Faculty

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New Brunswick, New Jersey

Vincent J. Picozzi Jr, MD, MMM
Director
Pancreas Center of Excellence
Virginia Mason Medical Center
Seattle, Washington

Agenda

Dinner will be available during the program.
All times are listed in Central Daylight Time

6:15 PM – 6:20 PM Welcome and Introductions
6:20 PM – 6:30 PM FAST FACTS: Myths and Facts in Pancreatic Cancer
Carmela L. Hoefling, MSN, APN, AOCNP
6:30 PM – 7:00 PM The Current Landscape in the Treatment of Advanced Metastatic Pancreatic Cancer: Helping You Help Your Patients
Vincent J. Picozzi Jr, MD
7:00 PM – 7:20 PM Taking Steps to Assure a Patient-centered Approach to Treatment: Shining Light of Palliative Care
Nina N. Grenon, DNP, AGCNP-BC, AOCN
7:20 PM – 7:30 PM Care Challenges in Pancreatic Cancer
Panel Discussion led by Carmela L. Hoefling, MSN, APN, AOCNP
Audience Q&A
Using Your Own Device?

For immediate access to tonight’s slides, please log on to
www.partnersinpancreaticcancer.com/ons2016

Fast Facts:
Myths and Facts in Pancreatic Cancer

Carmela L. Hoefling, MSN, APN, AOCNP
Advanced Practice Nurse
Rutgers Cancer Institute of New Jersey
New Brunswick, New Jersey

The Pancreas
Shining Light on Pancreatic Cancer

The Pancreas Has Two Functions

**Exocrine**
The pancreas produces enzymes that help to digest food

- Amylase
- Lipase
- Protease

**Endocrine**
The pancreas produces chemicals (hormones) that regulate blood sugar

- Glucagon
- Insulin
- Somatostatin
- Pancreatic polypeptide

Pancreatic Cancer 2015

- Cases Reported Worldwide: 280,000 New Cases Annually
- New Cancers Reported in the US
- Average Lifetime Risk of Pancreatic Cancer: 1 in 65
- 3% of All New Cancer Cases in the US

Stages of Disease

- **Stage 0**: The tumor is confined to the top layers of pancreatic duct cells and has not invaded deeper tissues. It has not spread outside of the pancreas.
- **Stage I A**: The tumor is confined to the pancreas and is 2 cm across or smaller. The cancer has not spread to nearby lymph nodes or distant sites.
- **Stage I B**: The tumor is confined to the pancreas and is larger than 2 cm across. The cancer has not spread to nearby lymph nodes or distant sites.
- **Stage II A**: The tumor is growing outside the pancreas but not into major blood vessels or nerves. The cancer has not spread to nearby lymph nodes or distant sites.
- **Stage II B**: The tumor is either confined to the pancreas or growing outside the pancreas but not major blood vessels or nerves. The cancer has spread to nearby lymph nodes but not to distant sites.

Stages of Disease

- **Stage III**
  The tumor is growing outside the pancreas and into nearby major blood vessels or nerves. The cancer may or may not have spread to nearby lymph nodes. It has not spread to distant sites.

- **Stage IV**
  The cancer has spread to distant sites.

**Metastatic Pancreatic Cancer**
- Systemic Chemotherapy

**Local Pancreatic Cancer**
- Locally Advanced
- Borderline Resectable
- Resectable
  - Surgery Resection
  - Adjuvant Chemotherapy

**How Much Do You Know About Pancreatic Cancer?**

**Myths**

**Facts**
Shining Light on Pancreatic Cancer

Myth or Fact?

Surgical resection is the only potentially curative treatment for exocrine pancreatic cancer

Fact

- Etiology of pancreatic cancer is poorly understood
- More than half diagnosed at advanced stage
- Difficult to detect and diagnose:
  - Early stages with no noticeable signs or symptoms
  - Symptoms like many other illnesses
  - Obscured by other organs
  - Can be difficult to see on imaging

Myth or Fact?

Obesity is the #1 most modifiable risk factor for pancreatic cancer.
Non-inherited Risk Factors

- Smoking #1 Modifiable Risk Factor
- Diabetes Mellitus
- Chronic Pancreatitis
- Obesity/Physical Inactivity

Inherited Risk Factors

- Familial pancreatic cancer
- Cystic fibrosis
- Genetic syndromes
  - Hereditary pancreatitis
  - Breast/ovarian cancer syndrome: BRCA 2
  - Hereditary nonpolyposis: Mismatch repair genes
  - Familial atypical multiple mole melanoma (FAMM)
    • CDKN2A mutation

Myth or Fact?

