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INTEGRATION OF PALLIATIVE CARE INTO STANDARD CARE IMPROVES SYMPTOM CONTROL IN HEAD AND NECK CANCER PATIENTS

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INTRODUCTION

Head and neck cancer patients (HNCP) usually present high symptom burden and psychological distress. Integrating palliative care specialists (PCS) into the standard care of HNCP can lead to better symptom control.

We aim to evaluate the physical and emotional symptom burden over time of HNCP attended in a dedicated head and neck palliative care outpatient clinic.

MAIN OBJECTIVE: To assess the impact of the PCS intervention by comparing the following at the third visit (V3) vs the first (V1), including: 1. pain control, 2. mood, 3. symptom burden, 4. need of assessment by other supportive specialists.

METHODS

- Prospective observational cohort study of HNCP conducted in a **PC outpatient clinic integrated into the HNC functional unit** (January 2020 - December 2021) (Research Ethics Board: PR318/19).
- **Inclusion criteria**: ≥ 18 years old; histologic diagnosis of HNC at any stage; patients seen on the first visit in the integrated PC outpatient clinic; informed consent signed.
- Demographic, clinical, and treatment variables were collected at these time points: first visit, at 1.5, 3, 6, 9, and 12 months.
- Symptoms were collected at every visit according to the Edmonton Symptom Assessment Scale-Revised (ESAS-r, Spanish version), and their intensity was scored on a numerical scale of 0 to 10 (0 = no symptom; 10 = worse intensity).
- The main variable was Symptom burden, defined as the sum of all ESAS scores and ranging from 0 to 110.
- Comparison of variables using T-Student and Chi-Square tests.

RESULTS

118 patients were included. 74 completed V1 and V3 after a median of 11.1 weeks (IQR 10-13). **Figure 1** shows COHORT CHARACTERISTICS (n=74)

Figure 1

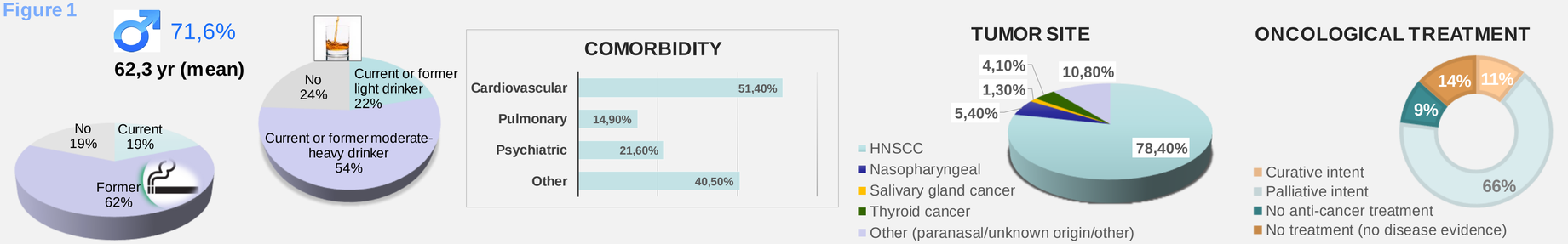


Table 1: COMPARISON OF SYMPTOM INTENSITY ACCORDING TO THE ESAS-R AND SYMPTOM BURDEN AT V1 AND V3

SYMPTOMS	Intensity at V1 (median [IQR])	Intensity at V3 (median [IQR])	p-value
Pain	3 [1.2;5]	3 [0;4.7]	**0.011**
Tiredness	4 [3;7]	5 [2;6]	0.443
Drowsiness	0 [0;2]	0 [0;2]	0.859
Nausea	0 [0;0]	0 [0;0]	0.095
Lack of appetite	3.5 [0;7.7]	3 [0;5]	**0.029**
Shortness of breath	0 [0;2]	0 [0;2]	0.167
Depression	4 [0.5;6.7]	4 [0;5]	**0.016**
Anxiety	2 [0;4.7]	2 [0;3]	**0.005**
Sleep disturbance	3 [0;6]	2 [0;4]	**0.001**
Dry mouth	4 [2;7]	4 [2;6.7]	0.333
Feeling of wellbeing	4 [2;5]	4 [2;5]	0.59
SYMPTOM BURDEN (mean [95%CI])	33.5 [29.9;37.1]	27.9 [24.5;31.4]	**<0.01**

Figure 2: EVOLUTION OF SYMPTOM BURDEN BETWEEN V1 AND V3

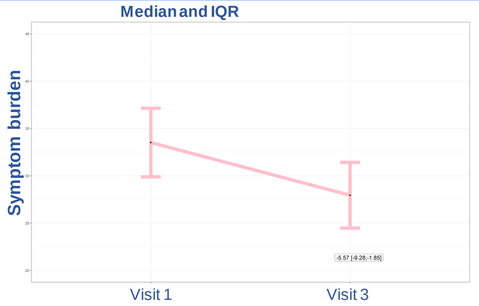
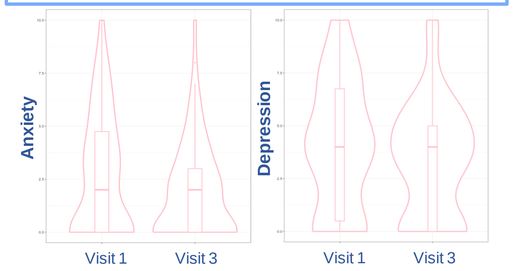


Figure 3: EVOLUTION OF ANXIETY AND DEPRESSION BETWEEN V1 AND V3



- **Comparing V1 and V3, we observed**:
  - decrease in overall symptom burden, sleep disturbance, and specific emotional symptoms (anxiety and depression) (Table 1; Figure 2 - 3).
  - increase in the percentage of patients assessed by:
    - social work (24.3% vs 43.2%; p=0.008),
    - psycho-oncology (6.76% vs 10.8%; p=0.47),
    - psychiatry (2.7% vs 6.8%; p=0.27).

- No statistically significant differences between disease status and anticancer treatment.

- At V1, analgesic treatment was modified in 69% of patients and psychotropic drugs in 31%.

CONCLUSIONS

* Physical and emotional symptom burden in HNCP decreases in the following 3 months after the integrated intervention of a PCS.

** Multidimensional evaluation performed by PCS promotes assessment by other supportive specialists.

*** Integrated PC intervention can improve the standard care of HNCP.

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