CHAPTER 20 PALLIATIVE CARE

20.1 Introduction

Palliation is appropriate whenever a decision is made based upon the patient's wishes and the clinical evidence that further intensive or curative treatment is not indicated. Recently an Australian author claimed 'that haematology is a neglected area in terms of sensitive care of the dying'.[1,2] Certainly, a recent major text dealing exclusively with lymphoma does not broach the subject as an 'issue' per se.[3]

There are specific reasons, perhaps, why haematologists who care for patients with lymphoma and similar diseases have not utilised the services of palliative care teams, both at a domiciliary and inpatient level, to the same extent as medical oncologists dealing with solid tumours. Simple measures described in this chapter will often significantly improve the quality of life in patients who clearly have terminal disease. These include treatments such as single-agent chemotherapy, corticosteroids and radiation therapy, which are of significant palliative value.

The aim of this chapter is to review issues specific to the palliation of lymphomas. The reader is referred to the Australian Palliative Care Clinical Pathway for guidelines on general palliative care.[4] These cover symptoms such as pain, dyspnoea, cough, excessive secretions, and fatigue, as well as cultural and psychosocial issues, and the management of complications of treatment. There is good evidence that specialist palliative care teams improve the control of pain and other symptoms as well as increasing the wellbeing of patients and their carers.[4,5] The palliative care team should be involved early in the management of patients, especially those with complex problems.

Advanced and incurable lymphoma may be asymptomatic and run a prolonged course requiring minimal or no treatment (see Chapter 12 — Low-grade lymphoma), or it may be aggressive and rapidly growing. Advanced lymphoma may manifest with large masses that are unsightly or cause obstruction. Obstruction occurs most commonly to the biliary tract and the superior vena cava. Because lymphomas are very sensitive to chemotherapy and radiotherapy, a wide range of therapeutic options remain open to deal with lymphomatous masses and their effects. As the aim of management is to improve wellbeing, anti-lymphoma treatment should be used only when the side-effect profile of the intervention is minimal.

20.2 Corticosteroids

Corticosteroids are lympholytic and may also reduce oedema associated with a mass. Corticosteroids are useful because they reduce the size of lymphomatous masses and may also stimulate appetite. Long-term use is associated with a large number of side effects that can be difficult to manage, such as diabetes and proximal myopathy. Therefore, where possible, steroids should be used in short courses.

20.3 Single-agent chemotherapy

A large number of chemotherapy agents are active against lymphoma and have low toxicity when used as single agents in a palliative sense. These include etoposide, mitoxantrone, and vinblastine. However, the likelihood of a response diminishes rapidly with repeated use or a long history of previous treatment. Therapy should be continued only if there is stable disease, or a response, and the patient's general fitness is sufficient to tolerate side effects.

20.4 Biotherapeutics

Apart from the obvious use of blood transfusions and blood component therapy for symptomatic relief, the use of monoclonal antibodies in a 'palliative mode' has been recognised. Rituximab (MabThera), a chimeric human mouse anti-CD20 monoclonal antibody lysing CD20 positive cells, can be used to achieve palliative responses in often heavily pre-treated patients (see Chapter12).

20.5 Radiotherapy

Radiotherapy, even in very low doses, is extremely effective in reducing massive local disease and alleviating problems from pressure. Durable responses have been documented with doses as low as 2x2 Gy. Girinsky reported on the use of this regimen in a series of 48 patients with low-grade lymphoma who all had advanced stages and previous treatment with at least two courses of chemotherapy. There was an 80% response rate, and 57% complete response rate. Freedom from relapse at two years was 56%.[6] Higher doses up to 30 Gy are indicated for intermediate or high-grade lymphomas.

Guideline — Palliative treatments in lymphoma	Level of evidence	Refs
Principles of palliation established in solid tumour malignancies apply in the management of patients with lymphoma.	III, IV	1, 2, 4, 5
Active treatments such as single-agent chemotherapy, corticosteroids, monoclonal antibodies and radiotherapy may be of significant value in terminally ill patients with lymphoma.	III, IV	3, 6

20.6 References

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4. Luhrs CA, Meghani S, Homel P et al. Pilot of a pathway to improve the care of imminently dying oncology inpatients in a Veterans Affairs Medical Center. J Pain Symptom Manage 2005; 29: 544-51.

5. National Breast Cancer Centre Advanced Breast Cancer Working Party. Clinical Practice Guidelines for the Management of Advanced Breast Cancer. 2001. Canberra, National Health and Medical Research Council, Commonwealth of Australia.

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