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MASCC/AFSOS/ISOO 2024 Abstract 1782

RESULTS

A total of 84 patients were included. Median palliative care follow-up [SD] was 3.5 [162] months. Median age [SD] at diagnosis was 66.6 [14.8] years. Most patients had a locally advanced/metastatic disease (N=56, 66%) with primary visceral presentation (N=32, 38%), encompassing leiomyosarcoma (N=21, 25%) and liposarcoma (N=17, 20%) histological subtypes. During follow-up, most patients had undernutrition (N=68, 81%), tumor wound (N=23, 27%), and lung effusion (N=21, 25%). Thirty-six patients (N=36, 43%) were in the second group of aggressive EOL care. (Table 1)

Table 1. Characteristics of the study population and univariate analysis

	Patients (n = 84)	Aggressive care at EOL		p-value
		≤ 1 criteria (n = 48)	≥ 2 criteria (n = 36)	
Age at diagnosis, years				0.52
Median (SD)	66.6 (14.8)			
Follow-up, month				
Median (SD)	3.3 (162)			
Gender, n (%)				1
Male	35 (41.7%)	20 (41.7%)	21 (58.3%)	
Female	49 (58.3%)	28 (58.3%)	15 (41.7%)	
Histological subtypes, n (%)				0.74
Leiomyosarcoma	21 (25.0%)	10 (11.9%)	11 (13.1%)	
Liposarcoma	17 (20.2%)	11 (13.1%)	6 (7.1%)	
Angiosarcoma	7 (8.3%)	4 (4.8%)	3 (3.6%)	
Rhabdomyosarcoma	5 (6.0%)	2 (2.4%)	3 (3.6%)	
Fibrosarcoma	5 (6.0%)	4 (4.8%)	1 (1.2%)	
Synovial sarcoma	3 (3.5%)	1 (1.2%)	2 (2.4%)	
Others	26 (31.0%)	16 (19.9%)	10 (11.9%)	
Anatomic sites, n (%)				0.91
Visceral	32 (38.1%)	18 (21.4%)	14 (16.7%)	
Limb	19 (22.6%)	11 (13.1%)	8 (9.5%)	
Retropertoneal	16 (19.0%)	9 (10.7%)	7 (8.3%)	
Mediastinal	12 (14.3%)	8 (9.5%)	4 (4.8%)	
Head and neck	5 (6.0%)	2 (2.4%)	3 (3.6%)	
Status at diagnosis				0.41
Localised	28 (33.3%)	18 (37.5%)	19 (27.8%)	
Locally advanced	38 (45.2%)	22 (45.8%)	16 (44.4%)	
Metastatic	18 (21.4%)	8 (16.7%)	10 (27.8%)	
ECOG Performance status at diagnosis				0.33
0	50 (59.5%)	30 (35.7%)	20 (23.8%)	
1	28 (33.3%)	13 (15.5%)	15 (17.9%)	
2	3 (3.5%)	2 (2.4%)	1 (1.2%)	
3	3 (3.5%)	3 (3.6%)	0 (0%)	
4	0 (0%)	0 (0%)	0 (0%)	
Anticancer drugs received, n (%)				0.92
No anticancer drugs administered	20 (23.8%)	12 (14.3%)	8 (9.5%)	
One line	12 (14.3%)	7 (8.3%)	5 (6.0%)	
Two lines	16 (19.0%)	8 (9.5%)	8 (9.5%)	
Three lines	17 (20.3%)	11 (13.1%)	6 (7.1%)	
≥ Four lines	19 (22.6%)	10 (11.9%)	9 (10.7%)	
Clinical syndromes				0.58
Undernutrition	68 (81.0%)	40 (58.8%)	28 (41.2%)	
Lung effusion	21 (25.0%)	15 (71.4%)	6 (28.6%)	
Tumor wound	23 (27.4%)	13 (56.5%)	10 (43.5%)	
Bowel obstruction	15 (17.9%)	7 (46.7%)	8 (53.3%)	0.40
Ascitis	10 (11.9%)	3 (30.0%)	7 (70.0%)	0.28
Spinal cord compression	7 (8.3%)	4 (57.1%)	3 (42.9%)	1
Superior vena cava syndrome	5 (5.6%)	3 (60.0%)	2 (40.0%)	1

Abbreviations: PC: Palliative Care; ECOG: Eastern Cooperative Oncology Group; SD: standard deviation

We reported a significant association between the numbers of palliative care outpatient interventions (outpatient consultation, $p < 0.005$; day hospital, $p < 0.005$; and telehealth consultation, $p = 0.025$) and aggressive EOL care (Figure 1). There were no associations between clinical variables and aggressive EOL care. (Figure 1)

Figure 1 Aggressive care at EOL considering ambulatory palliative care modalities as (A) consultation, (B) telehealth consultation, (C) day hospital

