Palliative care of the breast cancer patient

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Objectives

1. Palliative care alongside oncology offers practical ways to improve health, quality of care, and value
   • What are the benefits of concurrent care?
   • What does PC do alongside ONC?
   • Having difficult conversations.

2. How can we integrate these best practices?

3. What is special about breast cancer palliative care?
Care is not optimal

1. Too much variation in chemo near the end of life
2. Not enough attention to cost as part of the equation, making current situation unsustainable
3. Too much chemo when the ECOG Performance Status is 3-4
4. Too little and too late use of Palliative Care
5. Too little and too late use of hospice care
There is unwarranted practice variation in chemo at the end of life. Morden N, 2011
We are still hospital oriented and not hospice oriented near the predictable end of life.

Medicare Patients, Unadjusted Cancer Care Measures, By Hospital Characteristics, Morden 2011

<table>
<thead>
<tr>
<th>Measure</th>
<th>All</th>
<th>NCCN cancer centers</th>
<th>Non-NCCN NCI cancer centers</th>
<th>Academic hospitals</th>
<th>Community hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death in hospital (%)</td>
<td>30.2</td>
<td>32.6</td>
<td>32.4</td>
<td>33.8</td>
<td>29.7</td>
</tr>
<tr>
<td>Hospice use, last month of life (%)</td>
<td>53.8</td>
<td>53.4</td>
<td>52.4</td>
<td>50.3</td>
<td>54.2</td>
</tr>
<tr>
<td>Days in hospice, last month of life (per decedent)</td>
<td>8.4</td>
<td>8.6</td>
<td>8.1</td>
<td>7.6</td>
<td>8.5</td>
</tr>
<tr>
<td>Hospice initiated, last 3 days of life (%)</td>
<td>8.5</td>
<td>7.1</td>
<td>7.9</td>
<td>8.3</td>
<td>8.6</td>
</tr>
<tr>
<td>Hospitalized, last month of life (%)</td>
<td>64.9</td>
<td>60.2</td>
<td>61.7</td>
<td>64.4</td>
<td>65.1</td>
</tr>
<tr>
<td>Days in hospital, last month of life (per decedent)</td>
<td>5.3</td>
<td>5.6</td>
<td>5.6</td>
<td>5.9</td>
<td>5.3</td>
</tr>
<tr>
<td>ICU use, last month of life (%)</td>
<td>24.7</td>
<td>23.3</td>
<td>26.3</td>
<td>26</td>
<td>24.6</td>
</tr>
</tbody>
</table>
Communication with cancer patients is not optimal

• 60% of us prefer not to have “hard conversations” (DNR, AMDs, hospice) until “there are no more treatment options left”. Keating NL, et al. Cancer. 2010

• Half of all lung cancer patients have had NO discussion with any of their doctors about hospice 2 months before they die. Huskamp HA, et al. Arch Intern Med. 2009

• Oncologists document EOL discussions with 27% of NSCLC patients; 55% happen in the hospital, mean 33 days before death; 49% with oncologists. Mack J, et al. Ann Intern Med 2012

• Telling some one they are “incurable” is not enough – people want information about prognosis, what will happen to them, and their options.
81% of lung cancer and 69% of colon cancer patients think a person like them could be cured when none of them will be.
Communication with cancer patients is not optimal, but can be improved

• **ASK, TELL, ASK:** “What do you want to know? What do you know? Now that we have reviewed this, what is your understanding?”

• **State at diagnosis:** “This is not curable, but it is treatable. At some point, there won’t be good treatments against the cancer. And at some point I want you to meet the hospice team.”

• **ASK, TELL, ASK** at each transition point, disease progression, or different prognosis.

• **Have a hospice information visit** 3-6 months before death. This establishes hospice as part of the best practice.

