NCCN National Comprehensive Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Palliative Care

Version 2.2015

NCCN.org

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Discussion

* **Michael H. Levy, MD, PhD/Chair † £**
Fox Chase Cancer Center

* **Thomas Smith, MD/Vice-Chair**
The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins

Amy Alvarez-Perez, MD φ £
Roswell Park Cancer Institute

Anthony Back, MD † £
Fred Hutchinson Cancer Research Center/Seattle Cancer Care Alliance

Justin N. Baker, MD €
St. Jude Children's Research Hospital/ The University of Tennessee Health Science Center

Susan Block, MD £ θ
Dana-Farber Cancer Institute

Shalini Dalal, MD £
The University of Texas MD Anderson Cancer Center

Maria Dans, MD £
Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine

NCCN
Mary Anne Bergman
Jillian Scavone, PhD

NCCN Guidelines Panel Disclosures

Thomas R. Fitch, MD
Mayo Clinic Cancer Center

Jennifer Kapo, MD
Yale Cancer Center/Smilow Cancer Hospital

Jean S. Kutner, MD ₪ Þ £
University of Colorado Cancer Center

Elizabeth Kvale, MD £
University of Alabama at Birmingham Comprehensive Cancer Center

Sumathi Misra, MD ₪ Þ £
Vanderbilt-Ingram Cancer Center

William Mitchell, MD
UC San Diego Moores Cancer Center

Diane G. Portman, MD £
Moffitt Cancer Center

Todd M. Sauer, MD £
Fred & Pamela Buffett Cancer Center

David Spiegel, MD θ
Stanford Cancer Institute

Linda Sutton, MD † £
Duke Cancer Institute

Eytan Szmuilowicz, MD £
Robert H. Lurie Comprehensive Cancer Center of Northwestern University

Continue

Robert M. Taylor, MD ψ £
The Ohio State University Comprehensive Cancer Center - James Cancer Hospital and Solove Research Institute

Jennifer Temel, MD † £
Massachusetts General Hospital Cancer Center

Roma Tickoo, MD, MPH ₪ £
Memorial Sloan Kettering Cancer Center

Susan G. Urba, MD † £
University of Michigan Comprehensive Cancer Center

Carin Van Zyl, MD £
City of Hope Comprehensive Cancer Center

Sharon M. Weinstein, MD ψ £
Huntsman Cancer Institute at the University of Utah

‡ Hematology/Hematology oncology
† Medical oncology
Þ Internal medicine
£ Supportive care including palliative and pain management
θ Psychiatry and psychology, including health behavior
ψ Neurology/Neuro-oncology
φ Anesthesiology
₪ Geriatric medicine
€ Pediatric oncology
* Writing committee member

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NCCN Palliative Care Panel Members

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Clinical Trials: NCCN believes that the best management for any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

To find clinical trials online at NCCN Member Institutions, click here: nccn.org/clinical_trials/physician.html.

NCCN Categories of Evidence and Consensus: All recommendations are category 2A unless otherwise specified.

See NCCN Categories of Evidence and Consensus.

Updates in Version 2.2015 of the NCCN Guidelines for Palliative Care from Version 1.2015 include:
MS-1: The Discussion section was updated to reflect the changes in the algorithm.

Updates in Version 1.2015 of the NCCN Guidelines for Palliative Care from Version 1.2014 include:

Global Changes:
- "Benefits/risks" has been changed to *Benefits/burdens* throughout the guideline.
- "Physician-assisted suicide" has been changed to *request for hastened death* throughout the guideline.
- "Control" has been changed to *Management.*

PAL-2
- Under screening, added *"one or more of the following"* at the top of the list.

PAL-3
- Under "Life Expectancy ≤6 mo," changed *"hypercalcemia" to "Persistent hypercalcemia."*

PAL-4
- Under Symptoms
  - Diarrhea is new to the guideline.

PAL-6
- Under Assessment:
  - 1st bullet modified: "Limited *anticancer* treatment options"
  - 3rd bullet modified: "*High symptom burden, especially non-pain symptoms resistant to conventional management*"
  - The following bullets are new to the page:
    - ◊ "*Need for clarification of goals of care*"
    - ◊ "*Rapidly progressive functional decline or persistently poor performance status*"

PAL-7
- The following bullets have been added to "Staff issues":
  - "*Complex care coordination issues among multiple care teams*"
  - "*Burnout*"

PAL-9
- Under Interventions:
  - 1st bullet modified: "Discuss whether *anticancer* ~~intent and goals of~~ therapy *is* ~~are~~ palliative or curative"

PAL-9 (continued)
  - 2nd bullet modified: "Review the *burdens* ~~risks~~ of anticancer therapy, including possible effects on quality of life"
  - 16th bullet modified: "Focus on symptom ~~control~~ *management* and comfort"

PAL-10
- 1st column, 1st bullet under "In addition" modified as follows: "*when opioid is necessary for adequate management of pain and dyspnea*"
  - 4th bullet modified: ~~Do not administer~~"*Avoid* opioid antagonists"

PAL-11
- Under Interventions:
  - 3rd bullet, 4th sub-bullet has been modified: "If opioid naive, morphine, 2.5–10 mg PO q~~4~~ *2* hr prn, 1–3 mg IV q ~~1~~ *2* hr prn" *(Also for PAL-12)*
  - 5th sub-bullet modified: "If dyspnea is not relieved by opioids and is associated with anxiety, add benzodiazepines (if benzodiazepine naive, ~~starting with~~ lorazepam, 0.5–1 mg PO q *4* ~~1~~ hr prn)" *(Also for PAL-12)*

PAL-12
- Under Assess symptom intensity:
  - 1st sub-bullet modified: "Use *labored breathing or other physical signs of dyspnea in* noncommunicative patients"
  - 8th bullet modified: ~~Withhold/withdraw/initiate~~ "*Consider* time-limited trial of mechanical ventilation as indicated"

PAL-13
- Under Interventions:
  - 2nd bullet modified: "Treat ~~readily~~ reversible cause of anorexia"
  - 5th bullet modified
    - ◊ "Prednisone 10-20 mg BID" has been deleted
    - ◊ "*Dexamethasone 2–8 mg/d*" is new to the page (Also for PAL-14)
    - ◊ "*Consider cannabinoid*" is new to the page (Also for PAL-14)
- The following references were removed from the page:
  - [h]Dy S, Lorenz K, et al. Evidence-based recommendations for cancer fatigue, anorexia, depression, and dyspnea. 2008 J Clin Oncol 26:3886-3895-

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Palliative Care

Updates in Version 1.2015 of the NCCN Guidelines for Palliative Care from Version 1.2014 include:

PAL-13 (continued)

  - [l]August DA, Huhmann MB. A.S.P.E.N. clinical guidelines: nutrition support therapy during adult anticancer treatment and in hematopoietic cell transplantation. American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) JPEN J Parenter Enteral Nutr 2009 Sep-Oct;33(5):472-500

PAL-14

- 1st bullet modified: "Assess *meaning* ~~importance~~ of symptoms of anorexia and cachexia to patient and family"
- 2nd bullet modified: ~~If important,~~ "Consider appetite stimulant"
  - "*Olanzapine 5 mg/d*" is new to the page as well as the reference that corresponds to it: "*Navari RM, Brenner MC. Treatment of cancer-related anorexia with olanzapine and megestrol acetate: a randomized trial. 2010. Support Care Cancer 18(8):951-956.*"
- The last sub-bullet on the page has been modified: "Withholding or withdrawing ~~of enteral or parenteral~~ nutrition is ethically permissible ~~in this setting. It will not cause exacerbation of symptoms~~ and may improve some symptoms."

PAL-15

- 3rd bullet: modified dose of metoclopramide, 5–*10* ~~20~~ mg
- 5th bullet: removed "(eg, brain, meninges)"
- 6th bullet, 1st sub-bullet modified: ~~If not contraindicated by comorbid conditions, treat with~~ "*Consider treatment* with corticosteroids, a proton pump inhibitor, and metoclopramide"
- 9th bullet, 4th sub-bullet modified: ~~If due to opioids, initiate opioid~~ "*Consider* rotat*ing* and/or ~~consider~~ reducing opioid requirement with non-nauseating coanalgesics or procedural interventions"
- 11th bullet, 5th sub-bullet: "*Consider cannabinoid*" is new to the page.
- Footnote "j" has been modified, "An around-the-clock dosing schedule ~~would likely provide the greatest~~ *may provide the most consistent* benefit to the patient."

PAL-17

- Interventions, 1st bullet, 1st sub-bullet: "*Discontinue any non-essential constipating medication*" *is new to the page.*

PAL-18

- Diarrhea is new to the guideline.

PAL-21

- Footnote "o" has been modified: "*Discuss risk of mortality, morbidity, and re-obstruction.* Risk factors for poor surgical outcome include: ascites, carcinomatosis, palpable intraabdominal masses, multiple bowel obstructions, previous abdominal radiation, very advanced disease, and poor overall clinical status."
  - Removed footnote from 1st bullet, "Operative management"
  - Now corresponds to the 1st sub-bullet: "Risks must be discussed with the *patient/family*[o]"
  - "(eg, mortality, morbidity, re-obstruction)" was removed from the page
- 4th bullet, 2nd sub-bullet modified: ~~Administer~~ "*O*pioids" ~~Transdermal, subcutaneous, intravenous~~
  - 3rd sub-bullet modified: ~~Administer~~ "*A*ntiemetics: Do not use antiemetics that increase gastrointestinal mobility such as metoclopramide; however, these may be beneficial in incomplete bowel obstruction"
  - 4th sub-bullet modified: ~~Administer~~ "*C*orticosteroids: Dexamethasone 4–*12* mg IV, *daily* ~~TID-QID~~, discontinue if no improvement ~~is noted~~ in 3–5 days"
- 7th bullet modified: "Nasogastric or gastric tube drainage"
  - 3rd sub-bullet modified: "Consider ~~on~~ a limited trial ~~basis~~ only if other measures fail to reduce vomiting"
- 8th bullet, 1st sub-bullet modified: "Consider only if there is expected improvement of quality of life *and* ~~with~~ life expectancy of ~~many~~ months to years"

PAL-22

- "Evaluate type/severity of sleep-wake disturbance, including daytime impairments (eg, Epworth Sleepiness Scale)" is now the first bullet under Interventions for Sleep/Wake Disturbances
- 7th bullet, 1st sub-bullet, under Insomnia the list of drugs has been reordered
  - "Chlorpromazine, 25–50 mg PO at bedtime" is new to the list
  - "Quetiapine, 2.5–5 mg PO at bedtime" is new to the list
  - Footnote "p" has been removed from Mirtazapine and will be included in the manuscript

Updates in Version 1.2015 of the NCCN Guidelines for Palliative Care from Version 1.2014 include:

PAL-23

- *Dehydration* is new to the list under "Screen for and treat underlying reversible causes"
- Under Interventions
  - 2nd bullet has been modified: "Administer haloperidol 0.5–*2*~~10~~ mg IV q 1–4 h prn"
  - 5th and 10th bullets have been modified: "Titrate starting dose to optimal effect *with lowest possible dose*"

PAL-24

- 1st bullet under Interventions:~~Consider that agitation may be mistaken for pain resulting in higher doses of opioids, which may exacerbate delirium~~ has been modified and moved to the 1st sub-bullet under "Focus on symptom control" which has been changed to "Focus on symptom *management*." Two sub-bullets have been added:
  - *"Consider that under or over treatment of pain may exacerbate delirium"* and
  - *"Examine for impaction or distended bladder as potential causes of delirium"* are new to this page
- 5th bullet has been modified: "*Consider* ~~Rotate~~ opioid~~s~~ rotat*ion"*

PAL-25

- Interventions/Social Support Resource Management:
- "*Child life services if available"* is a new sub-bullet under "Ensure support and education to caregiver(s) and family members" (Also for PAL-26)

PAL-26

- 10th bullet modified: "Determine eligibility,~~ and~~ readiness, *and need* for specialized palliative *or* hospice care" ~~and needs that might be best met by hospice~~ (Also for PAL-27)

PAL-27

- 6th bullet modified: ~~Determine the patient/family~~ "*Elicit* values and preferences with respect to quality of life"
- 7th bullet*:* "*Determine prior experience with end-of-life care*" is new to the page

PAL-27 (continued)

- 10th bullet modified: "Encourage the patient to review and revise personal priorities, identify 'unfinished business,' heal interpersonal relationships, and put affairs in order" ~~(providers should demonstrate cultural sensitivity)~~

PAL-28

- 5th bullet modified: "Ensure continue*d*~~ing~~ *involvement of primary care physician and primary oncology team*" ~~process and refer to appropriate care~~

PAL-31

- 1st bullet modified: "The NCCN Palliative Care Panel believes that the most appropriate response to a request for ~~assistance in suicide~~ *hastened death* is to intensify palliative care. All ~~such~~ patients *making such a request* should be referred to a palliative care specialist. However, evaluating a patient's request for ~~physician-assisted suicide~~ *hastened death* is an important skill, even for clinicians who feel this practice is never morally acceptable. A request for hastened death often has important meanings that require exploration. Clarifying these meanings ~~can sometimes~~ *may* enlarge the range of useful therapeutic options ~~instead of providing a lethal prescription~~ *and might reduce the patient's wish to die*."
- 3rd bullet modified: "Distinguish wishing not to live in the patient's current state from wishing for a hastened death." ~~including euthanasia and physician-assisted suicide.~~
- 8th bullet modified: "Discuss alternatives to ~~physician-assisted suicide~~ hastened death such as withdrawal of life-sustaining treatment, voluntary cessation of eating or drinking, and/or sedation for refractory symptoms."
- 9th bullet modified: "Know the local legal status of hastened death. Some patients may be confused about legal/ethical distinctions; treatment withdrawal and aggressive treatments for symptoms, such as pain, are not requests for hastened death ~~physician-assisted suicide~~." ~~Physician-assisted suicide is legal only in Oregon, Montana, Vermont, and Washington and has specific guidelines~~. Euthanasia is not legal in any state in the United States.

Updates in Version 1.2015 of the NCCN Guidelines for Palliative Care from Version 1.2014 include:

PAL-33

- **Under "Confirm that the patient has refractory symptoms and is imminently dying" the 2 sub-bullets have been modified:**
  - **"Refractory symptoms are symptoms that cannot be adequately ~~controlled~~ *managed* despite ~~aggressive, skilled~~ *comprehensive, interdisciplinary* palliative care that does not compromise consciousness."**
  - **"Imminently dying ~~is a prognosis of hours to days~~ *patients have a prognosis of hours to days. If palliative sedation is being considered, this should be* confirmed by two physicians."**
- **4th bullet under "Typical sedatives used for palliative sedation parenteral infusions" the following modifications have been made:**
  - **"Thiopental: Initial infusion rate 20-80 mg/h; range 160-440 mg/h" has been deleted.**
  - **"Pentobarbital: Initial infusion 2-3 mg per kg load then 1-2 mg per kg/h" has been deleted.**
  - ***Propofol: Initial infusion rate 5–10 mcg/kg/min and titrate up* is new to the page.**
- **5th bullet has been modified: "Continue current pain and symptom management control interventions *and titrate as needed*."**

DEFINITION OF PALLIATIVE CARE[a]

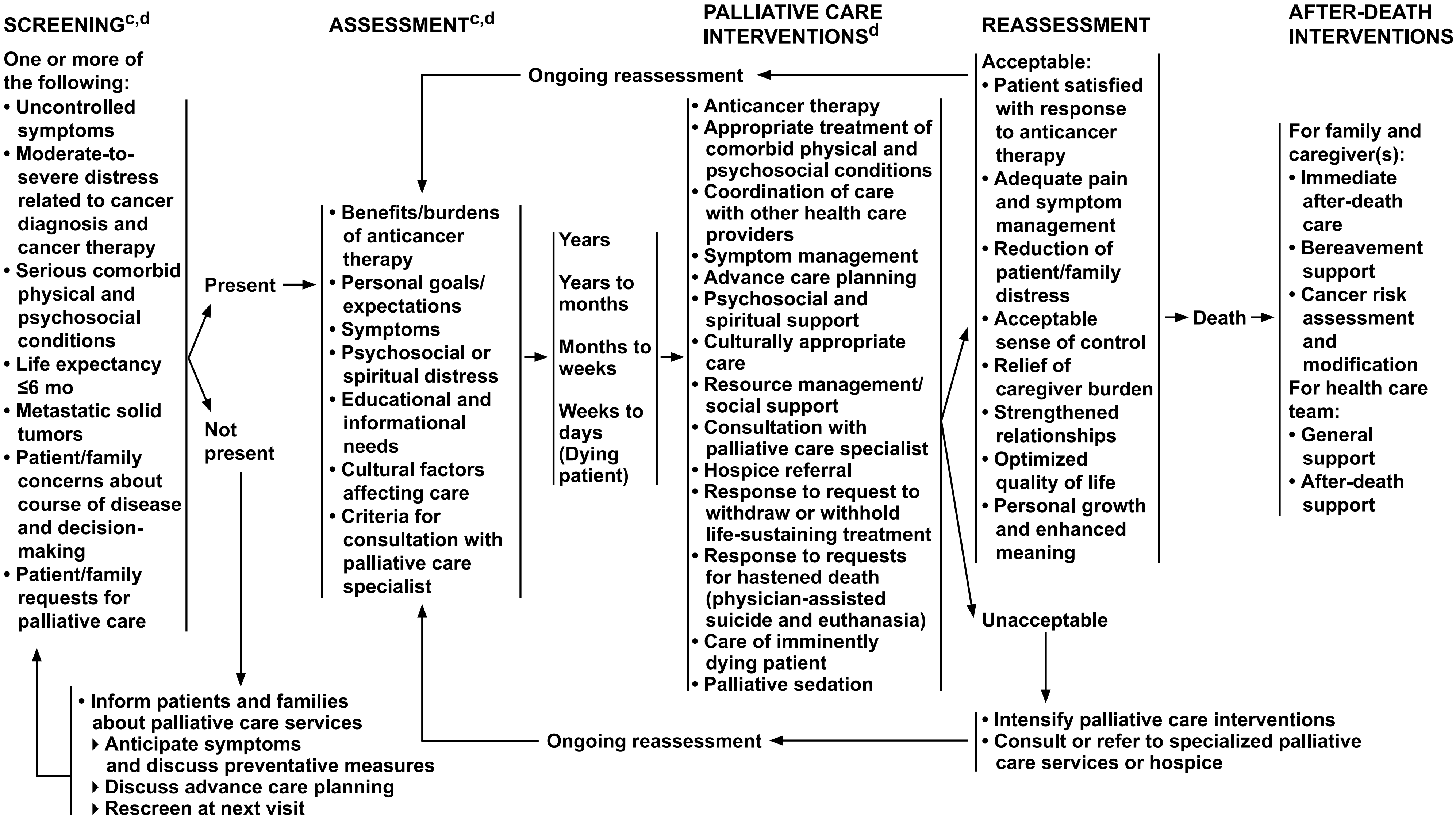
Palliative care is a special kind of patient- and family-centered health care that focuses on effective management of pain and other distressing symptoms, while incorporating psychosocial and spiritual care according to patient/family needs, values, beliefs, and cultures. The goal of palliative care is to anticipate, prevent, and reduce suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care begins at diagnosis and should be delivered concurrently with disease-directed, life-prolonging therapies and should facilitate patient autonomy, access to information, and choice. Palliative care becomes the main focus of care when disease-directed, life-prolonging therapies are no longer effective, appropriate, or desired. Palliative care should be initiated by the primary oncology team and then augmented by collaboration with an interdisciplinary team of palliative care experts.

