ADVANCED BREAST CANCER

PALLIATIVE CARE APPROACHES

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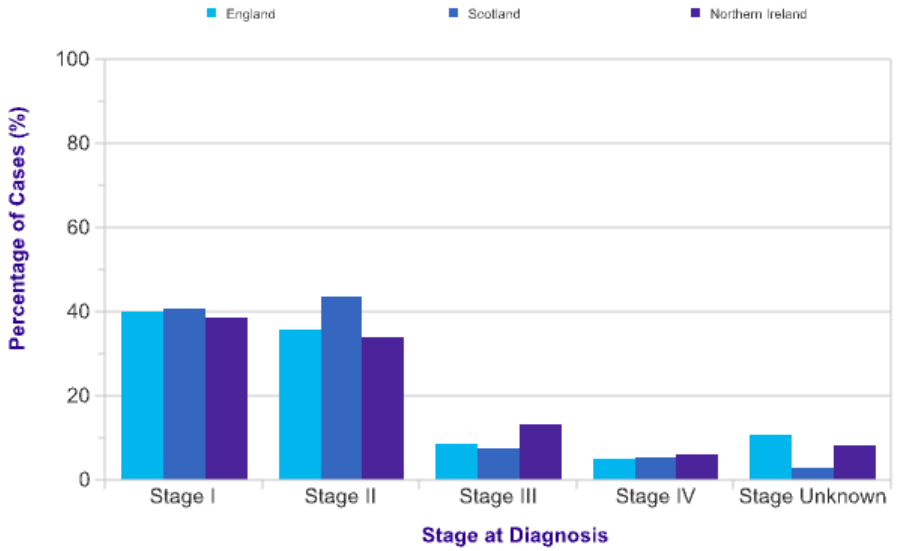
Road map

- Introduction
- Palliative care need and their assessment
- Management of site specific metastases
- Loco-regional palliation
- Palliative psychosocial care
- Approach to palliation

Breast cancer presentation



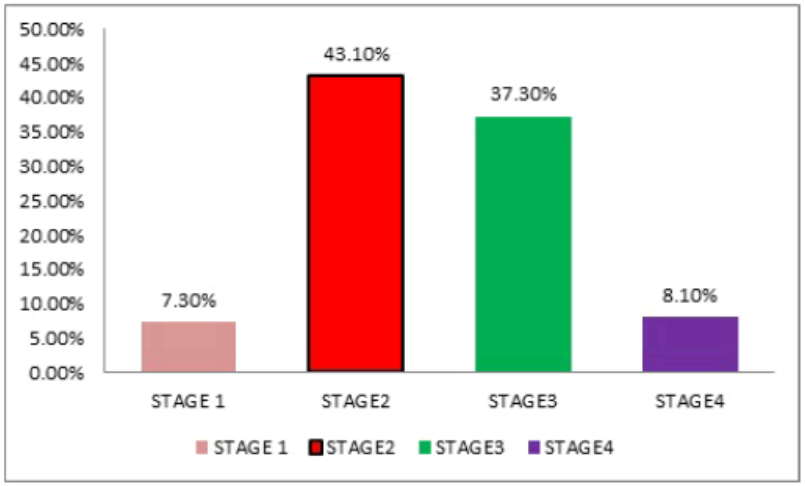


Figure 1 Stage wise distribution at presentation.

Background

- Approximately 6%–10% of newly diagnosed BC cases are metastatic, whereas 20%–50% of patients with early BC will eventually develop metastatic disease

- Though systemic treatment aims has improved survival in recent years - metastatic breast cancer (MBC) remains an incurable disease

- Hence palliation and supportive care gains importance

Difference between Supportive care and Palliative care

- European association of Palliative Care (EAPC)
- Supportive care is more appropriate for patients still receiving antineoplastic therapy /therapies
- Palliative care has its major focus on patients with far advanced diseases where anti neoplastic therapies have been withdrawn
- WHO –broader definition ; care from diagnosis or at the start of treatment

The BOW-TIE model

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Palliative Care need assessment

1. Patient assessment
   - disease status, expected disease progression, present functional level, symptoms, current therapies, and anticipated future problems
   - Patients understanding of the current situation
2. Family assessment
   - Socio-econmic assessment, psychosocial concerns, and the adequacy and availability of supports
3. Health care provider assessment
   - Resources available
   - Competence and focus

Management strategies depend on

- Symptoms
- Location of the disease
- Burden of disease
- Tumor characteristics
- Patient factors
- Available treatment modalities
- Resources available

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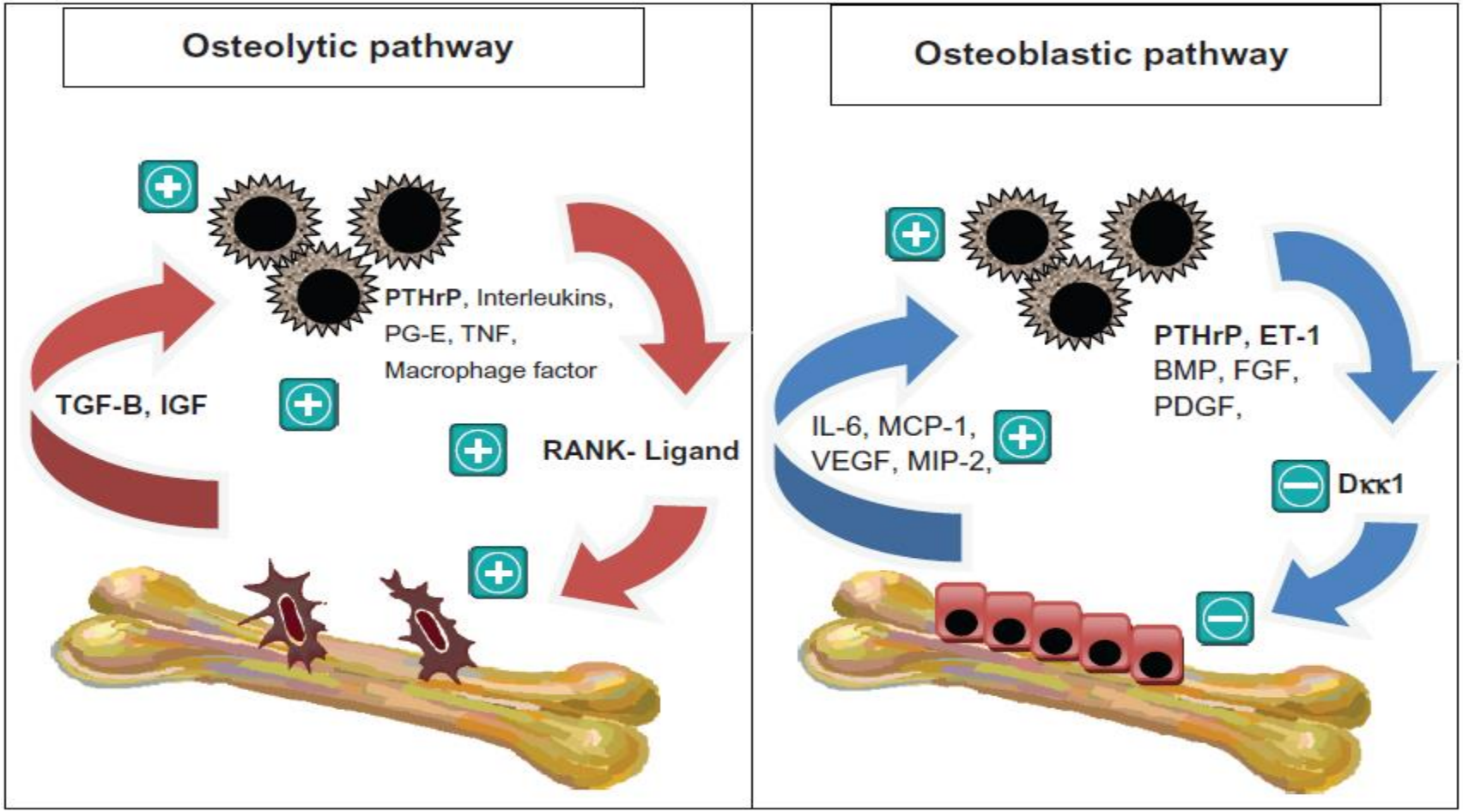
Management of site specific metastases

Bone metastases

- Bone is the most common site of recurrence in metastatic breast cancer
- reported in up to 70–80% of patients
- 48% of purely osteolytic, 38% being mixed, and 13% being purely osteoblastic
- Causes
  - bone pain
  - Hypercalcemia
  - pathologic fractures
  - spinal cord compression

Osteolytic vs Osteoblastic



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Bone metastases- management options

- Managing bone pain
  - Analgesics
  - Radiation
  - Surgical interventions
  - Bisphosphonates
  - Radiopharmaceuticals
- Managing established complication of bone Mets
  - Steroids
  - Surgery /radiotherapy
- Preventing complications of bone metastases
  - Bisphosphonates
  - Denosumab

