AUSTRALIAN AND NEW ZEALAND SOCIETY OF PALLIATIVE MEDICINE & THE AUSTRALASIAN CHAPTER OF PALLIATIVE MEDICINE: TESTS, TREATMENTS AND PROCEDURES HEALTH PROFESSIONALS AND CONSUMERS SHOULD QUESTION

ANZSPM is a specialty medical society that facilitates professional development and support for its members and promotes the practice of palliative medicine. AChPM is a Chapter of the RACP's Adult Medicine Division.

1. Do not delay discussion of and referral to palliative care for a patient with serious illness just because they are pursuing disease-directed treatment.

Palliative care provides an added layer of support to patients with life-limiting disease and their families. Symptomatic patients can benefit regardless of their diagnosis, prognosis or disease treatment regimen. Studies show that integrating palliative care with disease-modifying therapies improves pain and symptom control, as well as patient quality of life and family satisfaction. Early access to palliative care has been shown to reduce aggressive therapies at the end of life, prolong life in certain patient populations, and significantly reduce hospital costs.

Supporting Evidence

- Greer JA, Pirl WF, Jackson VA, et al. Effect of early palliative care on chemotherapy use and end-of-life care in patients with metastatic non-small-cell lung cancer. Journal of Clin Oncology 2012;30(4):394-400.
- Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. New England Journal of Medicine 2010;363(8):733-42.
- Bakitas M, Lyons KD, Hegel MT, et al. Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial. JAMA 2009;302(7):741-9.
- Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. Journal of Palliative Medicine 2008;11(2):180-90.
- Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. Arch Intern Med 2008;168(16):1783-90.

2. Do not delay conversations around prognosis, wishes, values and end of life planning (including advance care planning) in patients with advanced disease

Advance care planning is a process, which includes choosing a surrogate or alternate decision-maker and communicating values or wishes for medical care. Evidence shows that advance care planning conversations improve patient and family satisfaction with care and concordance between patients' and families' wishes, reduce the likelihood of patients receiving hospital care and the number of days spent in hospital, and increase the likelihood of receiving hospice care.

Supporting Evidence

- Houben CH, Spruit MA, Groenen MT, Wouters EF, Janssen DJ. Efficacy of advance care planning: a systematic review and meta-analysis. J Am Med Dir Assoc 2014;15(7):477-89.
- Poppe M, Burleigh S, Banerjee S. Qualitative evaluation of advanced care planning in early dementia (ACP-ED). PLoS One 2013;8(4):e60412.

- Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. BMJ 2010;340:c1345.

3. Do not use oxygen therapy to treat non-hypoxic dyspnoea in the absence of anxiety or routinely use oxygen therapy at the end of life

Oxygen is frequently used to relieve shortness of breath in patients with advanced illness. However, supplemental oxygen does not benefit patients who are breathless but not hypoxic. Supplemental flow of air is equally as effective as oxygen under these circumstances. The use of a fan for facial air streaming can also be effective.

Supporting Evidence

- Chronic obstructive pulmonary disease (COPD) evidentiary framework. Ont Health Technol Assess Ser 2012;12(2):1-97.
- Abernethy AP, McDonald CF, Frith PA, et al. Effect of palliative oxygen versus room air in relief of breathlessness in patients with refractory dyspnoea: a doubleblind, randomised controlled trial. Lancet 2010;376(9743):784-93.
- Uronis HE, Currow DC, McCrory DC, Samsa GP, Abernethy AP. Oxygen for relief of dyspnoea in mildly- or non-hypoxaemic patients with cancer: a systematic review and meta-analysis. Br J Cancer 2008;98(2):294-99.
- Philip J, Gold M, Milner A, Di Iulio J, Miller B, Spruyt O. A randomized, double-blind, crossover trial of the effect of oxygen on dyspnea in patients with advanced cancer. J Pain Symptom Manage 2006;32(6):541-50.