New onset diabetes is the most common presentation of pancreatic cancer

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Shining Light on Pancreatic Cancer

**Signs and Symptoms**

- **#1 sign:** Painless, obstructive jaundice
- Fatigue
- New-onset diabetes mellitus
- Non-specific GI symptoms
- Anorexia/weight loss
- Progressive weight loss
- Relate to back


**Work Up**

- Labs: CMP, CBC, CA19-9, prealbumin, LFTs, lipase
- Imaging
  - Abdominal US
  - Abdominal CT scan pancreatic protocol
  - CT scan chest
  - MRU/MRCP
  - PET scan
- EGD/EUS with biopsy
  - Tissue diagnosis
  - Staging
- ERCP
- Diagnostic laparoscopy

**Myth or Fact?**

Pain is the #1 most feared symptom among cancer patients

Management of Locally Advanced Symptoms R/T Disease Progression

1. Pain related to infiltration of retroperitoneal nerves
   - Opiates, celiac plexus block, radiation
   **Most feared symptom**

2. Biliary obstruction
   - Jaundice, pruritus, malabsorption, coagulation issues, pain

3. Gastric outlet obstruction (GOO)
   - Intractable N/V, anorexia, weight loss, malnutrition, dehydration, electrolyte abnormalities

4. Pancreatic exocrine insufficiency
   - Diarrhea, bloating, indigestion, steatorrhea, malabsorption

---

Management of Locally Advanced Symptoms R/T Disease Progression

5. Venous thromboembolism
   - DVT, PA, DIC, PV thrombosis, arterial thromboembolism

6. Fatigue
   - Depression, pain, opioids, anemia, chemotherapy, insomnia, dehydration, cachexia

7. Depression
   - Impacted by pain

---

Why Do All Nurses NEED to Know About Pancreatic Cancer?

- Pancreatic cancer knows no bounds—it can strike anybody, at anytime
- It is the only leading cancer killer with a 5-year survival rate still in the single digits
- It is referred to as a silent killer—it's difficult to detect and spreads so quickly
- Vague symptoms including back/abdominal pain, jaundice and nausea usually appear after the cancer is at an advanced stage making it difficult to treat
- Few patients diagnosed with pancreatic cancer have identifiable risk factors
Shining Light on Pancreatic Cancer

The Current Landscape in the Treatment of Advanced Metastatic Pancreatic Cancer: Helping YOU Help Your Patients

Vincent Picozzi, Jr., MD, MMM
Director
Pancreas Center of Excellence
Virginia Mason Medical Center
Seattle, Washington

Pancreas Cancer is the Most Challenging Cancer to Treat

<table>
<thead>
<tr>
<th>Year of diagnosis</th>
<th>Median survival (months)</th>
<th>5-year survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>1974</td>
<td>2.8</td>
<td>2.0%</td>
</tr>
<tr>
<td>1979</td>
<td>3.2</td>
<td>2.2%</td>
</tr>
<tr>
<td>1984</td>
<td>3.3</td>
<td>2.2%</td>
</tr>
<tr>
<td>1989</td>
<td>3.5</td>
<td>2.8%</td>
</tr>
<tr>
<td>1994</td>
<td>3.6</td>
<td>4.0%</td>
</tr>
<tr>
<td>1999</td>
<td>4.0</td>
<td>4.6%</td>
</tr>
<tr>
<td>2004</td>
<td>4.3</td>
<td>5.0%</td>
</tr>
<tr>
<td>2004-2011</td>
<td>4.8</td>
<td>6.2%</td>
</tr>
</tbody>
</table>
Pancreas Cancer is the Most Challenging Cancer to Treat

<table>
<thead>
<tr>
<th>Stage</th>
<th>Median survival (months)</th>
<th>5-year survival (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resected</td>
<td>20.9</td>
<td>22.6</td>
</tr>
<tr>
<td>Locally Advanced</td>
<td>7.6</td>
<td>II</td>
</tr>
<tr>
<td>Metastatic</td>
<td>2.9</td>
<td>III</td>
</tr>
<tr>
<td>Overall**</td>
<td>3.8</td>
<td>IV</td>
</tr>
<tr>
<td>Overall**</td>
<td>6.0</td>
<td></td>
</tr>
</tbody>
</table>