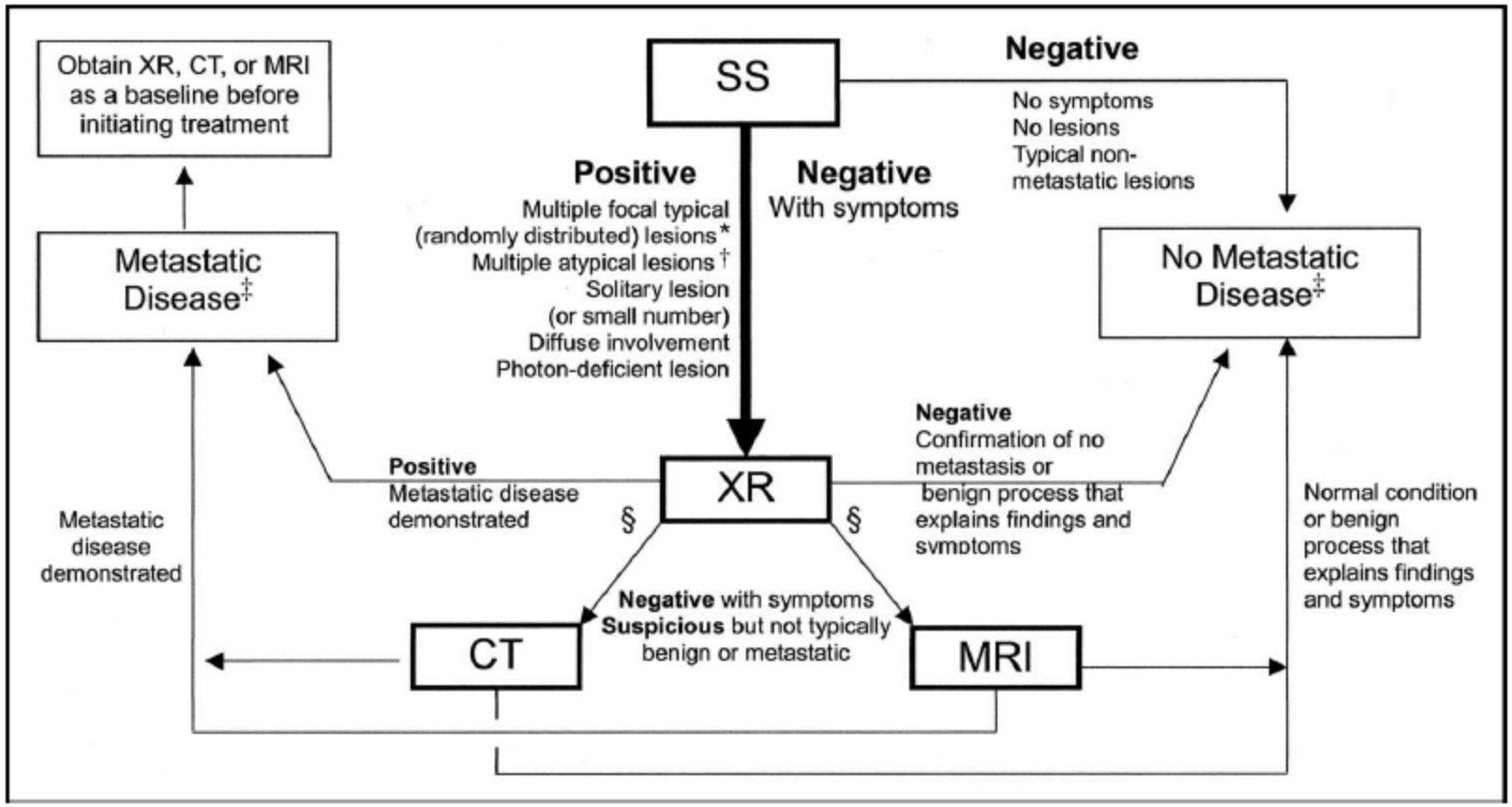
Approach for Bone Management

- DIAGNOSIS
  - IMAGING

Imaging for diagnosing bone mets

Imaging modality	Anatomic detail	Extent of imaging	Appearance of bone diseases	Diagnostic sensitivity	Diagnostic specificity	Cost
Bone scan	No	Whole body	Hot spots	Varies 62-100%	78-100%	Moderate
Xray	Yes	Local /regional/whole body	Lytic/sclerotic/mixed	Low 44-50%	-	Low
CT	Yes	Local/regional	Lytic/sclerotic for bone , higher attenuation for marrow	High 71-100%	-	Moderate
MRI	Yes	Regional	Lower or higher intensity on T1/T2 scans	High 71-100%	High 73-100%	Moderate
PET	No	Whole body	Hot spots	Varies 62-100%	High 96-100%	High

Diagnostic algorithm



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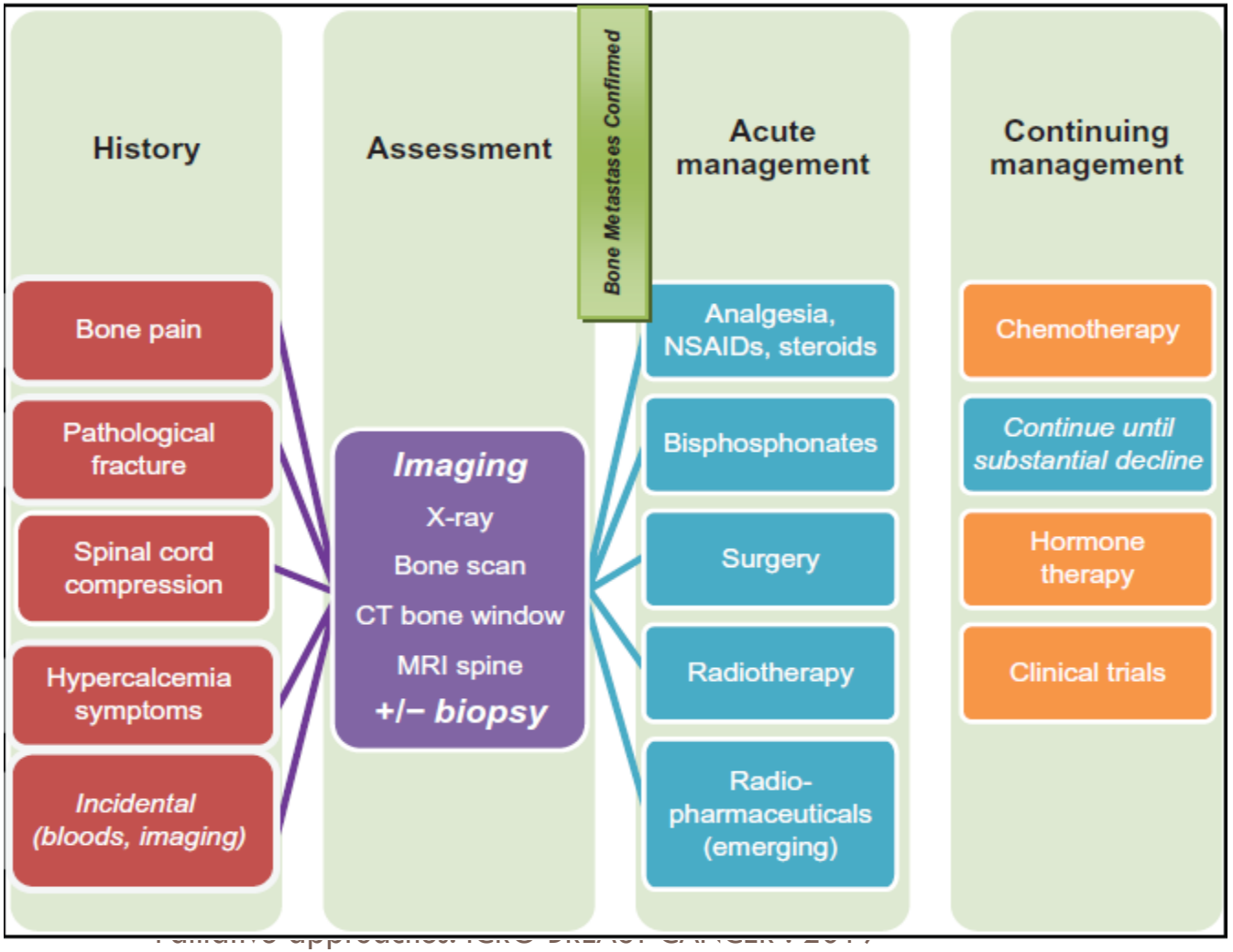
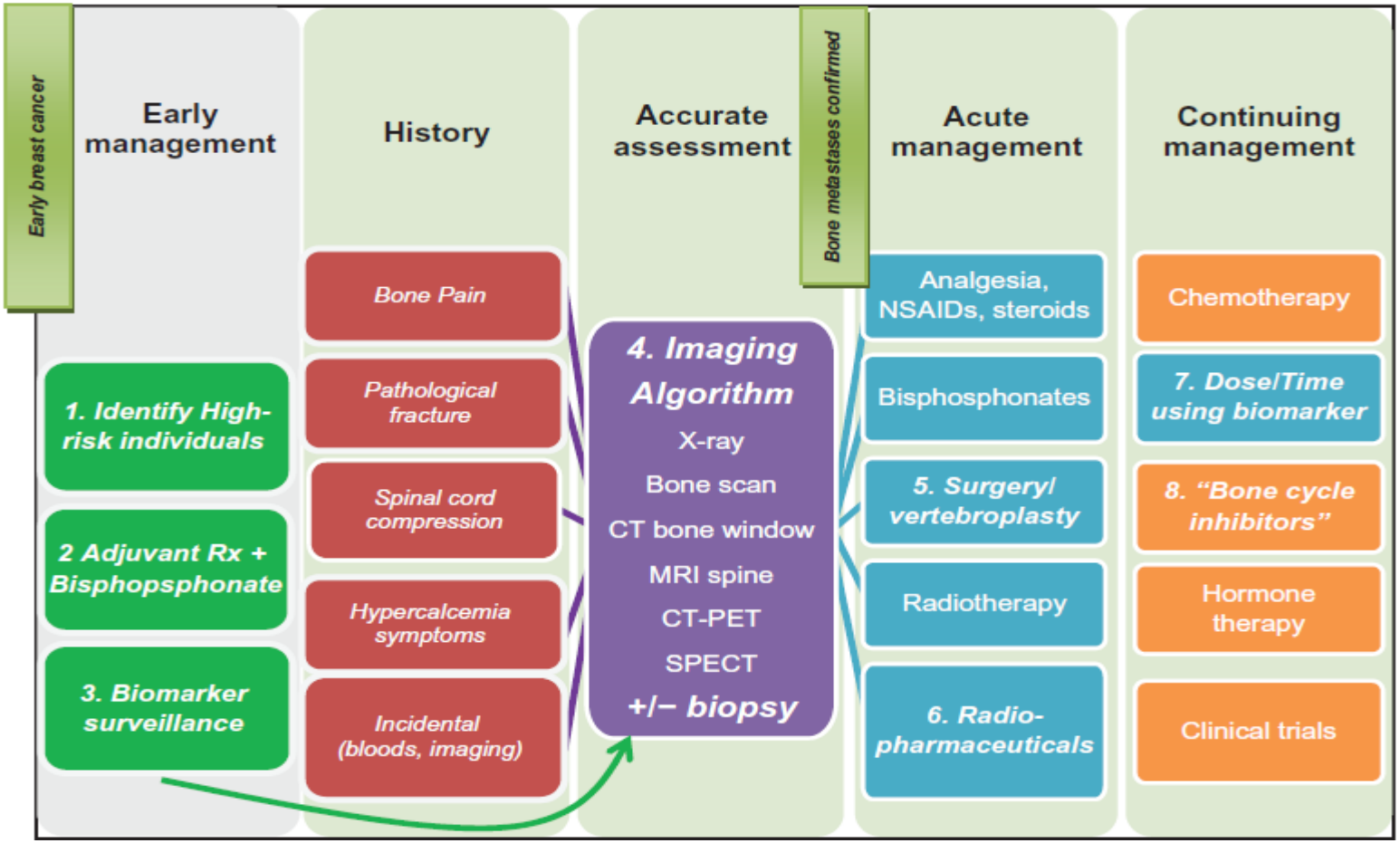
Bone metastases- reactive focus model



Bone metastases- proactive model



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Bone metastases- role of Surgery/interventions

- Surgery is usually not the primary choice of treatment in bone metastases
- The main goals of surgical treatment are
  - to alleviate the pain
  - to prevent an imminent fracture
  - to perform an osteosynthesis in cases of a pathological fracture
  - to restore patient mobility and
  - to improve the patient's quality of life.
- surgical intervention for patients with cancer with impending pathologic fractures lead better outcomes than established #

Bone metastases- role of Radiation

- The goals of palliative radiotherapy
  - pain alleviation
  - recalcification and stabilization of the bone
  - Minimising the risk of paraplegia

- Options of radiotherapy
  - Focal radiotherapy
  - Hemibody radiation
  - Radiopharmaceuticals

Bone metastases- role of Radiation : ASTRO guidelines

- Ideal fractionation schedule
  - Equivalence of various fractionation schedules ; 30Gy/10#, 24Gyin 6#, 20Gy/5# and 8Gy single #.
  - Fractionated RT – 8% repeat treatment
  - Single Fraction -20% repeat treatment
- When Single Fraction ?
  - Any uncomplicated bone mets
  - Spinal vs non-spinal-?

