

Care of the Adult Cancer Patient at the End of Life: ESMO Clinical Practice Guidelines (2021)

About the Guideline

- This guideline defines end of life (EoL) care as care for persons who have rapidly failing physical health due to a progressive illness and who are typically in their final few weeks or months of life.
- This guideline addresses only the adult patient with cancer in advanced stages in their final weeks and days.
- The guideline was created by European Society for Medical Oncology (ESMO).
- Evidentiary literature was reviewed to construct the recommendations as deemed applicable by the experts, and these recommendations were subject to a peer review process prior to publication.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline especially if you work in an acute care oncology setting.

Communication and the Family

- At end of life (EoL), shared decision making and the ability to speak clearly and effectively are necessary to avoid misunderstandings.
- Developing a plan of care that incorporates the patient and family's moral principles, goals and preferences are essential to reduce adverse bereavement outcomes.
- Parents of young children should receive support and guidance on how to communicate with their children, prepare them for the death of a parent, and support healthy emotional expressions of grief.

Nursing Considerations

- The nurse's role is essential at EoL for the patient and the family.
 - Core roles include providing support and guidance to the family during the dying process, managing the physical deterioration of the patient's body, and recognition and management of death and its aftermath.
 - Nurses advise the patient and family on changing the plan of care as appropriate.
 - Specific education is needed for nurses to work in EoL care.
- Palliative care teams are a significant and necessary part of care for patient and family at EoL.

Prognostic Factors in Advanced Cancer Care

- Physical signs and symptoms indicating a poor prognosis of days to weeks need to be assessed objectively by clinicians.

- Deteriorating performance status and additional or worsening symptoms such as shortness of breath, difficulty swallowing, loss of appetite, dry mouth, weight loss, and altered mental status are indicators of a poor prognosis.
- Routine use of validated prognostic tools may aid practitioners in providing a more accurate estimate of length of survival.

Rationalizing Treatments

- Treatments must be individualized and influenced by a risk-benefit assessment.
- Chemotherapy or immunotherapy are not recommended in the last weeks of life.
- Radiation therapy may be considered to control symptomatic pain or bleeding, but it is not recommended in the last days of life.

Routes of Drug Administration

- The intravenous (IV) or subcutaneous (SC) route is favored when a patient can no longer take oral medications.
- If using a SC catheter, it should be placed on the trunk or abdomen due to a patient's diminished peripheral perfusion.

Nutrition and Hydration

- In the last few weeks and days of life:
 - Oral dietary supplements, nutritional counselling, and reducing invasive modes of nutritional intake are preferred.
 - Comfort care should be offered to improve thirst, hunger, and other troubling eating symptoms.
 - Initiation of artificial nutrition is not recommended.
- IV or SC fluids have not been demonstrated to relieve or prevent symptoms of thirst, dehydration, or delirium and can worsen ascites, respiratory secretions, and edema.
- Routine mouth care should always be provided.

Medication and Intervention Review

- Therapies, such as preventative medications, antiseizure medications, and diabetes medications, should be continued based on risk-benefit assessments and the individual patient.
- Antibiotics may have a symptomatic benefit in cases of urinary tract infections.
- Anticoagulation prophylaxis is not recommended.
- Red blood cell transfusion may provide short-term quality of life improvement but is not associated with improved palliative care.
- Platelet transfusion may assist symptomatic bleeding for thrombocytopenia but is limited by its short half-life.

Symptom Management

Pain

- Pain assessment should be done routinely and consistently, using a standardized pain validation tool.
 - Pain assessments should be performed on an individual basis with close observation until death.
- Nonpharmacological measures that promote comfort may be beneficial.
- Opioid treatment decisions should not be affected by toxicity concerns or concerns about hastening death.
 - If pain crisis occurs, immediate release opioids in IV, SC, or sublingual form may offer faster pain control.

Nausea and Vomiting

- Metoclopramide is the medication of choice in late stages of cancer, and it should be titrated for therapeutic effect.
 - Alternative antiemetic medications include haloperidol, levomepromazine, or OLANzapine.
- There is no recommendation for or against the use of cyclizine or 5-HT₃ receptor antagonists.
- In patients with malignant bowel obstruction, octreotide or haloperidol is recommended.
- To decrease opioid-induced nausea and vomiting, switching the drug route from oral to SC is suggested.

Breathlessness

- For breathlessness, the initial focus should be optimal treatment of underlying disease.
- Slow-release morphine is recommended for severe, chronic refractory breathlessness in advanced disease.
 - The baseline dose should be 10 to 20 mg every 24 hours for patients who are opioid naïve, with a 25% to 50% increase for patients who are opioid tolerant.
- If recommended treatments for cancer-related breathlessness are ineffective, corticosteroids may be considered.
- Benzodiazepines may be considered with caution when anxiety and breathlessness are unrelieved by opioids.
- Benzodiazepines for palliative sedation may be considered in the final days of life if refractory breathlessness becomes unrelenting.
- Antidepressants are not recommended for breathlessness, unless in a clinical trial setting.
- Palliative oxygen therapy for breathlessness is not recommended in patients with a resting oxygen level greater than or equal to 90%.

Noisy Breathing

- Preventing fluid overload may reduce noisy breathing (NB).
- Oropharyngeal secretions that cause NB may be decreased by repositioning the patient.
- There is no recommendation for or against anticholinergic medications for NB.
- Oropharyngeal suctioning is not recommended for NB.
- Communicating to the family that NB is common, unlikely to be bothersome to the patient, and not associated with breathlessness is encouraged.

Delirium

- There is no recommendation for routine use of a screening tool for delirium in patients with cancer.
- For delirium prevention, lowering doses or stopping medications in the older patient with cancer is suggested.
- OLANzapine or quetiapine is suggested for symptomatic delirium.
- Benzodiazepines may be considered as acute management for patients with severe symptomatic distress and delirium.
- Sedation should only be used as a final attempt to achieve refractory symptom relief.

Psychological Issues

- Early assessment and treatment of anxiety and psychological distress during the disease process is recommended to decrease anxiety and depression, achieve better treatment compliance, and maintain open communication.

Spiritual Distress

- Routine cancer care should include an assessment of spiritual distress.
 - This includes being empathetic with the ability to listen, assess, and meet the needs of patients as they share their spiritual distress.
- Suggested resources include those of spiritual care professionals, mindfulness, art, narrative and music therapy, meaning-oriented therapy, and dignity therapy.
- Consultation from a trained pastor or spiritual care professional is recommended for a thorough spiritual analysis and counselling.

Bereavement Care

- In the pre-death phase, it is recommended that providers have a plan in which they assess the family and caregivers for psychological distress.
- To help family and caregivers cope and to alleviate anxiety, depression, and potential social and monetary trouble, refer them to psych-oncology, spiritual care, social work, or other suitable specialists.
- Clinical staff should be educated and knowledgeable about grief and loss and how to recognize risk factors for poor bereavement outcomes.
- Targeted communication strategies should be utilized to address concerns if families have differences of opinion about care or are not prepared for death.

- Resources for support and information about normal and adverse grief should be made available to direct help-seeking after death.
- Offering specialist resources to those who are at risk of suffering complex and/or lengthy grief disorder is strongly recommended.
- An evaluation from the family's viewpoint should be performed by the clinical team after death to determine if there were any unanticipated issues and to reach out to the family, as appropriate.

Reference

Crawford, G. B., et al. (2021). Care of the adult cancer patient at the end of life: ESMO clinical practice guidelines. *European Medical Society for Medical Oncology Open*, 6(4), 1–13. <https://doi.org/10.1016/j.esmoop.2021.100225>