

Reconsidering End-of-Life Treatment for People With Advanced Cancer

Patients who received systemic therapy during their final weeks of life did not have a higher overall survival rate.

July 31, 2024 By [Liz Highleyman](#)

Intensive treatment near the end of life may not be the best option for people with very advanced cancer, according to study results reported in [JAMA Oncology](#). Patients treated at oncology practices that frequently offer systemic therapy during the last two weeks of life did not have a survival advantage over those treated at practices that did so less often.

“Our study highlights the importance of open and honest communication about prognosis between providers and patients,” senior author Kerin Adelson, MD, of MD Anderson Cancer Center, said in a [news release](#). “Our findings may help oncologists reconsider treatment and instead provide patients with transparent information on supportive care options so they are able to make informed decisions.”

With the development of new types of [targeted therapy](#) and [immunotherapy](#), more cancer patients are being treated at later stages of disease. While this may be beneficial for some individuals, prior research has shown that systemic anticancer therapy at the end of life is associated with higher rates of hospitalization, later transition to hospice care, higher cost and worse quality of life.

The American Society of Clinical Oncology and the National Quality Forum developed a metric based on how many patients who died of cancer received chemotherapy during their last 14 days of life; the metric, dubbed NQF 0210, was later expanded to other types of systemic therapy, including targeted therapies and immunotherapies. The researchers [previously found](#) that while end-of-life chemotherapy has declined over time, late use of targeted therapy and immunotherapy has risen, so the likelihood of receiving any systemic therapy during the last two weeks of life remained constant at 17% in both 2015 and 2019.

Another recent study, also [published in JAMA Oncology](#), found that more physicians are starting people with metastatic melanoma, non-small-cell lung cancer (NSCLC) or kidney cancer on immune checkpoint inhibitors during their last month of life. In fact, end-of-life treatment accounted for 7% of all immunotherapy treatments in 2019. Patients at nonacademic cancer

centers and centers that treat fewer people were more likely to receive immunotherapy late, while those at academic or high-volume centers were more likely to receive it earlier and had about a 30% lower chance of dying within a month after starting treatment.

In real-world practice, oncologists can't always predict whether death is imminent within two weeks. Some doctors are uncomfortable with end-of-life conversations and are more likely than others to jump to the next line of treatment for very advanced cancer without giving patients a realistic prognosis. And patients, family members and caregivers sometimes push for more treatment in the hope of extending survival.

Adelson and colleagues set out to assess whether systemic treatment of very advanced cancer actually leads to longer survival.

"We wanted to find out if oncologic treatment of very advanced tumors is associated with improved survival or if there are times when it's futile to continue care and instead oncologists should shift focus to palliative and supportive care," lead author Maureen Canavan, PhD, of Yale Cancer Center said in [another news release](#).

The researchers compared survival outcomes for the overall population of patients with metastatic cancer who received care at practices with higher versus lower NQF 0210 rates. If a substantial proportion of patients benefit from treatment of very advanced disease, practices with higher NQF 0210 rates (meaning a higher proportion of people treated) would be expected to show improved overall survival across all patients with metastatic disease, while those receiving care at practices with lower NQF 0210 rates would have lower survival because they may be denied potentially beneficial treatment, the study authors explained.

Using the large Flatiron Health national electronic health records database, the researchers identified adults with six types of advanced or metastatic solid tumors (breast, colorectal, kidney, lung, pancreatic and urothelial). The study cohort included 78,446 patients. Just over half were women, and the mean age was 67 years. NSCLC was most common (44%), followed by colorectal cancer (20%).

The researchers stratified 144 oncology practices—both community practices and academic or research centers—into quintiles, or fifths, based on their NQF 0210 rates and compared overall survival rates between them. Patients were treated between 2015 to 2019, and data were analyzed between July 2021 and July 2023.

There was no statistically significant survival benefit for patients treated at practices that were most likely to use systemic therapy for very advanced cancer compared with those at practices least likely to do so, the researchers found. This finding held for all six types of advanced cancer. Similar patterns were seen when they extended the end-of-life time frame from 14 to 30 days.

"In this cohort study, patients with metastatic or advanced cancer treated at practices with higher NQF 0210 rates did not have improved survival," the study authors concluded. "Future efforts should focus on helping oncologists identify when additional therapy is futile, developing goals-of-

care communication skills and aligning payment incentives with improved end-of-life care.”

“A large body of research has shown that goals-of-care conversations are critical to ensuring patients receive care in line with their prognosis and personal goals,” Adelson said. “This is even more critical when we know additional therapy will not improve a patient’s survival but only cause toxicity and harm.”

In their discussion, the authors noted that financial incentives can play a detrimental role. They previously found that patients covered by commercial insurance are more likely to receive late treatment with expensive new targeted therapies and immunotherapies than those who rely on Medicaid or Medicare, which pay providers less. What’s more, although the NQF 0210 aimed to encourage timely enrollment in palliative care to improve the quality of remaining time and provide a positive death experience, access to such services is lacking.

“Communities with limited access to hospice services are more likely to receive aggressive end-of-life care, and the daily reimbursement rate for hospice is often too low to cover the extent of home care that a dying patient may need,” they wrote. “These barriers may make it harder for patients to transition to hospice, even when their oncologist addresses goals of care.”

The researchers suggested that policymakers could address payment reform and other economic factors to better align incentives with improved end-of-life outcomes—for example, reducing coverage of high-cost drugs in “nonbeneficial settings” and increasing reimbursement for earlier palliative care and hospice services.

“The money saved to society on systemic anticancer therapy at the end of life and downstream acute care use could be redirected to enhanced home care, home hospice services and more flexible criteria for inpatient hospice,” they wrote.

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