4. Do not use percutaneous feeding tubes in patients with advanced dementia; instead use oral assisted feeding

Strong evidence exists that artificial nutrition does not prolong life or improve quality of life in patients with advanced dementia. Substantial functional decline and recurrent or progressive medical illnesses may indicate that a patient who is not eating is unlikely to obtain any significant or long-term benefit from artificial nutrition. Feeding tubes are often placed after hospitalization, frequently with concerns for aspirations, and for those who are not eating. Contrary to what many people think, tube feeding does not ensure the patient's comfort or reduce suffering; it may cause fluid overload, diarrhoea, abdominal pain, local complications, less human interaction and may increase the risk of aspiration. Assistance with oral feeding is an evidence-based approach to provide nutrition for patients with advanced dementia and feeding problems.

Supporting evidence

- Teno JM, Gozalo P, Mitchell SL, et al. Feeding tubes and the prevention or healing of pressure ulcers. Arch Intern Med 2012;172(9):697-701.
- Hanson LC, Ersek M, Gilliam R, Carey TS. Oral feeding options for people with dementia: a systematic review, J Am Geriatr Soc 2011;59(3):463-72.
- Sampson EL, Candy B, Jones L. Enteral tube feeding for older people with advanced dementia. Cochrane Database Syst Rev 2009;2:CD007209.
- Finucane TE, Christmas C, Travis K. Tube feeding in patients with advanced dementia: A review of the evidence. JAMA 1999;282(14):1365-70.

5. To avoid adverse medication interactions and adverse drug events in cases of polypharmacy, do not prescribe medication without conducting a drug regime review

Older patients disproportionately use more prescription and non-prescription drugs than other populations. Evidence shows that such polypharmacy increases the risk of adverse drug reactions and hospital admissions. Medication review with follow up is therefore recommended for optimising prescribed medication and improving quality of life in older adults with polypharmacy.

Supporting evidence

- Lu WH, Wen YW, Chen LK, et al. Effect of polypharmacy, potentially inappropriate medications and anticholinergic burden on clinical outcomes: a retrospective cohort study. CMAJ 2015;187(4):E130-7.
- Scott IA, Hilmer SN, Reeve E, et la. Reducing Inappropriate Polypharmacy: The Process of Deprescribing. JAMA Intern Med 2015;175(5):827-34.
- Jodar-Sanchez F, Malet-Larrea A, Martin JJ, et al. Cost-Utility Analysis of a Medication Review with Follow-Up Service for Older Adults with Polypharmacy in Community Pharmacies in Spain: The conSIGUE Program', PharmacoEconomics 2015;33:599-610.
- Fried TR, O'Leary J, Towle V, et al. Health outcomes associated with polypharmacy in community-dwelling older adults: a systematic review. J Am Geriatr Soc 2014;62(12):2261-72.
- Hajjar ER, Cafiero AC, Hanlon JT. Polypharmacy in elderly patients. American Journal of Geriatric Pharmacotherapy 2007;5(4):345-51.
- Hilmer SN, Mager DE, Simonsick EM, et al. A drug burden index to define the functional burden of medications in older people. Arch Intern Med 2007;167:781-7.

How was this list created?

Fellows from the Australian and New Zealand Society of Palliative Medicine and Australasian Chapter of Palliative Medicine (ANZSPM/AChPM) convened a working group to produce an EVOLVE list for palliative medicine. The Royal Australasian College of Physicians (RACP) assisted this working group in compiling a list of 15 clinical practices in palliative medicine which may be overused, inappropriate or of limited effectiveness in a given clinical context based on a desktop review of similar work done overseas. This list was then sent out to all ANZSPM and AChPM members, seeking feedback on whether the items fully captured the concerns of clinicians in an Australasian palliative medicine context and if not, whether any items should be omitted and/or new items added. 40 responses to this email were received. Based on these, 3 items were removed leaving a shortlist of 12. An online survey was then sent to all ANZSPM and AChPM members asking respondents to rate each item against three criteria from 1 (lowest) to 5 (highest), and to nominate any additional practices worthy of consideration. The criteria used to rate the practices were strength of evidence, significance in palliative care and whether palliative care physicians could make a difference in influencing the incidence of the practice in question. Based on the 114 responses to this survey, the top 5 were selected.