STANDARDS OF PALLIATIVE CARE[b]

- **Institutions should develop processes for integrating palliative care into cancer care, both as part of usual oncology care and for patients with specialty palliative care needs.**
- **All cancer patients should be screened for palliative care needs at their initial visit, at appropriate intervals, and as clinically indicated.**
- **Patients and families should be informed that palliative care is an integral part of their comprehensive cancer care.**
- **Educational programs should be provided to all health care professionals and trainees so that they can develop effective palliative care knowledge, skills, and attitudes.**
- **Palliative care specialists and interdisciplinary palliative care teams, including board-certified palliative care physicians, advanced practice nurses, physician assistants, social workers, chaplains, and pharmacists, should be readily available to provide consultative or direct care to patients/families who request or require their expertise.**
- **Quality of palliative care should be monitored by institutional quality improvement programs.**

[a] Hui D, Mori M, Parsons HA, et al. The lack of standard definitions in supportive and palliative oncology literature. J Pain Symptom Manage 2012;43:582-592.
[b] Ferris FD, Bruera E, Cherny N, et al. Palliative cancer care a decade later: accomplishments, the need, next steps – from the American Society of Clinical Oncology. J Clin Oncol 2009;27:3052-3058.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.



SCREENING[c,d]

One or more of the following:
- Uncontrolled symptoms
- Moderate-to-severe distress related to cancer diagnosis and cancer therapy
- Serious comorbid physical and psychosocial conditions
- Life expectancy ≤6 mo
- Metastatic solid tumors
- Patient/family concerns about course of disease and decision-making
- Patient/family requests for palliative care

Present →

Not present →
- Inform patients and families about palliative care services
  - Anticipate symptoms and discuss preventative measures
  - Discuss advance care planning
  - Rescreen at next visit

ASSESSMENT[c,d]

- Benefits/burdens of anticancer therapy
- Personal goals/expectations
- Symptoms
- Psychosocial or spiritual distress
- Educational and informational needs
- Cultural factors affecting care
- Criteria for consultation with palliative care specialist

→

Years

Years to months

Months to weeks

Weeks to days (Dying patient)

→

PALLIATIVE CARE INTERVENTIONS[d]

- Anticancer therapy
- Appropriate treatment of comorbid physical and psychosocial conditions
- Coordination of care with other health care providers
- Symptom management
- Advance care planning
- Psychosocial and spiritual support
- Culturally appropriate care
- Resource management/social support
- Consultation with palliative care specialist
- Hospice referral
- Response to request to withdraw or withhold life-sustaining treatment
- Response to requests for hastened death (physician-assisted suicide and euthanasia)
- Care of imminently dying patient
- Palliative sedation

REASSESSMENT

Acceptable:
- Patient satisfied with response to anticancer therapy
- Adequate pain and symptom management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ Ongoing reassessment (to Assessment)

→ Death →

Unacceptable
- Intensify palliative care interventions
- Consult or refer to specialized palliative care services or hospice

→ Ongoing reassessment (to Assessment)

AFTER-DEATH INTERVENTIONS

For family and caregiver(s):
- Immediate after-death care
- Bereavement support
- Cancer risk assessment and modification

For health care team:
- General support
- After-death support

---

[c] Management of any patient with positive screening requires a care plan developed by an interdisciplinary team of physicians, nurses, social workers, and other mental health professionals, chaplains, nurse practitioners, physician assistants, and dietitians.

[d] Oncologists should integrate palliative care into general oncology care. Early consultation/collaboration with a palliative care specialist/hospice team should be considered to improve quality of life and survival.

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Assessment by Oncology Team (PAL-3)

SCREENING[c,d]

- Uncontrolled symptoms
  or
- Moderate-to-severe distress related to cancer diagnosis and/or cancer therapy
  or
- Serious comorbid physical, psychiatric, and psychosocial conditions
  or
- Life expectancy ≤6 mo
  - Indicators include:
    - ◊ Metastatic solid tumors
    - ◊ Many stage IV cancers
    - ◊ Poor performance status ECOG ≥3 or KPS ≤50
    - ◊ Persistent hypercalcemia
    - ◊ Brain or cerebrospinal fluid metastasis
    - ◊ Delirium
    - ◊ Superior vena cava syndrome
    - ◊ Spinal cord compression
    - ◊ Cachexia
    - ◊ Malignant effusions
    - ◊ Palliative stenting or venting gastrostomy
  or
- Patient/family concerns about course of disease and decision-making
  or
- Patient/family requests for palliative care

ASSESSMENT BY ONCOLOGY TEAM

Present →

- Benefits/burdens of anticancer therapy
- Symptoms
- Psychosocial distress

→ See PAL-4

- Personal goals/expectations
- Educational and informational needs
- Cultural factors affecting care

→ See PAL-5

- Criteria for consultation with a palliative care specialist

→ See PAL-6 and PAL-7

Not present →

- Inform the patient and family about palliative care services
  - Anticipate symptoms and discuss preventative measures
  - Discuss advance care planning
  - Rescreen at next visit

---

[c] Management of any patient with positive screening requires a care plan developed by an interdisciplinary team of physicians, nurses, social workers, and other mental health professionals, chaplains, nurse practitioners, physician assistants, and dietitians.

[d] Oncologists should integrate palliative care into general oncology care. Early consultation/collaboration with a palliative care specialist/hospice team should be considered to improve quality of life and survival.

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ASSESSMENT BY ONCOLOGY TEAM

Benefits/burdens of anticancer therapy →
- Natural history of specific tumor
- Potential for response to further treatment
- Potential for treatment-related toxicities
- Goals and meaning of anticancer therapy for patient and family
- Impairment of vital organs
- Performance status
- Serious comorbid conditions
- Confirm the patient's understanding of incurability of disease

→ Anticancer therapy interventions (See PAL-9)

Personal goals/ expectations →
- Patient goals and expectations
  - Advance care planning
- Family goals and expectations
- Priorities for palliative care
  - Goals and meaning of anticancer therapy
  - Quality of life
- Eligibility for hospice, with needs that might be met by hospice

→ Interventions (See PAL-27)
Advance Care Planning (See PAL-29)

Symptoms[e] →
- Pain → Pain Interventions (See PAL-10)
- Dyspnea → Dyspnea Interventions (See PAL-11)
- Anorexia/cachexia → Anorexia/Cachexia Interventions (See PAL-13)
- Nausea/vomiting (NV) → Nausea/Vomiting Interventions (See PAL-15)
- Constipation → Constipation Interventions (See PAL-17)
- Diarrhea → Diarrhea Interventions (See PAL-18)
- Malignant bowel obstruction → Malignant Bowel Obstruction (See PAL-20)
- Fatigue/weakness/asthenia → See NCCN Guidelines for Cancer-Related Fatigue
- Insomnia/sedation → Insomnia/Sedation Interventions (See PAL-22)
- Delirium → Delirium Interventions (See PAL-23)

[e] Look for opportunities to use single agents to treat multiple symptoms.

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PALLIATIVE CARE ASSESSMENT

Psychosocial distress →

- Psychosocial/psychiatric[e]
  - Depression/anxiety
  - Illness-related distress
- Spiritual or existential crisis

→ See NCCN Guidelines for Distress Management

→ Consider Consultation with Palliative Care Specialist (See PAL-6)

- Social support problems
  - Home
  - Family
  - Community
- Resources problems
  - Financial

→ Social Support/Resource Management (See PAL-25)

- Educational and informational needs
- Cultural factors affecting care

→

- Patient/family values and preferences about information and communication
- Patient/family perceptions of disease status

→ Interventions (See PAL-27)

Criteria for consultation with palliative care specialist → (See PAL-6)

---

[e] Look for opportunities to use single agents to treat multiple symptoms.

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Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

CRITERIA FOR CONSULTATION WITH PALLIATIVE CARE SPECIALIST

ASSESSMENT

Patient characteristics →

- Limited anticancer treatment options
- High risk of poor pain management or pain that remains resistant to conventional interventions, eg:
  - Neuropathic pain
  - Incident or breakthrough pain
  - Associated psychosocial and family distress
  - Rapid escalation of opioid dose
  - Multiple drug “allergies” or a history of multiple adverse reactions to pain and symptom management interventions
  - History of drug or alcohol abuse
- High symptom burden, especially non-pain symptoms resistant to conventional management (See PAL-4 for symptoms)
- Palliative stenting or venting gastrostomy
- Frequent ED visits or hospital readmissions
- Complex ICU admissions (those involving multi-organ system failure or prolonged mechanical ventilation)
- High distress score (>4) (See NCCN Guidelines for Distress Management)
- Communication barriers
  - language
  - literacy
  - physical barriers
- Resistance to engaging in advance care planning and care plan
- Need for clarification of goals of care
- Rapidly progressive functional decline or persistently poor performance status
- Cognitive impairment
- Severe comorbid conditions
- Request for hastened death

→ See Oncology Team Interventions (PAL-8)

Continued next page

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Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

CRITERIA FOR CONSULTATION WITH PALLIATIVE CARE SPECIALIST

ASSESSMENT

Social circumstances or Anticipatory bereavement issues →

- Family/caregiver limitations
- Inadequate social support
- Intensely dependent relationship(s)
- Financial limitations
- Limited access to care
- Family discord
- Patient's concerns regarding care of dependents
- Spiritual or existential crisis
- Unresolved or multiple prior losses
- Children under 18 years of age living in the household

Staff issues →

- Complex care coordination issues among multiple care teams
- Compassion fatigue
- Moral distress
- Burnout

→ **See Oncology Team Interventions (PAL-8)**

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ONCOLOGY TEAM INTERVENTIONS

- Consult with palliative care specialist/team[c,d]
- Collaborate with other health care professionals treating the patient
- Refer to appropriate health care professionals
  - Mental health and social services
  - Pastoral care
  - Health care interpreters
  - Others
- Mobilize community support
  - Religious
  - School
  - Community agencies
- Expedite referral to hospice services when appropriate

REASSESSMENT

Acceptable:
- Patient satisfied with response to anticancer therapy
- Adequate pain and symptom management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning
- Advance care planning in progress

→ Ongoing re-evaluation and communication between the patient and health care team

Unacceptable →
- Intensify palliative care interventions
- Consult with a mental health professional to evaluate and treat undiagnosed psychiatric disorders, substance abuse, and inadequate coping methods
- See NCCN Guidelines for Distress Management

→ Ongoing reassessment

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[c] Management of any patient with positive screening requires a care plan developed by an interdisciplinary team of physicians, nurses, social workers and other mental health professionals, chaplains, nurse practitioners, physician assistants, and dietitians.

[d] Oncologists should integrate palliative care into general oncology care. Early consultation/collaboration with a palliative care specialist/hospice team should be considered to improve quality of life and survival.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

BENEFITS/BURDENS OF ANTICANCER THERAPY

ESTIMATED LIFE EXPECTANCY

INTERVENTIONS

REASSESSMENT

Years
Year to months →

- Discuss whether anticancer therapy is palliative or curative
- Review the burdens of anticancer therapy, including possible effects on quality of life
- Confirm the patient's understanding of incurability of disease
- Provide appropriate anticancer therapy as outlined in NCCN disease-specific guidelines
- Provide appropriate prevention and management of symptoms caused by anticancer therapy
- Provide appropriate palliative care
- Prepare patient psychologically for possible disease progression

Months to weeks →

- Reassess understanding of goals of therapy and prognosis
- Offer best supportive care, including referral to palliative care or hospice
- Redirect goals and hopes to those that are achievable based on likely prognosis and life expectancy
- Provide guidance regarding anticipated course of disease
- Consider discontinuation of anticancer treatment

Weeks to days (Dying patient) →

- Discontinue anticancer therapy
- Intensify palliative care in preparation for death
- Provide guidance regarding anticipated dying process
- Focus on symptom management and comfort
- Foster patient participation in preparing loved ones
- Refer to palliative care/hospice team

Acceptable:
- Adequate pain and symptom management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ Continue anticancer therapy and palliative care

Unacceptable →

- Change or discontinue anticancer therapy
- Review patient hopes about and meaning of anticancer therapy
- Intensify palliative care interventions
- Review advance care planning
- Consult or refer to specialized palliative care services or hospice

→ Ongoing reassessment

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

PAIN

ESTIMATED LIFE EXPECTANCY | **INTERVENTIONS** | **REASSESSMENT**

Years
Year to months
Months to weeks
→ Treat according to NCCN Guidelines for Adult Cancer Pain

Weeks to days (Dying patient) →

- Treat according to NCCN Guidelines for Adult Cancer Pain

In addition:

- Do not reduce dose of opioid solely for decreased blood pressure, respiration rate, or level of consciousness when opioid is necessary for adequate management of pain and dyspnea
- Maintain analgesic therapy; titrate to optimal comfort
- Recognize and treat opioid-induced neurotoxicity, including myoclonus and hyperalgesia
- If opioid reduction is indicated, reduce by ≤50% per 24 h to avoid acute opioid withdrawal or pain crisis. Avoid opioid antagonists
- Balance analgesia against reduced level of consciousness based on patient preference
- Modify routes of administration as needed (PO, IV, PR, subcutaneous, sublingual, transmucosal, and transdermal), applying equianalgesic dose conversions
- Consult with a pain management/palliative care specialist
  - ▸ Consider sedation for refractory pain (See PAL-33)

Acceptable:

- Adequate pain and symptom management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→

- Continue to treat according to NCCN Guidelines for Adult Cancer Pain
- Monitor symptoms and quality of life to determine whether additional end-of-life measures are required

Unacceptable →

- Continue to treat according to NCCN Guidelines for Adult Cancer Pain
- Consider a consultation with a pain management/ palliative care specialist

→ Ongoing reassessment

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

DYSPNEA

ESTIMATED LIFE EXPECTANCY

Years

Year to months

Months to weeks

→

INTERVENTIONS

- Assess symptom intensity
- Treat underlying causes/comorbid conditions:
  - Radiation/chemotherapy
  - Therapeutic procedure for cardiac, pleural, or abdominal fluid
  - Bronchoscopic therapy
  - Bronchodilators, diuretics, steroids, antibiotics, or transfusions
  - Anticoagulants for pulmonary emboli
- Relieve symptoms
  - Oxygen therapy for symptomatic hypoxia
  - Educational, psychosocial, and emotional support for the patient and family
  - Nonpharmacologic therapies, including fans, cooler temperatures, stress management, relaxation therapy, and physical comfort measures
  - If opioid naive, morphine, 2.5–10 mg PO q 2 hr prn, 1–3 mg IV q 2 hr prn[f]
  - If dyspnea is not relieved by opioids and is associated with anxiety, add benzodiazepines (if benzodiazepine naive, lorazepam, 0.5–1 mg PO q 4 hr prn)
  - Noninvasive positive-pressure ventilation (eg, CPAP, BiPAP) support if clinically indicated for severe reversible condition

REASSESSMENT

Acceptable:
- Adequate dyspnea and symptom management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies

Unacceptable →
- Intensify palliative care interventions
- Consult or refer to specialized palliative care services or hospice

→ Ongoing reassessment

Weeks to days (Dying patient) → See Interventions (PAL-12)

---

[f] For acute progressive dyspnea, more aggressive titration may be required.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

DYSPNEA

ESTIMATED LIFE EXPECTANCY

- Years
- Year to months → See Interventions (PAL-11)
- Months to weeks

Weeks to days (Dying patient) →

INTERVENTIONS

- Assess symptom intensity
  - Use labored breathing or other physical signs of dyspnea in noncommunicative patients
- Focus on comfort
  - Continue to treat underlying condition as appropriate
- Relieve symptoms
  - Fans
  - Oxygen if hypoxic and/or subjective relief is reported
  - Nonpharmacologic therapies; educational, psychosocial, and emotional support (See PAL-11)
- If fluid overload is a contributing factor:
  - Decrease/discontinue enteral or parenteral fluid
  - Consider low-dose diuretics
- If opioid naive, morphine, 2.5–10 mg PO q 2 hr prn, 1–3 mg IV q 2 hr prn[f]
- Benzodiazepines (if benzodiazepine naive, lorazepam, 0.5–1 mg PO q 4 hr prn)
- Reduce excessive secretions[g] with scopolamine, 0.4 mg SC q 4 hr prn; 1.5 mg patches, 1–6 patches q 3 d;
  OR
  atropine 1% ophthalmic solution 1–2 drops SL q 4 h prn;
  OR
  glycopyrrolate 0.2–0.4 mg IV or SQ q 4 hr prn
- Consider time-limited trial of mechanical ventilation as indicated
  - Address patient and family preferences, prognosis, and reversibility of respiratory failure
  - Provide sedation as needed
- Provide anticipatory guidance for patient/family regarding dying or respiratory failure
- Provide emotional and spiritual support

REASSESSMENT

Acceptable:
- Adequate dyspnea and symptom management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies

Unacceptable →
- Intensify palliative care interventions and consider a consultation with a palliative care specialist
- Consider sedation for intractable symptoms (See PAL-33)

→ Ongoing reassessment

---

[f] For acute progressive dyspnea, more aggressive titration may be required.

[g] Hughes A, et al. Audit of three antimuscarinic drugs for managing retained secretions. Palliative Medicine. 2000; 14:221-222.

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ANOREXIA/CACHEXIA

ESTIMATED LIFE EXPECTANCY

Years
Year to months
→

INTERVENTIONS

- Evaluate rate/severity of weight loss
- Treat reversible cause of anorexia:
  - Early satiety
    - Metoclopramide
  - Symptoms that interfere with intake
    - Dysgeusia
    - Xerostomia
    - Oral-pharyngeal candidiasis
    - Mucositis
    - NV
    - Dyspnea
    - Depression/anorexia (Mirtazapine 7.5–30 mg hs)
    - Constipation
    - Pain
    - Fatigue
    - Eating disorders/body image
- Review/modify medications that interfere with intake
- Evaluate for endocrine abnormalities:
  - Hypogonadism
  - Thyroid dysfunction
  - Metabolic abnormalities (eg, increased calcium)
- Consider appetite stimulant
  - Megestrol acetate, 400–800 mg/d
  - Dexamethasone 2–8 mg/d
  - Consider cannabinoid
- Consider an exercise program
- Assess social and economic factors
- Consider nutrition consult
- Consider nutrition support, enteral and parenteral feeding (as appropriate)

REASSESSMENT

Acceptable:
- Weight stabilization or gain
- Improvement in symptoms that interfere with intake
- Improved energy
- Resolution of metabolic or endocrine abnormalities

→ Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies

Unacceptable →
- Intensify palliative care interventions
- Provide dietary consultation
- Consider clinical trial

→ Ongoing reassessment

Months to weeks

Weeks to days (Dying patient) → See Interventions (PAL-14)

Note: All recommendations are category 2A unless otherwise indicated.
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ANOREXIA/CACHEXIA

ESTIMATED LIFE EXPECTANCY

INTERVENTIONS

REASSESSMENT

Years

Year to months → See Interventions (PAL-13)

Months to weeks

Weeks to days (Dying patient) →

- Assess meaning of symptoms of anorexia and cachexia to patient and family
- Consider appetite stimulant
  - Megestrol acetate, 400–800 mg/d
  - Olanzapine 5 mg/d[h]
  - Dexamethasone 2–8 mg/d
  - Consider cannabinoid
- Focus on patient goals and preferences
- Provide family with alternate ways of caring for the patient
- Provide emotional support
- Treat for depression, if appropriate (mirtazapine 7.5–30 mg hs)
- Provide education and support to patient and family regarding emotional aspects of withdrawal of nutritional support.
- Inform patient and family of natural history of disease, including the following points:
  - Absence of hunger and thirst is normal in the dying patient
  - Nutritional support may not be metabolized in patients with advanced cancer
  - There are risks associated with artificial nutrition and hydration, including fluid overload, infection, and hastened death
  - Symptoms like dry mouth should be treated with local measures (eg, mouth care, small amounts of liquids)
  - Withholding or withdrawing nutrition is ethically permissible and may improve some symptoms.

Acceptable:
- Adequate anorexia/ cachexia symptom management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ **Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies** → **Ongoing reassessment**

Unacceptable →
- Intensify palliative care interventions
- Consult or refer to specialized palliative care services or hospice

→ **Ongoing reassessment**

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[h] Navari RM, Brenner MC. Treatment of cancer-related anorexia with olanzapine and megestrol acetate: a randomized trial. 2010. Support Care Cancer 18(8):951-956.