Bone metastases- role of Radiation : DEGRO guidelines

Therapeutic goal: pain reduction

- Single-dose radiotherapy 1 × 8 Gy (cave: > 8 Gy to the myelon may cause paresis; LoE III)

Therapeutic goal: stabilization, good prognosis

- Fractionated regimen preferable, e.g., 10–12 × 3 Gy (LoE IIb)

Oligometastases

- Full-dose fractionated regimen recommended, e.g., 20–25 × 2 Gy to 40–50 Gy (LoE IIb, III)

Technical aspects

- Target volume
  - affected part of bone with additional margin (1-2cm)
  - soft tissue component if present
  - For vertebrae –whole of vertebral body , plus/minus adjacent vertebra
  - Surgical clips/metal components of stabilisation to be included
- Technique
  - Most cases simple opposed fields /direct fields
  - Conformal techniques preferable when associated soft tissue component or near vital structures
- Prescription
  - Mid vertebral body

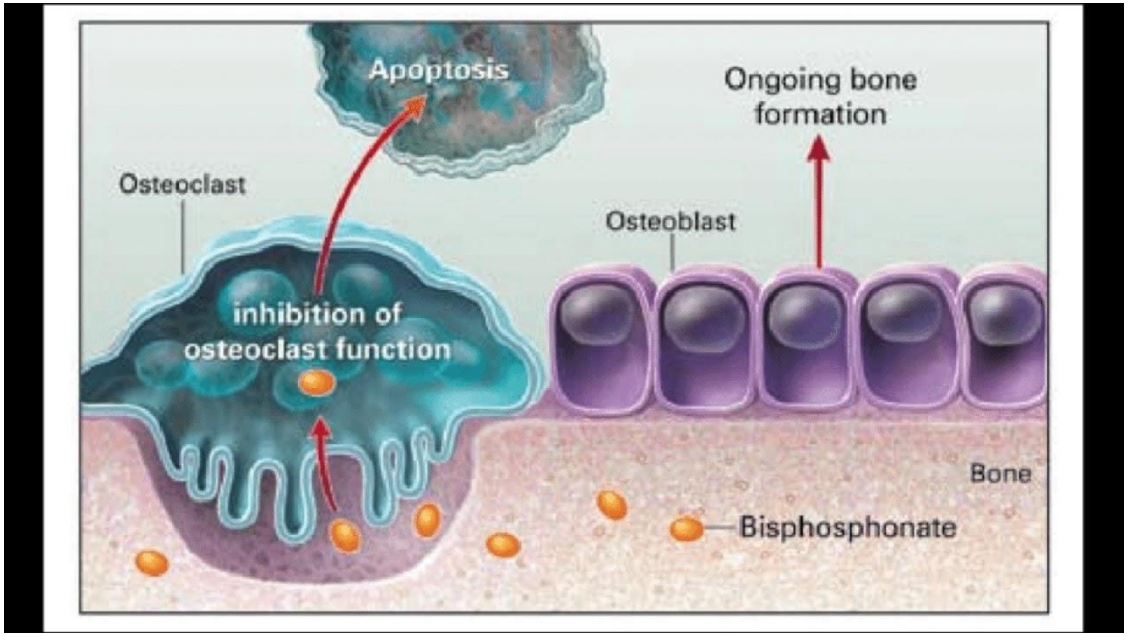
Radiation -generalised bone mets

- Hemi body irradiation

- Radionuclide therapy (samarium-153 and strontium-89)
  - For multiple painful mets, greater in number that can be reasonably treated by EBRT
  - most active in areas of bone growth present in osteoblastic metastases
  - pain relief onset of 2- 3 weeks, partial response rates of 55-95%, complete response rates of 5-20%.
  - Side effects : pain flare in 10-40% & self-limiting myelosuppression

Bone metastases- role of bisphosphonates

- Bisphosphonates are an important class of therapeutics in reducing the frequency of skeletal-related events (30%–40%) and improving bone pain (50%)
- Bisphosphonates inhibit osteoclasts by inducing apoptosis of osteoclasts, and are therefore potent inhibitors of bone resorption



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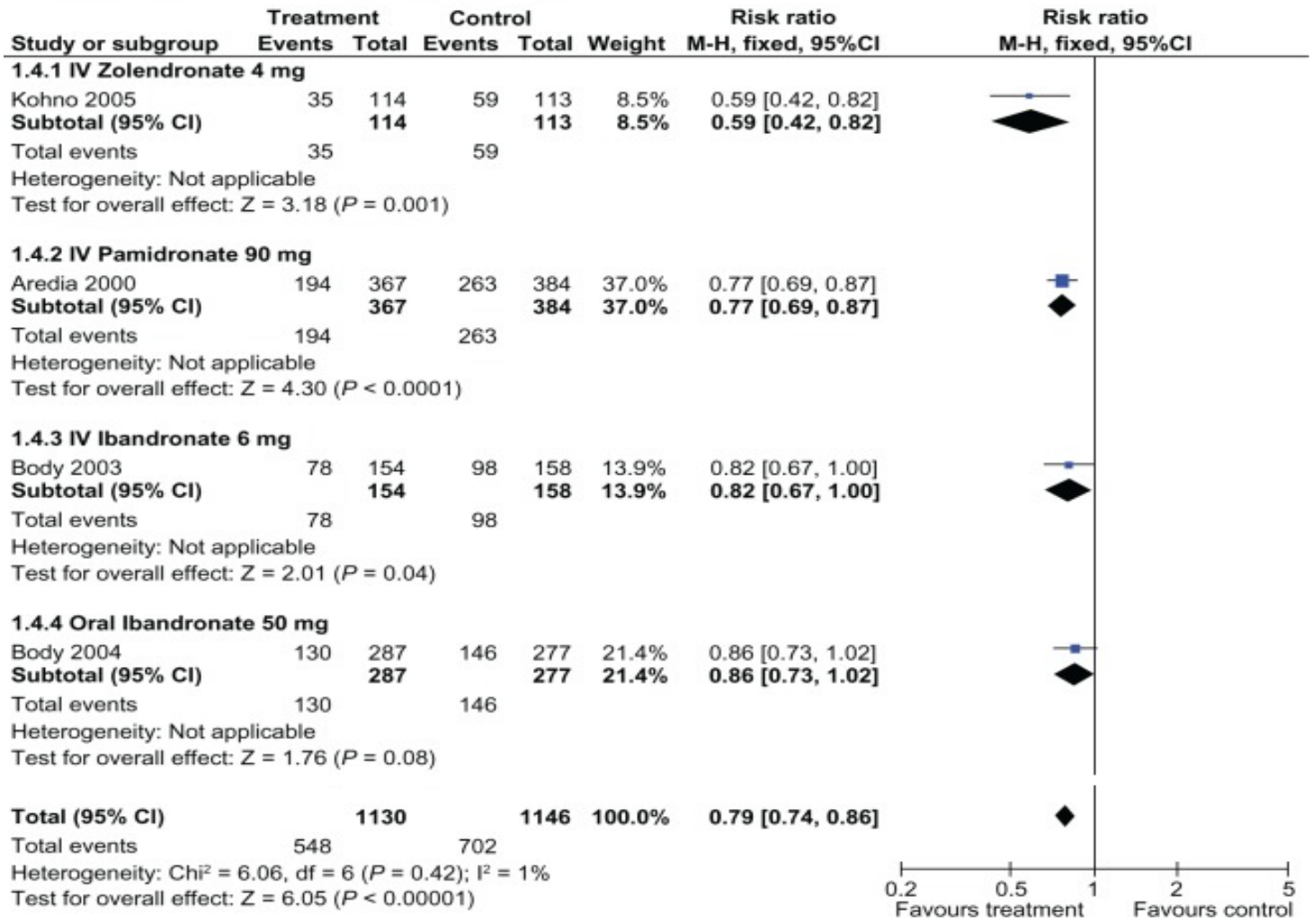
Choice of Bisphosphonates



Existing guidelines

	When to start?	Which bisphosphonate?	When to stop?
ASCO guidelines 2011[70]	Breast cancer + radiographic evidence of bone destruction: • Lytic disease on x-ray • Abnormal bone scan with CT/MR showing bone destruction Starting bone modifying agents in women with abnormal bone scan in the absence of bone destruction in X-ray/CT/MR is not recommended.	• IV PAM 90 mg every 3–4 weeks OR • IV ZOL 4 mg every 3–4 weeks OR • SC DMB 120 mg every 4 weeks	Once initiated, to continue until evidence of substantial decline in patient's general performance status
International expert panel guidelines 2008[66]	MBC + first sign of radiographic evidence of bone metastases, even if patient is asymptomatic	Nitrogen-bisphosphonate • IV preferable (ZOL, IBA, PAM) • PO for patients who cannot or need not attend hospital care (CLO, IBA)	Continue beyond 2 years but always based on individual risk assessment; should not discontinue treatment once SRE occurs

Metastatic spinal cord compression

Diagnostic steps for suspected MSCC

History with specific focus on

- Beginning of signs and symptoms
- Localization
- Character of pain (dependence on stress, motion and/or position)
- Time course
- Duration of neurologic deficit/back pain/loss of continence

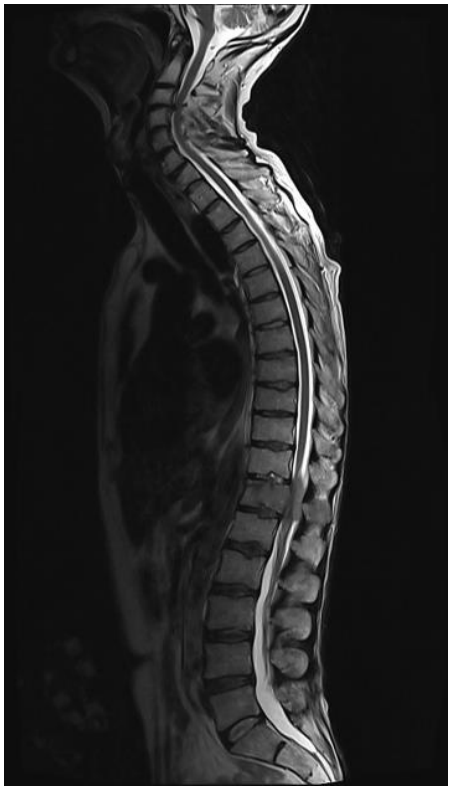
Clinical examination

- Neurologic examination (motor/sensory deficits)
- Clinical estimation of level of spinal compression
- Work-up of extent of extraspinal metastases

Imaging

Targeted according to clinical examination

- MRI (extent; intradural/extradural/intraspinal masses)
- CT (stability; extent of destruction)
- (Conventional X-rays [extent of deformity, stability])



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Guidelines for treatment of MSCC

Instability of vertebral column, bony compression and/or paresis/paraplegia

- Immediate (within maximally 24–48 h) surgical intervention and postoperative radiotherapy (LoE IIb)

Spinal cord compression without neurologic deficits

- In ambulatory patients: radiotherapy (LoE IIb)
- In case of analgesia as additional goal: short course of radiotherapy with increased single doses
- In case of remineralization as additional goal: fractionated radiotherapy with conventional single doses

