



Update on Palliative Care Interventions for Patients with Hematologic Malignancies

Jason A. Webb, M.D., DFAPA, FAAHPM, FACP

Section Chief & Assoc. Professor, Knight Cancer Institute, OHSU
Twitter: @JasAWebb Email: webbj@ohsu.edu

Objectives

- Describe disparities in palliative care for patients with hematologic malignancies.
- Discuss practice changing clinical trials for integrating PC and Heme Malignancy care.
- Describe future research needs for hematologic malignancies care.

Disclosures

- Funding:
 - PCORI
- Honoraria:
 - AAHPM
- Investments:
 - None

Palliative Care Needs of Patients with Blood Cancers



Why Early PC for Blood Cancers?

- Studies have demonstrated the benefits of early integration of specialty PC for patients with solid tumors¹
- Despite immense PC needs, patients with hematologic malignancies rarely utilize PC services²
- Need to develop population-specific PC interventions for hematologic malignancies (ex. AML vs CML)

Professional Recommendations



ASCO[®]

- “Any patient with metastatic cancer and/or high symptom burden”
- Accredited programs “required to offer palliative care either on site or by referral”



Commission
on Cancer

- “Institutions should develop processes for integrating palliative care into cancer care”



ONS[®]
Oncology Nursing Society

- “All patients with cancer benefit from palliative care”
- “Palliative care should begin at time of diagnosis”



NCCN
National
Comprehensive
Cancer
Network[®]

EoL “Quality Measures” Gap

- Patients with blood cancers are **more** likely to: ^{1,2}
 - Receive chemotherapy in the last 14 days of life
 - Spend time in an ICU in the last 30 days of life
- Patients with blood cancers are **less** likely to:
 - Access consultative palliative care services³
 - Use hospice services⁴
 - Or, are more likely to die within 7 days of enrollment, or within 24 hrs of enrollment ⁵
 - Median LOS of 11 days, vs. 19 for solid tumors ⁵

