Poster Presentation:
Cardiovascular Vital Signs at Solid Tumor Diagnosis: Hypertension and Tachycardia Prognostic for All-Cause Mortality

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Cardiovascular Vital Signs at Solid Tumor Diagnosis: Hypertension and Tachycardia Prognostic for All-Cause Mortality

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Background
Cancer and heart disease are the most common causes of adult deaths in US. The interplay between cancer, heart disease, and other comorbidities may share biological mechanisms.

Greater understanding of the interplay may improve cardiovascular disease and cancer outcomes.

Blood pressure (BP) assessment is essential before, during, and after cancer treatment.

Prognostication is essential for oncology decision-making but remains a clinical challenge.

Objective
To examine whether cardiovascular vital signs (VS) were prognostic for overall survival (OS) in a large, real-world cohort of unselected newly diagnosed cancer outpatients.

Methods
Design: Exploratory retrospective study of EMR.

Sample: adult outpatients with a solid tumor diagnosis who had at least 2 encounters ≥7 days.

Systolic Blood Pressure (SBP; mmHg) categories: <120, 120-129, 130-139, 140-149, ≥150

Resting Heart Rate (RHR; beats/min) categories: <60, 60-69, 70-79, 80-89, 90-100, 101-109, ≥110

For Kaplan-Meier analysis of RHR, we used lower (≤60), normal (60-100), and tachycardia (>100).

CoX Proportional Hazards Models examined potential prognostic factors (age, body mass index, extent of disease, gender, primary tumor site, race, and treatment modality) for OS.

Kaplan-Meier method estimated survival at T1 & T2.

Results
Table 1. Demographic Data (N=5819)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>T1</th>
<th>T2</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>61 ± 12</td>
<td>62 ± 12</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Male</td>
<td>54%</td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>77%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Cancer Site</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metastatic Disease</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>42%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>39%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Clinical Characteristics (N=5819)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBP&lt;120</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td>120-149</td>
<td>56%</td>
<td>54%</td>
</tr>
<tr>
<td>≥150</td>
<td>22%</td>
<td>19%</td>
</tr>
<tr>
<td>RHR&lt;60</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>60-109</td>
<td>99</td>
<td>80%</td>
</tr>
<tr>
<td>≥110</td>
<td>4%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Representative of US cancer Diagnoses (Gender & Race)

T1 - T2 Duration = 6 (0–36) mos

Post-diagnosis OS: 27 (25 – 28) mos

Figure 1. Kaplan-Meier Plot of Overall Survival (Months) by RHR Category at (A) Diagnosis (T1) and (B) Final Visit (T2)

Figure 2. Kaplan-Meier Plot of Overall Survival (Months) by SBP Category at (A) Diagnosis (T1) and (B) Final Visit (T2)

Conclusions
At diagnosis, tachycardia and elevated BP had clinically and statistically important relationships with survival in newly diagnosed outpatients with pretreatment solid tumors.

Tachycardia predicted shorter survival, whereas elevated BP was associated with a better prognosis.

The risk of death was 18-35% lower with elevated SBP than normal BP.

Tachycardia had a 2-3 fold-increase in mortality at both timepoints.

These estimates were robust and independent from other covariates.

The magnitude of associations between these VS and OS also increased progressively, with survival more pronounced with progressively higher RHR and lower BP cohorts.

These associations also remained evident over time.

Cardiovascular VS can help formulate survival predictions.

Future Research
Further research is warranted to confirm these observations and consider whether hypotension and high RHR should represent therapeutic targets in the management of solid tumors.

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Poster Presentation:
Coming Home to Die, Reality vs Expectations Mismatch

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Abstract

Goals of care discussions play an important role in the advance care planning of a patient with a serious illness. Preferred Place of Care and Death (PPC/PPD) are usually discussed as part of ongoing conversations during a patient’s journey with a life-limiting illness. As clinicians, whilst working at a Palliative Care Unit in Trinidad and Tobago, we have observed the concept of “coming home to die” takes on a different connotation. Patients refer to home as not a physical space but the island of Trinidad and Tobago. This case series attempts to share a few vignettes of patients who have left the United Kingdom, United States of America and Canada to spend the end of their lives in Trinidad and Tobago.