Acute onset of paresis/paraplegia

- Surgical decompression followed by radiotherapy
- Radiotherapy when decompression is not possible (LoE III)

Inoperability

- Radiotherapy; choice of fractionation depending on life expectancy (LoE III)

After surgical decompression

- Radiotherapy (LoE IIb)

In case of (in-field) recurrence after previous radiotherapy

- Surgery (when possible)
- Reirradiation (using high-precision techniques; LoE IV)

Bone metastases -management summary

Skeletal Related Event	Management	Effects
Bone pain	NSAIDs, Opioids	Analgesic effects
	Bisphosphonates	Inhibition of pathological bone resorption Analgesic effects
	Denosumab	Inhibition of pathological bone resorption Analgesic effects
	Radiation	Analgesic effects Tumor shrinkage
Pathological bone fracture	Surgery	Stabilization of fracture
	Radiation	Supportive therapy to prevent local recurrence
	Bisphosphonates	Prophylaxis
	Denosumab	Prophylaxis
Spinal cord compression	Steroids	Stabilization of vascular membranes Reduction of inflammation and edema
	Radiation	Tumor shrinkage effects
	Surgery	Relief for the compression
	Bisphosphonates	Prophylaxis
	Denosumab	Prophylaxis
Hypercalcemia	Hydration	Promotion of renal calciuresis
	Loop diuretics	Promotion of renal calciuresis
	Bisphosphonates	Inhibition of pathological bone resorption
	Denosumab	Inhibition of pathological bone resorption

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Brain metastases

- Brain metastases in breast cancer patients represent a catastrophic event that portends a poor prognosis,
- median survival 2 to 25.3 months despite treatment
- Affects about 20% of patients
- the median time to the development of BM from the diagnosis of primary cancer 30–40 months
- Palliative treatment goals
  - Pain control
  - Improving neurologic function /prevention of deterioration
  - Improving quality of life

Prognostication

Prognosis of Patients With Brain Metastases by Diagnosis-Specific Graded Prognostic Assessment (DS-GPA) Score

Lung Cancer	GPA Scoring Criteria		
Prognostic Factor	0	0.5	1.0
Age, years	> 60	50–60	< 50
KPS	< 70	70–80	90–100
ECM	+	n/a	–
No. of BM	> 3	2–3	1

Total Score = _____ →

Total Score	Median Survival Time in Months (95% CI)	
Lung Cancer	NSCLC	SCLC
0–1.0	3.02 (2.63 to 3.84)	2.79 (1.83 to 3.12)
1.5–2.0	5.49 (4.83 to 6.40)	4.90 (4.04 to 6.51)
2.5–3.0	9.43 (8.38 to 10.80)	7.67 (6.27 to 9.13)
3.5–4.0	14.78 (11.80 to 18.80)	17.05 (4.70 to 27.43)

Melanoma	GPA Scoring Criteria		
Prognostic Factor	0	1.0	2.0
KPS	< 70	70–80	90–100
No. of BM	> 3	2-3	1

Total Score = _____ →

Melanoma	
0–1.0	3.38 (2.53 to 4.27)
1.5–2.0	4.70 (4.07 to 5.39)
2.5–3.0	8.77 (6.74 to 10.77)
3.5–4.0	13.23 (9.13 to 15.64)

Breast Cancer	GPA Scoring Criteria				
Prognostic Factor	0	0.5	1.0	1.5	2.0
KPS	≤ 50	60	70–80	90–100	n/a
Subtype	Basal	n/a	LumA	HER2	LumB
Age, years	≥ 60	< 60	n/a	n/a	n/a

Total Score = _____ →

Breast Cancer	
0–1.0	3.35 (3.13 to 3.78)
1.5–2.0	7.70 (5.62 to 8.74)
2.5–3.0	15.07 (12.94 to 15.87)
3.5–4.0	25.30 (23.10 to 26.51)

Renal Cell Carcinoma	GPA Scoring Criteria		
Prognostic Factor	0	1.0	2.0
KPS	< 70	70–80	90–100
No. of BM	> 3	2–3	1

Total Score = _____ →

Renal Cell Carcinoma	
0–1.0	3.27 (2.04 to 5.10)
1.5–2.0	7.29 (3.73 to 10.91)
2.5–3.0	11.27 (8.80 to 14.80)
3.5–4.0	14.77 (9.73 to 19.79)

GI Cancers	GPA Scoring Criteria				
Prognostic Factor	0	1	2	3	4
KPS	< 70	70	80	90	100

Total Score = _____ →

GI Cancers	
0–1.0	3.13 (2.37 to 4.57)
1.5–2.0	4.40 (3.37 to 6.53)
2.5–3.0	6.87 (4.86 to 11.63)
3.5–4.0	13.54 (9.76 to 27.12)

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Brain metastases- management and palliation options

- Symptomatic and supportive
  - Corticosteroids
  - Anti epileptics
  - Anticoagulation
- Local therapy
  - Surgical resection
  - Whole brain radiotherapy
  - SRT/SRS
- Systemic therapy
  - Chemotherapy and biologics

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Brain metastases- management and palliation options

Symptomatic and supportive

- Corticosteroids
  - Improve neurologic symptoms in up to 75% of patients with cerebral edema
  - Dexamethasone is the corticosteroid of choice
  - 4 to 8 mg is as good as 16mg per day
  - 4 to 8mg per day in two divided doses- initial choice
  - Higher doses if symptom not relieved within 48 hrs.
  - No specific role in asymptomatic except to prevent radiation induced edema

Brain metastases- management and palliation options

Symptomatic and supportive

- AEDs
  - AEDs are indicated in the approximately 25% of patients who present with seizures
  - No role of prophylactic AEDs
  - In patients undergoing resection, short term prophylactic AED reduces risk of post op seizures by 40-50%
- Anticoagulation therapy
  - Can be safely given for patients with venous thromboembolism and brain Mets going for surgery

Multiple brain metastases

Multiple brain metastases-initial management

Prognostic category ([a])	Other features	Treatment options (evidence grade) references	Clinical benefit			
			S	LC	WB control	Neurocognition
Good prognosis Expected survival 3 mo or more	All brain metastases ≤3-4 cm[b]	• Radiosurgery and WBRT (level 1)[51,53] • Radiosurgery alone[23,54] (level 1) • WBRT (level 1)[59,85]		✔ ✔ ✔	✔ ✔	 ✔
Good prognosis Expected survival 3 mo or more	Brain metastasis/ metastases causing significant mass effect[c]	• Safe surgical resection of the brain metastasis/metastases causing significant mass effect and postoperative WBRT (level 3)[25,b] • WBRT (level 3)[59,85]	 ✔	✔ ✔	✔ ✔	
Poor prognosis Expected survival less than 3 mo		• WBRT (level 3)[59,85] • Palliative care without WBRT (level 3)[59,85]		✔ 	✔ 	

KPS, Karnofsky performance status; LC, local control; S, survival; WB, whole brain; WBRT, whole brain radiotherapy.

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WBRT

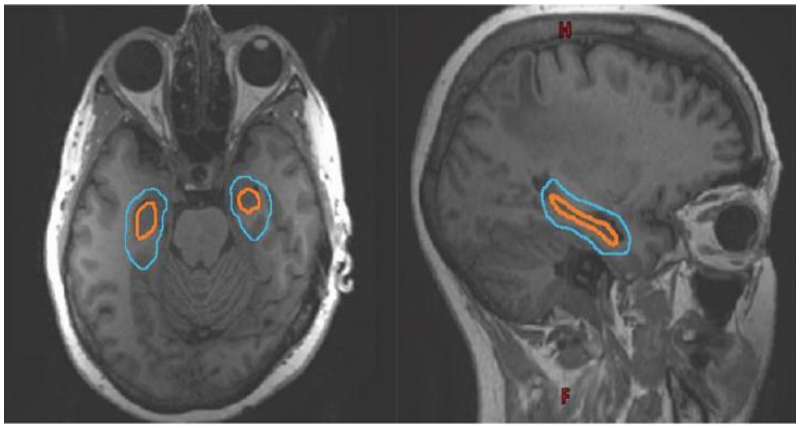
- Goals of treatment –
  - Response
  - palliation of symptoms
  - Brain only RFS
  - OS
- Response (clinical and radiological)-> 50%
- Palliation – > 60%

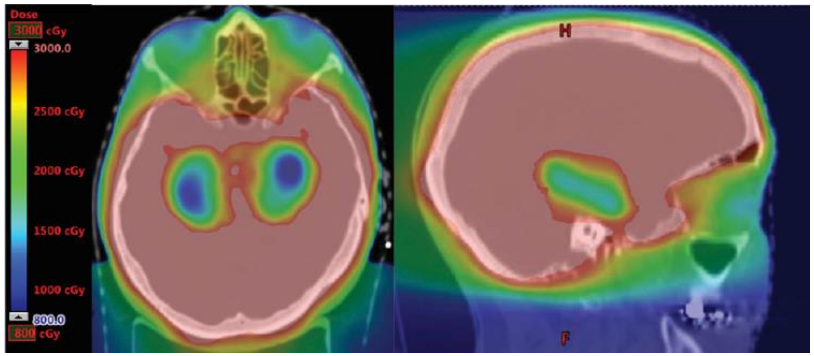
Brain metastases- management and palliation options

local therapy

- WBRT
  - the most frequently used treatment for multiple BM and improves neurologic symptoms and median survival, from 1 to 2 months without WBRT to 3 to 6 months with it.
  - multiple BMs, oligometastases with poorly controlled systemic disease, Large oligometastases
  - Re-irradiation after late WBRT failure
  - after surgery or SRS

Hippocampal sparing WBRT



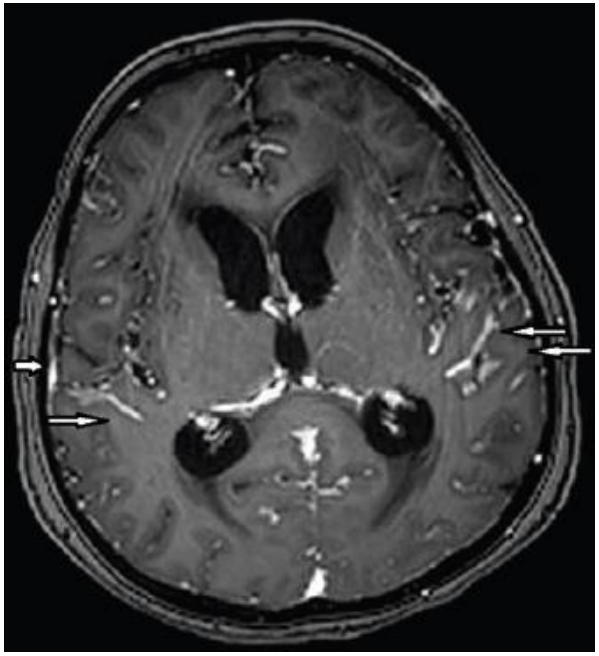


- New neurons generation – subgranular zone of hippocampal dentate gyrus
- Dose respose realtionship between dose to hippocampus and decline of of episodic memory
- IMRT –available technology
- Phase II study-hippocampal sparing leads to memory preservation
- Phase III trial NRG oncology CC001.