1. Howell, DA, et al. *BMC Pall Care*, 2010.

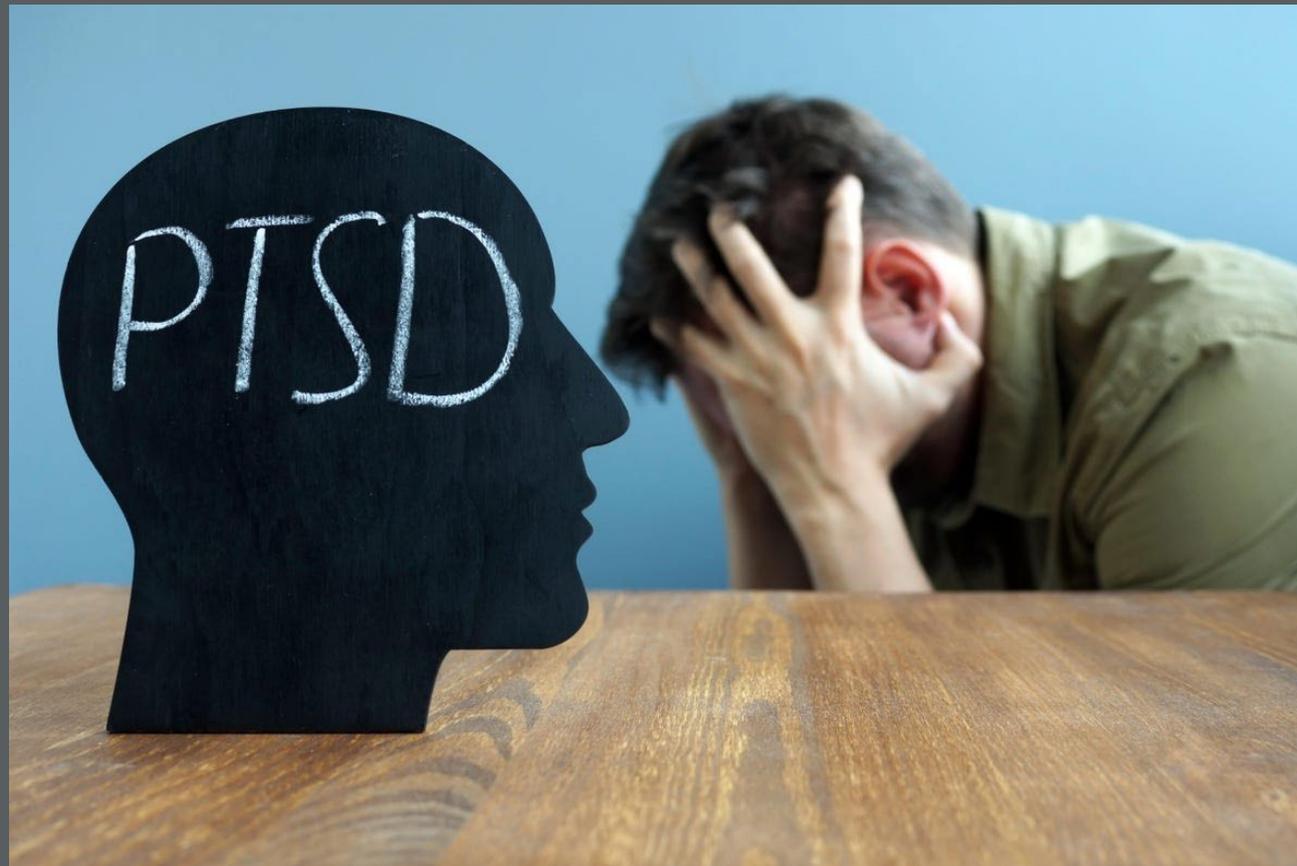
2. Hui, et al. *Cancer* 2014

3. Howell DA, et al. *Palliat Med* 2011.

4. Odejide, et al. *JNCI*, 2015.

5. LeBlanc TW, Abernethy AP, Casarett DJ. *Journal of Pain and Symptom Management*, 2014

Psychological Trauma of Blood Cancer Diagnosis & Treatment



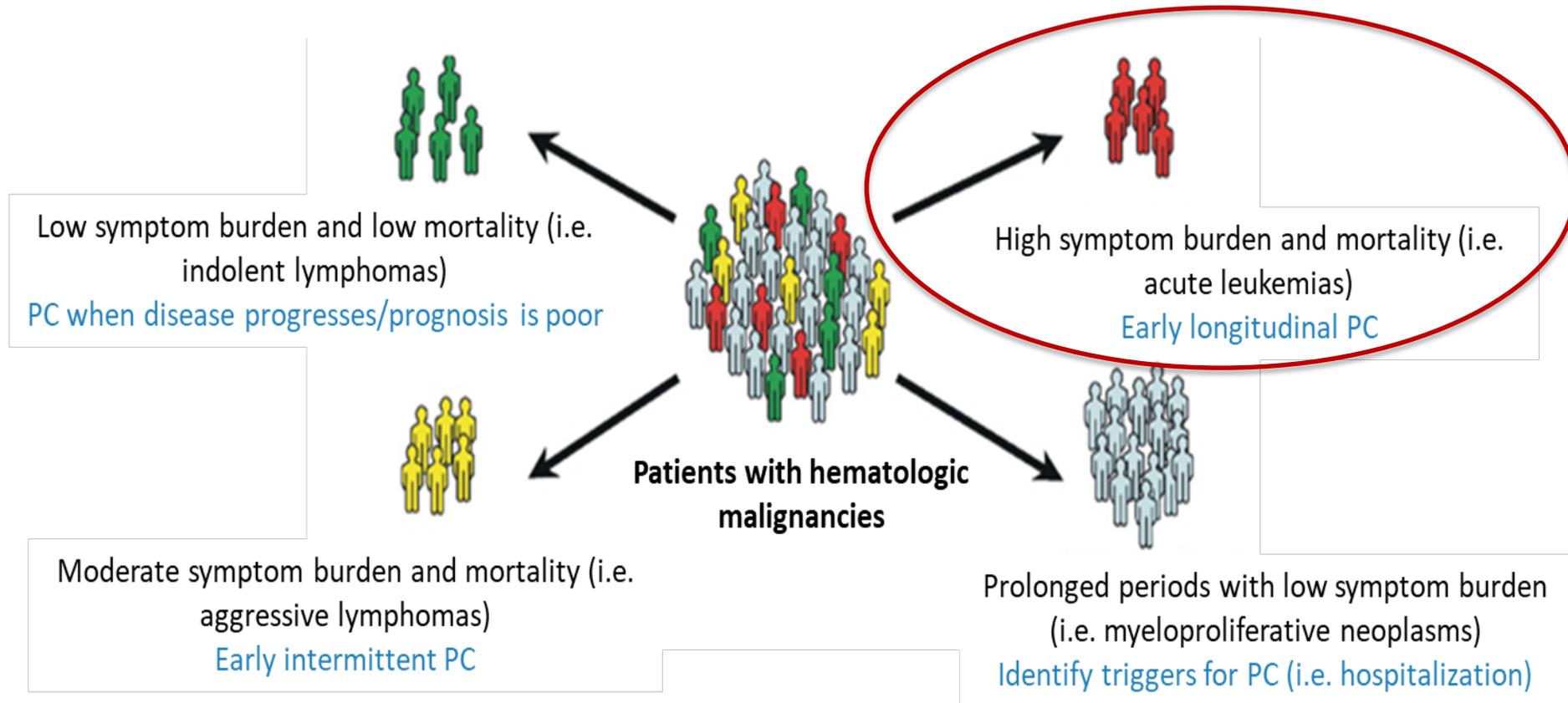
Original Article

Posttraumatic Stress Disorder (PTSD) Symptoms in Patients With Acute Myeloid Leukemia (AML)

Hermioni L. Amonoo, MD, MPP ^{1,2,3}; Thomas W. LeBlanc, MD ⁴; Alison R. Kavanaugh, NP^{3,5}; Jason A. Webb, MD⁶; Lara N. Traeger, PhD^{3,7}; Annemarie D. Jagielo, BSc, BA⁸; Dagny M. Vaughn, BA ^{8,9}; Madeleine Elyze, BA⁸; Regina M. Longley, BA⁷; Amir T. Fathi, MD ^{3,8}; Gabriela S. Hobbs, MD^{3,8}; Andrew M. Brunner, MD^{3,8}; Nina R. O'Connor, MD¹⁰; Selina M. Luger, MD¹¹; Jillian L. Gustin, MD¹²; Bhavana Bhatnagar, DO¹³; Nora K. Horick, MS^{3,14}; and Areej El-Jawahri, MD ^{3,8}

- Patients with high-risk AML who were hospitalized for intensive chemotherapy,
 - 28% had clinically significant PTSD symptoms at 1 month after diagnosis.

