley CJ, Bajwah S, Maddocks M, Wilharm C, Oluyase AO, Pralong A; BETTER-B Consortium. Practice review: Pharmacological management of severe chronic breathlessness in adults with advanced life-limiting diseases. Palliat Med. 2024 Dec;38(10):1079-1087. doi: 10.1177/02692163241270945. Epub 2024 Sep 12. PMID: 39264397.

Selected by: Aynharan Sinnarajah

Presented by: Aynharan Sinnarajah

Summary of Key Points:

- **Chronic breathlessness syndrome** is common
  - Persists despite optimal treatment of underlying pathophysiology and results in disability
  - NOTE: Not acute dyspnea (e.g. COPD exacerbation)
- Evidence for the use of pharmacological therapies (antidepressants, benzodiazepines, opioids, corticosteroids) in the management of chronic breathlessness is weak
- Evidence-based non-pharmacological options should be considered as first-line treatment due to the potential side effects of drugs.
- Opioids are the only drugs with some, albeit weak and conflicting, evidence in clinical trials and should therefore be used with caution and in low dose.

Methods used:

- Scoping review to identify relevant guidelines and systematic reviews
- Focused on the use of antidepressants, benzodiazepines, opioids, and corticosteroids for chronic breathlessness in patients with cancer, COPD, ILD, or chronic heart failure
- Guidelines published in the past 5 years
- Systematic reviews published in the past 10 years
- Primary studies where no systematic reviews were found
- Included additional relevant guidelines, systematic reviews, and primary studies known to the expert panel
- Consensus: 75% approval by international expert panel (20 clinical experts; patient representatives))

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Selected by: Aynharan Sinnarajah

Presented by: Aynharan Sinnarajah

Key Results/Findings:

- 8 international guidelines, 14 systematic reviews, 3 RCTs (antidepressants)
- "Evidence for the use of pharmacological interventions for the relief of breathlessness is weak – including opioids, benzodiazepines, antidepressants and corticosteroids"
- Step 1: Optimise underlying condition which causes breathlessness
- Step 2: Use non-pharmacological options (e.g. calming, breathing techniques, positioning, walking aids, handheld fan)
- Step 3: Pharmacological treatment **carefully**
  - Exceptional circumstances (++distress; dying phase): Can start with pharmacological
  - Low dose opioids titrated carefully; Modified release formulation, where possible
    - Nebulized opioids: Insufficient / Limited
    - Only Cancer, COPD (**but < 30mg MEDD**), ILD
    - Don't know whether helpful for CHF
  - Benzos: ONLY IF anxiety/panic associated with severe, refractory breathlessness
    - <=1mg per day; No long term use unless clear benefit
  - Dying phase: Can add Opioids + Benzos
  - Corticosteroids: No evidence
  - Antidepressants: No evidence (2 large RCTs + pilot RCT all negative)

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Selected by: Aynharan Sinnarajah

Presented by: Aynharan Sinnarajah

Discussion:

- Evidence for pharmacological therapies in managing chronic breathlessness is weak
- Non-pharmacological options should be the first-line treatment, with a staged approach to carefully introducing pharmacological treatments only in selected patients.

Strengths:

- Reviewed some newer RCTs
- Expert panel to provide practice recommendations

Limitations:

- Scoping review methodology did not appraise the quality of the included evidence
- Search strategy may have missed some relevant evidence
- Overall lack of high-quality evidence on pharmacological interventions for chronic breathlessness

Discussion

Estimating oncologist variability in prescribing systemic cancer therapies to patients in the last 30 days of life

Article Reference:

George LS, Duberstein PR, Keating NL, Bates B, Bhagianadh D, Lin H, Saraiya B, Goel S, Akincigil A. Estimating oncologist variability in prescribing systemic cancer therapies to patients in the last 30 days of life. Cancer. 2024 Nov 1;130(21):3757-3767. doi: 10.1002/cncr.35488. Epub 2024 Jul 30. PMID: 39077884.

Selected by:

Adir Shaulov

Presented by:

Jose Pereira

Background:

- Among patients with cancer approaching death, discontinuation of further cancer-directed systemic therapies may enhance pt's QOL.
- The prescribing behavior of the treating oncologist could be an important determinant of treatment continuation
- Extent of continuing systemic treatments closer to EOL varies between oncologists.
- Discontinuation decisions made harder by socioemotional processes: e.g.
    - need for difficult EOL conversations
    - pressure to "do more"
- A better understanding of the extent to which oncologists vary from one another in their use of these therapies at EOL could inform better care of terminally ill cancer patients.