Leptomeningeal metastases

- Diffuse or multifocal involvement of the subarachnoid space
- Poor prognosis- median overall survival <4 months
- Presents with focal /multifocal neurological signs/symptoms
- M/c –headache, cranial nerve palsies, radicular pain

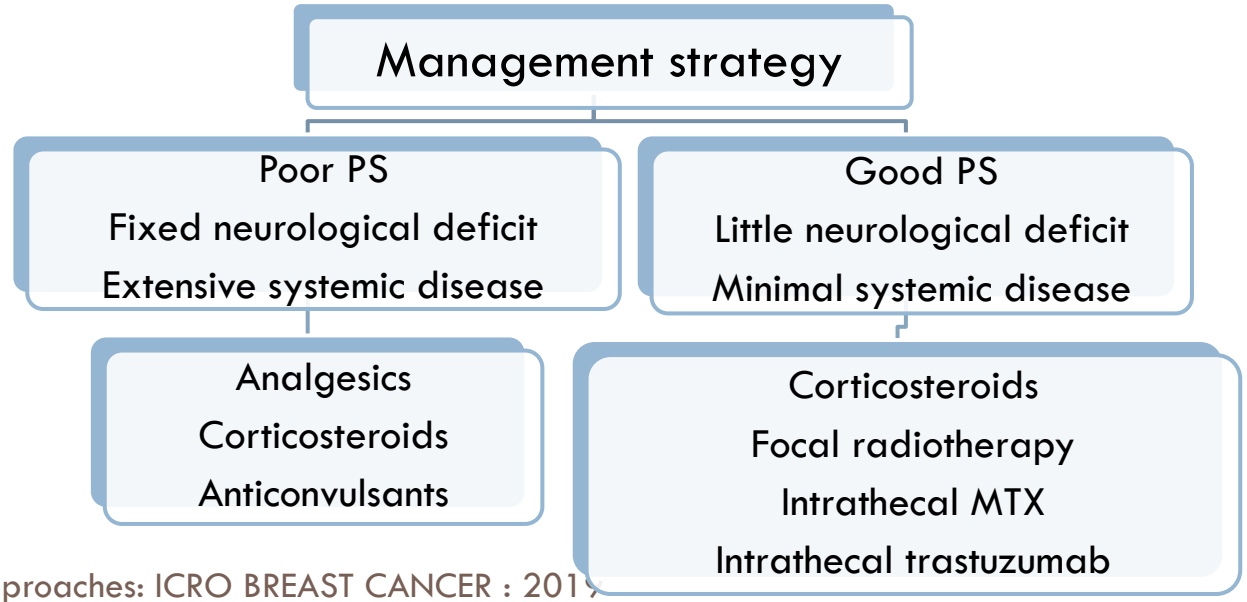
- Gadolinium enhanced MRI –leptomeningeal enhancement in T1+C, often scattered over the brain in a 'sugar coated' manner
- Gadolinium –enhanced MRI +ve in almost 50% with clinical findings & 60% in CSF negative patients



focal nodular enhancement and thickening on cerebellar follia

Leptomeningeal metastases

- CSF cytology is less sensitive but more specific
- CSF analysis
  - ↑pressure, ↑protein
  - ↓glucose, Lymphocytic pleocytosis
- serial CSF study increases sensitivity



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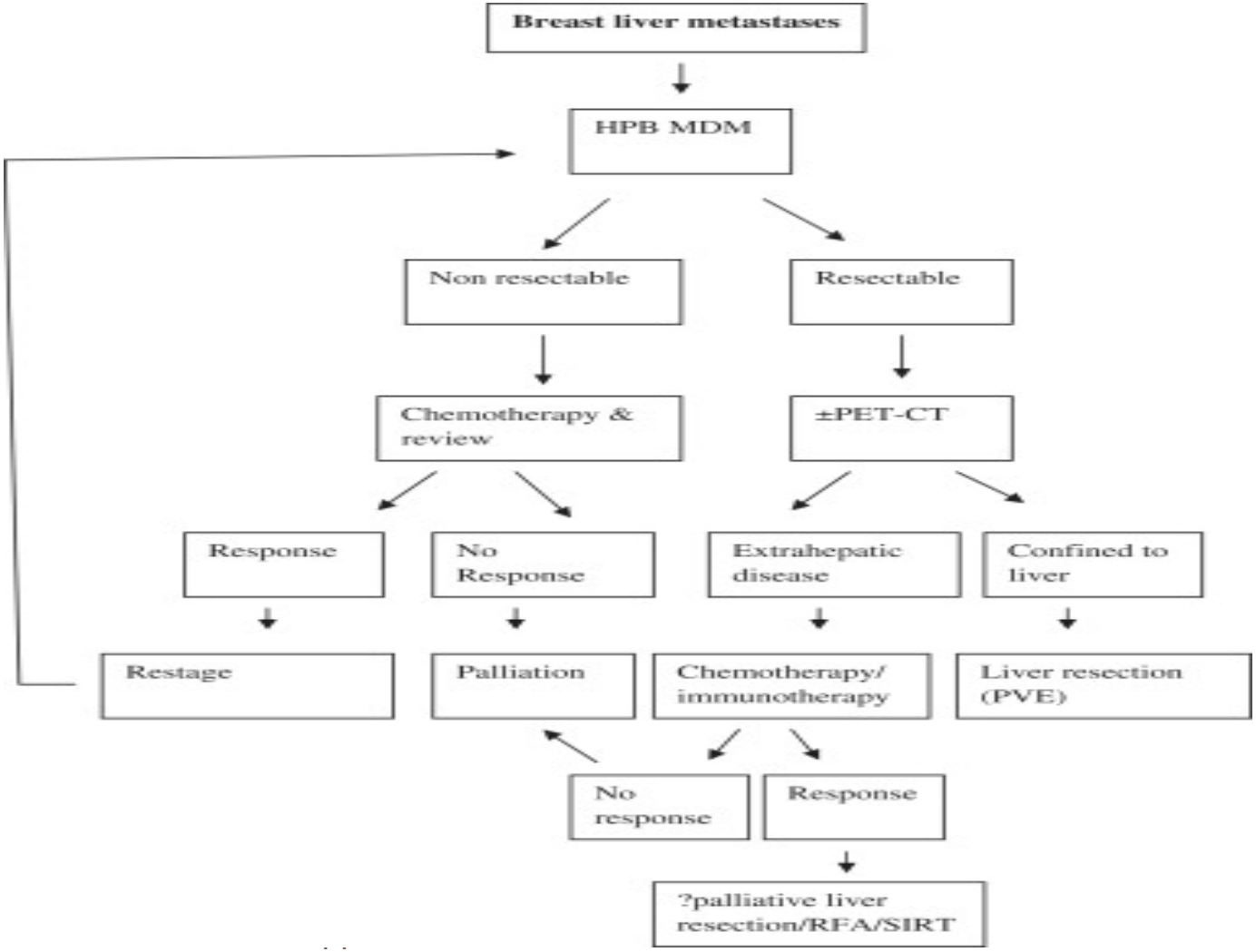
Liver metastases

- Living with liver metastases
- Basic management of liver metastases includes pain control with analgesics and steroids, anti-emetics and antihistamines for nausea or pruritus.
- Biliary stents and percutaneous drainage foer obstructive jaundice
- Tumor embolization
- Liver resection

Liver metastases management approach



Lung metastases

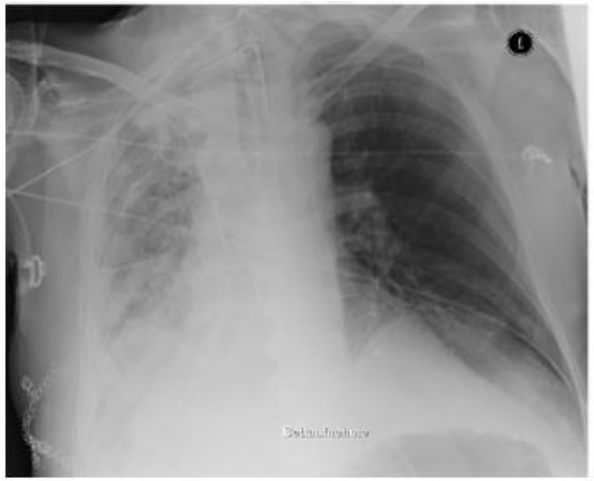
- Lung metastasis is common in recurrent /metastatic breast cancer -upto 71% in autopsy series
- cause respiratory compromise by
  - direct effect of the metastases on lung tissue
  - airway obstruction
  - from pleural effusion
- Although surgical resection may prolong survival it is not recommended
- Management
  - opioids, anxiolytics, antipsychotics & steroids
  - Radiotherapy for haemoptysis and obstruction

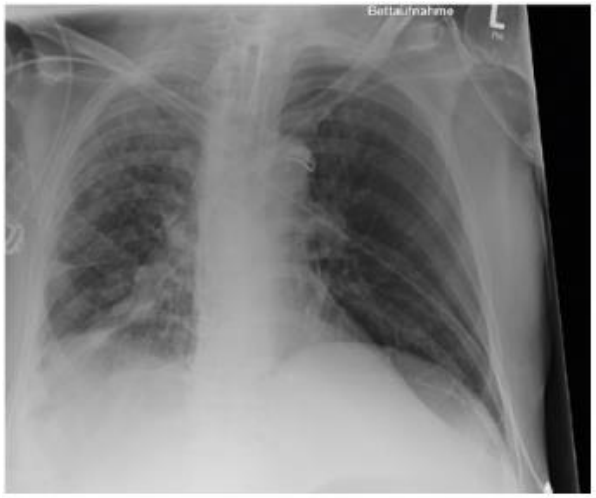
Malignant pleural effusion

- Malingnant Pleural effusion implies terminal stage of the disease
- MPE –av survival 6-36 months
- M/c symptoms – dyspnoea /breathlessness
- Local plus systemic therapy improves survival then systemic alone
- Goals of treatment
  - Removal of fluid
  - Prevent re –accumulation

Malignant pleural effusion – mangement strategies

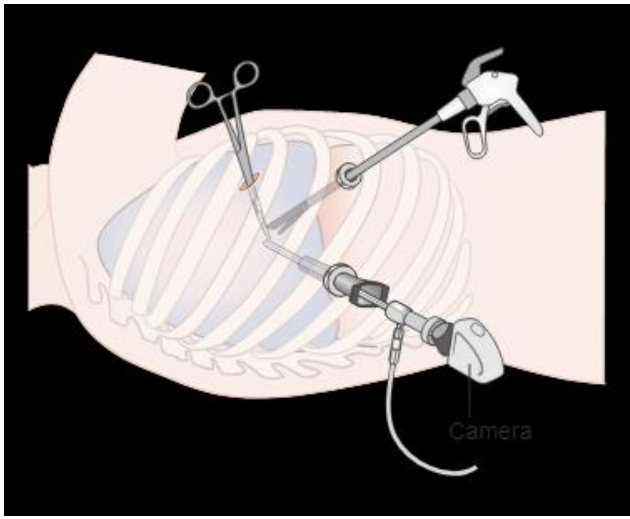
- Nonsurgical interventions
  - Repeated thoracentesis
    - Low success
    - Suboptimal quality of life
  - TIPC/IC drainage
    - Improve symptoms
    - Spontaneous pleurodesis in 50%
    - Increased risk of infection
    - Potential Nutritional loss
  - Chemical Pleurodesis –asbestos free talc
    - Safe and effective (97% success)
    - Recommended for those with >6 months survival
    - May develop fatal complications