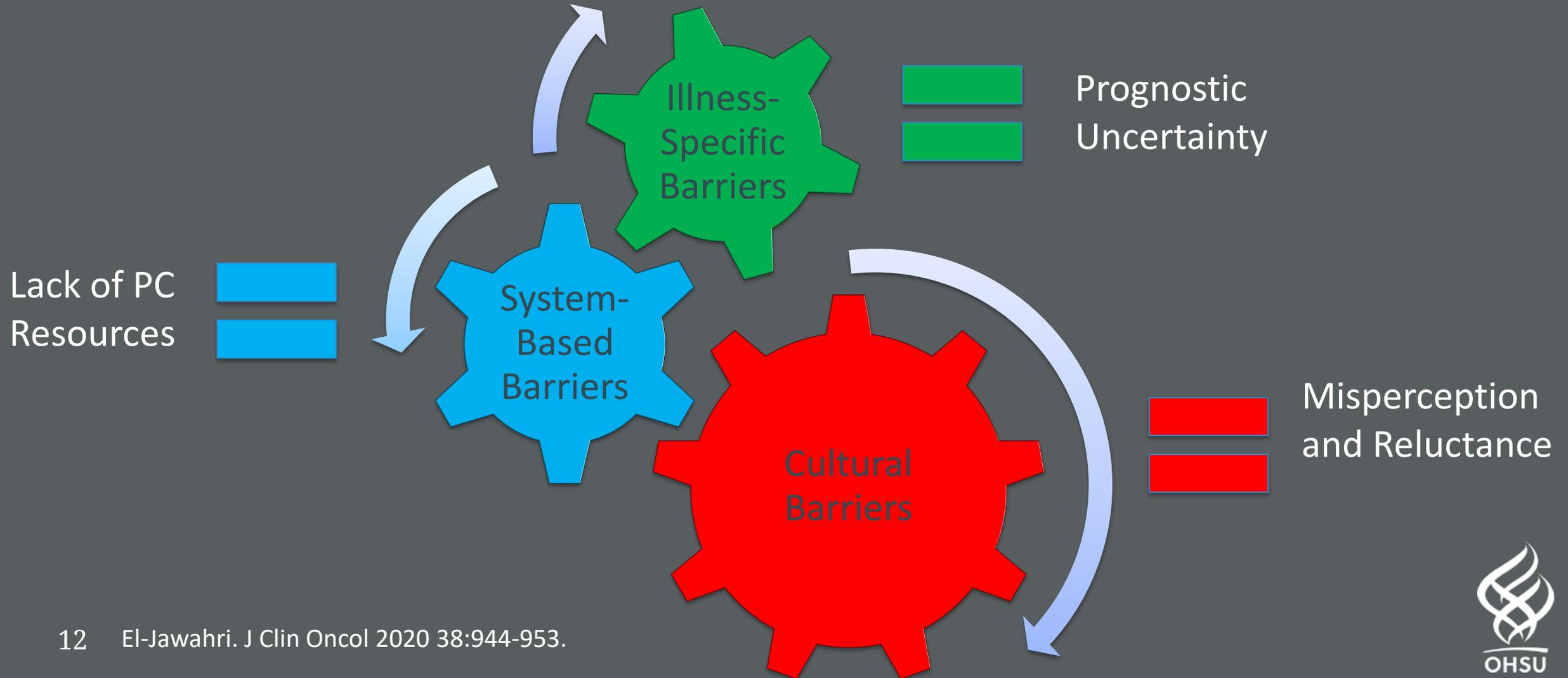
This is not one-size-fits all PC



Survival in AML



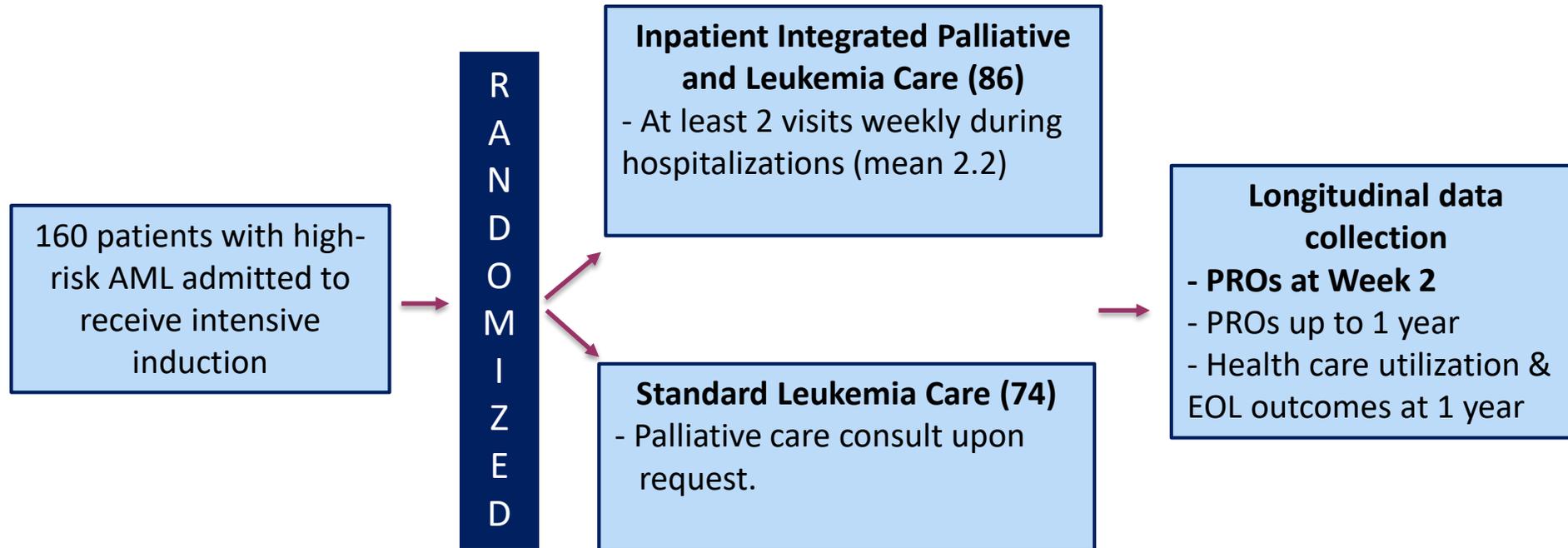
Barriers to PC Integration



A scenic view of a hospital complex on a hillside. In the foreground, a cable car is suspended from cables, and a bridge railing is visible. The hospital buildings are modern, with a prominent glass-walled structure. The background is a clear blue sky.

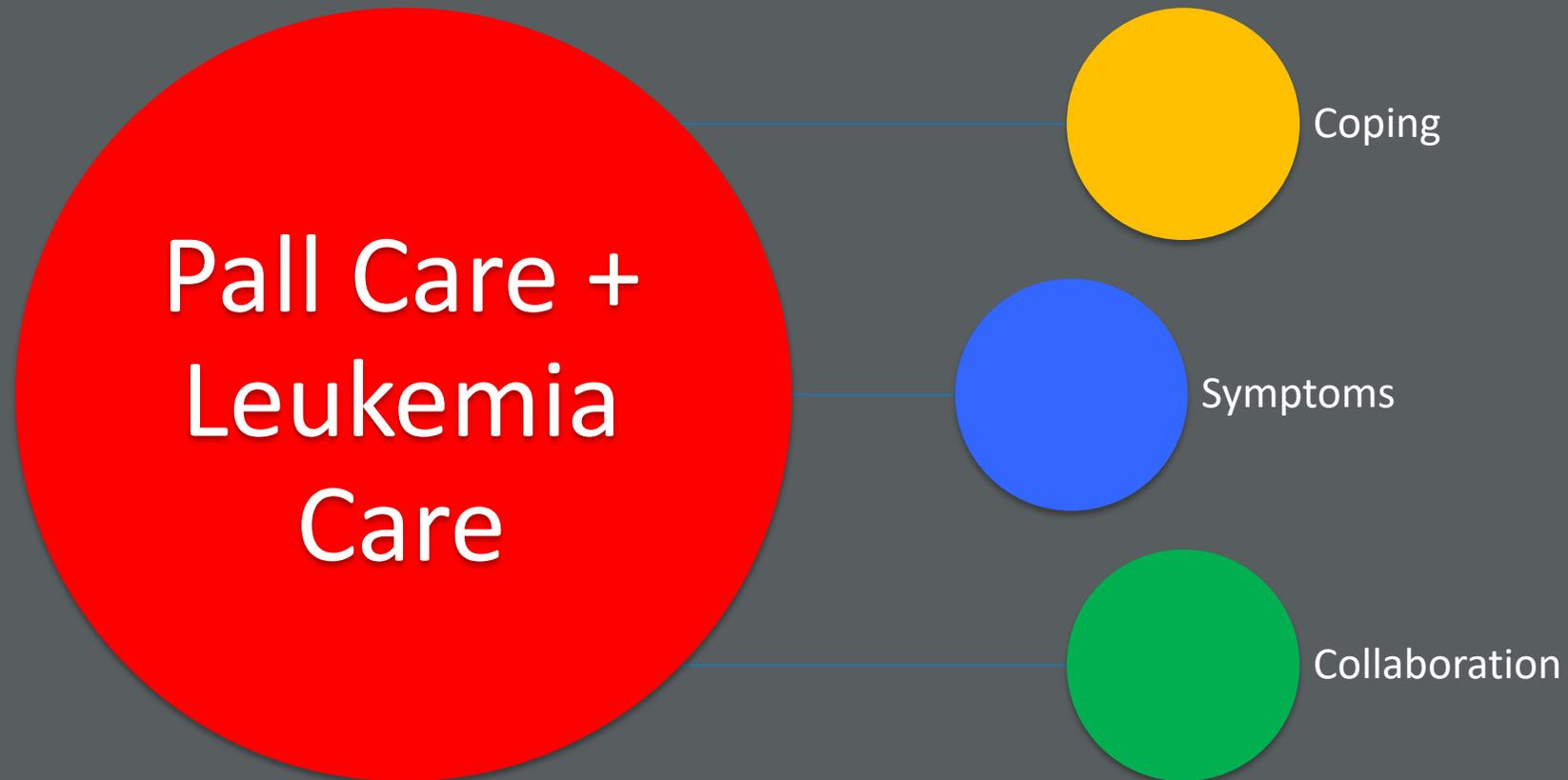
LEAP Study – Integrated PC for Patients with AML

LEAP Study Design



- **Randomization:** Stratified by study site, and diagnosis (newly diagnosed vs. relapsed/refractory)
- **Sites:** MGH, Duke, Penn, Ohio State

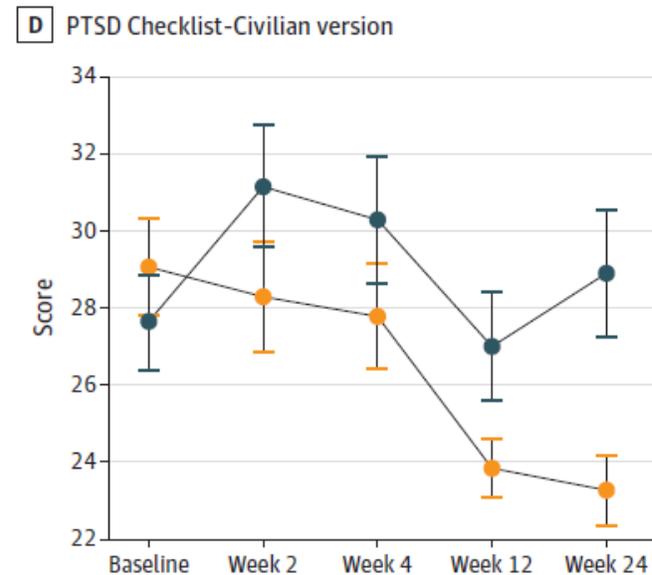
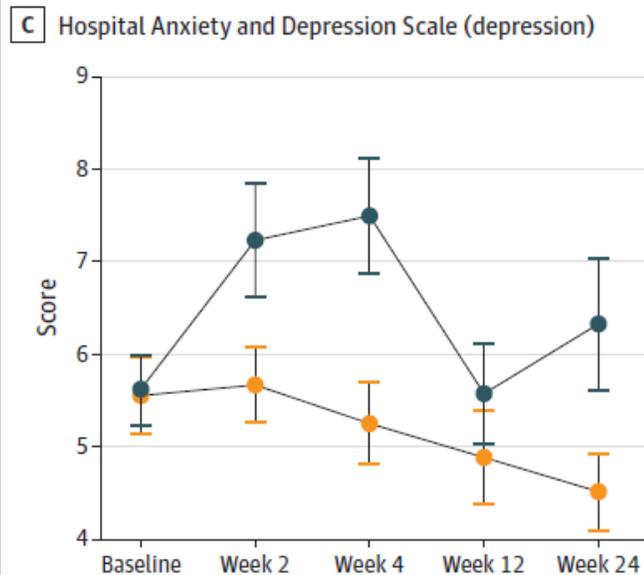
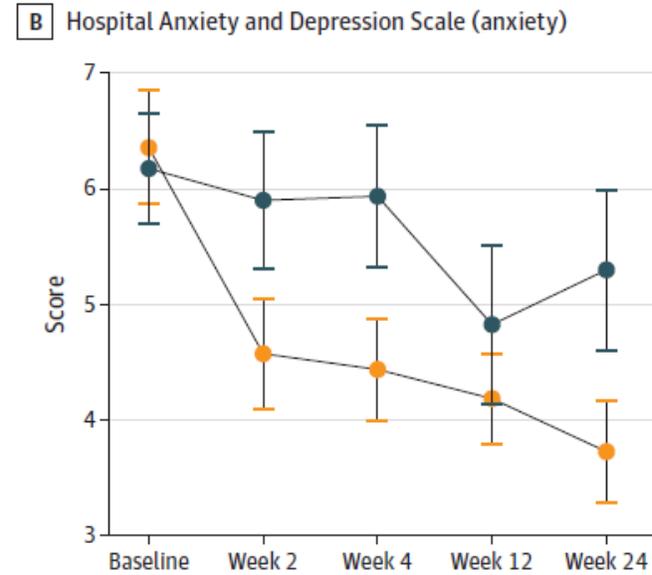
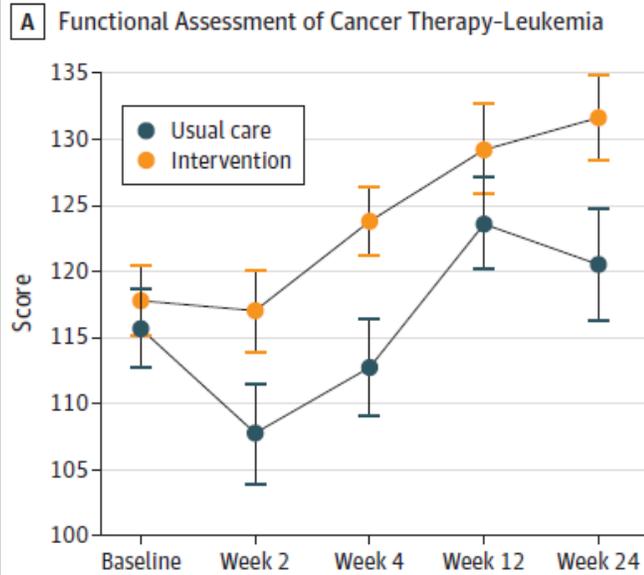
Integrated Palliative Care in AML