Note: All recommendations are category 2A unless otherwise indicated.
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NAUSEA AND VOMITING

ESTIMATED LIFE EXPECTANCY

- Years
- Year to months
- Months to weeks[i]
- Weeks to days (Dying patient)[i]

INTERVENTIONS[j,k]

- Chemotherapy/radiation therapy-induced (See NCCN Guidelines for Antiemesis)
- Severe constipation/fecal impaction (See PAL-17)
- Gastroparesis (metoclopramide, 5–10 mg PO QID 30 min before meals and at bedtime)
- Bowel obstruction (See PAL-20)
- Central nervous system (CNS) involvement
  - Corticosteroids (dexamethasone, 4–8 mg BID-TID)
  - Palliative radiation therapy
- Gastric outlet obstruction from intra-abdominal tumor or liver metastasis
  - Consider treatment with corticosteroids, a proton pump inhibitor, and metoclopramide
  - Endoscopic stenting
  - Decompressing G-Tube
- Gastritis/GERD
  - Proton pump inhibitor
  - H2-blocker
- Treat metabolic abnormalities
  - Hypercalcemia
  - Uremia
  - Dehydration
- Medication-induced
  - Discontinue any unnecessary medications
  - Check available blood levels of necessary medications (eg, digoxin, phenytoin, carbamazepine, tricyclic antidepressants)
  - Treat medication-induced gastropathy (eg, proton pump inhibitor, metoclopramide)
  - Consider rotating and/or reducing opioid requirement with non-nauseating coanalgesics or procedural interventions
- Psychogenic
  - Consider psychiatric consultation if patient has an eating disorder, somatization, phobia, or panic disorder causing NV. See NCCN Guidelines for Distress Management
- Non-specific NV
  - Initiate pharmacologic management with dopamine receptor antagonists (eg, haloperidol, metoclopramide, prochlorperazine)
  - If anxiety contributes to NV, consider adding lorazepam, 0.5–1 mg q 4 hr prn
  - If oral route is not feasible, consider sublingual, rectal, subcutaneous, or intravenous administration of anti-nausea therapy
  - Consider non-pharmacologic therapies, such as acupuncture, hypnosis, and cognitive behavioral therapy
  - Consider cannabinoid

If NV stops: See Reassessment (PAL-16)

If NV persists: See Interventions (PAL-16)

---

[i] In patients with advanced cancer, NV may be secondary to the cachexia syndrome (chronic nausea, anorexia, asthenia, changing body image, and autonomic failure).

[j] An around-the-clock dosing schedule may provide the most consistent benefit to the patient.

[k] Continuous intravenous or subcutaneous infusions of different antiemetics may be necessary for the management of intractable NV.

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PERSISTENT NAUSEA AND VOMITING

INTERVENTIONS

Titrate dopamine receptor antagonist (eg, prochlorperazine, haloperidol, metoclopramide, olanzapine) to maximum benefit and tolerance.

If NV persists:

↓

Add a 5-HT3 antagonist (eg, ondansetron)
± anticholinergic agent (eg, scopolamine)
± antihistamine (eg, meclizine)
± cannabinoid.
If NV persists: →

↓

Add a corticosteroid (eg, dexamethasone)
± olanzapine, if not already tried.
If NV persists: →

↓

Consider using a continuous IV/SC infusion of antiemetics; consider an opioid rotation if patient is on opioids. →

REASSESSMENT

Acceptable:
- **Adequate NV symptom management**
- **Reduction of patient/family distress**
- **Acceptable sense of control**
- **Relief of caregiver burden**
- **Strengthened relationships**
- **Optimized quality of life**

→ **Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies**

Unacceptable →
- **Intensify palliative care interventions**
- **Consult or refer to specialized palliative care services or hospice**
- **Consider palliative sedation (See PAL-33)**

→ **Ongoing reassessment (See Interventions, PAL-15)**

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CONSTIPATION

ESTIMATED LIFE EXPECTANCY

- Years
- Year to months
- Months to weeks
- Weeks to days (Dying patient)

→

Preventive measures
- Increase fluids
- Increase dietary fiber if patient has adequate fluid intake and physical activity
- Exercise, if appropriate
- Administer prophylactic medications
  - Stimulant laxative ± stool softener (senna ± docusate, 2 tablets every night)
  - Increase dose of laxative ± stool softener (senna ± docusate, 2–3 tablets BID-TID) with goal of 1 non-forced BM every 1–2 days

→

INTERVENTIONS

If constipation is present:
- Assess for cause and severity of constipation
  - Discontinue any non-essential constipating medication
- Rule out impaction, especially if diarrhea accompanies constipation (overflow around impaction)
- Rule out obstruction (physical exam, abdominal x-ray/consider GI consult)
- Treat other causes (eg, hypercalcemia, hypokalemia, hypothyroidism, diabetes mellitus, medications)
- Add and titrate bisacodyl 10–15 mg daily-TID with a goal of 1 non-forced bowel movement (BM) every 1–2 days
- If impacted:
  - Administer glycerine suppository ± mineral oil retention enema
  - Perform manual disimpaction following pre-medication with analgesic ± anxiolytic

If constipation persists:
- Reassess for cause and severity of constipation
- Recheck for impaction or obstruction
- Consider adding other laxatives, such as bisacodyl suppository (one rectally daily-BID); polyethelene glycol (1 capful/8 oz water BID); lactulose, 30–60 mL BID-QID; sorbitol, 30 mL every 2 h x 3, then prn; magnesium hydroxide, 30–60 mL daily-BID; or magnesium citrate, 8 oz daily
- Consider methylnaltrexone for opioid-induced constipation, except for post-op ileus and mechanical bowel obstruction, 0.15 mg/kg SC every other day, no more than once a day
- Tap water enema until clear
- Consider use of a prokinetic agent (eg, metoclopramide, 10–20 mg PO QID)

REASSESSMENT

- Acceptable:
- Adequate constipation symptom management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life

→ Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies → Ongoing reassessment

Unacceptable →
- Intensify palliative care interventions
- Consult or refer to specialized palliative care services or hospice

→ Ongoing reassessment

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DIARRHEA

ESTIMATED LIFE EXPECTANCY

SCREENING

Determine Diarrhea Grade[l] (Increase over Baseline)

ASSESSMENT

Years

Year to months

Months to weeks

- **Grade 1**: Increase of <4 stools/day over baseline; mild increase in ostomy output compared with baseline
- **Grade 2**: Increase of 4–6 stools/day over baseline; moderate increase in ostomy output compared with baseline
- **Grade 3**: Increase of >7 stools/day over baseline; incontinence; hospitalization indicated; severe increase in ostomy output compared with baseline; limiting self-care; Interferes with ADL
- **Grade 4**: Life-threatening consequences urgent intervention indicated

→

Provide immediate antidiarrheal therapy indicated by grade.
- **If chemotherapy induced, decrease or delay the next dose of chemotherapy**

Assess for Cause:
- **Recent antibiotic use**
- **Chemotherapy regimen side effects**
- **Drugs that frequently induce diarrhea**
- **Dietary changes**
- **Infection**
  - **Screen for C. diff**
- **If fecal impaction is suspected:**
  - **Confirm with rectal examination, or xray,**
  - **Premedicate patient with opiods or anxiolytics,**
  - **Treat with digital disimpaction,**
  - **Enemas until clear**

→ **See Anti-Diarrheal Interventions, Grades 1-4 (PAL-19)**

Weeks to days (Dying patient) → **See PAL-19**

[l] NCI Table 3: http://www.cancer.gov/cancertopics/pdq/supportivecare/gastrointestinalcomplications/HealthProfessional/page5#section_5.8

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ANTIDIARRHEAL INTERVENTIONS

ESTIMATED LIFE EXPECTANCY | **SCREENING** | **INTERVENTION**

Years

GRADE 1 →
- Provide oral hydration and electrolyte replacement
- Initiate antidiarrheal:
  - Loperamide 4 mg PO x 1, then 2 mg PO after each loose stool, up to 16 mg/day
- If patient not already on opioids:
  - Diphenoxylate/atropine 1–2 tabs PO q 6 hr PRN, Maximum 8 tabs/day
  - Tincture of Opium (10 mg/mL) 10–15 drops PO q 4 hr PRN
- Bland/BRAT diet (Bananas, Rice, Applesauce, Toast)
- Continue oral hydration and electrolyte replacement
- If chemotherapy-induced:
  - Decrease dose or discontinue chemotherapy

Year to months

Months to weeks

GRADE 2 →
- Provide IV fluids if patient is unable to tolerate oral fluids
- Initiate/continue antidiarrheal--as above
- Bland/BRAT diet (Bananas, Rice, Applesauce, Toast)
- Continue oral hydration and electrolyte replacement
- Consider anticholinergic agents
  - Hyoscyamine 0.125 mg PO/ODT/SL q 4 hr PRN, Max: 1.5 mg/day
  - Atropine 0.5–1 mg SC; IM; IV; SL q 4–6 hr prn
- If infection-induced (C. diff):
  - Metronidazole 500 mg PO/IV QID x 10–14 days
  - Vancomycin 125–500 mg PO QID x 10–14 days
- If infection-induced and not C.diff
  - Treat with appropriate antibiotics
- If chemotherapy-induced:
  - Delay or discontinue chemotherapy
- If ipilimumab-related diarrhea, consider
  - Corticosteroids for 0.1–1 mg/kg/day
  - Infliximab 5 mg/kg q 2–6 weeks

Persistent GRADES 2, 3, 4 →

Inpatient hospitalization (intensive care for Grade 4)
- Provide IV fluids and use antidiarrheal agents and anticholinergics as mentioned above
- Consider Octreotide 100–500 mcg/day SC or IV, q 8 hr or by continuous infusion

Weeks to days (Dying patient) →
- Ensure that the above interventions are consistent with the goals of care
- Consider IV hydration at home
- Start on around the clock opioids or increase dose of current opioid
- Consider Scopolamine 0.4 mg SC every 4 hrs prn
- Consider Octreotide 100-200 microgram SC q 8 hrs

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MALIGNANT BOWEL OBSTRUCTION[m]

ESTIMATED LIFE EXPECTANCY | **ASSESSMENT**

Years

Year to months

Months to weeks

→

- Screen for and treat underlying reversible causes
  - Adhesions
  - Radiation-induced strictures
  - Internal hernias
- Assess for malignant causes
  - Tumor mass
  - Carcinomatosis
- Assess the goals of treatment for the patient, which can help guide the intervention[n] (eg, decrease NV, allow patient to eat, decrease pain, allow patient to go home/to hospice)

→ See Interventions (PAL-21)

Weeks to days (Dying patient)[n]

→

- Consider medical management rather than surgical management
- Assess the goals of treatment for the patient, which can help guide the intervention[n] (eg, decrease NV, allow patient to eat, decrease pain, allow patient to go home/to hospice)
- Provide education and support to patient and family

→

- Pharmacologic management
- Intravenous or subcutaneous fluids
- Enteral tube drainage
  - Consider only if other measures fail to reduce vomiting
- Endoscopic management

→ See Reassessment (PAL-21)

---

[m] Plain film radiography may be helpful in confirming the clinical diagnosis of bowel obstruction. Consider a computed tomography scan if surgical intervention is contemplated, as it is more sensitive and may help identify the cause of obstruction.

[n] Most malignant bowel obstructions are partial, allowing time to discuss appropriate intervention with the patient and family.

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MALIGNANT BOWEL OBSTRUCTION

INTERVENTIONS

- Operative management
  - Risks must be discussed with the patient/family[o]
  - Improved quality of life should be the primary goal of surgical treatment
- Endoscopic management
  - Percutaneous endoscopic gastrostomy tube for drainage
  - Endoscopic stent placement
- Interventional radiology management
  - Ultrasound-guided gastrostomy tube for drainage
- Pharmacologic management when the goal is maintaining gut function:
  - Use rectal, transdermal, subcutaneous, or intravenous routes of administration
  - Opioids
  - Antiemetics: Do not use antiemetics that increase gastrointestinal mobility such as metoclopramide; however, these may be beneficial in incomplete bowel obstruction
  - Corticosteroids: Dexamethasone 4–12 mg IV, daily, discontinue if no improvement in 3–5 days
- Pharmacologic management when gut function cannot be maintained:
  - Administer anticholinergics (eg, scopolamine, hyoscyamine, glycopyrrolate)
  - Administer octreotide: (100–300 mcg SC BID-TID or 10–40 mcg/hr continuous SC/IV infusion)
- Intravenous or subcutaneous fluids
  - Consider if there is evidence of dehydration
- Nasogastric or gastric tube drainage
  - Usually uncomfortable
  - Increased risk of aspiration
  - Consider a limited trial only if other measures fail to reduce vomiting
- Total parenteral nutrition (TPN)
  - Consider only if there is expected improvement of quality of life and life expectancy of months to years

REASSESSMENT

Acceptable:
- Adequate management of malignant bowel obstruction symptoms
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies

Unacceptable →
- Intensify palliative care interventions
- Consult or refer to specialized palliative care services or hospice

→ Ongoing reassessment (See PAL-21)

---

[o] Discuss risk of mortality, morbidity, and re-obstruction. Risk factors for poor surgical outcome include: ascites, carcinomatosis, palpable intraabdominal masses, multiple bowel obstructions, previous abdominal radiation, very advanced disease, and poor overall clinical status.

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SLEEP/WAKE DISTURBANCES INCLUDING INSOMNIA AND SEDATION

ESTIMATED LIFE EXPECTANCY

Years

Year to months

Months to weeks

→

INTERVENTIONS

- Evaluate type/severity of sleep-wake disturbance, including daytime impairments (eg, Epworth Sleepiness Scale)
- Explore fears and anxiety regarding death/disease
- Provide sleep-hygiene education
- Provide cognitive-behavioral treatment
  - Includes stimulus control, progressive muscle relaxation
- Consider polysomnography if history is suggestive of sleep-disordered breathing
- Treat contributing factors:
  - Pain, depression, anxiety, delirium, and nausea
  - Medication side effects or withdrawal syndromes (eg, corticosteroids, opioids, anticonvulsants, caffeine, hormones, herbals, barbiturates, benzodiazepines, alcohol, tricyclic antidepressants)
  - Primary sleep disorders such as obstructive sleep apnea and periodic limb movement disorder
    - ◊ CPAP/BiPAP
  - For restless leg syndrome consider trial of the following:
    - ◊ Ropinirole
    - ◊ Pramipexole
    - ◊ Carbidopa-levodopa
- Provide pharmacologic therapies for refractory sleep/wake disturbance
  - Insomnia:
    - ◊ Trazodone, 25–100 mg PO at bedtime
    - ◊ Olanzapine, 2.5–5 mg PO at bedtime
    - ◊ Zolpidem, 5 mg PO at bedtime
    - ◊ Mirtazapine, 7.5–30 mg PO at bedtime
    - ◊ Chlorpromazine, 25–50 mg PO at bedtime
    - ◊ Quetiapine, 2.5–5 mg PO at bedtime
    - ◊ Lorazepam, 0.5–1 mg PO at bedtime
  - Daytime sedation:
    - ◊ Caffeine 100–200 mg PO q 6 hrs, last dose 4 PM
    - ◊ Methylphenidate, start with 2.5–20 mg PO BID, second dose no later than 6 hours before bedtime
    - ◊ Dextroamphetamine, 2.5–10 mg PO BID, second dose no later than 12 hours before bedtime
    - ◊ Modafinil, 100–400 mg PO each morning

Weeks to days (Dying patient) →

- Assess patient's desire to have insomnia and sedation treated
- Adjust doses of pharmacologic therapies
  - Consider chlorpromazine, 25–100 mg PO/PR at bedtime

REASSESSMENT

Acceptable:
- Adequate management of symptoms
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ **Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies**

Unacceptable →

- Re-evaluate contributing etiologies
- Change insomnia or antisedation therapy
- Intensify palliative care interventions
- Consult or refer to specialized palliative care services or hospice
- Consider referral for polysomnography

→ **Ongoing reassessment**

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

DELIRIUM

ESTIMATED LIFE EXPECTANCY

Years

Year to months

Months to weeks

→

- **Assess for delirium (eg, DSM criteria)**
  - **Hyperactive**
  - **Hypoactive**
- **Screen for and treat underlying reversible causes**
  - **Metabolic causes**
  - **Dehydration**
  - **Unrelieved pain**
  - **Hypoxia**
  - **Bowel obstruction/ obstipation**
  - **Infection**
  - **CNS events**
  - **Bladder outlet obstruction**
  - **Medication or substance effect or withdrawal (eg, benzodiazepines, opioids, anticholinergics)**
- **Assess, screen for, and maximize nonpharmacologic interventions (eg, reorientation, cognitive stimulation, sleep hygiene)**

Weeks to days (Dying patient) → **See Interventions (PAL-24)**

Severe delirium (agitation) →

INTERVENTIONS

- **Reduce or eliminate delirium-inducing medications as possible (eg, steriods, anticholinergics, benzodiazepines)**
- **Administer haloperidol 0.5–2 mg IV q 1–4 h prn**
- **Administer alternative agents: olanzapine, 2.5–7.5 mg/d PO/SL q 2-4 h prn (maximum = 30 mg/d); chlorpromazine, 25–100 mg PO/PR/IV q 4 h prn for bed-bound patients**
- **If agitation is refractory to high doses of neuroleptics, consider adding lorazepam, 0.5–2 mg SQ/IV q 4 h**
- **Titrate starting dose to optimal effect with lowest possible dose**
- **Consider opioid dose reduction or rotation**
- **Support caregivers**

Mild/ moderate delirium →

- **Administer haloperidol 0.5–2 mg PO BID/TID**
- **Administer alternative agents: risperidone, 0.5–1 mg PO BID; olanzapine, 5–20 mg PO daily; or quetiapine fumarate, 25–200 mg PO/SL BID**
- **Titrate starting dose to optimal effect with lowest possible dose**
- **Orient patient with family presence**

REASSESSMENT

Acceptable:
- **Adequate delirium symptom management**
- **Reduction of patient/family distress**
- **Acceptable sense of control**
- **Relief of caregiver burden**
- **Strengthened relationships**
- **Optimized quality of life**
- **Personal growth and enhanced meaning**

→

- **Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies, including tapering of doses**

Unacceptable →

- **Intensify palliative care interventions**
- **Consider consultation with a palliative care specialist or psychiatrist**