Case 1

JL was a 59 year old female who returned to Trinidad from Canada in 2017. She had a history of Stage IV colon cancer and was managed in Canada on multiple lines of chemotherapy. She indicated that she had input in her care from both the Oncology and Palliative Care teams in Canada. When we first met Mrs JL on the acute medical ward in a general hospital in Trinidad, she revealed that she returned to Trinidad three months prior. She was followed up by the Oncology team in Trinidad and was managing well with his family. Prior to him returning home, his wife, a registered nurse, contacted our palliative care unit to find out about the services which were offered. Our team was subsequently contacted for an outpatient clinic appointment since Mr JS was declining at home and having a greater symptom burden of vomiting and getting overall weaker. Although his wife was assisting in his care, this was becoming a challenge. Mr JS spent 10 days at the Palliative Care Unit and eventually passed away.

While on the unit, Mr JS expressed that he had missed living in the USA and one of the main reasons he returned to Trinidad was to pass on his construction and other skills to his grandson. He felt that he was able to impart some skills, but was hoping to pass on more while his grandson visited him at the Unit.

Case 2

BW was a 74 year old male who returned to Trinidad in July 2018 after a recent diagnosis of Stage IV pancreatic cancer. Mr WS was living and working in Maryland, USA, when he started to have constitutional symptoms. He was investigated and found to have Stage IV cancer. He opted out of oncological treatment. After discussions with his daughter, he returned home to the Southern part of Trinidad for end of life care. At this time Mrs BW was given a prognosis of short weeks. She was subsequently admitted for end of life care on the same day. Mrs BW was dyspneic, anuric, and had skin mottling. She passed away in the dying phase of her illness as they were able to optimize this valuable time with her.

Our team was contacted by Mrs BW’s daughter two days after she arrived in Trinidad on 19th September, reporting increased abdominal distension, decreased oral intake, lethargy, increasing pain and overall decline. We offered to see her immediately and also admission to the Caura Palliative Care Unit. Unfortunately, the patient did not want to be admitted to an institution and wanted to stay at home. We attempted to contact our colleagues in South Trinidad, who could make a private in-home visit and provide support for end of life care, but no one was available at that point.

After many calls, the palliative care team at Caura was able to connect BW’s family with Dr X on 20th September, who saw them for a goals of care meeting at her public palliative care clinic in a hospital in South Trinidad. She was able to give advice on managing Mrs. BW at home. Dr X. a private general practitioner with palliative care experience, was able to review Mrs. BW at home on 22nd September. At this time Mrs. BW was dyspneic, anuric, and had skin mottling. She passed away the next day, about one week after returning to Trinidad from the UK.

Learning Points

Case 2: Earlier referral to our palliative care service in this case could have prevented a hospital admission. In addition, a more structured approach to give the patient her wish of preferred place of death as home could have been achieved. Advanced care planning was only undertaken days before her admission to our service which was not ideal. However, JL’s family was very pleased to have the support of the palliative care team during the dying phase of her illness as they were able to optimize this valuable time with her.

Case 2: Mr WS’s daughter was a nurse, so was able to figure out that she may have needed assistance of a palliative care team in the course of her father’s illness. Ideally, referral or initial discussion with a palliative care team abroad would have helped immensely. Mr WS and his family could have been addressed earlier. His PPC/PPD may have been explored in more detail prior to returning home. Mr WS would have preferred to be at his daughter’s home, highlighting the need for home palliative care services to assist with the provision of care.

Case 3: Currently there is no formalized home hospice service in Trinidad, or fall care package that can be conveniently accessed. A few private doctors will assist with end of life care at home, but it depends on their availability and location of the patient. Additionally, visiting nurses and equipment have to be organized by families. Patients who desire their preferred place of care/death to be the family home, need to have many aspects of home care thought out. Ideally, these care needs should be organized in advance to actually requiring them, and depend on the patient’s location and financial means. Inpatient hospices are located in western and eastern parts of Trinidad, and there are no inpatient units in South Trinidad. This makes access to inpatient services challenging.