IPC for patients with AML is dose dependent (~2x/week), collaborative, and focused on coping and symptoms.



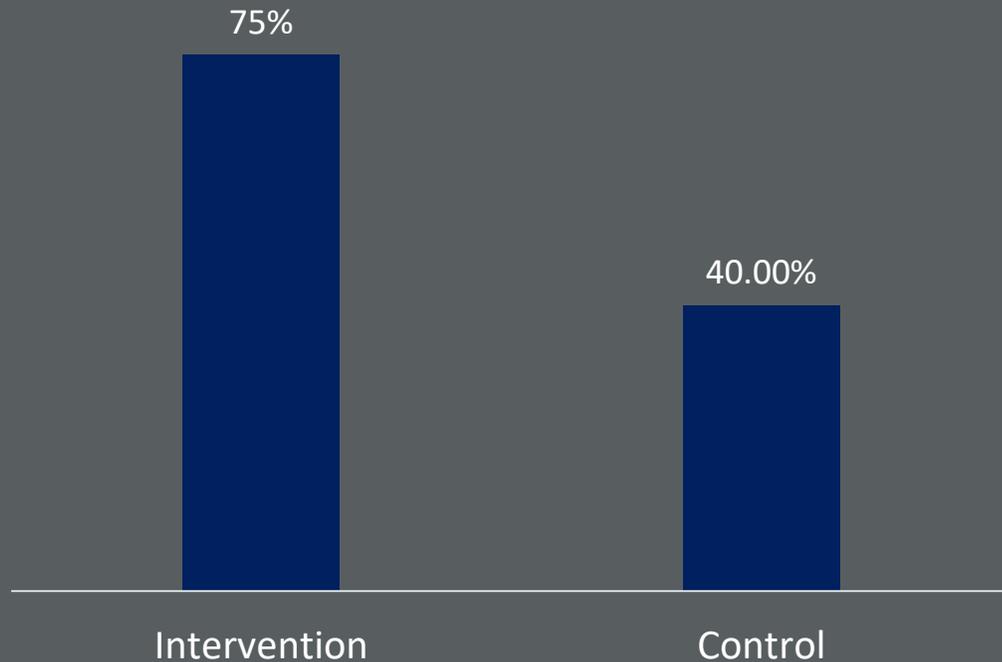
Figure 2. Effect of Integrated Palliative and Oncology Care on Patient-Reported Quality of Life and Psychological Distress by Scale



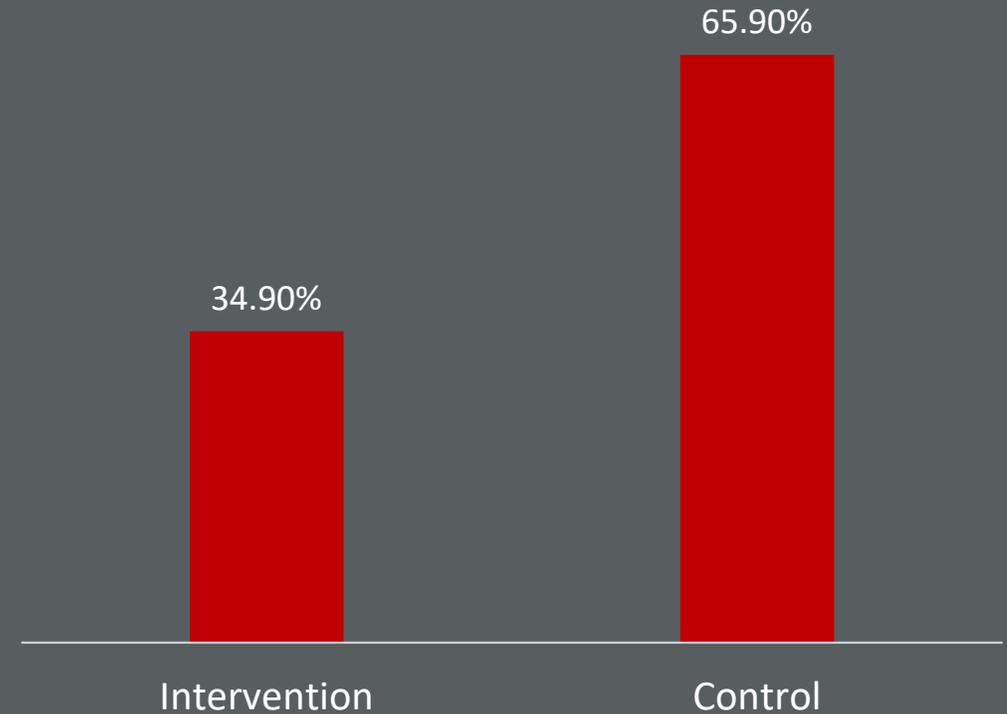
El-Jawahri, Leblanc, Kavanaugh, Webb et al., JAMA Oncol 2020