→ **Ongoing reassessment**

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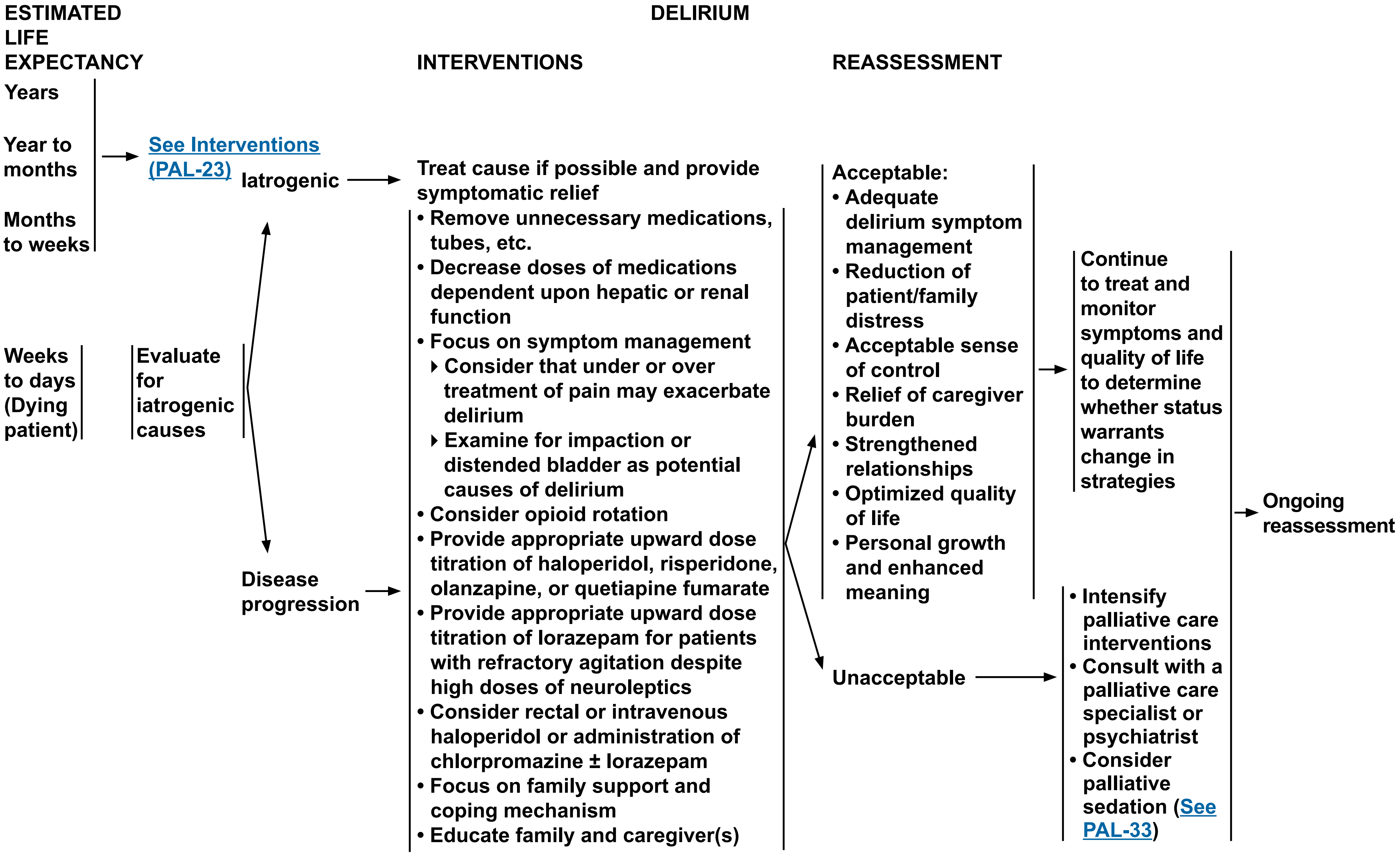
DELIRIUM



ESTIMATED LIFE EXPECTANCY

INTERVENTIONS

REASSESSMENT

Years

Year to months

Months to weeks → See Interventions (PAL-23)

Weeks to days (Dying patient)

Evaluate for iatrogenic causes

Iatrogenic → **Treat cause if possible and provide symptomatic relief**

- Remove unnecessary medications, tubes, etc.
- Decrease doses of medications dependent upon hepatic or renal function
- Focus on symptom management
  - Consider that under or over treatment of pain may exacerbate delirium
  - Examine for impaction or distended bladder as potential causes of delirium
- Consider opioid rotation
- Provide appropriate upward dose titration of haloperidol, risperidone, olanzapine, or quetiapine fumarate
- Provide appropriate upward dose titration of lorazepam for patients with refractory agitation despite high doses of neuroleptics
- Consider rectal or intravenous haloperidol or administration of chlorpromazine ± lorazepam
- Focus on family support and coping mechanism
- Educate family and caregiver(s)

Disease progression →

Acceptable:
- Adequate delirium symptom management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ **Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies**

Unacceptable →
- Intensify palliative care interventions
- Consult with a palliative care specialist or psychiatrist
- Consider palliative sedation (See PAL-33)

→ **Ongoing reassessment**

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SOCIAL SUPPORT/RESOURCE MANAGEMENT

ESTIMATED LIFE EXPECTANCY

Years

Year to months

Months to weeks

INTERVENTIONS

- Ensure that caregiver(s) are available
- Ensure a safe home environment
- Ensure adequate access to transportation
- Ensure sufficient financial resources
- Refer to social services as needed to assist with mobilization of family, community, and financial resources
- Ensure support and education to caregiver(s) and family members
  - ‣ Counseling
  - ‣ Child life services if available
  - ‣ Support groups
- Respond to caregiver-specific burdens and stresses
- Assess bereavement risk
- Discuss personal, spiritual, and cultural issues relating to illness and prognosis
- Obtain medical interpreters/translators who are not related to the patient and family as needed
- Assist family/caregiver(s) with respite care

REASSESSMENT

Acceptable:
- Adequate social support and resource management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ Ongoing re-evaluation and communication between the patient, caregiver(s), family members, and health care team

Unacceptable →
- Intensify efforts to communicate palliative care options
- Consider referral to psychologist or psychiatrist to evaluate and treat psychologic disorders
- See NCCN Guidelines for Distress Management

→ Ongoing reassessment

Weeks to days (Dying patient) → See Interventions (PAL-26)

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SOCIAL SUPPORT/RESOURCE MANAGEMENT

ESTIMATED LIFE EXPECTANCY

INTERVENTIONS

REASSESSMENT

Years

Year to months → See Interventions (PAL-25)

Months to weeks

Weeks to days (Dying patient) →

- Discuss prognosis on an ongoing basis in clear, consistent language with the patient, caregiver(s), and family, including information about the natural history of the specific tumor
- Evaluate and support the patient's desires for comfort
- Explain the dying process and expected events to the patient, caregiver(s), and family members
- Respond to caregiver-specific demands and stresses
- Reassess bereavement risk
- Ensure that care conforms with cultural and spiritual/religious practices
- Provide emotional support and address any patient-family or intra-family conflicts regarding intervention
  - Child life services if available
- Consider palliative care consultation to assist in conflict resolution when the patient, family, and/or professional team do not agree on benefit/utility of interventions
- Obtain medical interpreters/translators who are not related to the patient and family as needed
- Determine eligibility, readiness, and need for specialized palliative or hospice care

Acceptable:
- Adequate social support and resource management
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ Ongoing re-evaluation and communication between the patient and health care team

Unacceptable →
- Reassess patient and family
- Intensify palliative care interventions
- Consult or refer to specialized palliative care services, hospice, or ethics committee
- Consider referral to psychologist or psychiatrist to evaluate and treat psychologic disorders
- See NCCN Guidelines for Distress Management

→ Ongoing reassessment

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

GOALS AND EXPECTATIONS, EDUCATIONAL AND INFORMATIONAL NEEDS, AND CULTURAL FACTORS AFFECTING CARE FOR THE PATIENT AND FAMILY

ESTIMATED LIFE EXPECTANCY

Years

Year to months

Months to weeks

→

INTERVENTIONS

- Assess patient/family understanding of expected course of disease
- Assess for decision-making capacity and need for a surrogate decision maker
- Clarify with the patient how much information he or she wishes to have and how much information should be given to the family
  - Desire for information may change and may need to be challenged as death approaches
  - Provide information about expected course of disease and anticipated care needs
  - Provide anticipatory guidance on dying process
- Facilitate decisions on providing information to family
- Determine the decision-making preferences/styles of the patient and family
  - Facilitate congruence of patient goals and expectations with those of the family
  - Recognize that the involvement of the family may change over time
- Elicit values and preferences with respect to quality of life
- Determine prior experience with end-of-life care
- Address cultural customs and beliefs directly or through a cultural liaison
- Facilitate advance care planning (See PAL-29)
- Encourage the patient to review and revise personal priorities, identify "unfinished business," heal interpersonal relationships, and put affairs in order
- Determine eligibility, readiness, and need for specialized palliative or hospice care
- Foster realistic expectations
- Provide clear, consistent discussion with the patient and family about prognosis on an ongoing basis
- Respect goals and needs of the patient and family regarding the dying process
- Anticipate patient and family needs
- Provide anticipatory grief support and end-of-life education

REASSESSMENT

Acceptable:
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

Unacceptable →
- Reassess patient and family
- Intensify palliative care interventions
- Consult or refer to specialized palliative care services or hospice

→ **Ongoing reassessment**

Weeks to days (Dying patient) → See Interventions (PAL-28)

See Advance Care Planning (PAL-29)

Note: All recommendations are category 2A unless otherwise indicated.
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GOALS AND EXPECTATIONS, EDUCATIONAL AND INFORMATIONAL NEEDS, AND CULTURAL FACTORS AFFECTING CARE FOR THE PATIENT AND FAMILY

ESTIMATED LIFE EXPECTANCY | **INTERVENTIONS** | **REASSESSMENT**

Years

Year to months → See Interventions (PAL-27)

Months to weeks

Weeks to days (Dying patient) →

- Assess patient/family understanding of the dying process
- Educate patient and family on dying process
- Prepare for patient's death
- Facilitate anticipatory grief work
- Ensure continued involvement of primary care physician and primary oncology team
- Respect goals and needs of the patient and family regarding the dying process
- Promote that patient does not die alone unless dying alone is an established preference of patient
- Offer spiritual support
- Encourage planning for funeral/memorial services, as determined by personal preferences, cultural customs, and beliefs

Acceptable:
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

Unacceptable →
- Reassess patient and family
- Intensify palliative care interventions
- Consult or refer to hospice or specialized palliative care services

→ Ongoing reassessment (See PAL-27)

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ADVANCE CARE PLANNING

ESTIMATED LIFE EXPECTANCY

Years
Year to months
→

INTERVENTIONS

- Ask patient if he/she has a living will, medical power of attorney, health care proxy, or patient surrogate for health care
  - ▸ If not, encourage patient to prepare one
- Explore fears about dying and address anxiety
- Assess decision-making capacity and need for surrogate decision-maker
- Initiate discussion of personal values and preferences for end-of-life care
- If patient values and goals lead to a clear recommendation regarding future treatment in light of disease status, physician should make a recommendation about future care
- Document patient values and preferences and any decisions in accessible site in medical record (including MOLST/POLST if completed)
- Encourage the patients to discuss wishes with family/proxy
- Initiate discussion of palliative care options, including hospice if appropriate
- Introduce palliative care team if appropriate
- Refer to state and institutional guidelines for additional guidance

REASSESSMENT

Acceptable:
- Adequate advance care planning
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ **Ongoing re-evaluation and communication between the patient and health care team**

Unacceptable →
- Explore patient reluctance to engage in advance care planning
- Explore fears and worries about illness
- Refer to palliative care if the patient is having difficulty engaging in discussion of advance care planning
- Consider referral to a mental health clinician to evaluate mental health issues
- See NCCN Guidelines for Distress Management

→ **Ongoing reassessment**

Months to weeks
Weeks to days (Dying patient)
→ See Interventions (PAL-30)

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ADVANCE CARE PLANNING

ESTIMATED LIFE EXPECTANCY → **INTERVENTIONS** → **REASSESSMENT**

Years →
- See Interventions (PAL-29)

Year to months / **Months to weeks** →
- Address years-to-months interventions
- Determine patient and family preferences for the location of the patient's death
- Confirm the patient's values and decisions in light of changes in status
- If not previously done, make recommendations about appropriate medical treatment to meet the patient's values and goals
- Ensure complete documentation of the advance care plan in the medical record, including MOLST/POLST if applicable, to assure accessability of the plan to all providers across care settings
- Explore family concerns about the patient's plan and seek resolution of conflict between patient and family goals and wishes
- Consider consultation with a palliative care specialist to assist in conflict resolution when the patient, family, and health care team disagree
- Explore fears about the future and provide emotional support

Weeks to days (Dying patient) →
- Assure that all items identified above are complete
- Implement and ensure compliance with advance care plan
- Clarify and confirm the patient's decision about life-sustaining treatments, including CPR, if necessary
- Explore desire for organ donation and/or autopsy

REASSESSMENT

Acceptable:
- Adequate advance care planning
- Reduction of patient/family distress
- Acceptable sense of control
- Relief of caregiver burden
- Strengthened relationships
- Optimized quality of life
- Personal growth and enhanced meaning

→ Ongoing re-evaluation and communication between the patient/family and health care team

Unacceptable →
- Explore patient reluctance to engage in advance care planning
- Explore fears and worries about illness
- Refer to palliative care if the patient is having difficulty engaging in discussion of advance care planning
- Consider referral to a mental health clinician to evaluate mental health issues
- See NCCN Guidelines for Distress Management

→ Ongoing reassessment

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RESPONSE TO REQUESTS FOR HASTENED DEATH (PHYSICIAN AID-IN-DYING, PHYSICIAN-ASSISTED SUICIDE, EUTHANASIA)

- **The NCCN Palliative Care Panel believes that the most appropriate response to a request for hastened death is to intensify palliative care. All patients making such a request should be referred to a palliative care specialist. However, evaluating a patient's request for hastened death is an important skill, even for clinicians who feel this practice is never morally acceptable. A request for hastened death often has important meanings that require exploration. Clarifying these meanings may enlarge the range of useful therapeutic options and might reduce the patient's wish to die.**
- **Address the request explicitly. If a patient uses a euphemism for death or refers to it indirectly, ask for clarification. Do not assume that a wish for death to come soon is a wish for a lethal prescription.**
- **Distinguish wishing not to live in the patient’s current state from wishing for a hastened death.**
- **Explore the reasons for the request for a hastened death, and find out "why now?”**
  - **Reassess symptom management.**
  - **Reassess psychological/psychiatric issues, especially depression, anxiety, grief, psychosis, and delirium.**
  - **Ask about the patient's relationship to family or other important people.**
  - **Ask about individual values and personal views of spiritual/existential suffering.**
  - **Assess for fears of caregiver burden and abandonment and re-emphasize physician commitment to the patient.**
- **Request a consult with a mental health professional to diagnose and treat reversible causes of psychological suffering.**
- **Offer information about the natural history of the disease and explain the process of dying.**
- **Address the role of medical caregivers, including hospice if appropriate.**
- **Discuss alternatives to hastened death such as withdrawal of life-sustaining treatment, voluntary cessation of eating or drinking, and/or sedation for refractory symptoms.**
- **Know the local legal status of hastened death. Some patients may be confused about legal/ethical distinctions; treatment withdrawal and aggressive treatments for symptoms, such as pain, are not requests for hastened death. Euthanasia is not legal in any state in the United States.**
- **Examine your own response as a clinician to a particular patient's request. Requests for hastened death can force clinicians to confront their own personal, professional, moral, and legal responsibilities. Dealing with an individual patient can be quite different from thinking about the issue in abstract circumstances. Consider a consultation with an ethics committee, palliative care service, or experienced colleague. These cases are usually complex and often benefit from consideration of multiple perspectives.**
- **Clarify the care plan. Requests for hastened death should prompt ongoing discussion and active attempts to ameliorate physical, psychological, and spiritual distress. Re-emphasize your own commitment to providing continuing care for the patient. Maintain medications for symptom management.**

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CARE OF THE IMMINENTLY DYING PATIENT

For an imminently dying patient, consider using an end-of-life care order set, which may contain physical, psychosocial, and practical interventions, including the following:

- Physical
  - Intensify comfort measures:
    - ◊ Implement skin safety protocol according to risk assessment, including using a pressure-relieving mattress and regularly repositioning the patient for comfort as indicated; keep skin moist; reassess wound care for comfort; and premedicate for wound care as needed
    - ◊ Provide eye and mouth care to maintain moisture
    - ◊ Treat for urinary retention and fecal impaction
  - Ensure deactivation of implanted defibrillator and consider deactivation of implanted pacemaker
  - Discontinue unnecessary diagnostic tests and interventions such as transfusions, needle sticks, blood glucose monitoring, oxygen saturation monitoring, and suctioning
  - Replace check of vital signs with regular (eg, every 4 h) symptom assessments
  - Switch routes of medication administration when the oral route is no longer feasible
  - Adjust doses of medications to optimal comfort
  - Treat unclearable terminal secretions (death rattle) by changing the patient's positioning and reducing parenteral and enteral fluids.
    - ◊ For refractory secretions (See PAL-12)
  - Treat dyspnea by adjusting the dose of medication (See PAL-11)
  - Treat refractory restlessness and agitation with palliative sedation (See PAL-33)
  - Prepare to meet a request for organ donation and autopsy
- Psychosocial
  - Help support the patient and family to accept discontinuation of TPN and transfusions, dialysis, IV hydration, and medications that will not add to the patient's comfort
  - Consider social work and chaplain consults
  - Allow the patient and family to have uninterrupted time together
  - Ensure that the patient and family understand the signs and symptoms of imminent death and that they are supported throughout the dying process
  - Offer anticipatory bereavement support
  - Provide support to children and grandchildren
  - Encourage visits by children if consistent with family values
  - Support culturally meaningful rituals
  - Ensure that caregivers understand and will honor advance directives
  - Facilitate closure
- Practical
  - Mobilize in-hospital end-of-life care policies and procedures
  - Ensure that the patient's advance directives are documented and implemented
  - Recommend that the patient's wishes for resuscitation and/or do-not-attempt-resuscitation (DNAR) are documented and followed
    - ◊ If the patient/family have not documented a DNAR order, intensify patient/family education, counsel the family on the importance of a DNAR, or allow natural death (AND)
  - Ensure privacy for the patient and family; if not at home, arrange for a private room if possible
  - Facilitate around-the-clock family presence
  - Provide the patient and family with respectful space and uninterrupted time together
  - Facilitate funeral planning

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See After-Death Interventions (PAL-34)

PALLIATIVE SEDATION

- **Confirm that the patient has refractory symptoms and is imminently dying.**
  - **Refractory symptoms are symptoms that cannot be adequately managed despite comprehensive, interdisciplinary palliative care that does not compromise consciousness.**
  - **Imminently dying patients have a prognosis of hours to days. If palliative sedation is being considered, this should be confirmed by two physicians.**

- **Obtain informed consent for sedation from the patient and/or surrogate/family.**
  - **Discuss the patient's disease status, treatment goals, prognosis, and expected outcomes with the patient and/or surrogate.**
  - **Clarify that sedation will consist of the continuous administration of medications that will render the patient unconscious.**
  - **Review the ethical justification of the use of sedation with the patient/surrogate/family and members of the health care team.**
    - **An ethics consult may be considered in accordance with institutional guidelines and state regulations.**
  - **Explain that consent for sedation must be accompanied by consent for:**
    - **Discontinuation of life-prolonging therapies**
    - **Withholding of cardiopulmonary resuscitation**

- **Permit reassignment of health care professionals who cannot provide sedation due to personal or professional values and beliefs as long as patient care can be safely transferred to the care of another health care professional.**

- **Select an appropriate sedative treatment plan based upon the patient's response to recent and current medications. Typical sedatives used for palliative sedation parenteral infusions include:**
  - **Midazolam: Initial infusion rate 0.4–0.8 mg/h; range 20–102 mg/h**
  - **Propofol: Initial infusion rate 5–10 mcg/kg/min and titrate up.**

- **Continue current pain and symptom management control interventions and titrate as needed.**

- **Monitor patient symptoms regularly and titrate sedatives and other medications based on response and drug/drug interactions to establish and maintain a level of sedation that relieves the patient's refractory symptoms.**

- **Provide ongoing psychosocial and spiritual support for the patient's surrogate, family, and health care professionals.**

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DEATH

Death →

ASSESSMENT

A "peaceful death":
- Free from avoidable distress and suffering for the patient, family, and caregiver(s)
- In general accord with the patient's and family's wishes
- Consistent with clinical, cultural, and ethical standards

→

AFTER-DEATH INTERVENTIONS

For family and caregiver(s)
- Immediate after-death care:
  - Provide the family time with the body
  - Remove tubes, drains, lines, and the foley catheter unless an autopsy is planned
  - Inform family (if not present) of death
  - Ensure culturally sensitive, respectful treatment of the body
  - Address survivor concerns about organ donation and/or autopsy
  - File the death certificate, complete forms, and provide necessary information for the funeral director
  - Offer condolences
  - Inform other health care providers of the patient's death
- Bereavement support:
  - Formally express condolences on the patient's death (eg, card, call, letter)
  - Refer to appropriate bereavement services within the institution or in the community
  - Attend a debriefing meeting with the family if they desire one
- Discuss cancer risk assessment and modification with family members
- Identify family members at risk for complicated bereavement or prolonged grief disorder

For health care professionals

General support:
- Legitimize discussion of personal issues that impact patient care
- Create a climate of safety for discussion of patient deaths
- Provide regular opportunities for reflection and remembering for staff through a memorial ritual

After-death support:
- Review medical issues related to the patient's death
  - Explore concerns and questions regarding quality of patient care
- Review the family's emotional responses to the patient's death
- Review the staff's emotional responses to the patient's death
  - Include nurses, nursing assistants, physician team members (including medical students, residents, and fellows), social workers, and chaplaincy, as appropriate
  - Consider a bereavement ritual for staff (eg, brief reading, moment of quiet)
- Identify health care professionals at risk for complicated bereavement, moral distress, or compassion fatigue

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Discussion

NCCN Categories of Evidence and Consensus

Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.

Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise noted.

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Overview

The aim of the NCCN Guidelines for Palliative Care is to help assure that each patient with cancer experiences the best quality of life possible throughout the illness trajectory by providing guidance for the primary oncology team. The NCCN Palliative Care Panel is an interdisciplinary group of representatives from NCCN Member Institutions, consisting of medical oncologists, hematologists and hematologic oncologists, pediatric oncologists, neurologists and neuro-oncologists, anesthesiologists, psychiatrists and psychologists, internists, palliative care and pain management specialists, and geriatric medicine specialists. These guidelines were developed and are updated annually by the collaborative efforts of these experts based on their clinical experience and available scientific evidence.

Literature Search Criteria and Guidelines Update Methodology

Prior to the update of this version of the NCCN Guidelines® for Palliative Care, an electronic search of the PubMed database was performed to obtain key literature in palliative care published between November 2013 and November 2014, using the following search terms: (palliative care AND cancer) OR (palliative care AND oncology) OR (hospice AND cancer) OR ("end of life care" AND cancer). The PubMed database was chosen as it remains the most widely used resource for medical literature and indexes only peer-reviewed biomedical literature.

The search results were narrowed by selecting studies in humans published in English. Results were confined to the following article types: Clinical Trial; Practice Guideline; Randomized Controlled Trial; Meta-Analysis; Systematic Reviews; and Validation Studies.

The PubMed search resulted in 299 citations and their potential relevance was examined. The data from key PubMed articles selected by the panel for review during the Guidelines update meeting as well as articles from additional sources deemed as relevant to these Guidelines and discussed by the panel have been included in this version of the Discussion section (eg, e-publications ahead of print, meeting abstracts). Recommendations for which high-level evidence is lacking are based on the panel's review of lower-level evidence and expert opinion.

The complete details of the Development and Update of the NCCN Guidelines are available on the NCCN webpage.

Palliative Care in Oncology

More than 1.66 million people are expected to be diagnosed with cancer in the United States in 2015, and 589,430 people are expected to die of the disease.[1] Global cancer rates are increasing, with an associated rise in the number of cancer survivors living with symptoms and disabilities as a result of their disease and/or its treatment (see the NCCN Guidelines for Survivorship).[1-3] The need for comprehensive care for patients with cancer and their families is great. Approximately 16% of patients with cancer being discharged from a single hospital in Germany were assessed as having palliative care needs, with the greatest needs in patients with head and neck cancer, melanoma, and brain tumors.[4] More than one-third of patients with cancer in a large observational cohort study reported moderate to severe symptoms in the majority of categories (pain, nausea, anxiety, depression, shortness of breath, drowsiness, well-being, loss of appetite, and tiredness) in the last weeks of life.[5] Thus, the need for palliative oncologic care is great.

Palliative care in oncology mainly began as hospice and end-of-life care. During the past 20 years, increasing attention has been paid to quality-of-life issues in oncology throughout the disease trajectory.[3,6-10] As the hospice movement has grown in this country, palliative care has developed into an integral part of comprehensive cancer care.[3,11-15]

The Definition of Palliative Care

These guidelines define palliative care as a special kind of patient- and family-centered health care that focuses on effective management of pain and other distressing symptoms, while incorporating psychosocial and spiritual care according to patient/family needs, values, beliefs, and culture(s). The goals of palliative care are to anticipate, prevent, and reduce suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care begins at diagnosis and should be delivered concurrently with disease-directed, life-prolonging therapies and should facilitate patient autonomy, access to information, and choice. Palliative care becomes the main focus of care when disease-directed, life-prolonging therapies are no longer effective, appropriate, or desired. Palliative care should be initiated by the primary oncology team and then augmented by collaboration with an interdisciplinary team of palliative care experts.

Building on the WHO's recommended model of resource allocation in cancer care,[11] a 1999 NCCN Task Force recommended that palliative, symptom-modifying therapy should be provided simultaneously with disease-modifying therapy from diagnosis.[16] While palliative care previously focused on end-of-life care, the idea that palliative care needs to be integrated earlier into the continuum of cancer care is increasingly understood.[17-21] Palliative care needs to exist right from the time of diagnosis through survivorship and/or end-of-life care. Palliative care should begin with the presentation of symptoms, even before the source of those symptoms has been fully determined. As the cancer progresses and anticancer therapy becomes less effective, appropriate and desired palliative care becomes the major focus of the continuing care of the patient and family.[22] Patients with increased risk for cancer should also be provided with supportive care along with risk-reduction therapies. Palliative care should continue even after the patient's death in the form of bereavement support for the patient's survivors.

Impact of Palliative Care

A remarkable study showed that early introduction of palliative care can not only improve quality of life for patients with advanced cancer but can also improve survival.[23] A secondary analysis of this study further showed that patients receiving early palliative care were less likely to receive chemotherapy in the last 60 days of life (odds ratio, 0.47; 95% CI, 0.23–0.99; *P* = .05),[24] likely because these patients had a more accurate understanding of their prognosis, which impacted decisions about their care.[25]

A recent prospective study showed that early integration of palliative care facilitated the discontinuation of anticancer regimens and improved measures of quality of life for patients with advanced breast or gynecologic cancers. Further, palliative care consultation was a positive prognostic factor for overall survival.[26] Similarly, a retrospective analysis of 609 patients with terminal cancer suggested that increased duration of palliative care services was positively correlated with survival time.[27]

Results were recently reported from the ENABLE III trial, which examined outcomes after early versus delayed initiation of palliative care in patients with advanced cancer. Patients in the early palliative care group had significantly higher Kaplan-Meier 1-year survival rates than the delayed palliative care group (63% vs. 48%, *P = .038*).[28] The timing of interventions for caregivers was also examined in this trial, suggesting that earlier provision of palliative care for caregivers lessened their depression and stress burden scores.[29]

Palliative care consultations in patients with advanced cancers have also been shown to reduce the quantity and intensity of life-prolonging care received towards the end of life. Studies have demonstrated the potential for community-based palliative care services to reduce the number of end-of-life emergency department visits and in-hospital deaths.[30,31] Additionally, a recent retrospective analysis of patients with advanced cancer highlighted the importance of early palliative care consultations (>3 months before death) and revealed an association between outpatient palliative care and decreased aggressiveness of end-of-life care.[32] Finally, in a cohort of 5381 patients with advanced pancreatic cancer, patients who had received at least one palliative care consultation had lower odds of intensive care unit (ICU) admission, multiple emergency department visits, and multiple hospitalizations near death.[33]

Likewise, in another study, the lack of palliative care team consultation was shown to be a predisposing factor for futile life-sustaining treatments at the end of life.[34] Palliative care has been shown to reduce symptom burden, improve quality of life, and increase the odds of dying at home. In a recent study comparing standard care with ongoing palliative care in patients with advanced cancer who had a prognosis of 6 to 24 months to live, palliative care resulted in improved patient quality of life, satisfaction with care, and decreased symptom severity.[35] A recent Cochrane Database systematic review analyzing home palliative care in patients with advanced illness demonstrated reliable reduction of symptom burden and increased likelihood of dying at home without a negative impact on caregiver grief.[36] Additionally, palliative care has been shown to generate rapid improvement in symptom burden. A recent study demonstrated significant improvement in multiple symptoms within one day of a palliative care consultation, highlighting the potential benefit of palliative care even during brief hospital stays.[37] Finally, a study by Kamal and colleagues showed that provider conformance with supportive care quality measures significantly improved quality of life for patients with cancer who were receiving palliative care.[38]

Provider education and training in palliative care can also positively impact providers and patients. The OPTIM (Outreach Palliative Care trial of Integrated Regional Model) study is a multiregional, mixed-methods study that examined the effects of a palliative care intervention implemented across 4 regions of Japan.[39] The intervention consisted of provider education and training; education and awareness initiatives for the general public/patients; establishment of community-based palliative care teams to instruct community health care institutions; and establishment of regional palliative care centers to coordinate multidisciplinary community resources. Surveys were provided to patients, bereaved family members, physicians, and nurses both before and after the intervention; the results indicated an increased percentage of patients receiving palliative care and dying at home, increased patient- and family-reported quality of care, and decreased physician- and nurse-reported difficulties in providing palliative care.

Overall, research suggests that successful integration of palliative care early in the continuum of care reduces morbidity for patients with cancer and enhances patient and family/caregiver satisfaction (reviewed by Rocque and Cleary[40] and Khan et al[41]).

In February 2012, ASCO published a provisional clinical opinion based on 7 randomized controlled trials and expert consensus.[42] The ASCO panel stated that there is substantial evidence to show that “palliative care—when combined with standard cancer care or as the main focus of care—leads to better patient and caregiver outcomes." The ASCO panel concluded that strong consideration should be given to the integration of palliative care with standard oncology care early in the course of illness for patients with metastatic cancer and/or high symptom burden. In 2014, a dynamic service model for integrating palliative care into the continuum of oncology care was presented at an ASCO leadership conference.[43]

Provision of Palliative Care

Initially, the primary oncology team (interdisciplinary team of physicians, nurses, social workers, other mental health professionals, chaplains, physician assistants, pharmacists, and dietitians) can provide most of the palliative care needed by the patient and family. Intractable symptoms or complex psychosocial problems can benefit from the inclusion of palliative care experts.

Palliative care should be integrated into patient care through collaboration between the primary oncology team and palliative care specialists as needed over the course of disease.[44] Additionally, palliative care efforts should reach beyond the patient, to family and caregivers.

When further anti-cancer therapy is likely to do more harm than good, palliative care becomes the predominant care offered to patients with advanced cancer. When possible, inpatient palliative care can facilitate transfer to home hospice or inpatient hospice care. For patients too unstable for transfer out of the inpatient setting, palliative care provides end-of-life care for patients who die in the hospital. Several groups have described their ideas and approaches for, experience and outcomes with, and barriers to developing successful programs that integrate palliative care into routine oncologic care.[20,21,43-54]

Hospice Care

Hospice is the most established model of palliative care for patients with a prognosis of less than 6 months and is eligible for coverage by third-party payers and Medicare. Enrollment in hospice has been shown to reduce hospitalization and receipt of high-intensity nonhospice care at the end of life. An analysis of the SEER database revealed that men with advanced prostate cancer who were enrolled in hospice were less likely to receive high-intensity care, including ICU admission and inpatient stays, at the end of life.[55] Moreover, a study of 207 deceased patients with cancer who had stopped cancer treatment showed reduced emergency department visits, hospitalizations, and other noncancer clinic visits among patients enrolled in hospice.[56] Additionally, analyses of data from 3069 deceased patients more than 50 years of age (extracted from the Health and Retirement Study) revealed that hospice enrollment significantly decreased hospitalization, non-hospice health care utilization, and cost of care.[57]

According to the National Home and Hospice Care Survey, the number of adult patients with cancer using hospice care tripled during 1991 through 1992 to 1999 through 2000.[58] The 2013 edition of *NHCPO Facts and Figures: Hospice Care in America* states that 43.3% of Medicare decedents with a cancer diagnosis accessed ≥3 days of hospice in 2007, increasing from 36.6% in 2001.[59] However, the median length of hospice service was just under 19 days in 2012.[59] Most patients who receive hospice care in this country are referred too late for hospice care to exert its full benefit, and many patients are never referred at all.[55,60] A recent study of Medicare patients with advanced lung cancer in New York and California suggested that hospice was underutilized, with a significant proportion of patient deaths occurring without enrollment in hospice.[61]

End-of-life care can often be more aggressive than what is supported by current evidence. Generally, Medicare patients with poor-prognosis cancer received highly intensive end-of life-care.[62] Furthermore, administration of chemotherapy late in the course of cancer care, including in the last days of life, is growing more common,[63,64] and oncologists have reported that they have found hospice regulations and reimbursement limitations too restrictive.[65] Overall, provision of end-of-life care was inconsistent and varied widely across regions, even among comprehensive cancer centers.[62,66]

Palliative Care Standards

Assessing outcomes and evaluating palliative cancer care is essential to ensure high-quality, evidence-based care. Lorenz et al performed a systematic review of end-of-life care and outcomes and found that many aspects of palliative care lack high-quality evidence.[67] The third edition of the Clinical Practice Guidelines for Quality Palliative Care by the National Consensus Project was published in 2013,[68] and the National Quality Forum has developed a national quality framework for evaluating palliative care programs, extending beyond terminally ill patients with cancer to include a broad spectrum of patients with multiple illnesses.[69] These guidelines provide an in-depth assessment of many issues surrounding palliative care (eg, cultural, ethical, legal, physical, psychological, social, spiritual, and existential aspects of care). In addition, the American College of Physicians has developed evidence-based guidelines to improve palliative care of pain, dyspnea, and depression experienced at the end of life.[70]

ASCO recently published a statement on individualized care for patients with advanced cancer.[9] While significant improvements over the past decade were noted (eg, improvements in palliative care education and training for oncologists; an increase in hospital-based palliative care programs and community-based hospice organizations), the statement points out that conversations with patients about their palliative needs are still happening too late in the progression of their disease. Some of the key elements of individualized care listed in the report state that patients should be given:

- enough information to enable them to make informed choices regarding their treatment;
- encouragement to focus on symptom-directed palliative care when disease-directed therapies fail;
- the opportunity to participate in clinical trials that may improve their outcome or that of future patients; and
- the opportunity to die with dignity and peace of mind.

In August 2011, the Commission on Cancer (CoC) of the American College of Surgeons (ACS) released new accreditation standards for hospital cancer programs (http://www.facs.org/news/2011/coc-standards0811.html).[71] Their patient-centered focus requires that patients have access to palliative and hospice care, psychosocial support, and pain management—either on-site or by referral. The standards also state that palliative care should be provided by an interdisciplinary team of medical and mental health professionals, social workers, and spiritual counselors and should be available beginning at the time of diagnosis and continuously throughout treatment, surveillance, and bereavement.

Barriers to Timely Provision of Palliative Care

The major reasons for delayed referral to palliative care are professional reluctance and public confusion about the definition of palliative care. WHO first defined palliative care as care aimed at improving quality of life.[11] WHO expanded its earlier definition of palliative care as an approach that improves the quality of life of patients and their families facing life-threatening illness through the prevention, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems.[72] The definition of palliative care in this Guideline (PAL-1) is adapted from the National Consensus on Palliative Care and the National Quality Forum Framework for Palliative Care.[68,69] Hospice is the oldest and most widely utilized model of palliative care in the United States. Its primary focus is on patients with a prognosis of 6 months or less, for whom no further life-prolonging therapy is appropriate or desired, and who have the desire and capacity to spend most of their final months at home. Patients with cancer accounted for the largest percentage of hospice patients in the late 1970s but now account for only 37% of patients receiving hospice care in this country.[59] Despite the 6-month prognosis eligibility, the median length of service for hospice patients in 2012 was 18.7 days with an average stay of 71.8 days. Approximately 36% of hospice patients died or were discharged within 7 days of admission to hospice care.[59]

Despite the growth of clinical and academic palliative care over the past two decades and the efforts of most palliative care organizations clarifying that palliative care should be given at the time of diagnosis or when there are poorly managed symptoms regardless of prognosis, many people think that palliative care still refers only to care given at the end of life, leading to an inappropriate association of palliative care with death.[73-76] Supportive care has been suggested as an alternative name, to help break this association and facilitate earlier use of palliative care for patients in need. Supportive care in cancer initially focused on the support of patients receiving active cancer therapy with antiemetics, antibiotics, bone marrow stimulants, and transfusions.[77] However, some studies suggest that patients and providers may prefer supportive care terminology to refer to palliative care services.[78,79] At MD Anderson Cancer Center, a switch in the service name from "Palliative Care" to "Supportive Care" was associated with increased patient referrals, referrals at an increased interval before death, and referrals earlier in the course of disease.[80] Regardless of the terminology, patients and families should be informed that palliative care is an integral part of their comprehensive cancer care.[73,81,82]

A retrospective review of patients with advanced cancer seen at MD Anderson Cancer Center found that only 45% of patients had a palliative care consultation before death, and many of those occurred close to death.[83] Similarly, a retrospective study of 6076 patients with advanced pancreatic cancer revealed that only 52% of patients received a palliative care consultation.[84] Interestingly, in a recent survey only 37% of physicians reported that they had access to a specialized palliative care service that accepted patients on chemotherapy.[85] Thus, barriers to early referrals still exist (reviewed by Davis et al[21]). The American Academy of Hospice and Palliative Medicine (www.aahpm.org), founded in 1988, and the Center to Advance Palliative Care (www.capc.org), established in 1999, are organizations dedicated to advancing the discipline of hospice and palliative medicine. These organizations seek to expand access to quality palliative care services in hospitals and other health care settings for people with advanced illness.

Training in Palliative Care

Educational programs should be provided to all health care professionals and trainees so they can develop effective palliative care knowledge, skills, and attitudes. The number of palliative care programs in the United States is rapidly increasing. The establishment of hospice and palliative medicine as a medical subspecialty in 2008 received support from at least 10 cosponsoring American Board of Medical Specialties (ABMS; www.abms.org) boards, including Anesthesiology, Family Medicine, Internal Medicine, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Surgery, and Pediatrics. Support for expansion of palliative medicine education has been offered by the Liaison Committee on Medical Education (LCME; www.lcme.org), which has mandated palliative medicine education for medical schools. In addition, the Accreditation Council for Graduate Medical Education (ACGME; www.acgme.org) now requires training in palliative medicine for oncology fellows, including training in pain, psychosocial care, personal awareness, and hospice care.

Researchers at a large urban teaching hospital recently demonstrated the effectiveness of education on palliative care and referral criteria for increasing overall referrals to palliative care services and enhanced referrals for the purpose of pain management.[86] Effective training in palliative care can also positively impact provider, patient, and caregiver quality of life. One study suggested that an online palliative care education intervention for primary care physicians led to measurable improvements in patient outcomes such as pain, symptoms, and quality of life.[87] In a survey study, oncology fellows reported that training on end-of-life issues and goal-of-care discussions mitigated burnout and distress.[88]

Another recent survey of 254 hematology/oncology fellows found that palliative care education is still lacking, with only 32% of respondents reporting formal training in managing end-of-life depression and only 33% reporting explicit training in opioid rotation.[89]

Palliative care resources that may be useful for clinicians are listed in Table 1, below.