Malignant pleural effusion – mangement strategies

- Surgical interventions
  - VATS technique
    - Helps identifying candidates for complete lung expansion and pleurodesis
    - VATS decortication - removal of the pleura or part of it by thoracoscopic ports
    - Adv- direct visaulisation , can obtain tissue, allows for checking lung re-expansion , allows distribution of talc in uniform manner
    - Initial success rate of 90%
    - Reports of survival of 17 months



Breathlessness- other causes

Underlying cause	Potential treatment
Anemia	Blood transfusion
Acidosis	HCO_3
Bronchospasm	Bronchodilator therapy
Pneumonia	Antibiotic therapy
Pulmonary embolus	Anti-coagulate
Pneumonitis	Steroids
Atrial fibrillation	Anti-arrhythmic
Congestive cardiac failure	Diuretic
Pericardial tamponade	Drainage
Pleural effusion	Thoracentesis
Endobronchial tumor	Endobronchial laser
Extrinsic compression of bronchus	Radiotherapy
Carcinomatous lymphangitis	Steroids (anecdotes only)
Lung metastases	Chemotherapy/hormonal therapy

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Bowel obstruction

Physiopathology of MBO
Factors directly related to intra-abdominal tumor growth
Extrinsic intestinal compression
Endoluminal intestinal obstruction
Intramural intestinal infiltration
Infiltration of the mesenterium and plexus
Factors not directly related to intra-abdominal tumor growth
Paraneoplastric neuropathy
Chronic constipation
Opioid-induced intestinal dysfunction
Adynamic ileum
Inflammatory intestinal disease
Renal insufficiency/dehydratation
Mesenteric thrombosis
Postsurgical adherences
Radiogenic fibrosis

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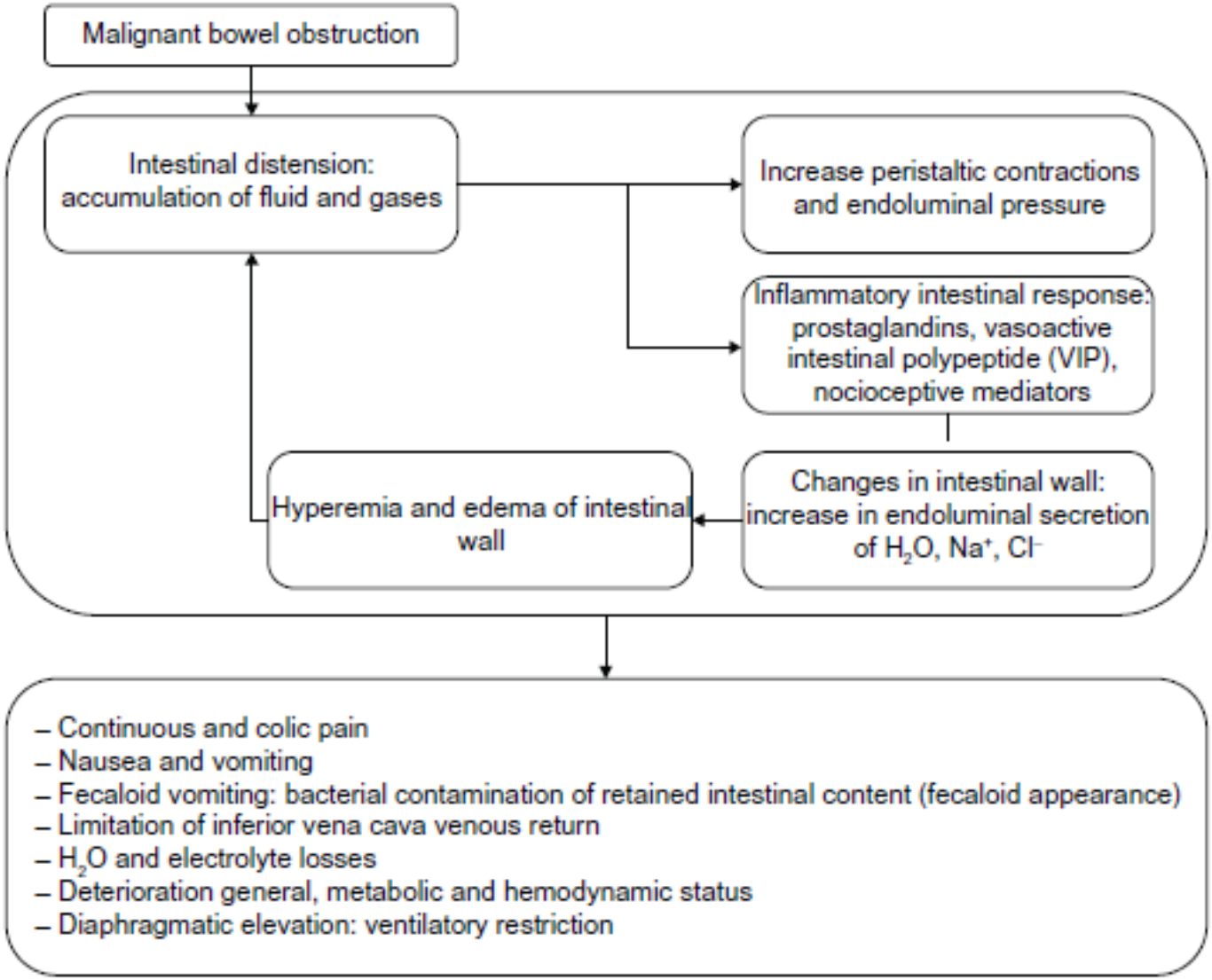
Bowel obstruction



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Bowel obstruction –management options

- GI decompression
- Surgery
- Endoscopic Palliation and stenting
- Percutaneous endoscopic gastrostomy
- Parenteral nutrition
- Pharmacological treatments
  - Morphine
  - Antiemetics
  - Anti secretory drugs
  - Corticosteroids
  - Octeotride

Management of locoregional issues /complications

Fungating lesions

- Chronic pain
- Malodorous discharges
- Bleeding
- Exudative secretions
- Frequent infections
- Maggots

Implications

Physical
Psychological
Social

Assessment guide for Malodour

Strong

Odour is evident on entering the room (2–3 metres from the patient) when the dressing is intact

Moderate

Odour is evident on entering the room (2–3 metres from the patient) when the dressing is removed

Slight

Odour is evident at close proximity to the patient when the dressing is removed

No odour

No odour is evident, even at the patient's bedside, when the dressing is removed

Malodor -Local care

Synthesis of Evidence Regarding the Topical Treatment of the Fetid Odor of MFWs ($n=11$)

Topical Intervention	Citations in Studies, n (%)[a]	Highest Level of Evidence Achieved	Highest Grade of Recommendation Achieved
Metronidazole	10 (50)	2b	B
Mesalt® dressing	1 (5)	2b	B
Curcumin ointment	1 (5)	2c	B
Activated carbon dressing	2 (10)	2c	B
Topical arsenic trioxide	1 (5)	4	C
Essential oils	4 (20)	4	C
Green tea extract	1 (5)	4	C
Hydropolymer dressings	1 (5)	4	C
Antiseptic solutions	1 (5)	5	D
Hydrogels	1 (5)	5	D
Debridement enzymes	1 (5)	5	D

Malodor -Local care

- Malodor causes social embarassment for the patient and her family and can be psychologically devastating
- The mainstay of treatment include anticancer therapy, local wound care and local therapy like radiation and surgery.

- Pallliative care with highest level of evidence includes
  - metronidazole
  - mesalt dressing
  - activated carbon dressing
  - and curcumin ointment

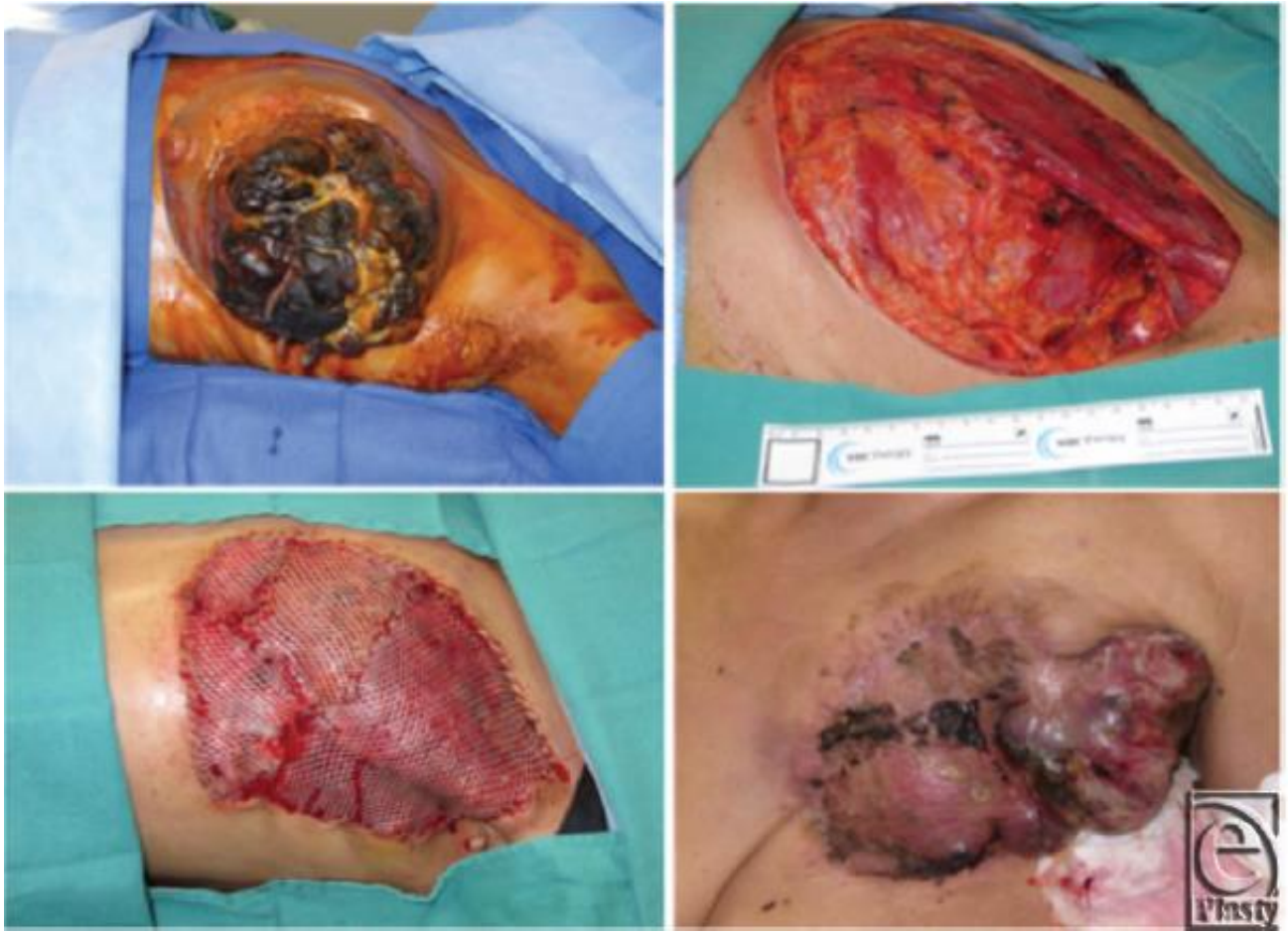
Surgery

- Rationale –
  - A reduction in the number of cancer cells/resistant clones
  - debulking
  - Immunocmpetency
  - Palliation