End of Life Outcomes

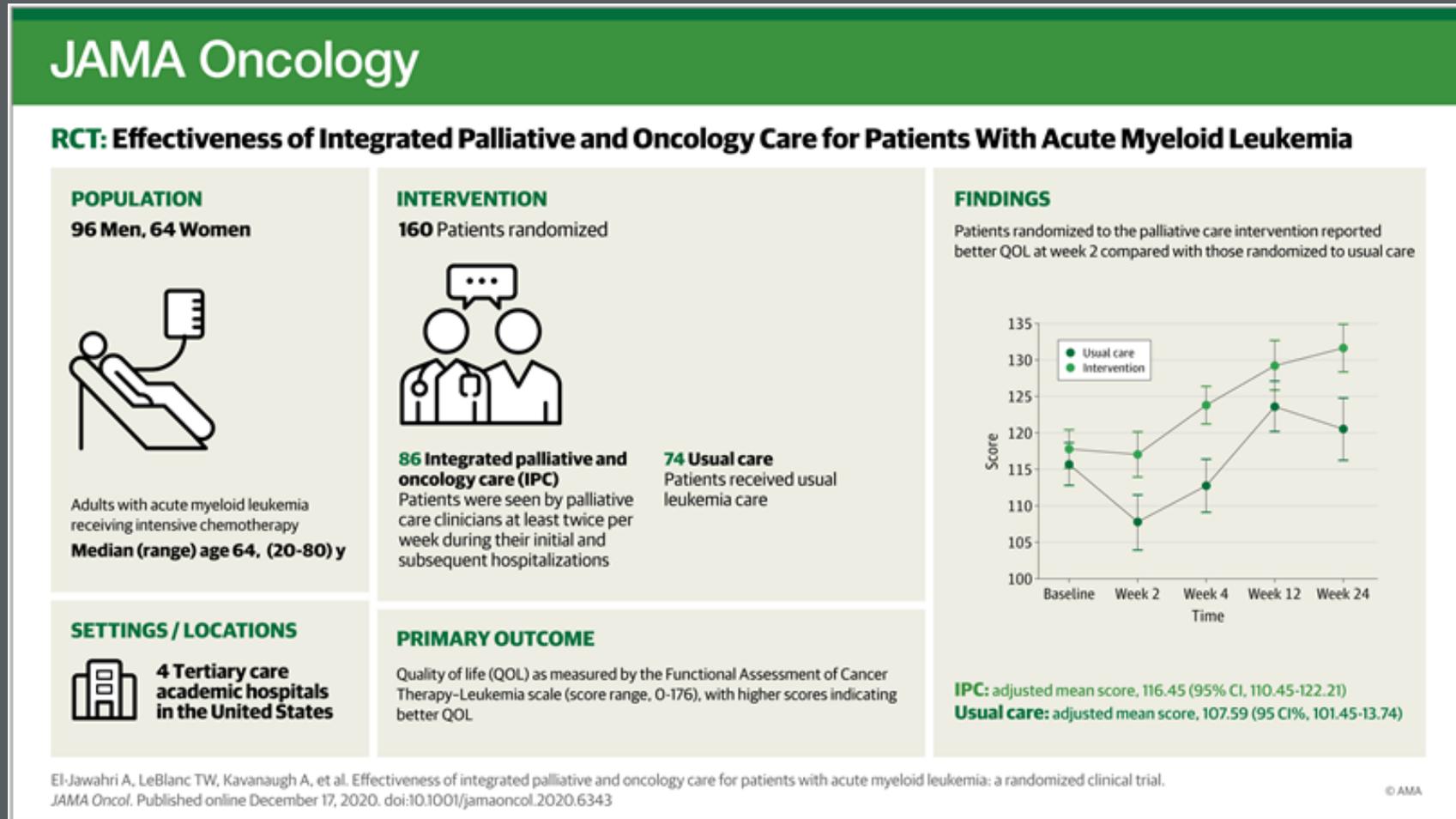
Patient reported discussions of EOL care preferences



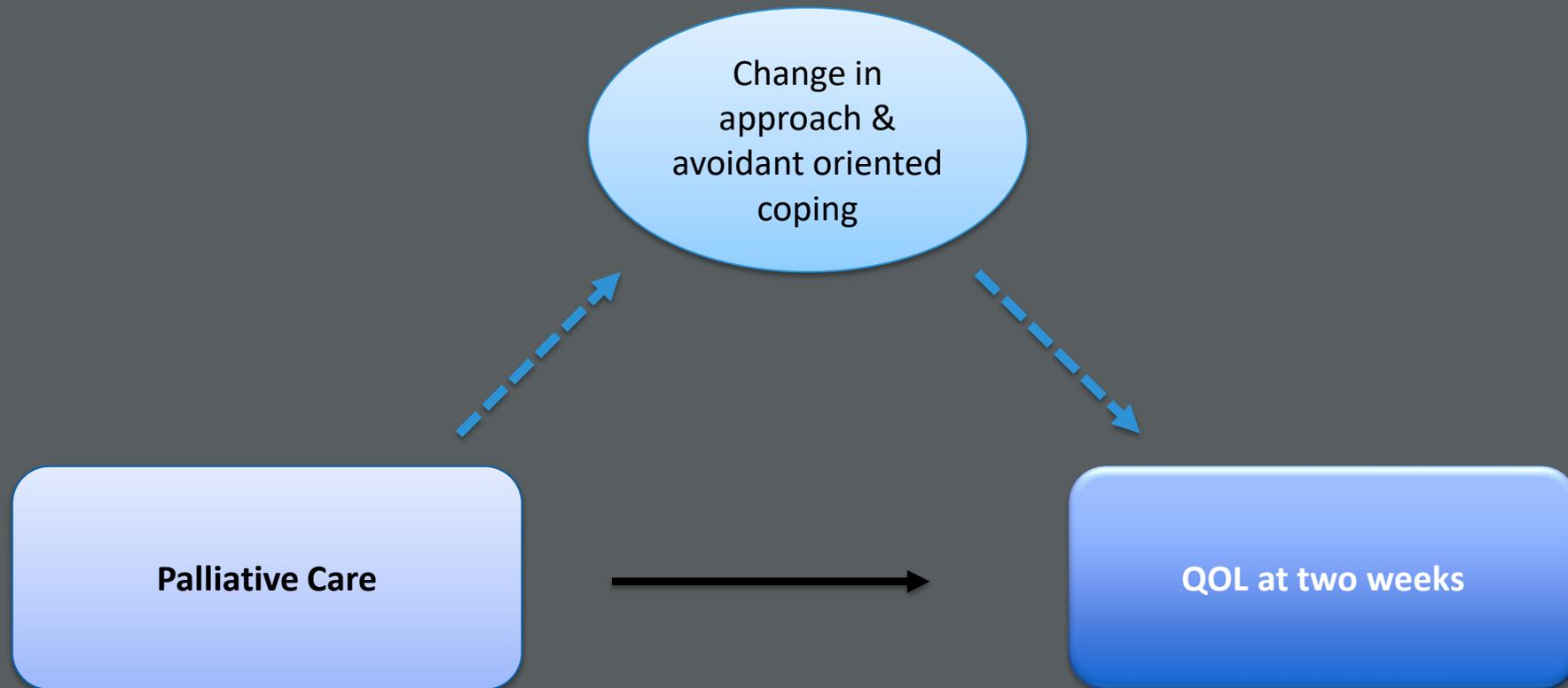
Chemotherapy in the last 30 days of life