3: 1-5 year survival

Pancreas Cancer is the Most Challenging Cancer to Treat: Biologic Challenges

- Genetically complex
- Stromal symbiosis
- Immunologically quiescent
- Early metastasis
- Large systemic impact (eg, pain, depression, weight loss)

Clinical Challenges in Increasing Pancreatic Cancer Survival

- Most patients diagnosed with advanced disease, currently no reliable markers for early detection
- Ineffective systemic therapies
- Majority of patients treated outside of multi-disciplinary setting
- Older average age at diagnosis → comorbidity and low treatment tolerance
- Pervasive nihilism among medical professionals
Shining Light on Pancreatic Cancer

Pancreas Cancer Pyramid of Success

- Early Detection
- Better Drugs
- Multidisciplinary Teams
- Supportive Care
- Optimism
- Hope

Optimism

A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty.

-- Winston Churchill

www.gavaterta.com

Pancreatic Cancer Action Network

A COMPREHENSIVE APPROACH

Alliance Research

+$

Build and Sustain Federal Support

Support Patients and Families

Motivate the Groups

DOUBLE SURVIVAL BY 2020

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Pancreas Cancer: Seven Important Complications

1. Pain
2. Depression
3. Diabetes
4. Weight loss
5. Nausea/vomiting, gastric blockage
6. Biliary obstruction/infection
7. Clotting and bleeding

Nutritional Intervention Can Improve QOL and Overall Survival in Advanced Pancreatic Cancer

- Dietary counseling and oral nutrition supplements over weeks n=107
- Improved dietary intake
- Weight stabilization
- Improved QOL (EORTC)
- Improved OS

Pancreas Cancer: Basic Presentations

- Localized
- Metastatic

Metastatic Pancreas Cancer: The Future of Treatment

- Patient Preference
- Tumor biology
- Comorbidity
- Economics

1st Line

2nd Line

3rd Line

Gemcitabine Monotherapy in 1st-Line Metastatic Pancreatic Cancer

- Median OS
  - Gemcitabine 5.7 mo
  - 5-FU 4.4 mo

Survival Time (months)

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What is Better than Gemcitabine??

FOLFIRINOX in 1st-Line Metastatic Pancreatic Cancer

FOLFIRINOX: Major Toxicities

Most Common Grade 3 or 4 Adverse Events Occurring in More than 5% of Patients in the Safety Population*

*Events listed are those that occurred in more than 5% of patients in either group. NS = not significant.

Gemcitabine/Nab-paclitaxel in 1st-Line Metastatic Pancreatic Cancer

Gemcitabine/Nab-paclitaxel:

Major Toxicities

<table>
<thead>
<tr>
<th>Event</th>
<th>Nab-Paclitaxel + Gemcitabine (N = 421)</th>
<th>Gemcitabine Alone (N = 400)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse event leading to death – no. (%)</td>
<td>18 (1)</td>
<td>16 (1)</td>
</tr>
<tr>
<td>Grade 3 hematologic adverse event – no./total no. (%)</td>
<td>155/90 (18)</td>
<td>10/388 (2.6)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>155/90 (18)</td>
<td>10/388 (2.6)</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>126/90 (14)</td>
<td>6/388 (1.6)</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>52/90 (6.2)</td>
<td>16/388 (4.2)</td>
</tr>
<tr>
<td>Anemia</td>
<td>50/90 (5.5)</td>
<td>48/388 (12.5)</td>
</tr>
<tr>
<td>Receipt of growth factors – no./total no.</td>
<td>10/90 (11.1)</td>
<td>9/388 (2.3)</td>
</tr>
<tr>
<td>Viable neutropenia – no./total no.</td>
<td>14/90 (15.6)</td>
<td>4/388 (1)</td>
</tr>
</tbody>
</table>

*NA = not applicable, and NR not reached. Measurement of the event was made of the basis of laboratory values; assessment of the event was made of the basis of investigator assessment of treatment-related adverse events.