Study Objective

- Determine cross-oncologist variation in the provision of systemic therapies to patients in the last 30 days of life.

Methods:

- Retrospective, observational study in USA
- Used Surveillance, Epidemiology, and End Results–Medicare data
- Used multilevel models to estimate oncologists' rates of providing cancer therapy
    - adjusted for pt characteristics and practice variation.
- Breast, lung, colorectal or prostate cancer
- Pts ≥ 66 or older at death; diagnosed 1999-2017 and died 2012-2017
- Received treatment in last 180 days of life were recorded.

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Selected by:

Adir Shaulov

Presented by:

Jose Pereira

Key Results:

- 17609 pts (62% lung cancer), 960 oncologists and 388 practices.
- Stage 4 cancer: 53%
- Time from diagnosis to death: mean 15 mths,
- Mean age at death: 74 yrs old (IQR 69–79)

- Considerable variability amongst oncologists
  - Oncologists in 95th percentile of prescribing within 30 days of death prescribed at a rate of 45% in comparison with 17% among 5th percentile.
  - A patient treated by an oncologist with a high end-of-life prescribing behavior (top quartile), compared to an oncologist with a low prescribing behavior (bottom quartile), had more than four times greater odds of receiving end-of-life cancer therapy (OR, 4.42; 95% CI, 4.00–4.89).

- Pt variables associated with systemic therapy within 30 days of death:
  - breast ca, white pts, married, stage 1-2, lower age, less months from diagnosis to death.

- Top 25th percentile of prescribing also had a higher proportion of hospitalized patients within 30 days of death (58% vs 51.9%), and higher rate of no or late (<3days) hospice use (75.2% vs 65.4%).

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Selected by:

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Presented by:

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Key Discussion points

- Remarkable variability in practice between oncologists that is not explained by disease and patient related factors.
- Raises questions as to reason for this variability:
  - Prognostication training?
  - Knowledge?
  - EOL conversation training?
  - Personal values?
  - Connections to industry?
  - What can be done to reverse it.

Strengths:

- Large study sample, data is representative of population.

Limitations:

- Not all variables accounted for (e.g. pt preferences)
- Limited to specific ages and diseases
- Only those receiving treatment within 180 days (many pts may have been missed)

Practice impact (Adir´s thoughts)

- Most studies on oncologist effect on EOL practices are qualitative.
- Shows need for continuous education of oncologists in the core skills of palliative care
  - E.g. prognostication and communication.
- “I also wonder if the rise of palliative care as a specialty has unintentionally removed the responsibility for these core skills from the treating oncologist.”

Discussion

Prescription Opioid Use Disorder Among Adults Reporting Prescription Opioid Use With or Without Misuse in the United States.

Article Reference:

Han B, Jones CM, Einstein EB, Dowell D, Compton WM. Prescription Opioid Use Disorder Among Adults Reporting Prescription Opioid Use With or Without Misuse in the United States. J Clin Psychiatry. 2024 Jul 15;85(3):24m15258. doi: 10.4088/JCP.24m15258. PMID: 39028542; PMCID: PMC11338316.

Selected by: Sharon Watanabe

Presented by: Sharon Watanabe

Background:

- Prescription opioids were involved in 20.7% of opioid deaths in US in 2021.
- Prescription-related opioid use disorder (POUD) is commonly considered to impact a subset of people with prescription opioid misuse.
- Public health/clinical efforts to mitigate POUD have focused on prevention of/ screening for opioid misuse.
- Prior to 2021, the National Survey on Drug Use and Health (NSDUH) asked about POUD symptoms only in respondents reporting prescription opioid misuse.
- However, POUD can also occur in people not reporting opioid misuse.