- Disadvantages
  - Accelerated regrowth or relapse- release on angiogenic factors and growth factors
  - Complications

- local treatments to palliative management of uncontrolled local and/or regional disease –toilet mastectomy
- bulk of retrospective data suggesting the importance of local treatment of primary tumor in non-oligometastatic breast cancer

Surgery for fungating wounds



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Outcomes

Management and Reconstruction in the Breast Cancer Patient With a Fungating T4b Tumor

Aditya Sood, MD, MBA, Lily N. Daniali, MD, Kameron S. Rezzadeh, BA, Edward S. Lee, MD, and Jonathan Keith, MD

Variable	*n* (%)
Location of first presentation	
Emergency department	3 (25)
Charity care clinic/community clinic	7 (58)
Private office	2 (17)
Chief complaint on presentation	
Open wound and/or skin involvement	12 (100)
Pain	8 (66)
Malodorous drainage	3 (25)
Breast mass increasing in size	3 (25)

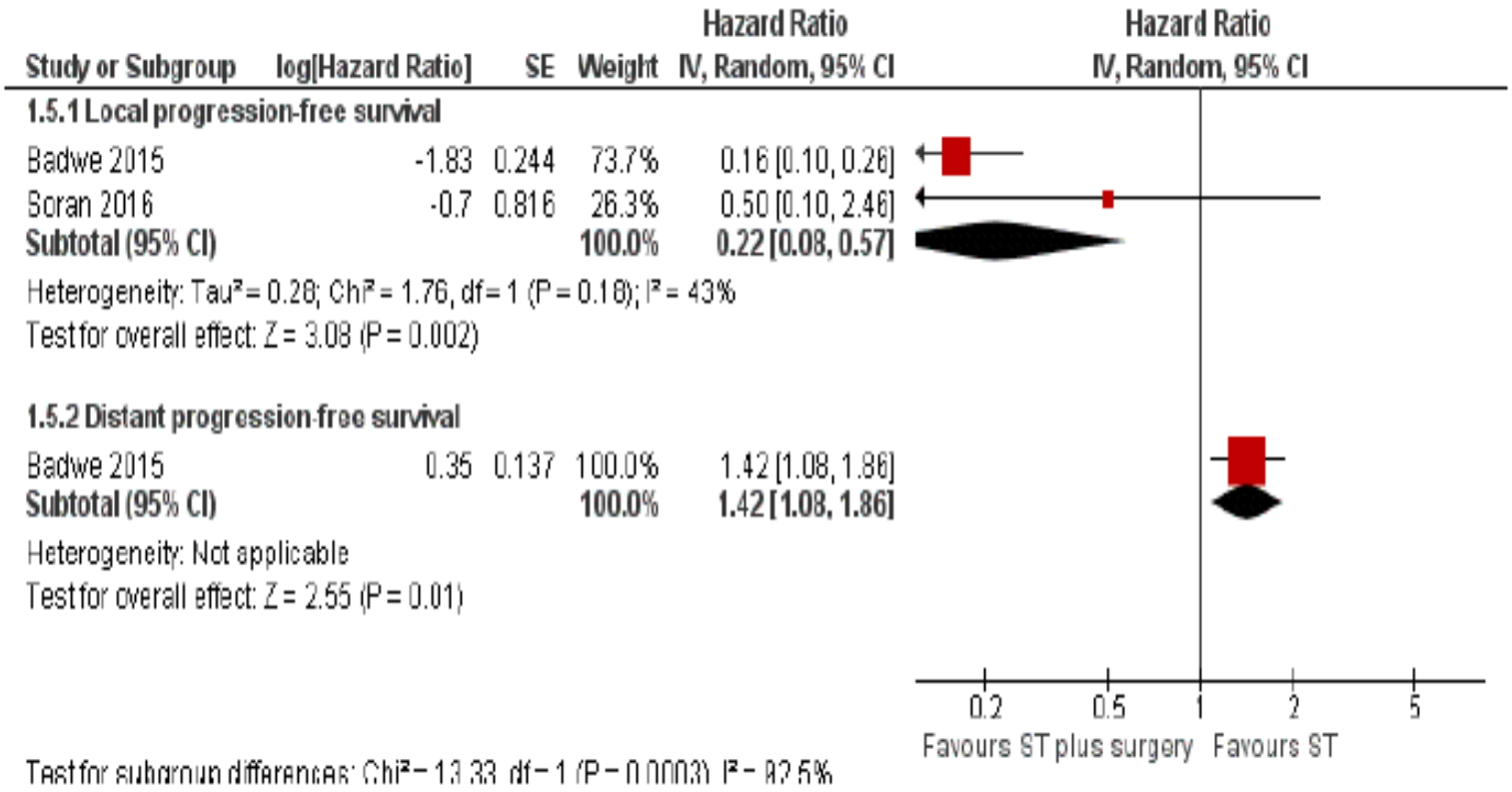
	n (%)
Surgical site at 6-wk follow-up	
Healed	7 (58)
Open wound requiring dressings	3 (25)
Not reported	2 (17)
Postoperative pain palliation	
Reduced pain	9 (75)
Persistent or increased pain	2 (17)
Not reported	1 (8)
Postoperative wound palliation	
Improved wound qualities (odor, drainage)	10 (84)
Unimproved wound qualities	1 (8)
Not reported	1 (8)
Adjuvant therapy	
Chemotherapy	4 (33)
Radiation	1 (8)

Cochrane Library

Cochrane Database of Systematic Reviews

Breast surgery for metastatic breast cancer (Review)

Tosello G, Torloni MR, Mota BS, Neeman T, Riera R



Radiotherapy for fungating wounds

- Numerous observational and single arm studies
- palliative radiation has a high response rate and is associated
  - with a median local progression-free survival of 10 months.
- linear correlation between tumor dose and local control such that a 15 Gy increase in dose potentially increases local control by twofold.
- Best control rates with doses above 30Gy
- most prevalent fractionation scheme is 30 Gy in 10
  - fractions- though wide variation; single fraction to upto 30 # are reported
- Tangential beam most commonly used , though VMAT for complex volumes

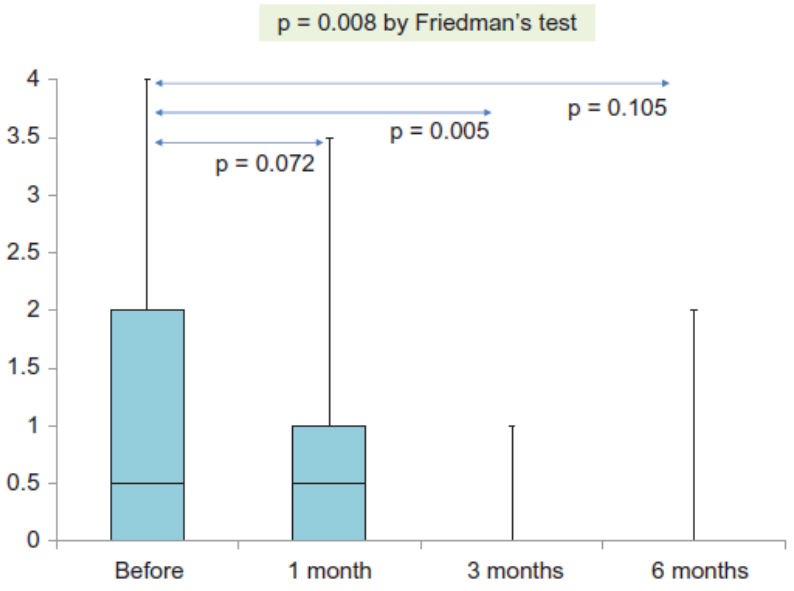
Palliation achieved

Original Article

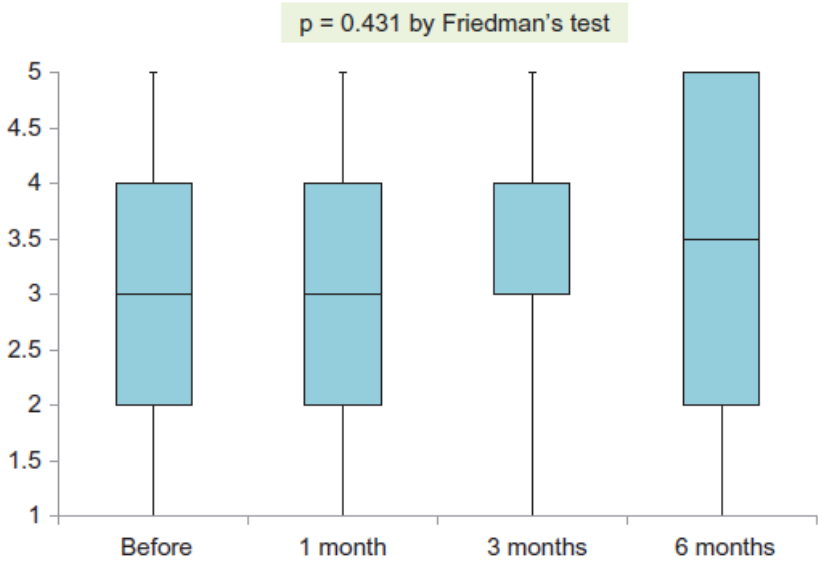
Palliative radiotherapy for breast cancer patients with skin invasion: a multi-institutional prospective observational study