**EDITORIAL**

Talking with Patients about Dying

Thomas J. Smith, M.D., and Dan L. Longo, M.D.
## Biggest Concerns for Patients with Serious Illness

<table>
<thead>
<tr>
<th>Concern</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with serious illness and their families leave a doctor’s office or hospital feeling unsure about what they are supposed to do when they get home</td>
<td>51%</td>
</tr>
<tr>
<td>Doctors do not spend enough time talking with and listening to patients and their families</td>
<td>50%</td>
</tr>
</tbody>
</table>

Source: ACS 2011 Public Opinion Research on Palliative Care
QOL concerns are not raised or discussed in cancer clinical settings.

Q: After diagnosis and before starting treatment, did anyone on care team ask what is important to you/family in terms of QOL?

2010 ACS CAN National Poll on Facing Cancer in the Health Care System (www.acscan.org)
Care is not optimal

1. Too much variation in chemo near the end of life
2. Not enough attention to cost as part of the equation
3. Too much chemo when the ECOG Performance Status is 3-4
4. Too little and too late use of Palliative Care
5. Too little and too late use of hospice care
American Society of Clinical Oncology Identifies Five Key Opportunities to Improve Care and Reduce Costs: The Top Five List for Oncology

Lowell E. Schnipper, Thomas J. Smith, Derek Raghavan, Douglas W. Blayney, Patricia A. Ganz, Therese Marie Mulvey, and Dana S. Wollin

INTRODUCTION

Advancements in the prevention, diagnosis, and treatment of cancer have contributed to improved survival, better quality of life, and declining death rates in the United States. With these successes have come important opportunities for improvement. Patients and families want “everything done,” despite not having sophisticated awareness of the evidence base that should be guiding the physician. Concerns about litigation regularly factor into physician’s decision making, especially in situations in which the outcome might be limited sur-
Do Not Use Chemotherapy for Patients with Solid Tumors Who Have Had No Benefit from Prior Evidence-based Interventions.

The practice of giving n-th line chemotherapy is common.

- At a large university center, 50% of patients with solid tumors received chemotherapy within 14 days of their death.
- In a large community practice, 26% of patients with NSCLC received 4th-line chemotherapy, including 20% within 2 weeks of their death.
- In Sweden, 23% of patients with solid tumors received chemotherapy in their last 30 days of life.
- In Germany, 10% of similar patients received 4th-line chemotherapy.

It’s not about the MONEY, it’s about having the tough discussion.

- Have a script
- Set the stage at visit one
- Revisit prognosis. “What’s your understanding of where we are?”
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
Do Not Routinely Give Chemotherapy to Patients with Poor Performance Status (PS), ECOG 3 or 4.

- Patients with poor PS have more toxicity and markedly less chance of response.

- Not every cancer, but for most patients with solid tumors, ASCO and National Comprehensive Cancer Network (NCCN) guidelines call for a switch to palliative (non-chemotherapy) care when the ECOG PS $\geq$ 3.
  - ECOG 3 is “in bed or chair more than 50% of the time.”
  - Simple question: “Did this person walk unaided into clinic?”
Do Not Use Chemotherapy for Patients with Solid Tumors and Poor ECOG PS

The practice of giving chemotherapy with poor PS is common.

- 2000-2007, large HMO
- 292 stage IIIB-IV patients
- 82 (28%) had PS 3 or 4
- 39% of PS 3-4 patients received first line chemotherapy

- Survival may have been better in the group who got chemo… “healthy person effect” or chemo effect? Time to do trials before widespread adoption.

Do Not Routinely Give Chemotherapy to Patients with Poor Performance Status (PS), ECOG 3 or 4.

- NSCLC patients who get chemotherapy near the end of life (aggressive-approach chemotherapy)
  - do not live any longer than those who stop chemotherapy earlier, but
  - do have delayed or no use of hospice
  - Which CAN be harmful.