Communication Skills Training

Clear, consistent, and empathetic communication with the patient and family about the natural history of the cancer and its prognosis is at the core of effective palliative care.[90-92] It is important to assess and reassess patient goals and preferences regarding communication of difficult news over the course of disease.[93] When patients understand the goals of treatment, they can make choices that are consistent with their life goals. In addition, effective patient-physician communication can decrease patient stress, increase adherence to treatment, and improve outcomes.[94,95] Open communication with relatives or caregivers of patients with cancer is also critical, particularly when patients near the end of life. A nationwide survey of cancer-bereaved children demonstrated that this population valued communication of medical information about disease, treatment, and death; the results showed that communication of this information prior to their loss improved children’s trust in the care provided and decreased their depression rates.[96]

However, doctors are often hesitant to have honest discussions with their patients, in part because these discussions can be very difficult and emotionally draining for the physicians.[97] Survey data from 620 oncologists revealed a high level of perceived burden regarding discussions about discontinuing anticancer treatments, and study results have indicated a desire on the part of providers for additional communication skills training.[98,99]

Valuable insight has been garnered regarding provider communication and patient understanding from the Cancer Care Outcomes Research and Surveillance (CanCORS) study of approximately 10,000 patients with lung or colorectal cancer. A survey of 1193 patients from CanCORS found that 69% of patients with advanced lung cancer and

81% of those with advanced colorectal cancer thought that their palliative chemotherapy could cure them.[100] While it is unclear whether these patients were told their prognosis, if they did not understand or choose to understand the information, or if they merely answered the survey with a high degree of optimism,[101] this result demonstrates a clear need for improvement in the area of physician-patient communication. Additional analyses of 722 patients with stage IV lung or colorectal showed that only 33% of patients recognized that their chemotherapy regimens were "not at all" likely to cure their cancer.[102] Similar misconceptions also apply to palliative radiation therapy. In a study of 384 patients with inoperable lung cancer, 64% of patients did not understand that their radiation therapy was not curative.[103] Notably, in a cohort of 686 patients with metastatic lung or colorectal cancer from CanCORS, only 16.5% were able to correctly state their prognosis.[104]

Training in communication has been shown to improve clinician communication skills[105-108] and to possibly decrease physician burnout and improve physician empathy and mood.[109] For example, a recent randomized controlled trial showed that an 11-hour communication skills training workshop for oncologists was effective at improving communication skills, including those specific to the transition to palliative care.[110]

NCCN Guidelines for Palliative Care

The NCCN Guidelines for Palliative Care were developed to facilitate the appropriate integration of palliative care into oncology practice. The guidelines outline procedures for screening, assessment, palliative care interventions, reassessment, and after-death care. The panel initially focused on the needs of patients in their last 12 months of life. The panel chose this period to distill the content of textbooks and curricula into guidelines that could facilitate clinical decision-making in the same way that NCCN disease-oriented and symptom-oriented guidelines have. More recent versions of these guidelines have expanded the focus to all patients and family experiencing cancer throughout the disease trajectory, consistent with the Provisional Clinical Opinion from ASCO.[42]

Palliative Care Screening

The primary oncology team should screen all patients at every visit for one of more of the following: 1) unmanaged symptoms; 2) moderate to severe distress related to cancer diagnosis and therapy; 3) serious comorbid physical, psychiatric, and psychosocial conditions; 4) life expectancy of 6 months or less; 5) metastatic solid tumors; 6) patient or family concerns about the course of disease and decision-making; and/or 7) patient or family requests for palliative care. Patients who meet these screening criteria and those who make a specific request for palliative care should undergo a full palliative care assessment.

Patients who do not meet these screening criteria should be re-screened at the next visit. In addition, the oncology team should inform patients and their family members about palliative care services. Anticipation of palliative care needs and prevention of symptoms should also be discussed, and conversations regarding advance care planning should be initiated.

Palliative Care Assessment

Patients who meet screening criteria (see above) should undergo a comprehensive palliative care assessment by their primary oncology team evaluating the benefits and burdens of anticancer therapy; physical symptoms; psychosocial or spiritual distress; personal goals and expectations; educational and informational needs; and cultural factors affecting care.[6-8]

Assessment for Benefits and Burdens of Anticancer Therapy

Many cancer symptoms can be relieved by control of the cancer with anti-cancer therapy. Assessment of the benefits and burdens of anticancer therapy for each individual is based on the existing NCCN disease-specific guidelines (the most recent version of all guidelines can be found on the NCCN website at www.NCCN.org). Special attention should be given to the natural history of the specific tumor; the potential for response to further treatment; the meaning of anticancer therapy to the patient and family; the potential for treatment-related toxicities including impairment of vital organs and performance status; and serious comorbid conditions. Specific recommendations regarding anticancer therapy for patients with various life expectancies are discussed in *Palliative Care Interventions*, below.

Assessment of Personal Goals and Expectations

Patients and their families should also be asked about their personal goals and expectations. Their priorities for palliative care, including their goals and perceived meaning of anticancer therapy and the importance they place on quality of life, should be assessed. Goals and expectations that might be better met by the hospice model of palliative care should be identified. When appropriate, it is important to determine the patient's understanding of the incurability of their disease and whether patients wish to know survival statistics.

Assessment of Physical Symptoms

The most common symptoms that need to be assessed are pain, dyspnea, anorexia, cachexia, nausea, vomiting, constipation, malignant bowel obstruction, fatigue, weakness, asthenia, insomnia, daytime sedation, and delirium.[111] Palliative interventions for these symptoms are discussed individually below.

Assessment of Psychosocial Distress

Assessment of psychosocial distress should focus on illness-related distress and psychosocial, spiritual, or existential issues according to the NCCN Guidelines for Distress Management. Special problems with social support and resources (ie, home, family, community, or financial issues) must also be assessed. Recommendations for the management of psychosocial distress can be found below and in the NCCN Guidelines for Distress Management.

Assessment of Educational and Informational Needs and Cultural Factors Affecting Care

The values and preferences of patients and families about information and communication should also be assessed. The oncology team should inquire about cultural factors affecting care and perceptions of the patient/family regarding the patient's disease status.

Criteria for Consultation with Palliative Care

Criteria for consultation with a palliative care specialist are based on patient characteristics, social circumstances, and anticipatory bereavement issues. The oncology team should consider consultation for patients with limited anticancer treatment options; high symptom burden, especially non-pain symptoms resistant to conventional management; history of allergies or adverse effects to multiple palliative interventions; frequent emergency department visits or hospital readmissions; complicated ICU admissions (multi-organ system failure or prolonged mechanical ventilation); palliative stenting/gastrostomy; a high distress score (eg, ≥4 on the Distress Thermometer; see the NCCN Guidelines for Distress Management); cognitive impairment; severe comorbid conditions; or communication barriers. In addition, consultation with palliative care specialists should be considered for those with rapidly progressive functional decline or persistently poor performance status; those needing clarification of the goals of care;

those at high risk for poor pain management; those who make a request for hastened death; and/or those who are resistant to engaging in advance care planning.

Social circumstances or anticipatory bereavement issues that indicate a need for referral for consultation with a palliative care specialist include family/caregiver limitations, inadequate social support, financial limitations, limited access to care, family discord, intensely dependent relationships, financial limitations, limited access to care, patient's concern regarding care of dependents, spiritual or existential distress, and/or unresolved or multiple prior losses.

Palliative care consultation should also be considered when complex care coordination issues exist among multiple care teams, or if staff issues such as compassion fatigue, moral distress, or burnout are present. For more information regarding psychosocial issues affecting care providers, see the section on *Psychosocial Support for Palliative Care Providers*.

Palliative Care Interventions

The oncology team should initiate palliative treatments following the specific recommendations described in these guidelines for common symptoms. Comorbid physical and psychosocial conditions should be treated by appropriate clinicians. Consultation or collaboration with palliative care specialists or teams is recommended for patients with more complex problems to improve their quality of life and survival.[23,42] Referrals should be made as needed to mental health and social services, pastoral care, health care interpreters, hospice services, or other specialists. Finally, the oncology team can be helpful in mobilizing community support through religious organizations, schools, or community agencies.

The panel divided patients into 3 groups to address the effect of life expectancy on the delivery of palliative care interventions: 1) patients with years to months to live; 2) patients with months to weeks to live; and 3) dying patients in their final weeks to days. Patients in their final hours of life are referred to as *imminently dying* and may require special interventions. The panel recognizes the lack of precision in estimating life expectancy but believes that this delineation will be useful for the delivery of appropriate palliative care interventions. The patient and family's personal, spiritual and existential, cultural, and religious goals and expectations may change throughout these timeframes. Optimal provision of palliative care requires ongoing reassessment and modification of strategies, as well as ongoing communication between the patient, family, and health care team.

Indicators that patients are in their last 6 months of life include decreased performance status (ECOG score ≥3; KPS score ≤50), persistent hypercalcemia, central nervous system metastases, delirium, superior vena cava syndrome, spinal cord compression, cachexia, malignant effusions, liver failure, kidney failure, or other serious comorbid conditions. Many patients with stage IV cancers, especially those with metastatic lung cancer, pancreatic cancer, and glioblastoma multiforme, would benefit from palliative care beginning at diagnosis, because expected survival is limited.[112-114]

For patients whose life expectancy is "years to months" or "months to weeks," it is important to determine how much information a patient wishes to know and how much of that information should be shared with the patient's family. In patients queried regarding preferences about receiving prognostic information and detailed information on their disease, studies show that the majority express a desire to receive this information.[115-118] Patients will also require answers to any questions about what to expect in the next few months and anticipatory guidance on the dying process. In addition, determining the decision-making styles of patients and their families helps facilitate congruence of a patient's goals and expectations with those of the family. Clinicians should also determine the patient's assessment of the relative importance of quality of life compared with length of life. Patients should be assisted in reviewing and revising their life priorities, resolving their unfinished business, and putting their financial and personal affairs in order.

Dying patients may wish to prepare for death and to help prepare family members to go on without them. Both patients and families benefit from education on the dying process. Families should be guided through their anticipatory grief, and arrangements should be made to ensure that the patient's and family's needs and goals regarding the dying process are respected. Planning to ensure continuing care and referrals to appropriate care is important. Arrangements should be available to ensure that the patient does not die alone unless that is the patient's preference.

Clinicians should discuss the prognosis with patients and their families clearly and consistently to help them develop realistic expectations. Information about the natural history of the specific tumor and the realistic outcomes of anticancer therapy should be included in the discussion. Many investigators have shown that seriously ill middle-aged and older patients tend to be more optimistic and less accurate about their prognosis than their physicians; such misunderstanding of the situation can affect their preferences for cardiopulmonary resuscitation and for life-extending measures.[119] Spiritual, existential, and cultural issues are often best addressed through collaboration with pastoral care counselors, professional translators, the patient's personal clergy, and representatives from the patient's cultural community. Religious and cultural issues surrounding the beliefs and practices near the time of death must be anticipated and carefully managed.[120] Finally, social and spiritual support and resource management interventions should be provided to ensure a safe end-of-life care environment, a competent primary caregiver, and access to necessary medications and treatments. Providers must be sensitive to cultural values that may influence the best way for this information to be presented and discussed.

Palliative care interventions for managing specific symptoms and the benefits and burdens of anticancer therapy are discussed below as outlined in the algorithms. Additional palliative care interventions for other symptoms will be developed as deemed necessary.

Anticancer Therapy

A recent Institute of Medicine (IOM) report, *Communicating with Patients on Health Care Evidence*, found that 90% of Americans surveyed want to know their options for tests and treatments and to be involved in decision making for their health, with almost 50% wanting to discuss the option of doing nothing.[121,122] However, the report also found that far fewer respondents had such discussions with their physicians.

Patients who have years to months to live and a good performance status are likely to be interested in continuing anticancer therapy to prolong survival and reduce cancer-related symptoms.[123-126] Anticancer therapy may be conventional evidence-based treatment as outlined in the NCCN disease-specific guidelines (available at www.NCCN.org) or treatment in the context of a clinical trial. In some of the advanced-stage cancers, chemotherapy may be superior to best supportive care and may prolong survival.[127,128] Furthermore, patients with advanced non-small cell lung cancer who are not eligible for systemic chemotherapy may benefit from targeted therapies that are effective for relieving symptoms, maintaining stable disease, and improving quality of life without the adverse events that may be associated with cytotoxic cancer therapies.[129] Physicians, patients, and their families should discuss intent, goals, and range of choices; benefits and burdens of anticancer therapy; and possible effects on quality of life. In addition, the oncology team should prepare the patient psychologically for possible disease progression.

Anticancer therapy may at times go beyond what is evidence-based. Interestingly, data from a CanCORS study of 1574 patients with metastatic non-small cell lung cancer suggested that many patients received higher doses and a greater number of palliative radiation treatments than what is supported by current evidence.[130] Additionally, a study of patients with metastatic colorectal cancer revealed that more than 90% of patients consulted with a medical oncologist, and 82% of these patients received chemotherapy.[131]

Patients with months to weeks to live should be provided with guidance regarding the anticipated course of the disease. Physicians should reassess patient's understanding of goals of therapy and preferences regarding prognostic information. These patients are typically tired of therapy, homebound, and more concerned about the side effects of more treatment. The focus of treatment for these patients shifts from prolonging life towards maintaining quality of life. These patients should consider potential discontinuation of anticancer treatment and be offered best supportive care, including referral to palliative care or hospice.[132,133] To avoid demeaning the value of end-of-life care, palliative care should not be described as "just hospice."

In general, patients with weeks to days to live (ie, dying patients) should not be given anticancer therapy, but should be given intensive palliative care focusing on symptom management and preparation for the dying process.

Symptom Management

Special considerations in the implementation of these guidelines based on life expectancy are delineated in the algorithms. The major focus of these special considerations is the withholding and withdrawal of aggressive interventions; prevention and elimination of side effects associated with pharmacologic pain management; the acceptance of loss of function for the sake of relief of symptoms; and the treatment of the unique symptoms of patients in their final hours of life.

With regard to symptoms, the management of pain, dyspnea, anorexia/cachexia, nausea and vomiting, constipation, diarrhea, malignant bowel obstruction, fatigue, delirium, and psychological distress is fundamental[134-136] and discussed in detail below. As a general principle, if/when appropriate, providers should try to use palliative interventions that may address multiple symptoms.

Pain

See the NCCN Guidelines for Adult Cancer Pain. In addition, it is important to note that dying patients in their last weeks of life have several specific requirements. For instance, opioid dose should not be reduced solely for decreased blood pressure, respiration rate, or level of consciousness when opioid is necessary for adequate management of dyspnea and pain. In fact, opioids can be titrated aggressively for moderate/severe acute/chronic pain.[137] In addition, palliative sedation can be considered for refractory pain (see below) following consultation with pain management/palliative care specialists.

Dyspnea

Dyspnea is one of the most common symptoms in patients with advanced lung cancer.[138] The American Thoracic Society consensus statement defines dyspnea as "a subjective experience of breathing discomfort that consists of qualitatively distinct sensations that vary in intensity."[139]

Symptom intensity should first be assessed in all patients. Symptom intensity in non-communicative patients with weeks to days to live should be assessed using labored breathing or other physical signs of dyspnea. Next, underlying causes or comorbid conditions should then be treated using chemotherapy or radiation therapy; therapeutic procedures for cardiac, pleural, or abdominal fluid[140-142]; bronchoscopic therapy; or bronchodilators, diuretics, steroids, antibiotics, transfusions, or anticoagulants for pulmonary emboli.

Both pharmacologic and non-pharmacologic interventions have been assessed for management of dyspnea. A recent review concluded that little definitive data evaluating the effectiveness of dyspnea interventions exist and that randomized controlled trials are needed.[143] Other reviews have determined that there are sufficient data to make treatment recommendations.[141,144] Pharmacologic interventions may include opioids with or without benzodiazepines.[141,145-150] Benzodiazepines can be tried for treatment of dyspnea if it is associated with anxiety; the beneficial effect of benzodiazepines on dyspnea in patients with advanced cancer is small.[150]

Of the opioids, morphine has undergone the most extensive investigation for treating dyspnea in patients with cancer, but recent studies have also assessed opioids such as fentanyl and oxycodone. A single-institution trial of nebulized fentanyl in patients with cancer with dyspnea showed improved oxygenation and reduced tachypnea, and 79% of patients said it improved their breathing.[151] An attempted randomized, placebo-controlled trial at the same institution was not successful, because the practice had already diffused widely with over 1000 doses being prescribed.[152] Multiple case reports give promising data about fentanyl, but further placebo-controlled trials are needed.[153] In a small randomized controlled trial, prophylactic subcutaneous fentanyl was effective for improving dyspnea and fatigue at rest and following a 6-minute walk test.[154] A study revealed that nebulized fentanyl reduced intensity and unpleasantness of dyspnea in patients with chronic obstructive pulmonary disease (COPD).[155] Nebulized fentanyl has not yet been studied in patients with cancer, but it can be considered in patients who do not respond well to the other interventions in these guidelines. Additionally, an observational study of 136 patients with terminal cancer also suggested that continuous infusion of subcutaneous oxycodone may provide relief of dyspnea in addition to relief of pain.[156]

Scopolamine, atropine, hyoscyamine, and glycopyrrolate are options to reduce excessive secretions associated with dyspnea.[157-161] Glycopyrrolate does not effectively cross the blood brain barrier,[162] and thus is less likely than the other drug options to cause delirium.[163,164] Scopolamine can be administered subcutaneously or transdermally; physicians should be aware that the onset of benefit for transdermal scopolamine patches is about 12 hours,[165] and they are thus not an appropriate choice for imminently dying patients. A subcutaneous injection of scopolamine can be administered when the patch is applied or if management of secretions is inadequate. Non-pharmacologic interventions include the use of handheld fans directed at the face. A randomized, controlled, crossover trial demonstrated that breathlessness was reduced in patients when they directed a handheld fan toward their faces.[166] A time-limited trial of mechanical ventilation, as clinically indicated, and/or oxygen therapy for hypoxia may also be beneficial. In a recent feasibility study of 200 patients with solid tumors randomized to receive either noninvasive positive-pressure ventilation (biphasic positive airway pressure, BiPAP) or oxygen therapy, patients in the ventilation group had greater improvements in dyspnea symptoms and required lower doses of opiates than patients in the oxygen group.[167] However, a smaller phase II randomized trial comparing high-flow oxygen to BiPAP for persistent dyspnea in patients with advanced cancer revealed no significant differences between the two approaches.[168] High-flow nasal oxygen and BiPAP may temporarily improve hypoxemia, but are never available outside the hospital setting. As life expectancy decreases, the role of mechanical ventilation and oxygen diminishes, and the role of opioids, benzodiazepines, glycopyrrolate, and scopolamine increases. If fluid overload is a contributing factor, enteral and parenteral fluids should be decreased or discontinued, and low-dose diuretics can be considered.

Anorexia/Cachexia

Cachexia is physical wasting with loss of skeletal and visceral muscle mass and is very common among patients with cancer.[169,170] Many patients with cancer lose the desire to eat (anorexia), which contributes to cachexia. Cachexia can also occur independently from anorexia, as proinflammatory cytokines and tumor-derived factors directly lead to muscle proteolysis.[169,170] Cachexia leads to asthenia (weakness), hypoalbuminemia, emaciation, immune system impairment, metabolic dysfunction, and autonomic failure. Cancer-related cachexia has also been associated with failure of anti-cancer treatment, increased treatment toxicity, delayed treatment initiation, early treatment termination, shorter survival, and psychosocial distress.[169-171] A recent study that examined cancer cachexia in a cohort of 1473 patients across all weight ranges showed that muscle depletion conveys a similarly poor prognosis as involuntary weight loss, regardless of body mass index.[172]

Treatment includes the relief of symptoms that interfere with food intake (eg, depression, pain, constipation, nausea/vomiting), metoclopramide for early satiety, and the use of appetite stimulants (eg, megestrol acetate, dexamethasone, olanzapine) when increased appetite is an important aspect of quality of life.[141,144,173-177] A recent systematic review and meta-analysis of megestrol acetate revealed improved appetite and slight improvements in weight gain when using this drug to treat anorexia/cachexia in patients with cancer.[174] While one in four patients treated with megestrol acetate will have an increase in appetite and one in 12 will have an increase in their weight, clinicians need to know that one in 6 will develop thromboembolic phenomena and one in 23 will die.[174]

A combination therapy approach may yield the best possible outcomes for patients with cancer cachexia. A randomized phase III trial in 332 patients with cancer-related anorexia/cachexia revealed superior outcomes for patients receiving a combination regimen that included medroxyprogesterone, megestrol acetate, eicosapentaenoic acid and L-carnitine supplementation, and thalidomide, versus therapy with any of the above single agents.[178] Another phase III trial of 104 patients with advanced gynecologic cancers and cachexia supported the merits of combination therapy; compared with megestrol acetate alone, patients receiving megestrol acetate plus L-carnitine, celecoxib, and antioxidants had improved lean body mass, appetite, and quality of life.[179]

Although cannabinoid-based interventions (eg, dronabinol, cannabis) have some demonstrated efficacy for treating chemotherapy-induced nausea and vomiting and AIDS-related anorexia, the data to support cannabinoid-based interventions for treating anorexia/cachexia in patients with cancer are very limited.[180] A randomized clinical trial of cannabis extract and delta-9-tetrahydrocannabinol in patients with cancer-related anorexia-cachexia syndrome did not demonstrate a benefit of these agents over placebo on appetite and quality of life.[181] Another randomized trial comparing megestrol acetate to dronabinol in treating cancer-associated anorexia revealed megestrol acetate to be superior for promoting weight gain (75% vs. 49% of patients) and appetite (11% vs. 3%) in patients with advanced cancer.[182] However, to a lesser extent, dronabinol did improve appetite and weight gain in some study patients. Ultimately, for some patients with cancer-related anorexia, cannabinoids could be helpful. However, it is important to note that cannabinoid administration in elderly patients may induce delirium, and providers should be aware of the local state rules and regulations regarding medicinal cannabinoid use.