Naoki Nakamura[1,2,*], Jiro Kawamori[2], Osamu Takahashi[3],

Malodor scores



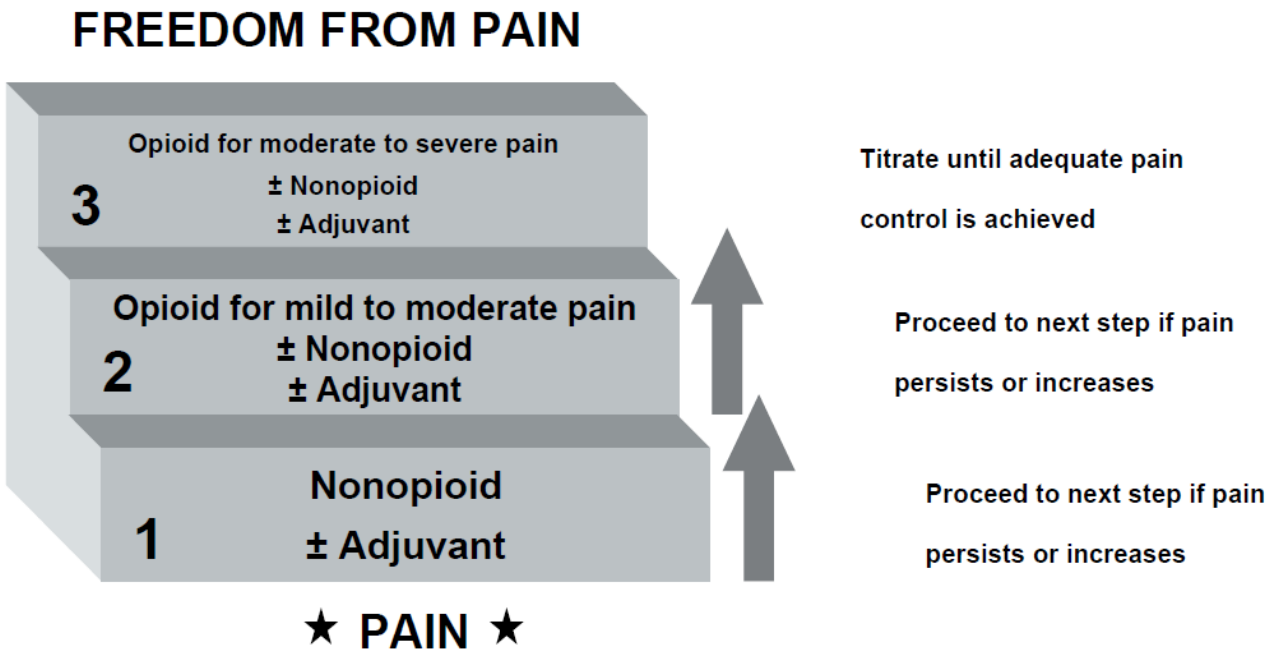
Pain scores



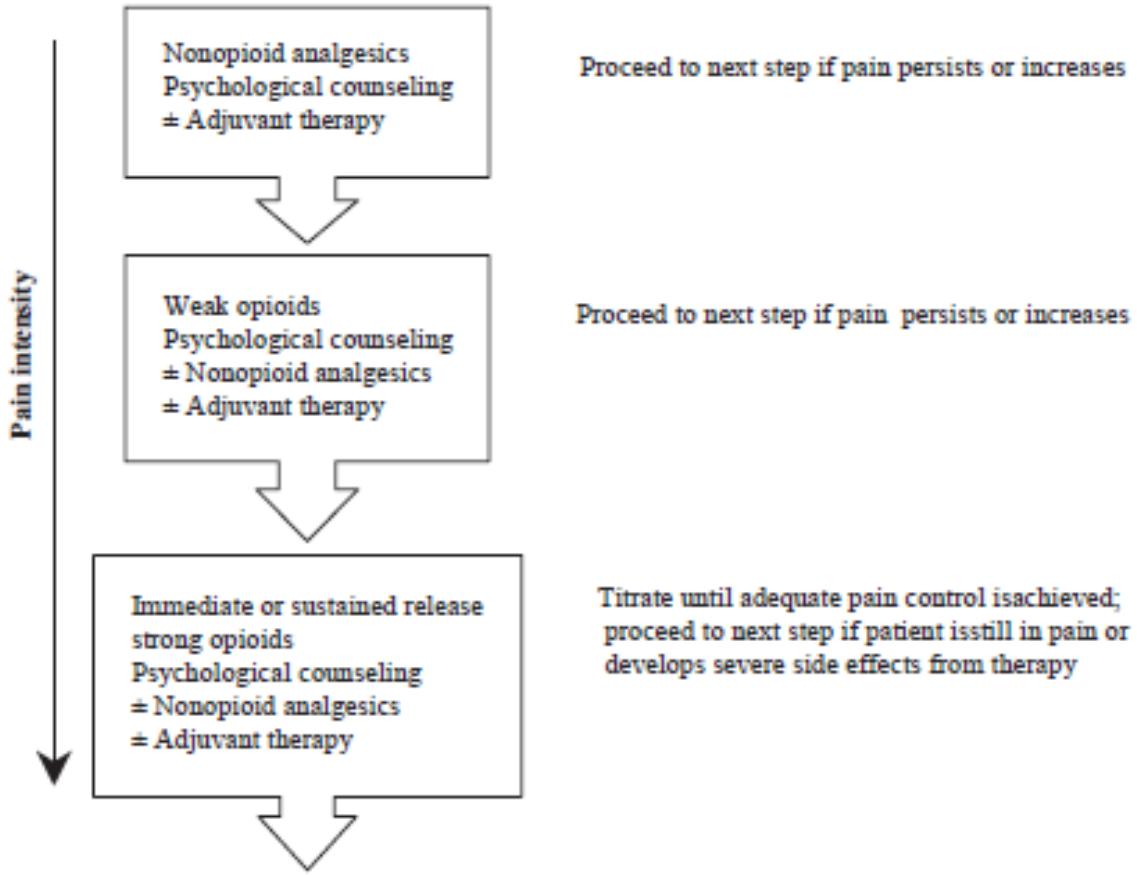
Pain management

- Assessment of pain

- Evaluating the cause of pain



Pain management –modified ladder



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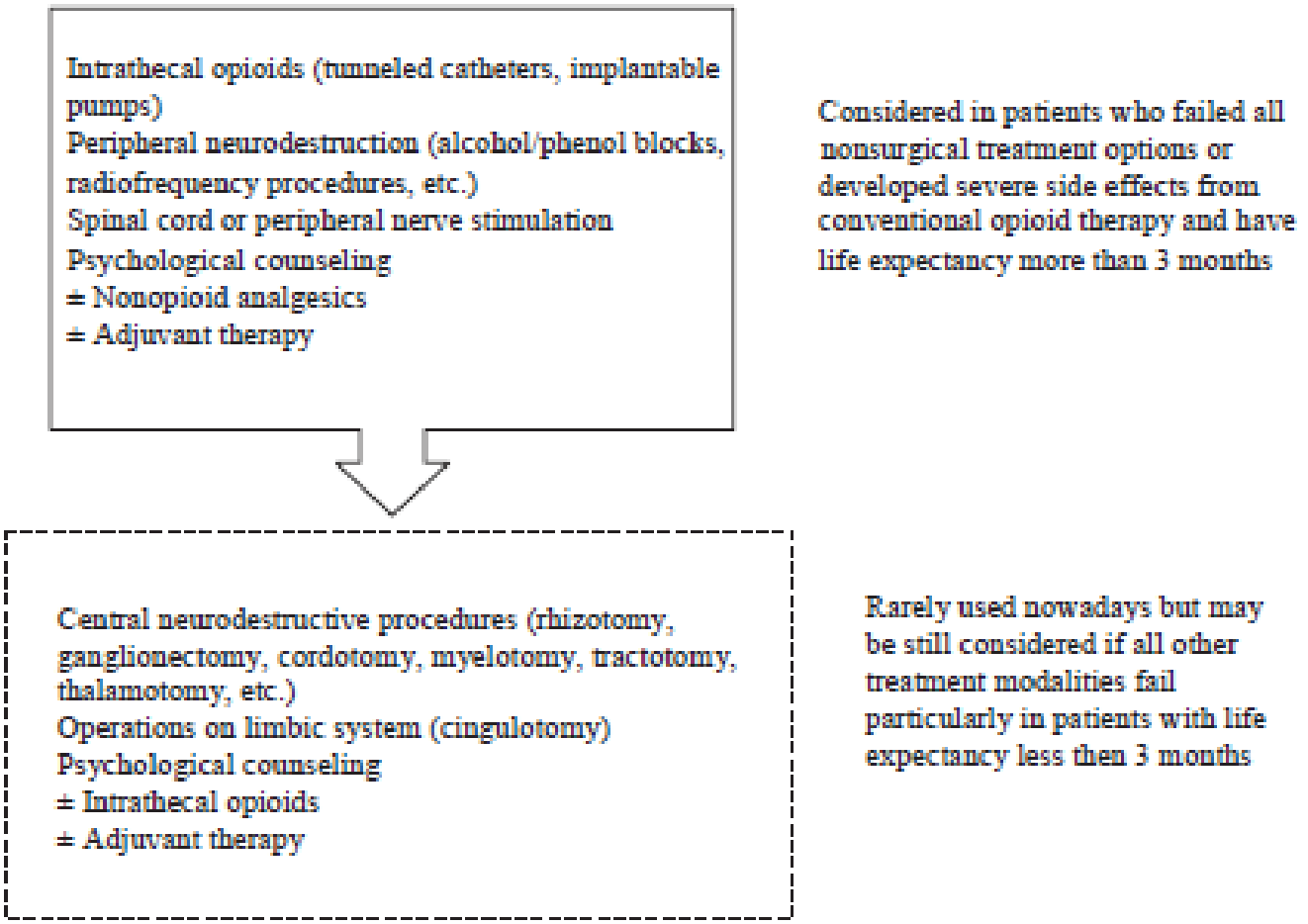
Pain management –modified ladder



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Palliative psychosocial care

Palliative care resource allocations: pain management and end-of-life care with metastatic disease.

	Basic	Limited	Enhanced	Maximal
Pain Management[a]	Pain consideration[b] (simple assessment) Pain drugs[a], including morphine (basic) Management of pain-related physical symptoms CAM and non-drug pain management	Other pain drugs[a] Radiotherapy (single and multi-fraction) PT and OT for functional limitations or pain management	Pain screening Pain care plan Opioid pumps, methadone, fentanyl patch Consultation with specialist in pain therapy Surgery (cord compression, fracture, obstruction)	Locoregional anesthesia, spinal analgesia
Psychosocial (End-of-life)	Psychosocial (end-of-life) consideration[b] Patient, family, and caregiver education[c] Psychosocial support: community-based Bereavement support: community based	Patient, family, and caregiver education[c]: emotional aspects of death Advanced care planning	Screening and referrals for depression/distress by mental health specialist Psychosocial counseling by mental health specialist Antidepressants Social services for financial, legal and family matters	Psychiatrist, psychologist, or social worker coordinated mental health care
Spiritual (End-of-life)	Spiritual consideration[b] Spiritual support: community based		Clinic or hospital associated spiritual support Hospital or hospice spiritual reflection and meditation space	

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Evaluation and management of common psychological symptoms

- Anxiety
  - Anxiolytic pharmacotherapy
    - Benzodiazepines and nonbenzodiazepine anxiolytics
  - Nonpharmacological interventions
    - Supportive psychotherapy and behavioral interventions
- Depresssion
  - Pharmacological
    - SSRI – third generation preferred (venlaflaxine /trazodone)
    - TCA – for those suffering from agitation
    - Psychostimulants –methylphenidate (rapid action)
  - Non pharcmacological
    - supportive psychotherapy, cognitive-behavioral techniques
- Existential suffering

Conclusion

- Patients with advanced breast cancer and their families have complex needs, which, when unmet, can result in severe distress and undermine their quality of life.
- The management depends on patient symptoms, location of the metastases, burden of disease, co-morbidities and other patient factors along with resource availability
- Management of the physical complications of metastatic disease involves similar interventions as the management of early-stage disease
- Additional palliative care needs include supportive care services that can address end-of-life symptom and pain management, as well as psychosocial and spiritual concerns
- Optimizing and individualizing therapy requires the full engagement of an interdisciplinary approach to palliative care with strong emphasis on the assessment of needs and anticipated needs