Gemcitabine/Nab-paclitaxel:

Major Toxicities

<table>
<thead>
<tr>
<th>Event</th>
<th>Nab-Paclitaxel + Gemcitabine (N = 421)</th>
<th>Gemcitabine Alone (N = 400)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 3 nonhematologic adverse event occurring in &gt;5% of patients – no. (%)</td>
<td>70 (17)</td>
<td>73 (18)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>70 (17)</td>
<td>73 (18)</td>
</tr>
<tr>
<td>Peripheral neuropathy §</td>
<td>70 (17)</td>
<td>73 (18)</td>
</tr>
<tr>
<td>Anorexia</td>
<td>24 (6)</td>
<td>23 (6)</td>
</tr>
<tr>
<td>Grade 3 peripheral neuropathy</td>
<td>24 (6)</td>
<td>23 (6)</td>
</tr>
<tr>
<td>Median time to onset – days</td>
<td>190</td>
<td>113</td>
</tr>
<tr>
<td>Median time to improvement for grade 2 – days</td>
<td>48</td>
<td>57</td>
</tr>
<tr>
<td>Median time to improvement to grade 1 – days</td>
<td>51</td>
<td>NR</td>
</tr>
<tr>
<td>Use of capsaicin – no./total no. (N = 421)</td>
<td>2/70 (0.5)</td>
<td>NR</td>
</tr>
</tbody>
</table>

*NA = not applicable, and NR not reached. Measurement of the event was made of the basis of investigator assessment of treatment-related adverse events. Peripheral neuropathy was reported on the basis of groupings of preferred terms defined by standardized queries in the Medical Dictionary for Regulatory Affairs.

5-FU/MM-398 as Second-line Treatment in Metastatic Pancreatic Cancer

Overall Survival: Intent to Treat Population (ITT)*

*Protocol-defined primary analysis data cut (Feb 14, 2014, after 305 events). Survival follow-up is ongoing and the final results will be reported once all patients are off treatment and at least 90% events have taken place.

Pancreas Cancer: Commonly Used Drugs: 2016

- 5-FU
- Gemcitabine
- Erlotinib
- Capecitabine
- Nab-paclitaxel
- MM-398
- Cisplatin
- Oxaliplatin
- Irinotecan
- Docetaxel

Metastatic Pancreatic Cancer: Factors to Consider in Choice of Therapy

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age</th>
<th>Performance status</th>
<th>Comorbidity</th>
<th>Travel distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td>Metastatic sites</td>
<td>Rate of progression</td>
<td>? Stents (biliary, duodenal)</td>
<td>? Molecular profiling</td>
</tr>
<tr>
<td>Therapy</td>
<td>Insurance coverage</td>
<td>IV access required</td>
<td>Drug toxicities</td>
<td>Clinical trial availability</td>
</tr>
</tbody>
</table>
Metastatic Pancreatic Cancer: Important Current Research Directions

- Novel chemotherapy
- Molecular profiling
- Anti-stromal therapy
- Immunotherapy

TH-302: Mechanism of Action

Many conventional chemotherapeutics address only the cells near the blood vessels. Evofosfamide targets cells in hypoxic zones within the tumor.

Pancreas Cancer: Molecular Navigation

Shining Light on Pancreatic Cancer

PEGPH20: Biological Effects

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HALO-301 Phase III Design

- Randomized (2:1 PAG:AG), double-blind, placebo-controlled, global
- Plan to initiate March 2016, approximately 200 sites in 20 countries
- Interim analysis when target number of PFS events reached
- PFS powered with a hazard ratio of 0.59 (to detect a 41% risk reduction for progression)

FG-3019 Suppresses Survival Mechanisms of PDAC Tumor Cells, Sensitizing them to Chemotherapy

- E-cadherin (green) and cleaved caspase 3 (orange) showed that most apoptotic cells were epithelial
- Apoptosis in presence of FG-3019 suggests that CTGF promotes survival of pancreatic tumor cells and resistance to chemotherapeutic agents
- FG-3019 sensitizes tumor cells to apoptosis by down-regulation of XIAP expression

Combined Effects of Baseline CTGF and FG-3019 Exposure on OS

<table>
<thead>
<tr>
<th>Group</th>
<th>Baseline CTGF</th>
<th>Day 15 Cmax</th>
<th>Median OS (mo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt; median</td>
<td>&gt; 150</td>
<td>11.22</td>
</tr>
<tr>
<td>2</td>
<td>&gt; median</td>
<td>&lt; 150</td>
<td>8.01</td>
</tr>
<tr>
<td>3</td>
<td>&lt; median</td>
<td>&lt; 150</td>
<td>8.01</td>
</tr>
<tr>
<td>4</td>
<td>&gt; median</td>
<td>&gt; 150</td>
<td>4.38</td>
</tr>
</tbody>
</table>