Do Not Use Chemotherapy for Patients with Solid Tumors Who Have Had No Benefit from Prior Evidence-based Interventions

This is not taking away “the last chance” or hope.
- Patients should know the chance of benefit, risks of toxicity, and alternatives.
- “We want you to know the options. We know that we can make your quality of life worse...it is time to change courses.”
- Some patients may choose treatment, but others will choose to avoid toxicity.
- Current data suggest that those who use palliative and hospice care live longer, not shorter. And better.
- ASCO has always recommended that treatment not be given unless there is a definable benefit.
People who use hospice for even one day live longer.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Added survival</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>+ 81 days, P = 0.0540</td>
<td></td>
</tr>
<tr>
<td>Lung cancer</td>
<td>+ 39 days, P &lt; 0.0001</td>
<td></td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td>+ 21 days, P = 0.0102</td>
<td></td>
</tr>
<tr>
<td>Colon cancer</td>
<td>+ 33 days, P = 0.0792</td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>+ 12 days, P = 0.6136</td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td>+ 4 days, P = 0.8266</td>
<td></td>
</tr>
</tbody>
</table>

Solutions:
Documentation, and Use QOPI

- Always document ECOG PS.
- Use QOPI to monitor practice patterns about chemotherapy near the end of life.
- When oncologists were given feedback about their own practice patterns, chemotherapy near the end of life dropped from 50% to 20%.

Blayney D, et al. JCO 2009
There are two important types of delirium


- Hypoactive
  - distinguish from depression
  - or metabolic problems
  - 0.5 mg Haloperidol
  - quetiapine
  - Do NOT use benzo’s

- Hyperactive
  - distinguish from psychosis
  - or acting out
  - 1-5 mg Haloperidol
Solutions: Learn a New Script, and have a hospice “information visit”

- Have your hospice provider see the person when you think they have 6 months left to live.
- This is NOT “Three strikes and you’re OUT!”
- It is “The cancer has now grown through 3 of our best chemotherapy regimens. I wish it was different, but it is time to stop trying to treat the cancer.
- Remember when we first discussed your lung cancer, I said there might be time when chemotherapy would cause more harm than good…that time is now.
- I am going to call those hospice people that you met 3 months ago to discuss enrollment. Let’s talk about some important issues....”

Personalized communication about personalized medicine....
We miss opportunities to recognize hospice-eligible patients, they are readmitted, and cost more.

U of Iowa Hospitals. 688 in-hospital deaths. 209 decedents had preceding admission; NHPCO, National Hospice and Palliative Care Organization worksheets.

*Only 14% had any discussion of hospice, despite being eligible; 14 of 17 enrolled, all from ONE service*

<table>
<thead>
<tr>
<th>Table 1. Comparison of Cost Between Patients Enrolled and Not Enrolled in Hospice During a Terminal Hospital Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled in hospice before last admission</td>
</tr>
<tr>
<td>n = 7</td>
</tr>
<tr>
<td>Cost</td>
</tr>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>Palliative Care Consultation</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Magnesium Oxide 400 mg bid reduces hot flash frequency and severity by half
(Park H (PGY-III), Parker GL, Dodson PW, Boardman C, Smith T. J Supp Care Ca 2011)

Hot Flashes are bothersome in many cancer survivors and others
• Two patients reported relief of hot flashes with magnesium taken for unrelated reasons. Smith TJ. J Clin Oncol. 2009 Mar 1;27(7):1151-2
• Pilot trial of 25 patients, magnesium oxide 400 mg bid, Hot flash score= (number)x(severity)
• Randomized placebo trial starts Fall 2011 in NCCTG/Alliance

Figure 1: Hot flash score reduction over time
N=25 at all points.
Objectives

1. Recognizing the problem:
   - Care is not optimal, and we are partly to blame.
   - Value is missing in some of our spending
   - Costs are rising at an unsustainable rate

2. Lung cancer treatment can be made more effective and cost effective
   - Palliative care alongside oncology care
   - Better models of care
The American Society of Clinical Oncology now recommends concurrent palliative care for seriously ill cancer patients – at the beginning...