Discussion

It is important to explore patients’ preferences on place of care and death. This is vital in attempting to honour these wishes as best as we could as health care practitioners. We recognize that these wishes may change over the course of a patient’s illness. Reflecting upon these cases, our team identified the importance in highlighting the existent palliative care services in Trinidad and Tobago to our international colleagues. It could be useful to those patients returning home to die or even for a vacation. There is Caripalca (Francois et al) and the World. A few may want to return to their birth country to spend the end of their lives. We believe that informing our International Health Care Practitioners on the services available in Trinidad and Tobago can assist in formulating smooth transitions of palliative care patients from one country to another. This is even more important in the post-COVID era.

There are online sites that provide contact information on the palliative care services located in Trinidad and Tobago and the Caribbean. These include the International Association for Hospice and Palliative Care (and The Caribbean Palliative Care Association). We look forward to global collaboration in Palliative Care through the continuity of care that we provide to our patients.
Poster Presentation:
End-of-Life During the COVID19 Pandemic – Highlighting the role of a dedicated Palliative care Social worker during this time of crisis.

Anna Cecilia Tenorio, MD, Cynthia Johnson, M.A.C.E., BCC, and Sarah Grudier, LCSW, APHSW-C
Department of Supportive and Palliative Care, Department of Internal Medicine, Houston Methodist Hospital, Houston, Texas, USA
End of Life During the COVID19 Pandemic – Highlighting the role of a dedicated Palliative care Social worker during this time of crisis.

Anna Cecilia Tenorio, MD, Cynthia Johnson, M.A.C.E., BCC, and Sarah Grudier, LCSW, APHSW-C

Abstract

Our world has become more complex and difficult with the emergence of the COVID19 Pandemic. We are facing to face challenging situations we have never experienced before. During the last decade our health care system was pushed to its limits. With the numbers rising, came the increasing need to provide care to patients. This created a strain on our healthcare professionals due to the overwhelming emotional demands brought on by the pandemic.

Crucial amid a pandemic are health care providers that can assist patients and families during this time of crisis. Social workers are vital in addressing the psychological, emotional, and financial challenges through action, intervention and use of resources.

Palliative care (PC) providers are also essential during pandemics since they provide specialized care to individuals with serious illness. They help address physical, emotional, and spiritual suffering that patients go through by providing physical, emotional, and spiritual support from psychological and spiritual distress (Fernandes & Hughes, 2019).

A Palliative care team (PCT) consists of multiple team members that include physicians, nurses, social workers, psychologists and chaplains. Currently, there are limited literature that outlines and documents what social workers, specifically palliative care social workers (PCSW) can assist with during pandemics (Social Work Today, 2020). In this case report, we will be able to describe and highlight the significant role of our PCSW in a patient affected by the pandemic.

Case Study

This is a case of a 61-year-old male with a complicated medical history, including but not limited to, repeated strokes and multiple organ transplants. The patient was admitted to the hospital due to expose secondary to pneumonia related to COVID19. Our PCT was consulted to assist with clarification of goals of care and intervention and use of resources.

Our PCSW was also consulted to assist with clarification of goals of care and intervention and use of resources. During this pandemic, our PCSW became the patient’s and family’s advocate in facilitating communication, lowering distress, and was the driving force in allowing end of the wish to keep the patient’s family. The patient’s wife shared, “Our (PCT) was consulted to assist with clarification of goals of care and intervention and use of resources. Our PCSW was assisting in the transformation between the patient and his family and Telemedicine. Telemedicine has grown tremendously in the past decade, and with this pandemic, it has evolved into an essential tool to help provide healthcare to patients alike ‘shelter in place’ and social distancing.”

Telemedicine technology was able to provide families and patients the ability to communicate via a web based audio and video through an iPad. The PCSW was able to assist in obtaining a dedicated plan that was left by the patient’s bedside so the family can speak with their spouse, they wanted. Our patient’s wife was thankful that she was given access to the video call. The wife stated, “I would be able to connect to the video, and I know she can hear me, and I will talk to her. However, even though it was difficult to hear her response, since his voice was too faint, I know she still appreciated hearing my voice, because he would wake up more whenever I talk.”