Nutrition consultation should also be considered, because calorie-dense, high-protein supplementation has demonstrated some efficacy for weight stabilization,[141,169,183-185] although some studies show nutritional interventions to be ineffective.[186] A meta-analysis found that while nutritional intervention does not significantly affect weight gain or energy intake, it can improve some aspects of quality of life, including emotional functioning, dyspnea, and hunger.[187] Nutritional support, including enteral and parenteral feeding as appropriate, should also be considered when the disease or treatment affects the ability to eat and/or absorb nutrients and the patient's life expectancy is months to years.[188] The goals and intensity of nutritional support change as life expectancy is reduced to weeks to days. Overly aggressive enteral or parenteral nutrition therapies can actually increase the suffering of dying patients.[188-191] In addition, a recent randomized controlled trial of patients with cancer enrolled in hospice found that parenteral hydration had no effect on dehydration symptoms such as fatigue and hallucination and had no effect on quality of life or survival.[192] Therefore, instead of artificial hydration and nutrition, palliative care in the final weeks of life focuses on treating dry mouth and thirst, and providing education and support to the patient and family regarding the emotional aspects of withdrawal of nutritional support. Family members should be informed of alternate ways to care for dying patients.

Nausea and Vomiting

Chemotherapy-induced nausea and vomiting has a major impact on a patient's quality of life.[193] Nausea and vomiting induced by chemotherapy or radiation therapy should be managed as outlined in the NCCN Guidelines for Antiemesis. Patients can also experience nausea and vomiting unrelated to chemotherapy and radiation, resulting from gastric outlet obstruction, bowel obstruction, constipation, opioid use, or hypercalcemia.[194] These causes should be identified and treated. Proton pump inhibitors and histamine-2 (H2) receptor antagonists can be used to manage gastritis or gastroesophageal reflux. Gastric outlet obstruction may benefit from treatment with corticosteroids; alternative treatment options include endoscopic stenting or insertion of a decompressing G-tube. Many medications can also cause nausea and vomiting, and blood levels of possible culprits, such as digoxin, phenytoin, carbamazepine, and tricyclic antidepressants, should be checked.[195,196]

Non-specific nausea and vomiting can be managed with dopamine receptor antagonists (eg, prochlorperazine, haloperidol, metoclopramide, olanzapine) or benzodiazepines (anxiety-related nausea). Persistent nausea and vomiting can be treated by titrating dopamine receptor antagonists to maximum benefit and tolerance.[197-201] For persistent nausea, adding 5-HT3 (5-hydroxytryptamine 3) receptor antagonists[202,203] and/or anticholinergic agents and/or antihistamines,[204] corticosteroids,[204,205] continuous or subcutaneous infusion of antiemetics, antipsychotics (eg, olanzapine or haloperidol),[206] and/or cannabinoids can also be considered.[207] Opioid rotation may also help alleviate symptoms.[208] Agents that target the cannabinoid system may offer some efficacy in treating refractory chemotherapy-induced nausea and vomiting.[209] Dronabinol and nabilone are two cannabinoid agents approved for treating chemotherapy-induced nausea and vomiting that is refractory to standard antiemetic therapies. Alternative therapies (eg, acupuncture, hypnosis, cognitive behavioral therapy) can also be considered.[210-212] Palliative sedation (see below) can be considered as a last resort if intensified efforts by specialized palliative care or hospice services fail.

A systematic review assessed the level of evidence for antiemesis unrelated to chemotherapy.[213] While the authors concluded that antiemetic recommendations have moderate to weak evidence at best, the strongest evidence supports the use of metoclopramide; studies of multidrug combination therapies do not support their effectiveness.

Constipation

Constipation occurs in approximately 50% of patients with advanced cancer and most patients treated with opioids.[214] Although several drugs including antacids, anticholinergic drugs (antidepressants, antispasmodics, phenothiazines, and haloperidol), and antiemetics are known to cause constipation,[215] opioid analgesics are most commonly associated with constipation. Providers should discontinue any nonessential constipating medications. In addition to physical discomfort, constipation in patients with advanced cancer can cause psychological distress and anxiety regarding continued opioid use.[216] Opioid-induced constipation should be anticipated and treated prophylactically with a stimulating laxative to increase bowel motility with or without stool softeners.[217] While there is little evidence on which is the best initial bowel regimen in patients with cancer, one small study compared the use of senna alone versus a senna-docusate combination. The results demonstrated that the addition of the stool softener docusate was not necessary.[218] Increasing fluid intake, dietary fiber, and physical activity should also be encouraged, when appropriate.

If constipation is present, the cause and severity must be assessed. Impaction, obstruction, and other treatable causes, such as hypercalcemia, hypokalemia, hypothyroidism, and diabetes mellitus, should be assessed and treated. Constipation may also be treated by adding bisacodyl 10 to 15 mg, 2 to 3 times daily with a goal of 1 non-forced bowel movement every 1 to 2 days. If impaction is observed, glycerine suppositories may be administered or manual disimpaction may be performed.

If constipation persists, adding other laxatives may be considered, such as rectal bisacodyl once daily or oral polyethylene glycol, lactulose, magnesium hydroxide, or magnesium citrate. If gastroparesis is suspected, the addition of a prokinetic agent, such as metoclopramide, may be considered. Recent studies have shown that methylnaltrexone, a peripherally acting antagonist of μ-opioid receptors, helps relieve opioid-induced constipation while maintaining pain management.[219,220] Based on these results, the NCCN Palliative Care Panel recommends considering 0.15 mg per kilogram of body weight of methylnaltrexone every other day (no more than once a day) for patients experiencing constipation that has not responded to standard laxative therapy. Methylnaltrexone should not be used in patients with a postoperative ileus or mechanical bowel obstruction.

Diarrhea

In patients with cancer, diarrhea can be caused by a number of potential factors, including anticancer treatment-related side effects, infection, antibiotic use, dietary changes, or fecal impaction.[221] Diarrhea is a common side effect of various chemotherapeutics (eg, fluorouracil and irinotecan),[222,223] as well tyrosine kinase inhibitors and certain biologic agents (eg, ipilimumab, cetuximab, panitumumab)[224]. Abdominal and pelvic radiation therapy (alone or as part of chemoradiation regimens) can also induce gastrointestinal toxicity resulting in diarrhea.[222]

The National Cancer Institute Common Toxicity Criteria are typically used for measuring diarrhea in this patient population.[221] The panel recommends that patients be screened to determine the grade of diarrhea. Providers should provide immediate intervention for dehydration based on grade and assess for potential cause(s).

For patients with years, years to months, or months to weeks of estimated life expectancy who have grade 1 or 2 diarrhea, recommendations include hydration and electrolyte replacement (oral or IV fluids as appropriate), antidiarrheal medications, and a bland/BRAT (Bread, Rice, Applesauce, Toast) diet. For treating grade 2 diarrhea, anticholinergic agents such as hyoscyamine or atropine can be considered. Infection-induced diarrhea should be treated with the appropriate antibiotic. If diarrhea persists, the use of low doses of morphine concentrate can be considered and would be more cost effective than tincture of opium. Patients with persistent grade 2, or grades 3 or 4 diarrhea should receive inpatient treatment. In addition to fluid replacement, antidiarrheal therapy, and anticholinergics, octreotide can also be considered.

For patients with weeks to days of estimated life expectancy, the above interventions can be considered as consistent with the goals of care. At-home IV hydration may be considered in addition to scopolamine or hyoscyamine. If diarrhea persists, consider octreotide. Patients should begin around-the-clock opioids or receive an increased dose of ongoing opioid regimens.

Malignant Bowel Obstruction

Malignant bowel obstructions are usually diagnosed clinically and confirmed with radiography. For patients with years to months to live, surgery following CT scan is the primary treatment option. While surgery can lead to improvements in quality of life, surgical risks should be discussed with patients and families. Although surgery is the primary treatment for malignant obstruction, some patients with advanced disease or patients in generally poor condition are unfit for surgery and require alternative management to relieve distressing symptoms. Risk factors for poor surgical outcome include ascites, carcinomatosis, palpable intra-abdominal masses, multiple bowel obstructions, previous abdominal radiation, advanced disease, and poor overall clinical status.[225] In these patients, medical management can include pharmacologic measures, parenteral fluids, endoscopic management, and enteral tube drainage.

Pharmacologic management of malignant bowel obstruction can be separated into two groups of patients: those for whom the goal is to maintain gut function and those for whom gut function is no longer possible. When the goal is maintaining gut function, patients can be treated with opioids, antiemetics, and corticosteroids, alone or in combination. When gut function is no longer considered possible, pharmacologic options also include somatostatin analogs (eg, octreotide) and/or anticholinergics.[226-231] Antiemetics that increase gastrointestinal mobility such as metoclopramide should not be used in patients with complete obstruction, but may be beneficial when obstruction is partial. Use of octreotide is recommended early in the diagnosis because of its efficacy and tolerability.[232,233] Despite positive findings from several smaller randomized trials, a recent phase III trial of octreotide in 86 patients with malignant bowel obstruction failed to demonstrate a significant effect of this drug on days free of vomiting, number of vomiting episodes, symptom management, and other secondary endpoints.[234]

A venting gastrostomy tube (inserted by interventional radiology, endoscopy, or surgery), a percutaneous endoscopic gastrostomy tube, or an endoscopically placed stent can also palliate symptoms of malignant bowel obstruction.[235,236] Total parenteral nutrition can be considered to improve quality of life in patients with a life expectancy of years to months. These interventions have been shown to have little positive impact on survival time, but may improve quality of life.[112,113]

Fatigue/Weakness/Asthenia

The data on methylphenidate for treating cancer-related fatigue have been mixed. While some trials have suggested a dose-dependent benefit of this agent on fatigue symptoms,[237,238] other studies have failed to produce positive results.[239] Phase III randomized trials of modafinil for treating cancer-related fatigue suggested that modafinil had a modest efficacy and was most effective for those with severe fatigue.[240,241] For more information, see the NCCN Guidelines for Cancer-Related Fatigue.

Sleep/Wake Disturbances

Patients with cancer often suffer from insomnia or daytime sedation.[242-244] In a recent study of 442 patients with advanced cancer, 330 (75%) patients were assessed as having baseline sleep disturbance as assessed by the Edmonton Symptom Assessment System (ESAS) sleep item.[245] Patients should first be evaluated for sleep/wake disturbances using, for example, the Epworth Sleepiness Scale.[246] If patients have a history of sleep-disordered breathing (eg, excessive snoring, gasping for air, observed apneas, frequent arousals, sudden involuntary movement of arm or legs during sleep, unexplained daytime drowsiness), polysomnography should be considered. Polysomnography should also be considered for patients with head and neck cancers, because obstructive sleep apnea (OSA) is prevalent in patients with this disease.[247,248] Primary sleep disorders, such as OSA and periodic limb movement disorder, should be treated with continuous positive airway pressure (CPAP) or BiPAP.[249] Restless leg syndrome, if present, can be treated with ropinirole, pramipexole, or carbidopa-levodopa.[250-257] Fears and anxiety regarding death and disease should be explored, and other contributing factors to sleep/wake disturbances should be treated, including pain, depression, anxiety, delirium, and nausea. Cognitive behavioral therapy may be effective in treating sleep/wake disturbances in patients with cancer.[144,258-262]

For refractory insomnia, pharmacologic management includes the short-acting benzodiazepine lorazepam, the non-benzodiazepine zolpidem, antipsychotic medications such as chlorpromazine, quetiapine, and olanzapine, and sedating antidepressants such as trazodone and mirtazapine.[263] The panel suggests that mirtazapine may be especially effective in patients with depression and anorexia. Benzodiazepines should be avoided in older patients and in patients with cognitive impairment, because they have been shown to cause decreased cognitive performance.[264] Caution should be exercised when administering zolpidem due to the known risk of next-morning impairment. In 2013, the U.S. Food and Drug Administration required lower recommended doses of zolpidem (ie, from 10 mg to 5 mg for immediate-release products and from 12.5 mg to 6.25 mg for extended-release formulations).[265]

For refractory daytime sedation, the guidelines suggest several options. The central nervous system stimulants methylphenidate or dextroamphetamine should be given with a starting dose of 2.5 to 5 mg orally (PO) with breakfast. If the effect of the drug does not last through lunch, a second dose can be given at lunch, preferably no later than

2:00 PM. Doses can be escalated as needed.[266] Another option for refractory daytime sedation is the psychostimulant modafinil, which has been approved in adults for excessive sleepiness associated with OSA/hypopnea syndrome (OSAHS), shift work sleep disorder, and narcolepsy.[267] The panel also recommends caffeine and dextroamphetamine as additional options for refractory daytime sedation. The last dose of caffeine should be given no later than 4:00 PM.

Dying patients should be assessed for their desire to have their insomnia or sedation treated. The doses of their pharmacologic therapies can be adjusted as appropriate. The addition of an anti-psychotic drug (chlorpromazine or quetiapine) can be considered in patients whose insomnia is refractory.

Please also see the NCCN Guidelines for Adult Cancer Pain and the NCCN Guidelines for Cancer-Related Fatigue for their discussions on sleep/wake disturbances.

Delirium

Delirium should be assessed using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria.[268] Reversible causes should be identified and treated appropriately.[269] Delirium presents as hypoactive or hyperactive subtypes that may require different approaches to management.[270] Recent studies have suggested that hypoactive delirium was the most prevalent subtype in palliative care patients and that this condition is often underdiagnosed due to its presentation.[271,272]

Two comprehensive reviews describe the evidence base for recommended pharmacologic and non-pharmacologic treatments for delirium in patients with cancer.[144,273] Non-pharmacologic interventions (eg, reorientation, cognitive stimulation, sleep hygiene) should be maximized before pharmacologic interventions are used. Delirium-inducing medications (ie, steroids, anticholinergics) should be reduced or eliminated as much as possible.[274] Benzodiazepines should not be used as initial treatment for delirium in patients not already taking them.

The symptoms of moderate delirium can be managed with oral haloperidol, risperidone, olanzapine, or quetiapine fumarate.[275-277] The symptoms of severe delirium (ie, agitation) should be managed with antipsychotic, neuroleptic drugs such as haloperidol, olanzapine, or chlorpromazine.[278] Because of its hypotensive side effect, intravenous chlorpromazine should only be used in bed-bound patients. A benzodiazepine, such as lorazepam, may be added for agitation that is refractory to high doses of neuroleptics.[279] The presence of therapeutic levels of neuroleptics usually prevents the paradoxical excitation sometimes seen when delirious patients are given lorazepam. The dosages of these symptom-management medications should be titrated to optimal relief. Opioid dose reduction or rotation can also be considered for patients with severe delirium. Caregivers should be supported in caring for their loved one and coping with this distressing condition.

Delirium in patients with advanced cancer and limited life expectancy may shorten prognosis.[280] In these patients, iatrogenic causes should be eliminated whenever possible. Opioid rotation can be considered (see NCCN Guidelines for Adult Cancer Pain) if the delirium is believed to be caused by neurotoxicity of the current opioid. If delirium is a result of disease progression, palliative care must be focused on symptom management and family support. Neuroleptic and benzodiazepine medications should have their dose increased and/or their route of administration changed to ensure adequate delirium symptom management.[281] Unnecessary medications and tubes should be removed. For refractory delirium in dying patients, palliative sedation can be considered following consultation with a palliative care specialist and/or psychiatrist (see below).

Please also see the NCCN Guidelines for Distress Management for further discussion of delirium in patients with cancer.

Psychosocial Distress – Social Support/Resource Management

For distress related to psychological or psychiatric complications and spiritual or existential crisis, please see the NCCN Guidelines for Distress Management.

For best outcomes, psychosocial care should be integrated into routine cancer care across all disease stages and in both the inpatient and outpatient settings.[54,282] A recent systematic review of patients with advanced cancer identified psychosocial resources among the factors that promoted personal growth during the experience of cancer.[283]

For patients with estimated life expectancy ranging from years to months experiencing psychosocial distress, social support/resource management should be offered. Patients should be cared for in a safe environment with available caregivers. In addition, it is important to ensure that the patient has adequate financial resources and to refer to social services as needed. Support and education should be provided to the caregivers and family members.[284,285] Personal, spiritual, or cultural issues related to the patient's illness and prognosis should be discussed. Bereavement risk should be assessed. If language is a barrier, a professional health care interpreter, who is not related to the patient or family, should be available for patients, caregivers, and families as needed.

In a dying patient with an estimated life expectancy of weeks to days, the patient's desires for comfort should be evaluated and supported. The process of dying and the expected events should be explained to the patient, caregivers, and family members. For children of parents with cancer, a survey-based study demonstrated that receiving end-of-life information enhanced trust in the care provided to their parents.[96] Bereavement risk should be reassessed. Patients and family members should be provided with emotional support to address any intra-family conflict regarding palliative care interventions. Eligibility and readiness for specialized palliative/hospice care should be determined.

Advance Care Planning

The oncology team should initiate discussions of personal values and preferences for end-of-life care while patients have a life expectancy of years to months. Recent studies have shown that these discussions frequently happen too late in the trajectory of disease, often during acute hospital care and often with health professionals other than the primary oncologist.[286-288] Further, earlier end-of-life care discussions have been associated with less aggressive care and increased use of hospice,[289,290] while less aggressive care has been associated with an improved quality of life.[291] Studies suggest that most patients with cancer would prefer to die at home,[292,293] but lack of timely advance care planning can render this impossible.

ASCO has developed a booklet to help patients and their families understand and discuss the cancer diagnosis and treatment options (http://www.cancer.net/coping/advanced-cancer-care-planning). A recent randomized controlled trial found that a video decision support tool increased the likelihood that patients would choose to forgo resuscitation.[294] A randomized controlled trial of a structured intervention to facilitate end-of-life discussions (consisting of an information pamphlet and provider discussion) led to earlier designation of do-not-resuscitate orders and decreased the likelihood of patients dying in the hospital.[295] In addition, a recent study showed that electronic prompts and email reminders to doctors could increase rates of documentation of code status in patients with advanced lung cancer.[296]

Advance care planning should include an open discussion about palliative care options, such as hospice; personal values and preferences for end-of-life care; the congruence between the patient's wishes/expectations and those of the family/health care team; and information about advance directives. It may be helpful to determine the patient and family's prior experience(s) with end-of-life care. Patients should be asked if they have completed any advance care planning such as living wills, powers of attorney, or delineation of specific limitations regarding life-sustaining treatments including cardiopulmonary resuscitation, mechanical ventilation, and artificial nutrition/hydration. The patient's values and preferences and any decisions should be documented in the medical record, including MOLST or POLST (Medical Orders for Life-Sustaining Treatment or Physician Orders for Life-Sustaining Treatment) if completed.

When the patient's life expectancy is reduced to months to weeks, the oncology team should actively facilitate completion of appropriate advance directives and ensure their availability in all care settings. MOLST/POLST should be documented and accessible to all providers across care settings. The team should also confirm the patient's values and decisions in light of changes in status. Palliative care consultation can be considered to assist in conflict resolution when the patient, family, and/or medical professional team do not agree on the benefit/efficacy of interventions.