"...combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden."
Objectives

Palliative care alongside oncology offers practical ways to improve health, quality of care, and value

• What are the benefits of concurrent care?
• What does PC do alongside ONC?
• Having difficult conversations.
• How can we integrate these best practices?
Cancer patient symptoms are improved by PC consultation or transfer
Memorial Symptom Assessment Scale, Condensed; 30 pts with at least 2 consult days and symptoms > 0. Khatcheressian J, et al. Oncology September 2005
ESAS scale 0-10; Elsayem A, et al. JCO 2004
Some useful hints

• **Dyspnea**
  – “Are you short of breath?” better than O$_2$ sat
  – Use a fan or open the window
  – Treat with opiates and/or benzos
  – Nebulized fentanyl 25 mcg in 2 ml NS
Nebulized fentanyl for dyspnea

Patients said that it helped
- Improved 26/37 (79%)
- Unsure 3/27 (9%)
- None 4/37 (12%)

Graph showing changes in Oxygen Sat and Resp Rate over time.
Palliative care in addition to usual oncology care allowed lung cancer patients to **live almost 3 months longer** than those who got usual oncology care.


**Longer and better survival**
- Better understanding of prognosis
- And goals of care
- Less IV chemo in last 60 days
- Less aggressive end of life care
- More and longer use of hospice
Palliative care in addition to usual oncology care allowed lung cancer patients to live almost 3 months longer than those who got usual oncology care.


Longer and better survival
✓ Better understanding of prognosis
✓ Less IV chemo in last 60 days
✓ Less aggressive end of life care
✓ More and longer use of hospice
✓ $2000 per person savings to insurers and society
Every study to date shows significant savings – in addition to better care
What is the source of the cost savings?

• More at home hospice, fewer hospitalizations.
• Avoided ICU days.
• Less chemotherapy, imaging, and complications at the end of life.
• If palliative care consults, the chances of appropriate discharge to hospice rises from 1% to 30%. (Morrison RS, Dietrich J, Ladwig S, Quill T, Sacco J, Tangeman J, Meier DE. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. Health Aff (Millwood). 2011 Mar;30(3):454-63.)
Palliative care is possible, practical, reimbursable, and should pay for itself, mostly.

Table 3. Median Time for Components of Initial Outpatient Palliative Care Clinic Visit (Temel et al, JPM 2011)

<table>
<thead>
<tr>
<th>Component</th>
<th>Median time (range) minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC consultation</td>
<td>55</td>
</tr>
<tr>
<td>Total time</td>
<td>55</td>
</tr>
<tr>
<td>Illness understanding</td>
<td>10</td>
</tr>
<tr>
<td>Symptom management</td>
<td>20</td>
</tr>
<tr>
<td>Decision making</td>
<td>0</td>
</tr>
<tr>
<td>Coping</td>
<td>15</td>
</tr>
<tr>
<td>Planning and referrals</td>
<td>0</td>
</tr>
</tbody>
</table>

Number of visits 3-4 TOTAL in 3 months

Reimbursement DEPENDS
- Who does the service (MD, NP, MSW)
- How we bill – extended service codes, time, counseling
- Standardized forms
- Efficiency
So, how do we do this?

1. Recognize that we \textit{don’t} do this.
2. Learn key concepts about communication.
3. Change our Best Practices to well defined clinical pathways to help us practice better
1. Recognize that we don’t do this.

- 60% of us prefer not to have “hard conversations” (DNR, AMDs, hospice) until “there are no more treatment options left”. Keating NL, et al. Cancer. 2010
- Half of all lung cancer patients have had NO discussion with any of their doctors about hospice 2 months before they die. Huskamp HA, et al. Arch Intern Med. 2009
- Oncologists document EOL discussions with 27% of NSCLC patients; 55% happen in the hospital, mean 33 days before death; 49% with oncologists. Mack J, et al. Ann Intern Med 2012
2. Always do a symptom assessment – and have standard algorithms to treat the problems.