P = .02

Key Attributes of Listeria Monocytogenes for Being an Effective Vaccine Vector

- Two key attributes for inducing robust innate and adaptive immunity
  - Naturally targets dendritic cells
  - Intracellular localization
- Permit re-administration to boost existing immune responses
- Practical considerations
  - Ease and cost of manufacturing
  - Thermostable formulation
- Acceptable safety profile
  - Live-attenuated Listeria Sua38/ΔinlB
  - KBKA Listeria

Kaplan-Meier Estimates of OS According to Treatment Group

Shining Light on Pancreatic Cancer

Potential Mechanisms of Action of Agonistic CD40 mAb on Various Immune Effectors

Agonist CD40: A Way to Combine Chemotherapy with Immunotherapy?

Can WE Double Survival in Pancreatic Cancer?
5-Year Stage-specific Survival in Pancreatic Cancer Patients
(diagnosis 2004 – 2011)

*Adjusted to SEER stage distribution

VM vs. SEER

Local: ↑ 92%
Regional: ↑ 68%
Distant: ↑ 105%
Overall*: ↑ 84%

"The future ain't what it used to be."
– Yogi Berra

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Problem

- Pancreatic cancer
  - Significant morbidity and mortality
  - <7% overall survival rate
- >80% present with advanced disease
- Symptoms – physical and psychological
  - High burden
  - Predictably worsen
  - Palliative and hospice care provided at end of life
  - Late referrals to palliative care (PC) – adverse effect on quality of life (QoL)
- Goal of treatment is largely palliative

Common Symptoms of Pancreatic Cancer

- **Physical** - Pain, anorexia, weight loss, fatigue, jaundice, nausea/vomiting, fatigue, constipation, diarrhea
- **Psychological** - Depression, anxiety, insomnia, and existential distress
- **Complications associated with the disease** - thrombosis, biliary obstruction, gastric outlet obstruction
Shining Light on Pancreatic Cancer

General Management Issues
- Reversal of common bile duct obstruction
- Symptom management
- Pain control
- Nutrition
- Pancreatic enzyme replacement
- New onset diabetes
- Treatment of venous thrombosis
- Psychosocial support

What Palliative Care is and What it is Not

Palliative Care
It’s not about dying.
It’s about living.
Palliative Care Defined

**Center for Medicaid and Medicare**
- Patient, family-centered care that optimizes QoL by anticipating, preventing, and treating suffering
- Addresses physical, intellectual, emotional, social, and spiritual needs
- Facilitates patient autonomy, access to information, and choice

**National Consensus Project**
- Aims to relieve suffering, to support best possible QoL for patients with advanced chronic or life-threatening illnesses and their families
- Includes:
  - General approach to patient care routinely integrated with disease-modifying therapies
  - Growing practice specialty for highly trained specialist physicians, nurses, social workers, chaplains, etc.

Components of Palliative Care

- Symptom Management
- Practical Support
- Multi-disciplinary Palliative Care Teams
- Traditional Models
- Integrated Model

What Constitutes Palliative Care?

- Can be delivered concurrently with life modifying therapy
- Minimization of suffering
- Anticipation and planning for future symptoms to prevent suffering
- Aggressive, well-planned symptom control
- Psychosocial support for patient and family
- Maximization of patient's dignity and control
- Protection from burdensome interventions

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Models of Palliative Care Delivery

Dichotomous Model of Healthcare

Integrated Model of Healthcare

Eight Domains of Palliative Care:
Developed by the National Consensus Project (NCP) and The National Quality Forum (NQF)

Domain 1: Structure and Process of Care
Domain 2: Physical Aspects of Care
Domain 3: Psychological and Psychiatric Aspects of Care
Domain 4: Social Aspects of Care
Domain 5: Spiritual, Religious, and Existential Aspects of Care
Domain 6: Cultural Aspects of Care
Domain 7: Care of the Imminently Dying Patient
Domain 8: Ethical and Legal Aspects of Care

Integrating Palliative Care to Improve QoL

The ENABLE II Trial
- Psycho-educational palliative interventions
- Improved QoL and less depression
- Trend towards reduced symptom intensity
- Median survival improved ($P = .14$)
  - Intervention group 14 months
  - Control group 8.5 months
Integrating Palliative Care to Improve QoL
- Standard cancer care simultaneously with palliative care
- Improved QoL and reduced major depression
- Reduced ‘aggressiveness’
- Less chemotherapy <14D before death
- More likely to receive hospice care; less likely to be hospitalized in last month of life
- Improved survival (P<.02)
  - 11.6 months vs 8.9 months