Methods:

- 2021 NSDUH: Nationally representative data from 47291 adults
- Computer-assisted self-administered interviewing (private, confidential)
- Past year prescription opioid use, misuse, symptoms/severity of POUD (DSM-5) regardless of misuse status
- Tolerance, withdrawal omitted in persons without misuse
- Other substances, mental health, physical health/functional status, substance use treatment

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Selected by: Sharon Watanabe

Presented by: Sharon Watanabe

Key Results:

- 27.0% (68.5 M, extrapolated to US population) used prescription opioids
- 12.1% (8.3 M) misused prescription opioids
- 7.0% (4.8 M) had POUD
- Of persons with POUD, 62.0% did not report misuse (49.1% mild/11.0% moderate/1.9% severe); 38.0% did report misuse (15.4% mild/9.4% moderate/ 13.2% severe)
- Among adults with cancer on prescription opioids, 7.1% had POUD without misuse (unable to estimate prevalence of POUD with misuse)
- Prevalence of receiving treatment for POUD 3.5 x higher in adults reporting opioid misuse with than those who don't

Key Discussion Points:

- Moderate-to-severe POUD is more frequent among adults who report misusing prescription opioids than those who don't.
- However, most adults with POUD do not report misuse and could be overlooked for treatment.
- Need to screen for and treat POUD among adults taking prescription opioids regardless of whether they report misuse or not.

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Selected by: Sharon Watanabe

Presented by: Sharon Watanabe

Strengths:

- Validated nationally representative survey
- Robust response rate of 47.0%

Limitations:

- Cross-sectional
- Excluded some populations with higher rates of POUD, e.g., unhoused, incarcerated
- Recall and social desirability bias

Screened Out - How a Survey Change Sheds Light on Iatrogenic Opioid Use Disorder

Article Reference:

Kolodny A, Bohler RM. Screened Out - How a Survey Change Sheds Light on Iatrogenic Opioid Use Disorder. N Engl J Med. 2024 Dec 12;391(23):2183-2184. doi: 10.1056/NEJMp2410911. Epub 2024 Nov 6. PMID: 39504517.

Selected by:

Sharon Watanabe

Presented by:

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Additional Comments:

- Estimated prevalence of OUD in US jumped from 1.6 M in 2019 to 6.1 M in 2022 by including persons who use prescription opioids as prescribed
- Most persons with OUD were prescribed opioids for pain (4.8 M)
- Most persons with POUD don't misuse their medications (3.0 M)
- Assessing whether people using opioids for pain have OUD can be challenging.
- Study findings may help to explain why some people are unable to taper off opioids and why switching to buprenorphine often improves outcomes

Practice Impact:

- Be aware that persons who are prescribed opioids in the context of life-limiting illness can develop OUD, if they are exposed long enough
- They do not necessarily demonstrate aberrant behaviours
- Screening is needed so that treatment can be offered and adverse outcomes mitigated; however, DSM 5-based screening instruments appropriate in the palliative care context have yet to be developed
- Screening for risk of developing OUD is still helpful
- Limit exposure to opioids (i.e., taper dose if underlying disease is improving; buprenorphine may have a role if long-term opioid therapy is warranted)

Discussion

Identifying Palliative Care Needs in Patients With Heart Failure Using Patient Reported Outcomes

Article Reference:

Lykke C, Jurlander B, Ekholm O, Sjøgren P, Juhl GI, Kurita GP, Larsen S, Tønder N, Høyer LV, Eidemak I, Zwisler AD. Identifying Palliative Care Needs in Patients With Heart Failure Using Patient Reported Outcomes. J Pain Symptom Manage. 2024 Dec;68(6):561-572. doi: 10.1016/j.jpainsymman.2024.09.002. Epub 2024 Sep 11. PMID: 39270879.

Selected by:
Jose Pereira

Presented by:
Jose Pereira

Background:

- Heart failure (HF) is a multifaceted syndrome with high symptom-burden and mortality.
- Affects millions worldwide;
  - Prevalence increasing (aging population, improved survival from ischemic heart disease)
- Palliative care is recommended as part of integrated HF treatment in many guidelines, but implementation is sparse.
- No formal consensus on which patients potentially could benefit from palliative care.
- There is a lack of systematic assessment and established criteria for referral.