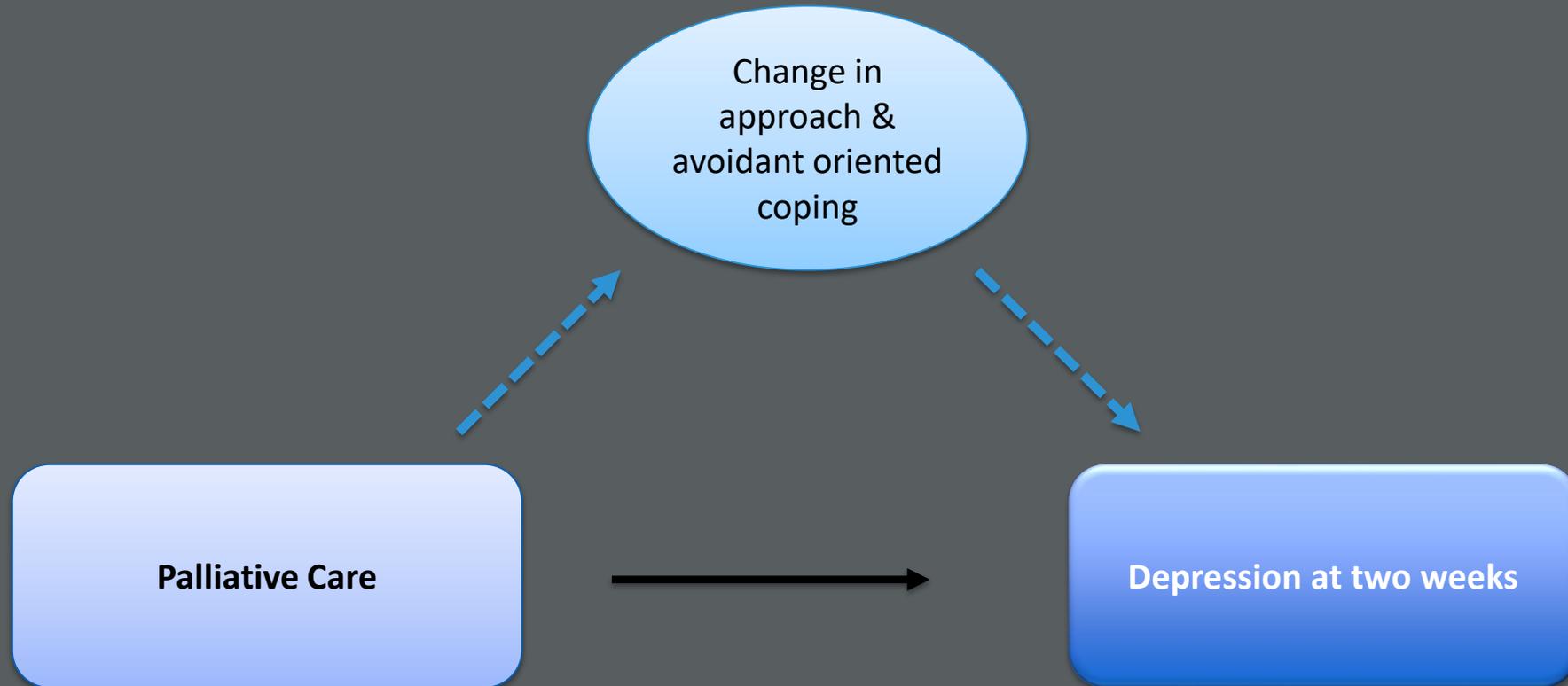
IPC = New Standard of Care



Coping Mediates the Effect of PC Intervention



Coping Mediates the Effect of PC Intervention



ORIGINAL ARTICLE



Check for updates

Emotion And Symptom-focused Engagement (EASE): a randomized phase II trial of an integrated psychological and palliative care intervention for patients with acute leukemia

Gary Rodin^{1,2,3}  • Carmine Malfitano¹ • Anne Rydall¹ • Aaron Schimmer^{4,5} • Charles M. Marmar⁶ • Kenneth Mah¹ • Christopher Lo^{1,2,7} • Rinat Nissim^{1,2} • Camilla Zimmermann^{1,2,3,8}

- RCT comparing a manualized supportive psychotherapy intervention compared to UC for patient with AML.

EASE: Phase 2 RCT

- Two components to the intervention with primary outcomes at 8 weeks:
- EASE-psy → Psychological Intervention
 - Psychotherapy delivered over 8 weeks
- EASE-Phys → Physical Symptom Intervention
 - Weekly physical symptom screening to trigger a pall care consult over 8 weeks.

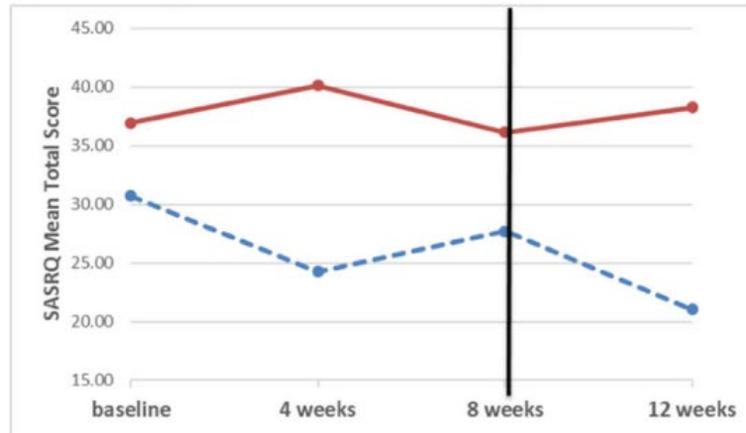
EASE: Phase 2 RCT

- EASE intervention compared to UC:
 - Significant treatment-group differences favoring EASE were observed:
 - Traumatic stress symptoms at 4 and 12 weeks
 - Pain intensity and interference at 12 weeks
 - ($p < .05$).