<table>
<thead>
<tr>
<th>MSAS-C: 0=none, 1=a little bit, 2=somewhat, 3=quite a lot, 4=very much, 7=refused</th>
<th>Reported by: Patient</th>
<th>Caregiver</th>
<th>RN</th>
<th>MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to respond: Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Delirious: Yes</td>
<td>No</td>
<td></td>
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</tbody>
</table>

**NB. Use haloperidol or Seroquel (Quetiapine), NOT BENZODIAZEPINE.**

<table>
<thead>
<tr>
<th>Pain</th>
<th>Tiredness</th>
<th>Nausea</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Drowsiness</th>
<th>Anorexia</th>
<th>Constipation</th>
<th>Dyspnea</th>
<th>Secretions</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td></td>
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<td>3</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4</td>
<td>Dexameth Ginseng</td>
<td>Ginseng</td>
<td>Anti-D’s Methylphen Ketamine – single dose</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7</td>
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<td></td>
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</tbody>
</table>


# Ginger 0.5-1.0 g/day. Ryan et al. Support Care Cancer. 2012

2. Always do a symptom assessment – and have standard algorithms to treat the problems.

What can I do? Recommendations for responding to issues identified by patient-reported outcomes assessments used in clinical practice.
2. Always do a religious/spiritual assessment – and get some help.

Table 1. FICA© tool for clinicians

<table>
<thead>
<tr>
<th>Item</th>
<th>Question for health care practitioner to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Do you consider yourself to be spiritual or religious?</td>
</tr>
<tr>
<td>I</td>
<td>Do you consider yourself to be a person of faith? Where do you find your strength? How important is this to you?</td>
</tr>
<tr>
<td>C</td>
<td>Are you a member of a faith community?</td>
</tr>
<tr>
<td>A</td>
<td>How would you like your health care team to address these issues?</td>
</tr>
</tbody>
</table>

Generates referral to Pastoral Care

**FICA Spiritual History Tool**
www.gwumc.edu/gwish/clinical/fica.cfm

Is religion important to you? Would you like to see a chaplain?
2. Always do a prognosis assessment.

<table>
<thead>
<tr>
<th>%</th>
<th>Ambulation</th>
<th>Activity Level Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Level of Consciousness</th>
<th>Estimated Median Survival in Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Full</td>
<td>Normal No Disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>Full</td>
<td>Normal Some Disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
<td>N/A</td>
</tr>
<tr>
<td>80</td>
<td>Full</td>
<td>Normal with Effort Some Disease</td>
<td>Full</td>
<td>Normal or Reduced</td>
<td>Full</td>
<td>N/A</td>
</tr>
<tr>
<td>70</td>
<td>Reduced</td>
<td>Can't do normal job or work Some Disease</td>
<td>Full</td>
<td>As above</td>
<td>Full</td>
<td>145</td>
</tr>
<tr>
<td>60</td>
<td>Reduced</td>
<td>Can't do hobbies or housework Significant Disease</td>
<td>Occasional Assistance Needed</td>
<td>As above</td>
<td>Full or Confusion</td>
<td>29 4</td>
</tr>
<tr>
<td>50</td>
<td>Mainly sit/lie</td>
<td>Can't do any work Extensive Disease</td>
<td>Considerable Assistance Needed</td>
<td>As above</td>
<td>Full or Confusion</td>
<td>30 11</td>
</tr>
<tr>
<td>40</td>
<td>Mainly in Bed</td>
<td>As above</td>
<td>Mainly Assistance</td>
<td>As above</td>
<td>Full or Drowsy or Confusion</td>
<td>18 8 41</td>
</tr>
<tr>
<td>30</td>
<td>Bed Bound</td>
<td>As above</td>
<td>Total Care</td>
<td>Reduced</td>
<td>As above</td>
<td>8 5</td>
</tr>
<tr>
<td>20</td>
<td>Bed Bound</td>
<td>As above</td>
<td>As above</td>
<td>Minimal</td>
<td>As above</td>
<td>4 2</td>
</tr>
<tr>
<td>10</td>
<td>Bed Bound</td>
<td>As above</td>
<td>As above</td>
<td>Mouth Care Only</td>
<td>Drowsy or Coma</td>
<td>1 1</td>
</tr>
<tr>
<td>0</td>
<td>Death</td>
<td>-</td>
<td>-</td>
<td>--</td>
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<td></td>
</tr>
</tbody>
</table>
Have a referral script. Write it down at diagnosis, revisit at transitions, have that hospice information visit 3-6 months before death.