Where the patient wants to die should be determined. Most patients with cancer would prefer to die at home,[292,293] but sometimes their care needs or support system at home cannot support their care. Some patients request to receive end-of-life care in a skilled nursing facility or an in-patient hospice facility.[293,297] A prospective study showed that patients dying in an ICU had higher levels of physical and emotional distress compared with patients dying at home or in hospice. Additionally, caregivers of these patients had a greater incidence of prolonged grief disorder.[298] Providing palliative care services has been shown to decrease deaths in ICUs.[297] A recent retrospective cohort study showed that patients who wanted to die at home were more likely to do so if they had daily hospice visits, if they were married, if they had advance directives, if they did not have moderate or severe pain, or if they had good performance status.[293] A second retrospective study suggested that referral to specialist palliative care at a greater interval of time prior to death increased the likelihood of patient's dying at home or in hospice rather than in the hospital.[299] If advance care plans have not been completed, the oncology team should explore the patient's reluctance to engage in advance care planning and refer to palliative care if needed.

In patients with a life expectancy of only weeks to days, the patient's decision regarding cardiopulmonary resuscitation and other life-sustaining treatments must be clarified and confirmed. Providers should facilitate continued involvement of the primary care physician and primary oncology team. The desire for organ donation and/or autopsy must also be explored with the patient. Overall, the oncology team must implement and ensure compliance with the patient's advance care plan.

Palliative Care Reassessment

The outcome measures for these guidelines are much more difficult to define than those for NCCN disease-specific guidelines. The panel reviewed end-of-life care outcomes from several surveys of North

American citizens.[73,300-302] The panel chose a modified version of Singer's outcomes until more precise outcome measures are available. Acceptable palliative care should provide the following: 1) adequate pain and symptom management; 2) reduction of patient and family distress; 3) acceptable sense of control; 4) relief of caregiver burden; 5) strengthened relationships; and 6) optimized quality of life, personal growth, and enhanced meaning. The panel added "having an advance care plan in progress" as part of the criteria for acceptable outcome. Research is ongoing regarding better ways to measure "dying well."[303]

All patients should be reassessed regularly, and effective communication and information sharing must exist between the patient, caregivers, and health care providers. Patients and family members benefit most from ongoing discussions about the natural history of the disease and prognosis in clear, consistent language. If the interventions are unacceptable upon reassessment, the oncology or palliative care team should intensify palliative care and reassess the patient and family situation. The oncology team should also consult specialized palliative care services, hospice, or an ethics committee. Referral to a psychiatrist or psychologist to evaluate and treat undiagnosed psychiatric disorders, substance abuse, and inadequate coping mechanisms should be considered. If psychosocial distress persists, palliative care options should be intensified, and the patients should be managed according to the NCCN Guidelines for Distress Management.

Patients' treatment goals and expectations may change and evolve as disease progresses. Reassessment should be ongoing, with continuation or modification of life-expectancy–guided palliative care until the patient's death or survivorship.

Special Palliative Care Interventions

Requests for Hastened Death

Special palliative care interventions include responses to requests for hastened death (ie, physician aid-in-dying, physician-assisted suicide, euthanasia). The most appropriate response to a request for hastened death is to intensify palliative care. All such patients should be referred to a palliative care specialist. A request for hastened death often has important meanings that require exploration. Clarifying these meanings can sometimes enlarge the range of useful therapeutic options instead of providing a lethal prescription. Open exploration of the patient's request for hastened death can often identify unmet needs and new palliative care interventions that may be helpful. Alternatives to physician-assisted suicide, such as withdrawal of life-sustaining treatment, voluntary cessation of eating and drinking, and/or sedation, should be considered and discussed with patients and families. Psychiatric consultation to diagnose and treat reversible causes of psychological suffering should be requested. Patients should be assured that their health care team is committed to providing continuing care. Although physician-assisted suicide, under specified conditions, is legal in the states of Oregon, Montana, Vermont, and Washington, euthanasia is not legal in any of the United States.[304-307] It is important for physicians to know the local legal status of hastened death, as other states have pending legislation regarding either prohibiting or permitting physician-assisted suicide.

Palliative Sedation

Palliative sedation can effectively manage symptoms in imminently dying patients (life expectancy of hours to days) with refractory symptoms that persist despite comprehensive, interdisciplinary palliative care. If palliative sedation is being considered, two physicians should confirm that the patient is imminently dying. Informed consent must be obtained from the patient and/or a surrogate or family member following discussions that clarify patient's disease status, treatment goals, prognosis, and expected outcomes. Clinicians may find that applying usual benefit/risk analysis to this type of intervention will suffice in medical decision-making. Palliative sedation has its ethical justification in the Doctrine of Double Effect,[308-313] which means that the possible harm (possible respiratory depression, starvation, and hastened death) that may come as a side effect of doing good (relieving intolerable suffering) is justified. Furthermore, results from a study that prospectively matched terminally ill patients with cancer receiving or not receiving palliative sedation suggest that sedation does not, in fact, shorten life.[314] Similar results were obtained from recent systematic reviews , although many of the included studies lacked high-quality data.[315,316] An ethics consult may be considered in accordance with institutional guidelines and state regulations.

Palliative sedation is best performed by palliative care experts. The most common sedatives used for palliative sedation are midazolam and propofol by parenteral infusions.[311] Infusional lorazepam and amobarbital may also be used.[311,317] Recent studies suggested that palliative sedation may also be feasible in the home setting and could be utilized in patients who wish to die at home.[318,319]

Care of the Imminently Dying Patient

An imminently dying patient is defined as one within hours of death who is not stable enough for transport. Caring for an imminently dying patient is intense for the patient, family, and health care team. A recent international qualitative study described many of the common non-pharmacologic palliative care activities provided in the last days of life.[320] An end-of-life care order set that includes physical, practical, and psychosocial interventions may be beneficial for practitioners to use for imminently dying patients.

The physical aspects of care for an imminently dying patient focus on adequate symptom management and comfort, keeping in mind the patient's wishes and values. Approaches may include intensifying ongoing care; adjusting medication doses for optimal comfort; discontinuing unnecessary interventions (eg, diagnostic tests, transfusions, artificial nutrition, hydration, dialysis, needle sticks); ensuring access to symptom-relief medication through alternate routes if oral administration is difficult; providing physical comfort by providing a pressure-relieving mattress and regular repositioning; eye and mouth care to maintain moisture; treating urinary retention and fecal impaction; deactivating an implanted defibrillator; managing terminal restlessness and agitation with palliative sedation; reducing death rattle/terminal secretion (eg, repositioning patient; reducing parenteral and enteral fluids; adding medications such as scopolamine, hyoscyamine, atropine, or glycopyrrolate)[161]; and preparing for patient and family requests for autopsy and/or organ donation.

The psychosocial aspects of care for an imminently dying patient take into account individual and family goals, preferences, cultures, and religious beliefs. The care plan may include consultation with social workers or chaplains to meet social and spiritual needs; open communication between the patient, family, and care team regarding the physical and psychological aspects of the dying process and the importance of honoring any advance directives; and anticipatory grief counseling to help facilitate caregiver closure. Patients who are actively dying in their final hours of life should be allowed to spend uninterrupted time with family.

The practical aspects of care for an imminently dying patient in the hospital include: mobilizing in-hospital end-of-life care policy and procedures; ensuring that the patient's advance directive is documented and implemented and a do-not-attempt-resuscitation (DNAR) or allow natural death (AND) order is written and followed; securing a private room for the patient; and enabling family presence around-the-clock. If the patient and family have not documented a DNAR order, patient/family education and counseling should be intensified to try to help them accept this level of care to prevent harm to the patient from futile attempts at cardiopulmonary resuscitation. Providers should be aware that policies regarding resuscitation may differ based on treatment setting. A patient with a documented inpatient DNAR order may also require DNAR orders for out-of-hospital settings (eg, residential care, ambulance transport). In states where the MOLST/POLST is honored across all treatment settings, it will protect the patient.

A Peaceful Death

These NCCN Guidelines are the first to include death as an expected outcome and after-death care for the family as an essential part of the continuum of cancer care. Many studies have attempted to define a "good death" or a "peaceful death" from the perspective of clinicians, patients, and families.[321-324] Interestingly, one study found that patients, families, and physicians had very similar ideas of what constitutes a peaceful death: freedom from pain, being at spiritual peace, and being with family ranking among the top three considerations by all three groups.[324] End-of-life care should be flexible enough to ensure that the death is viewed as a peaceful death by those involved.[324] The definition of a "peaceful death" used by the NCCN Palliative Care Panel is "one that is free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patient's and family's wishes; and consistent with clinical, cultural, and ethical standards."[325]

Final results of the prospective, longitudinal cohort Coping With Cancer study of 396 patients with advanced cancer and their caregivers were recently reported. The study found a higher quality of life in the last weeks of life in patients who avoided visits to the ICU and feeding tubes, did not die in the hospital, worried less, prayed or meditated, were visited by a pastor in the hospital or clinic, and felt a strong therapeutic alliance with their physicians.[291]

After-Death Care Interventions

Comprehensive palliative care for the patient's family and caregivers continues after the patient's death. Immediate issues include ensuring culturally sensitive and respectful treatment of the body, including removal of tubes, drains, lines, and the Foley catheter (unless an autopsy is planned); providing family time with the body; addressing concerns about organ donation or autopsy; facilitating funeral arrangements through completion of necessary paperwork; and informing insurance companies and other health care providers of the patient's death.

Bereavement support should be offered, beginning with a personal visit or telephone call from the patient's primary oncology team, followed by a condolence letter. Family members at risk for complicated bereavement or prolonged grief disorder should be identified, and complicated grief should be treated.[326-328] Children of patients with cancer represent a uniquely at-risk population for psychosocial dysfunction. Additionally, a recent study suggested that certain predictors of prolonged grief could be identified in family caregivers at the time of the patient's entry to palliative care; these factors included pre-death symptoms of prolonged grief, spousal relationship to the patient, impact of caring on schedule, poor family functioning, and low levels of optimism. [329]

Bereavement care is often best provided by an experienced hospice team or a skilled mental health care professional. The family may request a debriefing meeting from the medical team and may require assistance in identifying community bereavement resources. A well-supported end-of-life care experience will facilitate the family's acceptance of appropriate referrals for cancer risk assessment and risk modification. If not already recommended, providers should direct family members towards genetic screening, especially if the deceased patient was positive for known genetic markers that confer risk. For more information, see the NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian and Genetic/Familial High-Risk Assessment: Colorectal.

Palliative Care Research

The evidence base for the treatment recommendations for physical and psychosocial symptoms in patients with cancer is generally weak.[330,331] Clinical trials in palliative oncology face many challenges, including recruitment difficulties, high attrition rates, and insufficient funding.[332-334] Several groups have recommended considerations for the design of future palliative care clinical trials, including standardization of reporting, the integration of technology for data collection, the use of validated outcome measures, and the use of trial designs other than the randomized controlled trial.[335-339] In addition, formal feasibility studies can help ensure the success of subsequent larger trials.[336,340] Despite the challenges associated with conducting large-scale palliative care research studies, several notable studies have examined the impact of palliative care efforts on patient and family/caregiver outcomes (reviewed by El-Jawahri et al[330]). Ongoing studies continue to evaluate improved methods for early integration of palliative care into oncologic treatment.[341]

Putting Palliative Care Guidelines into Practice

These guidelines have the goal of providing the best quality of life possible for each patient and were developed to accompany the appropriate cancer treatment guidelines. Institutions should develop processes for integrating palliative care into cancer care, both as part of usual oncology care and for patients with specialty palliative care needs. Many approaches have been described.[45-53]

Patients and families should be informed that palliative care is an integral part of their comprehensive cancer care. Educational programs should be provided to all health care professionals and trainees so that they can develop effective palliative care knowledge, skills, and attitudes. Skilled palliative care specialists and interdisciplinary palliative care teams, including board-certified palliative care physicians, advanced practice nurses, and physician assistants, should be readily available to provide consultative or direct care to patients and families who request or require the expertise. Finally, the quality of palliative care should be monitored by institutional quality improvement programs.

The experiences of patients with cancer throughout the disease course begin with the diagnosis. Patient conditions usually move from ambulatory to sedentary as disease advances and performance status worsens. When life expectancy is a matter of days or hours, patients may become unable to communicate. These patients may be at home, living with a family member, or in a health care facility. Through understanding the patient's status relative to the natural disease trajectory and by using these guidelines, the oncology team can provide the most appropriate treatment for each patient. Oncologists and patients should discuss at the outset whether the treatment will be curative or palliative. Many palliative care questions must be considered early in each patient's comprehensive cancer care. The primary oncology team is responsible for working with patients to raise and answer these questions. Oncologists must identify patients' goals for the remainder of life to get a better sense of whether they understood and accepted the diagnosis and prognosis. Additionally, oncologists must explain the types of therapies that are available and how these therapies can affect the patient's daily life. As the cancer progresses and the value of further anticancer therapy diminishes, palliative therapy should be intensified. The issue of whether patients want more anticancer therapy must be openly addressed. The delivery of clear and consistent prognostic information can help patients make the most appropriate decisions.

Patients should be made aware that undergoing anticancer therapy does not have to sidetrack them from addressing end-of-life issues. Collaborating with palliative care experts extends oncologists' therapeutic repertoire and diminishes the stress of caring for patients who have incurable disease. Increasing emphasis on palliative care in oncology should improve patient outcomes and provide new avenues for clinical research and professional satisfaction. Timely introduction of members of the institutional or community palliative care team allows patients to meet the individuals who will help them and their families through their experience. Because the diagnosis of cancer and impending death is such a frightening experience, oncologists must try to alleviate those fears by assuring patients that the members of a team will work with them and their families to make things less burdensome. Additionally, oncologists must discuss the natural history of the patient's disease and prognosis with the family and palliative care team to anticipate and manage symptoms and problems commonly associated with the diagnosis and treatment of cancer.

Palliative care is intensified late in the course of disease to help patients and families understand the disease and begin to make end-of-life plans. Sometimes patients and families do not accept the prognosis or do not begin to make preparations.[342,343] These things may be a sign that patients do not fully understand the disease and may lead to the desire by patients and families for aggressive treatments that may be both futile and toxic.[343] Palliative care supports education so that patients can better understand the disease.

Oncologists must ensure that advance care plans are in place as early as possible in the disease trajectory. This focus on the patients' wishes assures patients that they will be provided with no more and no less aggressive care than they desire and also relieves them of concerns about burdening family members with difficult end-of-life decisions. The combined efforts of the oncology team and the hospice/palliative care team can improve the overall outcome for patients and their families.

Psychosocial Support for Palliative Care Providers

After the loss of a patient, psychosocial support should be provided for the staff. A bereavement or memorial ritual for medical staff (eg, brief reading, moment of quiet) can be considered. Funeral attendance by health care professionals can be considered for individual patients. Health care professionals should also review medical issues related to patient death, explore concerns and questions about quality of patient care, and review emotional responses of family and staff to the patient's death.

Oncology and palliative care teams commonly encounter patient loss and deal with grief, and over time the resultant emotional distress can lead to provider burnout, compassion fatigue, and/or moral distress.[344-347] These syndromes can manifest as symptoms of depression, anxiety, fatigue, and low mental quality of life.[348] Such staff should be identified and assisted. Unfortunately, although considerable research has been dedicated to evaluating patterns and interventions to mediate patient, family, and caregiver distress and grief, much less attention has been devoted to these same issues among health care providers and teams. For a summary of the literature on provider compassion fatigue and burnout among oncology providers, see reviews by Najjar and colleagues (2009),[344] Shanafelt and Dyrbye (2012),[348] and Sherman and colleagues (2006).[349]

Although limited in quantity, most studies on compassion fatigue are derived from the oncology nursing literature. A large survey of hospice and palliative care providers (ie, clinical, administrative, allied health workers) revealed a strong correlation between burnout and compassion fatigue, and revealed the need for enhanced support of individuals in this field.[350] Additionally, a cross-sectional survey of nurses, medical assistants, and radiology technicians at a comprehensive cancer center revealed concerning levels of burnout and compassion fatigue in both inpatient and outpatient care settings.[351] A resiliency program was piloted and eventually scaled hospital-wide to educate providers on these issues and provide interventional strategies. Improvements in burnout and secondary traumatic stress were observed.[351,352] Several studies from the Mayo Clinic demonstrated that mindfulness training through the Stress Management and Resiliency Training (SMART) program was able to improve anxiety, stress, quality of life, and mindfulness among providers.[353-355]

Qualitative research on compassion fatigue interventions reveals that oncology clinicians rated the following resources as helpful: educational interventions, support programs or resources in the workplace, retreats, and self-care measures.[344,356] Unfortunately, despite the reported desire for such interventions, access can be limited. In a nationwide survey of oncology nurses, only 60% of survey respondents reported access to an employee assistance program, 45% reported no offerings of education addressing workplace coping, and 82% of respondents reported no off-site programs such as retreats.[356]

Generally, evidence-based interventions for compassion fatigue, moral distress, and burnout in physicians are lacking. When asked to provide useful preventative measures and coping strategies, palliative care specialists recommended emphasizing the rewarding aspects of their work and strategies for “enhanced meaning-making.”[357] Experts in the field have also highlighted the importance of self-awareness and self-care measures for oncologists and palliative care specialists to decrease levels of compassion fatigue.[358] To this end, self-care was established as a core competency area for fellows in hospice and palliative medicine.[358] Examples and evidence for additional preventative strategies and solutions for oncologist burnout are reviewed by Shanafelt and Dyrbye.[348]

Hope

These guidelines are intended to help oncology teams provide the best care possible for patients with incurable cancer. Patients with advanced disease frequently are overly optimistic about their chances of cure, treatment response, symptom relief, and survival. One study found that those who overestimated their survival were more likely to die a bad death.[119] Using a decision aid, Smith et al found that most patients want honest information, even if it is bad news.[359] Although use of the decision aid typically took 20 minutes and was challenging for the oncologist, it did not the patient to give up hope or become distressed. Physician discussion about death with the patient and family can improve quality of care, quality of life, and caregiver quality of life.[360] Honest information respects the autonomy of a patient to make decisions based on what is known about the outcomes of potential treatment decisions.[361] Palliative care can help patients and families meet short-term goals, such as important life-cycle events, and achieve realistic expectations. In this sense, the care outlined in these guidelines provides a different kind of hope than that for cure of the disease itself.[104,359,362] Palliative care provides hope for dignity, comfort, and closure and for growth at the end of life.

Table 1: Palliative Care Internet Resources for Clinicians[a]

Palliative Care Clinical Competencies

www.epec.net
Education in Palliative and End-of-life Care (EPEC): Comprehensive curriculum covering fundamentals of palliative medicine; teaching guides

www.StopPain.org
Department of Pain Medicine and Palliative Care at Beth Israel Medical Center: Online education for physicians, nurses, and pharmacists

Clinical, Educational, Professional, and Public Resources

www.palliativedrugs.com
Palliativedrugs.com: Extensive information on pharmacologic symptom management

www.aahpm.org
American Academy of Hospice and Palliative Medicine: Physician membership organization; board review courses; publications

www.abim.org
The American Board of Internal Medicine: Physician Board Certification

www.nhpco.org/
National Hospice and Palliative Care Organization: Nonprofit membership organization representing hospice and palliative care programs and professionals in the United States

www.hpna.org/
Hospice & Palliative Nurses Association: Specialty nursing organization with evidence-based educational tools for the nursing team

www.hms.harvard.edu/cdi/pallcare
Center for Palliative Care at Harvard Medical School: Faculty development courses, other educational programs

www.nationalconsensusproject.org/
National Consensus Project for Quality Palliative Care: Clinical practice guidelines

www.americangeriatrics.org/
American Geriatrics Society: Clinical guidelines and continuing education

Palliative Care Program Development

www.capc.org
Center to Advance Palliative Care: Technical assistance for clinicians and hospitals seeking to establish or strengthen a palliative care program

www.capc.org/palliative-care-leadership-centers/
Palliative Care Leadership Centers: Eight exemplary palliative care programs providing site visits, hands-on training, and technical assistance to support new palliative care clinicians and programs nationwide

[a] All websites accessed March 2015.

Adapted with permission from Meier DE et al. Oncology 2005;19. Available at http://www.cancernetwork.com/display/article/10165/104428.

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