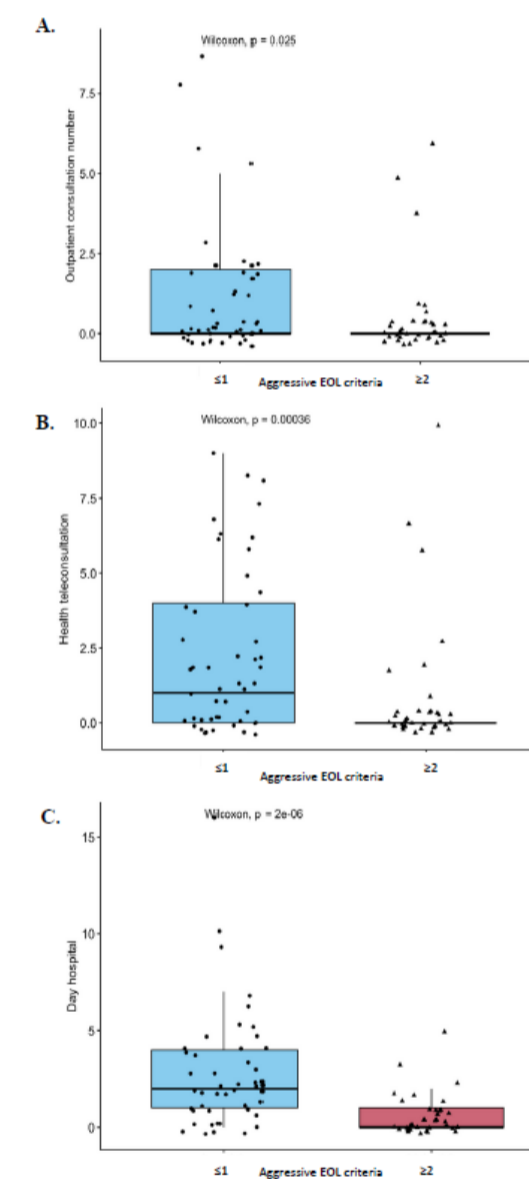


Table 2. Multivariate analysis of EOLs by follow-up method and socio-demographic criteria

Variable	N	Odds ratio	p
nb_lines	84	1.26 (0.88, 1.92)	0.24
nb-Cs	84	0.73 (0.50, 0.98)	0.06
nb_HDU	84	0.34 (0.16, 0.59)	<0.001
nb_Tos	84	1.01 (0.73, 1.42)	0.95
Gender			
Female	49	Reference	
Male	35	1.17 (0.31, 4.40)	0.81
ECOG			
0	50	Reference	
≥1	34	2.12 (0.63, 7.76)	0.23
age_ding	84	1.00 (0.95, 1.04)	0.87
e.status			
localised	28	Reference	
locally advanced	38	1.79 (0.44, 7.82)	0.42
metastatic	18	4.55 (0.81, 31.71)	0.10
e.histology			
leiomyosarcoma	21	Reference	
liposarcoma	17	0.72 (0.11, 4.62)	0.73
Other	46	0.76 (0.17, 3.24)	0.71

After multivariate analysis, the day hospital appears to be a protective factor against aggressive end-of-life care with an odds ratio <1 ($p < 0,001$). This also applies to consultations ($p = 0,06$) (Table 2)

BACKGROUND

Soft tissue sarcomas (STS) are rare cancers with a poor prognosis. Aggressive end-of-life (EOL) care in Oncology is a key issue. The specific nature of STS may give rise to a different attitude to EOL care compared with other cancers.

OBJECTIVES

We evaluate palliative care outpatient interventions on aggressive EOL care for advance STS and seek to establish an association between sociodemographic factors and EOL aggressiveness criteria.

METHODS

A single-centre retrospective cohort study with deceased STS patients over a two-year period at Institut Curie (Paris, France). Aggressive EOL criteria was based on Earle et al. (2003) and sorted into two groups : the first group ≤ 1 criterion and the second group ≥ 2 criteria. We tested association between clinical variables (age, gender, histological subtype, anatomic site, initial disease status, undernutrition, tumor wound, lung effusion, bowel obstruction, spinal cord compression, and superior vena cava syndrome) and three palliative care outpatient interventions (outpatient consultation, day hospital, and telehealth consultation).

DISCUSSION

Our study found no association between sociodemographic factors and EOL aggressiveness criteria. This result differs from the association found in many studies based on a population followed for all types of cancers combined (Bylicki *and al.* 2019). This may be due to sampling fluctuation and the size of our cohort.

To our knowledge, there are no studies in the scientific literature on the different modalities of palliative care in France and on the aggressive EOL care. This may be partly due to the fact that palliative care interventions in France differ from Anglo-Saxon models.

With the evolution of oncology therapies and patients' will to play an active role in their care, it may be worthwhile to redefine new criteria for aggressive end-of-life care. Perhaps using patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs).

CONCLUSION

Our results suggest the importance of outpatient palliative care follow-up to reduce the aggressive EOL care for STS patients. These results are confirmed by a multivariate analysis model. Day hospital and consultations appear to reduce the aggressive EOL care.

It seems worthwhile to expand this study into a multi-center study. This will allow a wider range of results to be obtained.

REREFENCES

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