Discharge Planning and Transition to Hospice

Our PCSW assisted with the transition of the patient to an inpatient hospice facility that accepted COVID19 patients. With the appropriate PPE, the patient’s family was able to assist the patient, granting the wife the wish to be a face-to-face visit before the patient died. A (PCT) was able to call the patient’s wife by PCSW revealed that the patient and the wife were able to share their “final words together in person, achieving a sense of closure and peace. The patient’s wife shared, “I can’t thank you enough for what you did for us.”

Legacy Projects

Our PCSW also assisted in creating legacy projects for the patient’s family. Legacy projects reflect the values and beliefs we hold that have impacted others in a profound way. Legacy projects have been used to assist patients and families in reading memories, to remember their loved ones (by Collins, 2016). The beauty of legacy project, is the ability of patients and families to create the memorial together. However, with the current pandemic, creating legacy projects together was impossible. The PCSW provided the family with information to create a memory book online to honor the patient’s life and legacy (News Google, 2020).

The PCSW and the rest of the PCT was able to safely obtain patient’s hand to create treasured mementos of my husband. They mean so much to our kids and of course to me as well. Again, thank you from the bottom of our broken hearts. “Thank you so much for doing this for my kids and me. We can never repay all of you for these treasured mementos of my husband.”

Fig. 1 Patient’s hand etched on glass picture frame with original poem– “Touch this band of mine, every time you feel alone. My spirit will always be with you, embracing you without end. My love will always be in your heart, until we meet again.”

Fig. 2 Thumbprint cards with original poem right next to the fingerprint written by palliative care team member– “My fingerprint on paper, To remind you of my love forever. My thumbprint is a remembrance, That we will always be together”.

Fig. 3 Example of patient’s thumbprint card given to family as part of legacy projects.

Conclusion

Having a dedicated PCSW in the current time of COVID19 pandemic has been shown to be very beneficial for this patient and his family’s situation. The PCSW’s utilization of resources, empathy and passion to assist patients and families during this unprecedented time has truly reflected her resilience and sustainability as an integral member of a PCT.

The telemedicine resource have allowed for the PCSW to find connections with and between patients and their families during this time of social distancing. The legacy projects allowed for the patients families to find meaning amidst the chaos and be able to educate the family members during patient’s end of life. As a result of our PCSW's (and PCT’s) support, we were able to create the PCSW's (and PCT's) legacy project to help the patient and his family during during times when he could not express the right words that would match her expectations and while she was struggling with the grief of losing her husband. She said, “I have been there at the hospital every time he was a patient, and he needs me to be with him. I don’t care about the time I want to be near him “But because of our PCSW’s and PCT’s support, the patient’s wife was able to be near him and he was able to say goodbye and was able to appropriately cope during patient’s end of life.”

Palliative care social worker and chaplain as part of the palliative care interdisciplinary team

A palliative care team (PCT) is an interdisciplinary team that function as a unit. Teamwork is viewed as an essential function of the PCT (Fernandes & Hughes, 2019). Healthcare teams have been shown to provide better care to patients than clinicians who work alone (Fernandes & Hughes, 2015).

Our PCSW assisted our palliative care physician (PCP) in providing emotional support and expressive counseling to patient’s wife, when poor prognosis was voiced. The allowed for patient’s wife and family to have the opportunity to discuss their beliefs, decisions toward do-not-resuscitate (DNR) code status, comfort care measures and transitioning to hospice care.

Palliative care chaplains (PCC) assist the PCT by helping people cope with stress and spirituality when they are facing end of life, chronic medical conditions, mental or emotional problems (Koenig, 2009). Our palliative care chaplains (PCC) and our PCSW combined the patient’s wife’s request to have “Face to face visit” before the patient dies. The wife stated, “I have been there at the hospital every time he was a patient, and he needs me to be with him. I don’t care about the time he want to be near him “But because of our PCSW’s and PCT’s support, the patient’s wife was able to be near him and he was able to say goodbye and was able to appropriately cope during patient’s end of life.”

References


Colon, Y. (2019). “I can’t thank you enough for what you did for us.”

Blacker, S., & Christ, G. H. (2011).”, “I have been there at the hospital every time he was a patient, and he needs me to be with him. I don’t care about the time he want to be near him “But because of our PCSW’s and PCT’s support, the patient’s wife was able to be near him and he was able to say goodbye and was able to appropriately cope during patient’s end of life.”