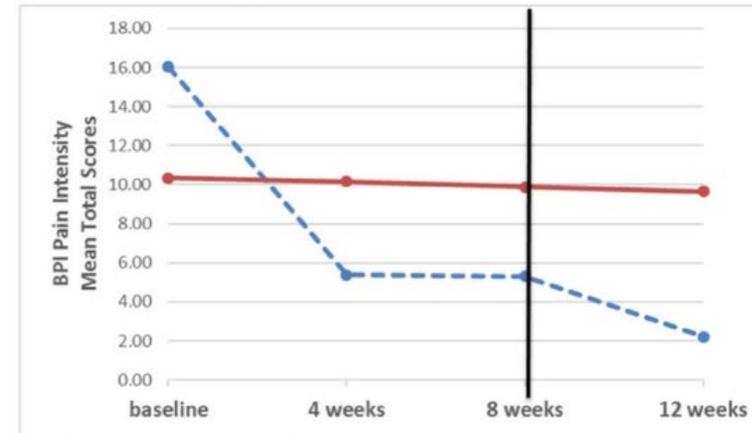
EASE: Phase 2 RCT



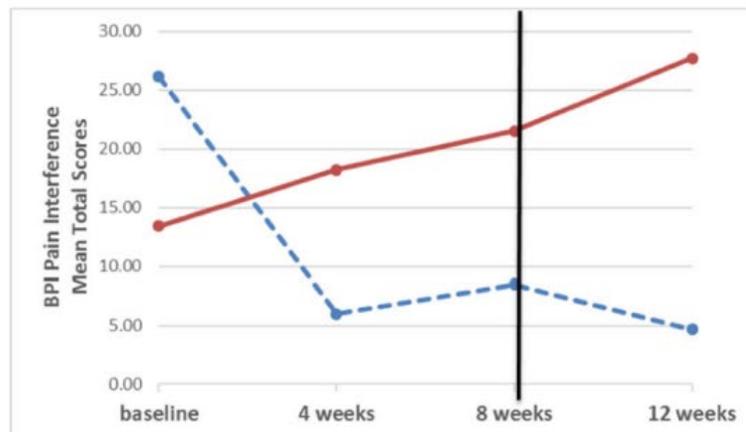
a Severity of traumatic stress symptoms



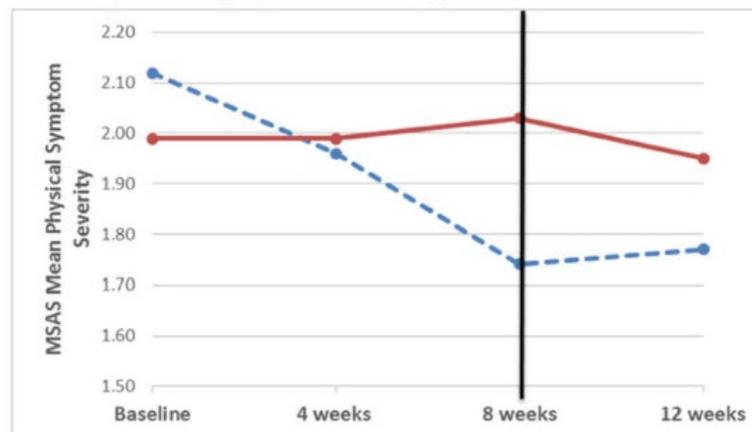
b Pain intensity



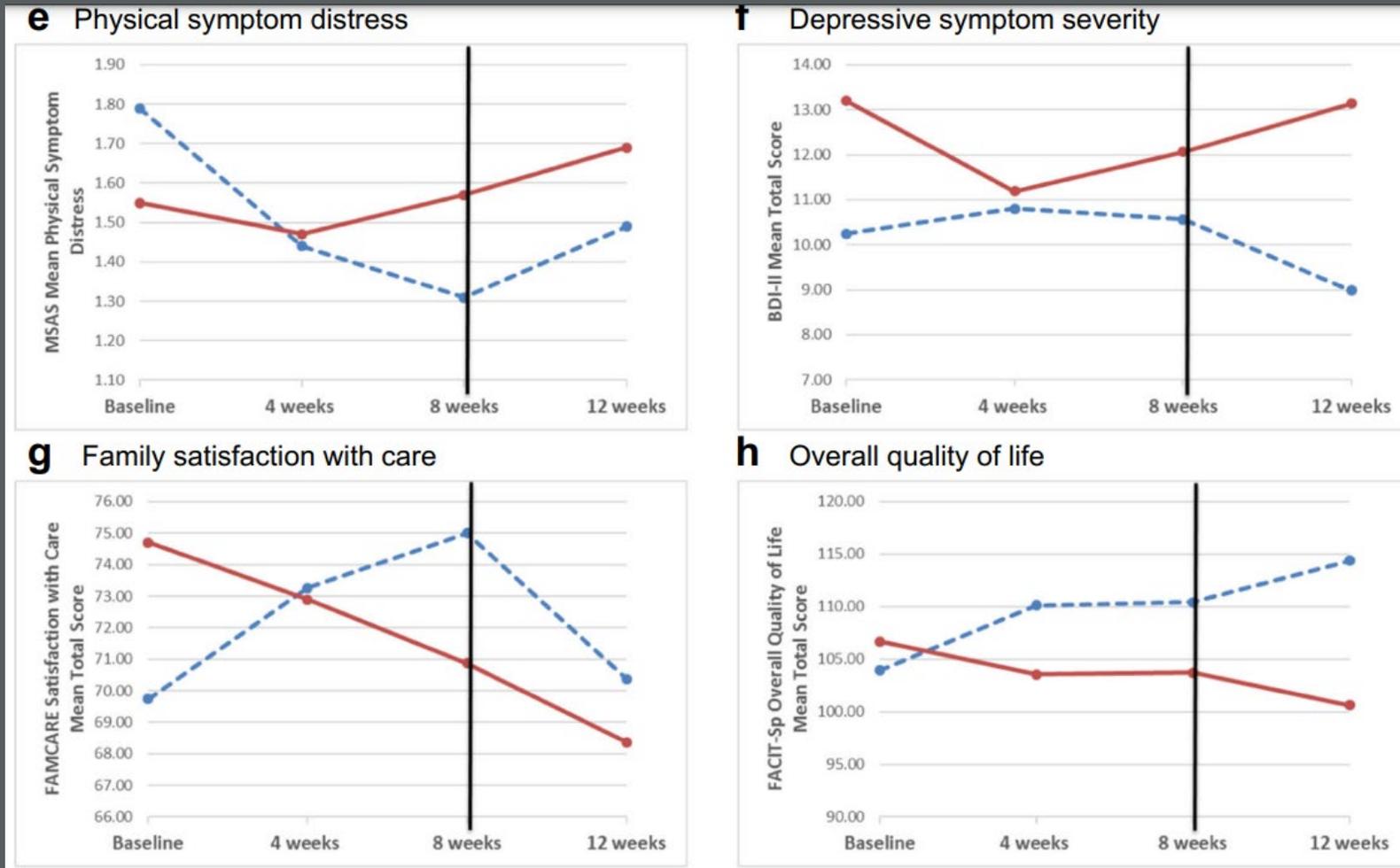
c Pain interference



d Physical symptom severity



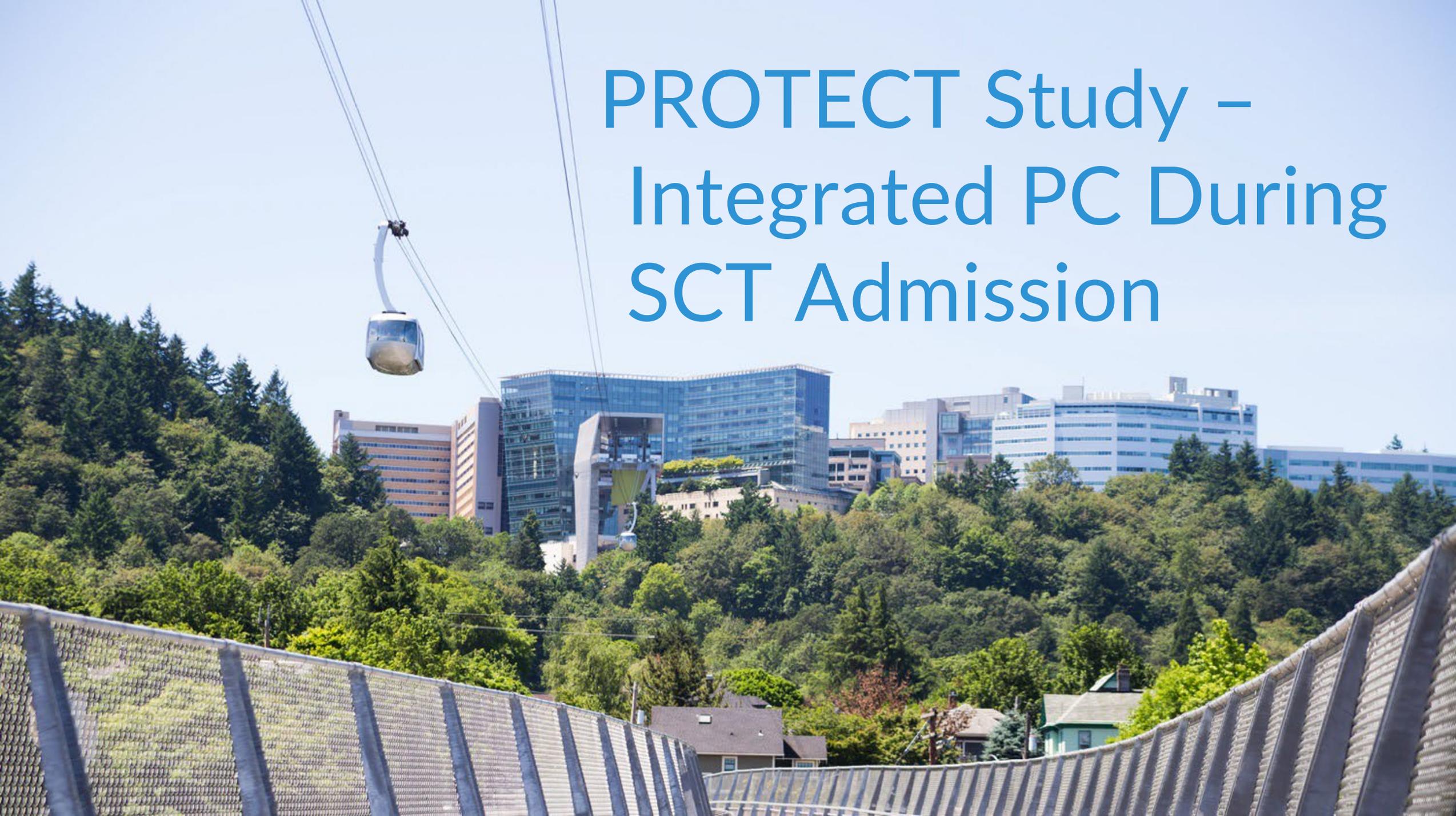
EASE: Phase 2 RCT



IPC + AML Take Home Points:

- In these two randomized clinical trials of supportive care interventions for patients with AML, IPC or EASE led to substantial improvements in:
 - QOL
 - Psychological distress
 - EOL care
 - Family Satisfaction of Care
- Integrated palliative care should be considered a new standard of care for patients with AML.

