

ESMO Palliative Care Grant Report

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(Florian Strasser, MD) from 11/3 – 5/4/2007**

During my one month observation and research visit at the palliative care center in St. Gallen from 11 March to 5 April 2007 I had the opportunity to acquire knowledge and techniques in the structure and organization of several research projects and a palliative care service integrated into oncology.

Clinical care and service development

In the clinical part I attended in St.Gallen on rounds were: new patient admissions at the two palliative care units and the interdisciplinary team meetings with physiotherapy, social workers, nutritionist, psycho-oncologist and chaplains. Furthermore, I took part in specialized meetings such as round tables with patients, family members and the nursing team, interdisciplinary case discussions and error management rounds.

I worked in the palliative care outpatient unit and in a specific interdisciplinary nutrition and fatigue clinic with a nutritionist, a specialized nurse and a psycho-oncologist. I got insight in the assessment strategies and applied tools.

In addition I was involved in the palliative medicine consult service and visited the chronic pain clinic. Based on my experiences I am confident that I gained detailed insight in requirements of manpower, team processes and infrastructure for the development of an effective palliative care service including an ambulatory palliative medicine service.

As a first step in Hamburg, it is intended to complement the already existing palliative care consult services, with specific tools like round tables, interdisciplinary team meetings with nutritionists, social workers and psycho oncologists and advanced structured assessments.

Although it is currently not possible to provide the necessary manpower of a specialized palliative interdisciplinary clinic focused on nutrition and fatigue, we will certainly discuss how we can better integrate nutritionists and psycho-oncologists in our palliative care service in Hamburg. The foundation of an in-patient palliative care unit with 8 beds is still planned for the beginning of 2008. Mechanisms of team building, education and productive dealing with team conflicts I observed in St. Gallen will be discussed in our local multidisciplinary organizing committee and will certainly influence the development of our palliative care unit.

I personally used the opportunity to expand my knowledge and techniques in the management of symptoms, pain and nutritional problems of patients with end stage cancer disease.

Research

During my visit to St. Gallen I participated in three research projects of the group of Dr. Florian Strasser.

In a project of the European Palliative Care Research Collaborate (EPCRC), it is planned to assess in a multi-center trial, patterns of physical activities in advanced cancer patients by use of electronic body fixed sensors (AMoEBS-Protocol). In a first step we conducted interviews with experts in the field of palliative care in St. Gallen and Hamburg to evaluate key physical activities in palliative care patients important for symptom control outcome and for home return. A first aim is to define a definite list of 10 to 15 syndromes for further use within the AMoEBS trial.

In a second step it is planned to conduct a patient survey of relevant daily life activities in a palliative care setting. Furthermore, we will conduct one expert focus group to identify relevant physical activities in palliative care patients. It is planned to conduct a structured interview with 4 to 6 experts in the field on palliative care or medical oncology. According to a predefined interview guideline with open and closed question sections, the expert focus group will select a list of preferred physical activities in the palliative care setting. A detailed content analysis of the interview will be conducted comparing the results with the answers from the initial survey in St. Gallen. Following the expert survey from St. Gallen, the interview will contain questions regarding the most important activities and their association with a successful home return and symptom control. Additionally, we will discuss the topic on the basis of a list of physical activities based on the Barthel-Index, the IADL- Scale of Lawton and Brody (instrumental activities of daily living) and the restricted activities list of the cantonal hospital St.Gallen. In close collaboration with the group of Dr. Strasser in St. Gallen, I will conduct these surveys during the next six months in Hamburg. Depending on the local developments of the infrastructure of the palliative care service in Hamburg we will decide in what extent we will participate in the actual study evaluating the validity of activity and position patterns derived from the body fixed sensors and video recordings.

In addition, I was involved in a study looking at secondary causes of cancer-related anorexia. Dr. Strasser and Dr. Omlim had already explored the frequency of secondary anorexia in a patient population with fatigue or nutritional problems as well as in patients on regular opioid medication. A novel clinical assessment checklist based on literature review and multiprofessional clinical expert opinions was developed and used in this patient population. Charts of these patients were retrospectively reviewed using the predefined intervention checklist with the aim to evaluate the practice guidance potential. During my visit I started the case-control-study and searched for matched case control patients in the oncological outpatient clinic of the department using the alphabetical electronic database. Matching criteria were tumor-type, age (decade) and sex. To be included the matches' patients had to have documented anorexia or weight loss. The charts of the matched patients were reviewed for the presence of secondary causes of anorexia using the items of the checklist and for possible therapeutic interventions. The results were presented at the ASCO meeting 2007.

Among the patients treated in our outpatient clinic are many fulfilling similar criteria of the study. Therefore, after completion and evaluation of the study it is planned to analyze the possible impact of checklist in the setting of the oncology outpatient clinic in Hamburg in a small randomized controlled trial using the checklist from St. Gallen. The aim of the study is to explore and evaluate the practice guiding potential of the checklist in a randomized trial. The practice-guiding potential is defined as number of patients receiving a pre-defined intervention in a defined secondary cause of anorexia with use of the secondary anorexia checklist compared to a control group from our oncology clinic not being assessed with the checklist. It is planned to include 30 patients in each arm of the study. For each of the given symptoms on the checklist, possible interventions are defined. The charts of the respective patients will be reviewed for onset or change of therapeutic interventions. This study will begin within the next six months. The calculated budget of 1,600 Euro includes about 1,000 Euro for 3-4 days of exclusive research work of Dr. Wierecky and additional salary for student assistants as well as the fees for the local ethical committee and material costs. It is planned to present the results of this study at a meeting next year and to publish it within one year in a joint venture with St. Gallen.

During my visit the E-MOSAIC trial was initiated. This is a randomized phase III multicenter trial evaluating the effects of the E-MOSAIC intervention using palm and real-time longitudinal monitoring sheet (LoMoS) in patients treated with chemotherapy for advanced cancer in palliative intention. I had the chance to become acquainted with design and procedures of the trial and learned techniques of the palm based assessment. We deviated from our original plan of becoming an initial trial center because of current internal restructuring and shortness of nursing staff in our oncology clinic. Whether we will establish

Hamburg as a trial centre for the E-MOSAIC trial at this time will be a matter of discussion in our palliative care team during the next time. It is planned to conduct a feasibility study within our palliative care team implementing focus groups with physicians and nurses dealing with the impact of symptom control and the role of symptom assessment in daily patient care. Concretely, we will at first, establish a physician focus group consisting of 4 physicians from our oncology clinic and 2 physicians from the palliative care team and a nursing staff focus group with 6 nurses of our oncology clinic. For each group at least 3 meetings are planned each meeting dealing with a specific issue (symptom control and assessment, team communication etc.) following a predefined discussion structure. It is planned to decide about further strategy in a concluding joint team conference.

With the participation in these projects I had the chance to become acquainted with the specific challenges of research in the field of palliative medicine. I have acquired knowledge and experience – usable in Hamburg - how to plan palliative assessments and how to integrate them in clinical oncology routine practice. It is planned to work on these projects intensively during one month of exclusive research in June 2007.

Next steps

Concerning the further development of the palliative care service in Hamburg, it is our firm goal to apply for the ESMO special accreditation as an "ESMO Designated Center of integrated Oncology and Palliative Care" in 2008/2009.

To maintain a durable collaboration between the centers in St. Gallen and Hamburg regarding clinical development and joint research projects, it is planned to implement weekly telephone conferences for the next two months at least monthly phone calls from thereafter.

I would like to thank the ESMO Palliative Care Working Group for providing financial support. The grant has offered me the opportunity to further extend my knowledge and skills in clinical and academic aspects of palliative care.