- Palliative care is about **improving quality of life**, providing an **extra layer of support**, and having a team focus on your care.

- Hospice is about **improving quality of life**, providing an **extra layer of support**, and having a team focus on your care. *Hospice is not a place you go* (usually) but specially trained nurses who can come to your house to fix pain and other symptoms, keep you up and going. We will still be involved in your care.
2a. Reorganize our Medical Chart

• Communication
  – What do you want to know?
  – What do you know
  – How are you coping?
  – What is important to you?
  – What are you hoping for?
  – AMD/Code status  Full  DNR  Not discussed
  – How are you coping?

• Symptom Assessment Scale
• Spiritual Assessment
• Prognosis
3. Change our standards of care to incorporate national guidelines and best practices about palliative care.

**Communication:** Appoint someone in the office to discuss ADs, DPMA, hospice in first 3 visits – and document.

Limit to 3 rounds Of chemo and good PS – follow our own guidelines. Give feedback by doctor.

Insist on hospice referral with 3-6 months to live (not 2 weeks)

Audit referrals with < 14 days, give feedback to physician.

Every guideline should have a set point to add PC, and stop chemo based on evidence.
How to recommend transition

• Tell patient that you do not recommend additional chemotherapy because the prospects for benefit are very low; it is more likely to be a burden.

• Indicate that recommendation is based on guidelines developed by breast cancer experts at Hopkins and by other groups like ASCO and NCCN

• If patient is reluctant to forgo additional chemotherapy suggest consultation with breast cancer or palliative care experts at Hopkins or elsewhere

Courtesy of John Fetting, MD
How to recommend transition

• Recommend excellent palliative care at Hopkins or through hospice with emphasis on control of symptoms and quality of life
• Reassure patient that you will take care of her or stay involved in her care even after cancer chemotherapy stops
  – EMR Shadow Visits every Thursday @ 10 am. Encourage team calls.
  – “You are not done with me yet. I am still your doctor.”

Courtesy of John Fetting, MD
Approach to patients who still want chemotherapy

- Establish with patient specific goals of chemotherapy and indications for stopping
- Discuss plan with team to assure that they know goals of chemo and indications for stopping
- Recommend palliative care consult so that range of patient and family needs can be addressed

Courtesy of John Fetting, MD
Calmare™ scrambler therapy works for chemotherapy induced neuropathic pain

- Patient-specific cutaneous electro-stimulation similar to spinal cord stimulation, but non-invasive
- 10 daily 30 minute sessions using pads like EKG pads. Above/below pain, following the dermatomes.
- Feels like bee-sting; adjust to tolerance
- No side effects in over 4000 patients. FDA approved Feb 09.
- Pilot study of 16 patients with CIPN, first in US.
- The pts had a mean age of 58.6 years; 4 men, 14 women; the duration of CIPN was 3 months to 8 years. The most common drugs were taxanes, platinums, and bortezomib.
- No adjustments to their other drugs.
MC5-A Calmare™ therapy works for chemotherapy induced neuropathic pain – nothing else does.

60% reduction in pain scores
Smith T, et al, JPSM 2011

74% reduction in pain scores
97% would repeat the treatment

Mayo Clinic Results: 48% reduction in CIPN
MC5-A Calmare™ therapy works for other neuropathic pain

- Randomized trial done in Italy by the inventor, Giuseppe Marineo, PhD.
- 52 pts randomized to control (switch meds, based on EFNS guidelines) or Scrambler therapy
- Failed back syndrome, post herpetic neuralgia, spinal cord stenosis
- Randomized but not blinded
- 28% reduction in control group
- 91% reduction in Scrambler group

Conclusions

• Hospice and palliative care can improve symptom management for breast cancer patients
• Almost all patients want truthful information about prognosis, treatment options, living and dying
• People will choose chemo for very small benefits, delaying entry into hospice
• Refer patients to palliative care or hospice when they are still on treatment
• Discuss palliative and hospice care as a standard medical treatment for cancer when there is not good treatment left...
• ... and have a discussion about dying. “What are you hoping for?”