PROTECT Study – Integrated PC During SCT Admission





ASH | Annual Meeting & Exposition

- Mu
- Pa
- Un
- Tr

913 Multi-Site Randomized Trial of Inpatient Palliative Care for Hospitalized Patients Undergoing Hematopoietic Stem Cell Transplantation

Program: Oral and Poster Abstracts

Type: Oral

Session: 906. Outcomes Research – Myeloid Malignancies: Symptom Burden and Supportive Therapies

Hematology Disease Topics & Pathways:

Research, adult, Clinical Research, health outcomes research, patient-reported outcomes, Study Population, Human

Monday, December 11, 2023: 2:45 PM

Areej El-Jawahri, MD¹, Thomas W LeBlanc, MD², Alison Kavanaugh^{3*}, Jason Webb, MD^{4*}, James Fausto^{5*}, Lara Traeger^{3*}, Joseph Greer, PhD^{3*}, Vicki Jackson, MD^{3*}, Nora Horick^{6*}, Zachariah Defilipp, MD⁷, Yi-Bin Chen, MD, MS³, Stephanie J. Lee⁸ and Jennifer Temel^{3*}

Protect Trial

- **Sites:** Three academic hospitals (Penn, MGH, Duke).
- **Population:** Allo + Auto Transplants During Inpatient Care
- **Randomization:** Usual SCT Care vs. Integrated Early PC
- **Intervention:** Two (2) visits per week by PC Clinician (MD/DO or APP)
 - Symptom Management
 - Coping Support
- **Primary outcome measures at week-2:**
 - QoL (FACT-BMT)
 - Depression (HADS-D)
 - Anxiety (HADS-A)
 - PTSD (Civilian PTSD Checklist)
 - Symptom Burden (ESAS)

PROTECT Trial - Results

- Enrolled 360 patients (70% of eligible pts)
- Mean age = 55.4 (SD=12.5), 61.9% male, 76.6% White
- 23.4% racial minorities, 8.7% Hispanic ethnicity
- 50.2% underwent allogeneic HSCT between October 2018 and July 2022.

Results – RCT PC for SCT

- Compared to those receiving usual care, participants receiving the inpatient palliative care intervention reported: (week-2 primary endpoint)
 - **Better QOL** (95.5 vs. 89.3, $P < 0.001$) at week-2.
 - **Lower depression** (5.9 vs. 6.9, $P = 0.041$) **and PTSD symptoms** (26.0 vs. 28.2, $P = 0.022$) at week-2.
 - **Lower symptom burden** (35.3 vs. 40.1, $P = 0.018$) at week-2.
 - **Better fatigue scores** (28.6 vs. 25.6, $p = 0.014$) at week-2.

Conclusions

- In this multi-site randomized clinical trial, inpatient palliative care led to substantial improvements in patients' QOL, depression and PTSD symptoms, symptom burden, and fatigue during HSCT hospitalization compared to usual care.
- *Integrated palliative care should be considered a new standard of care for patients hospitalized for HSCT.*

Future Clinical Trial: SCOPE - Leukemia



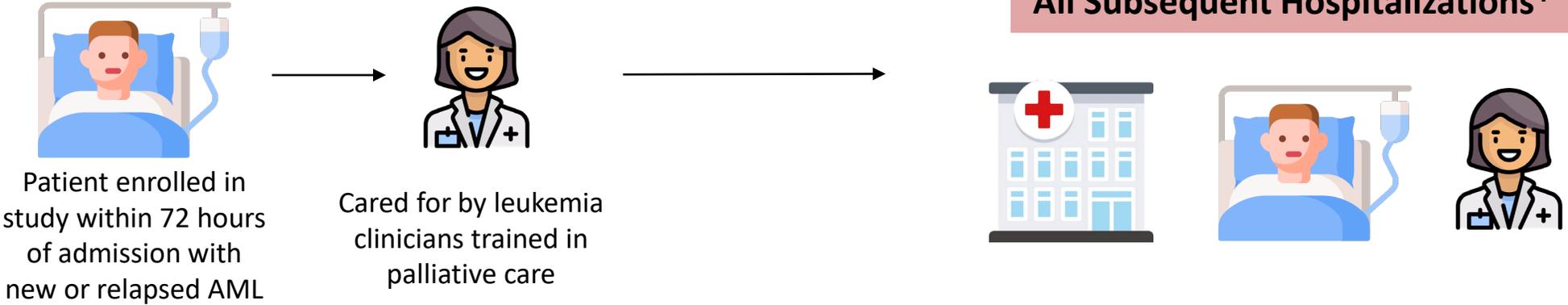
SCOPE-Leukemia

- Specialty Compared to Oncology Delivered Palliative Care for Patients with Acute Myeloid Leukemia
- Cluster randomized comparative effectiveness trial of primary palliative care (PPC) vs. specialty palliative care (SPC) in 1150 patients with high-risk AML and their caregivers.

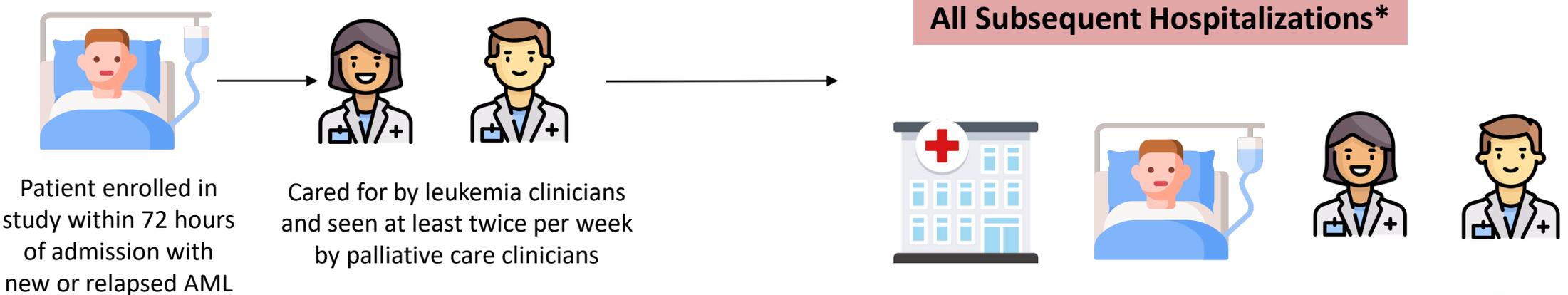
([NCT05237258](https://clinicaltrials.gov/ct2/show/study/NCT05237258))

Intervention Delivery

Primary Palliative Care



Specialty Palliative Care



* Until death or end of study (minimum of 12 months)

Study Design



Patients admitted to hospital with AML are:

Primary Palliative Care
Leukemia clinicians who care for patients with AML are trained in palliative care

Cared for by leukemia clinicians who have been trained in palliative care

Specialty Palliative Care

Cared for by leukemia clinicians and seen at least twice weekly by palliative care clinicians

Study Outcomes

Primary Outcome
Patient quality of life

Secondary Outcomes
Patient Outcomes

Depression and anxiety
Post traumatic stress disorder
End-of-life communication
Chemotherapy before death

Caregiver Outcomes

Quality of life
Depression and anxiety
Caregiving burden

R
A
N
D
O
M
I
Z
E
D



20 PCRC
Institutions

Take Home Points

- IPC should be the new standard of care for patients with AML and those undergoing HSCT during inpatient admissions.
- Longitudinal integrated PC + Leukemia/SCT care results in improved QoL and psychological outcomes for patients with AML and those undergoing SCT.
- Scaling palliative care integration may involve primary PC interventions/training vs. need for specialty care integration.



Thank You



Update on Palliative Care Interventions for Patients with Hematologic Malignancies

Jason A. Webb, M.D., DFAPA, FAAHPM, FACP

Section Chief & Assoc. Professor, Knight Cancer Institute, OHSU
Twitter: @JasAWebb Email: webbj@ohsu.edu