Integrating Palliative Care to Improve QoL
- Palliative care + standard of care
- Visits every month vs standard of care alone
- At 4 months, significant difference in the intervention group
  - QoL (FACIT)
  - Symptom severity (ESAS)
  - QoL at the end of life (QUAL-E)
  - Satisfaction with care (FAMCARE-P16)

Consequences of Late Referrals to Palliative Care
- Compared to care at home with hospice:
  - Care in ICU associated with 5x family risk of post-traumatic stress disorder
  - Care in hospital associated with 8.8x family risk of prolonged grief disorders
Shining Light on Pancreatic Cancer

Palliative Care Improves Value

- Symptoms
- Quality of life
- Length of life
- Family satisfaction
- Family bereavement outcomes
- Care matched to patient-centered goals
- Hospital costs decrease
- Need for hospitalization/ICU decreases

Organizational Mandates

- National and International Organizations Advocate for PC
  - Component of comprehensive cancer care throughout trajectory of illness
  - Regardless of treatment goals
- National Comprehensive Cancer Network (NCCN)
- World Health Organization (WHO)
- Palliative Care for People with Cancer
- American Society of Clinical Oncologists (ASCO) (2012)

ONS Position Statement, November 2014

The Major Barrier: Access

- Oncologist 1 for every 145 patients with a new cancer diagnosis
- Palliative medicine 1 for every 1,300 people with serious illness
- In 20 states No access to post-graduate training in palliative education
Palliative Care Delivery
- Primary or generalist-level palliative care
- Specialist-level palliative care

Palliative Care Addresses Three Major Domains

- Patient-family and professional communication about achievable goals for care and the decision-making that follows
- Effective and patient-centered communication
- Coordinated, communicated, continuity of care and support for practical needs of both patients and families in all settings during the patient’s illness

When to Discuss Palliative Care
- At the time of sharing diagnosis of chronic illness
  - Relief of symptoms
    - Impact on person’s lifestyle
    - Impact on person’s self-image
  - Uncover the meaning that patient places on how to live with their illness
  - Major changes in course of disease
Guiding Clinicians to Improve Communication

- Serious Illness Conversation Guide
  - To help train and support clinicians when discussing goals of care
  - This short simple guide assists the clinician in discussing:
    - Patients’ understanding of their illness
    - Patients’ preference for information
    - Patients’ preference for family involvement in care
    - Patients’ personal life goals, fears and anxieties, and trade-offs they are willing to accept

Conclusions

- Patients with pancreatic cancer are faced with a chronic illness with many distressing symptoms
- Treatments are multimodal and aggressive, potentially having an overall negative impact on their QoL with limited survival
- Providing PC preferably early in the course of disease is ideal
- Every clinician caring for patients needing PC should be adequately trained to provide the services
- Patients with refractory symptoms should be referred to the PC specialists
Conclusions

- Implications with this model include:
  - Restructuring all nursing and medical school curriculum to include key concepts of PC
  - Funding is needed for PC education of health care providers
- Patients and family members have a right to be educated about enormous benefits that PC can provide

Thank You

References available via downloadable slide set at: partnersinpancreaticcancer.com/ons2016

Panel Discussion/Q&A
References


References


References


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References

Panel Discussion Questions

1. The systemic treatment of PC can have multiple side effects that are particularly distressing for the patient. Diarrhea from irinotecan and peripheral neuropathy from oxaliplatin are a few. How can we as nurses manage these side effects and avoid them affecting a patient’s quality of life?

2. Communication with the patient, their family and the multidisciplinary team is crucial in the management of PC. What is a patient’s understanding of their disease? What do they want to know? How can we actively involve them and their family in the decisions of their treatment?

Panel Discussion

3. PC is a rapidly developing and ultimately fatal cancer. It is difficult to detect and most often diagnosed at an advanced stage. How can health care providers increase public awareness regarding the possible prevention of pancreatic cancer? Are there screening tools for those with high risk factors?

4. PC has a high incidence of depression, anxiety, insomnia and existential distress. How can we help our patients not only manage the physical aspects of the treatment of pancreatic cancer but the psychosocial aspects as well?

5. Weight loss and cachexia are common in patients with PC and the etiology is multifactorial. What are measures we can incorporate into our plan of care to improve dietary/metabolic health, prevent further weight loss, and improve a patient’s QOL during treatment?