Study Objective

- To describe the symptom-burden in patients with HF and identify their palliative care needs using patient-reported outcome measures (PROMs)

Methods

- Danish observational cross-sectional study
- Adult HF patients; systolic HF (LVEF < 40%); symptoms NYHA II, III, and IV
- Used validated disease-specific and generic PROMs (online survey).
  - EORTC- QLQ-C15-PAL, HeartQoL, SF-36v1, MFI-20 and HADS
- Palliative care needs were assessed using validated patient reported outcomes measures; SF-36v1, HeartQoL, EORTC- QLQ-C15-PAL, MFI-20 and HADS.
- Conducted in a Department of Cardiology (in-patient and outpatients), Denmark.
- NYHA III and IV collapsed (relatively low number of NYHA IV pts).

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Selected by:

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Presented by:

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Key Results

- 314/400 (79%) pts completed the questionnaire (74% men).
- Outpatients: 86%. Mean age: 74 years (range 35–94 years)
- NYHA III or IV classes: 42%

- Self-rated their health as fair or poor: 53%

- Symptom SCORES: Fatigue (mean 49.2), Dyspnea (mean 44.4), Pain (mean 21.4), Insomnia (31), Appetite loss (mean 29)

- Symptom intensity increased with age and higher NYHA

- Number of symptoms:
  - NYHA III/IV: mean of 8.9 mild symptoms, 5.4 severe symptoms
    - 67% experiencing at least four severe symptoms
  - NYHA II: mean of 5.1 mild symptoms, 1.6 severe symptoms.
    - 19% at least four severe symptoms.

- Symptom/problem presence (proportion of pts):

	NHYA II	NYHA III/IV
Stay in bed/chair during day:	50%,	81%
Help with daily activities:		30%
Dyspnea:	55%	92%
Pain:	32%	58%
Insomnia:	43%	64%

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Selected by:

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Key Results

- Anxiety: 22% of pts (HADS score ≥8)
- Depression: 25% of pts (HADS score ≥8)

- Heart QOL: Physical functioning scores lower than emotional functioning:
  - Physical 1.36; Emotional 2.13 (poor QOL)
  - Global QOL: 1.58

Key discussion points

- Patients with HF have a high prevalence of symptoms and may have potential palliative care needs.
- As with other studies, special attention should be paid to women, elderly adults, and pts with more severe disease (higher symptom-burden)
- Not be appropriate to assume that palliative care should be initiated only as a treatment of last resort.
  - Unpredictable trajectory of HF, don't wait for "trigger" event to initiate palliative care

Identifying Palliative Care Needs in Patients With Heart Failure Using Patient Reported Outcomes

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Selected by:
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Strengths and Limitations

- Strength: Large sample size
- Limitations:
  - Not necessarily generalizable to whole Danish population
  - Limited to pts with systolic HF (? Preserved ejection fraction)
  - Burden of all instruments?
- Physical and psychological symptoms highlighted: Recognize other dimensions of suffering important

Practice Impact

- Patients with HF have a high prevalence of symptoms and, thus, potential palliative care needs.
- Predominantly, women, older patients, and those with higher severity of disease have the highest symptom burden.
- PROMs can help cardiologists address palliative care needs
- Systematic assessment needed

Discussion

Honourable Mentions

- O'Connor BP, Pesut B. **A longitudinal study of within-person trajectories in quality of life in patients receiving early palliative care.** Qual Life Res. 2024 Oct;33(10):2733-2742. doi: 10.1007/s11136-024-03722-z. Epub 2024 Jun 22. PMID: 38907833. https://pubmed.ncbi.nlm.nih.gov/38907833/

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- Perera M, Halahakone U, Senanayake S, Kularatna S, Parsonage W, Yates P, Singh GK. **Components of home-based palliative and supportive care for adults with heart failure: A scoping review**. Palliat Med. 2025 Jan;39(1):86-98. doi: 10.1177/02692163241290350. Epub 2024 Oct 30. PMID: 39474849; PMCID: PMC11673332. https://pubmed.ncbi.nlm.nih.gov/39474849/

- Finucane A, Canny A, Mair APA, Harrop E, Selman LE, Swash B, Wakefield D, Gillanders D. **A rapid review of the evidence for online interventions for bereavement support**. Palliat Med. 2025 Jan;39(1):31-52. doi: 10.1177/02692163241285101. Epub 2024 Oct 15. PMID: 39407434; PMCID: PMC11673319. https://pubmed.ncbi.nlm.nih.gov/39407434/

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.

Listen on Apple Podcasts

Listen on Google Podcasts

Listen on Spotify

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

Thank You to our Journal Watch Contributors!

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