Article Review

Palliative Medicine Review: Prognostication

Paul A Glare, M.B.B.S., F.R.A.C.P. and Christian T. Sinclair, M.D.

Key Points

- ✓ Patients and families receiving palliative care want information about life expectancy to help plan realistically for their future.

- ✓ Expertise in prognostication has diminished due to the ready availability of diagnostic test and effective therapies. Therefore, many physicians find themselves underprepared to estimate life expectancy effectively.

- ✓ To address various issues requiring physicians to utilize prognostic skills, Fries and Ehrlich define "the 5D's of prognostication" as (1) disease progression/recurrence, (2) death, (3) disability/discomfort, (4) drug toxicity, (5) dollars (costs of health care).

- ✓ Prognostication involves two components: formulation and communication.

- ✓ An openly discussed prognosis has the potential to greatly alter a patient's treatment plan.

- ✓ To ensure adequate informed consent for ongoing care, the following should be reviewed:

    - o A thorough appraisal of the clinical situation.
    - o The treatment options based on the clinical situation.
    - o The patient's prognosis based on the possible treatments.
    - o The preferences of informed patients or proxies.

- ✓ Clarification of prognosis is vital to ensure patients make decisions based on likely outcomes rather than hopeful results. Palliative care teams can help align patient goals based on prognostic information.

- ✓ Discharge planning is a crucial function of palliative care consult services. The typical palliative care consulting will involve predicting the time of death, the impact of disease modifying therapies, and the future disease course.

- ✓ The palliative care physician must integrate these data points with the various options for providing care and the patient and family's goals, priorities and expectations.

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Key Points

- ✓ It is well recognized that hospital palliative care teams can play a major role in improving patient insight, including knowledge about their prognosis.

- ✓ Clinicians report difficulty in formulating and communicating a prognosis. Reasons for the difficulty include (1) feelings that patients want too much certainty and accuracy from the prediction (2) the physician's tendency to be optimistic, (3) the need to reformulate the prognosis at regular intervals, (4) the lack of formal educational opportunities about prognosis, and (5) the belief in a prognostic self-fulfilling prophecy.

- ✓ The approach to formulating an individual prognosis can be divided into two main methods which are not mutually exclusive:
    - o clinical prediction of survival (CPS: depends of clinical experience and knowledge to make a subjective judgment about an individual's prognosis
    - o actuarial estimation of survival (AES): uses factors established through data and research to more narrowly define an individual prognosis for a patient.

- ✓ Comparing CPS or AES to determine which to use is not straightforward as both have distinct advantages and disadvantages.

- ✓ A common clinical roadblock to realistic prognostication is relying on statistics to communicate a general prognosis. The statistics may not be relevant to the individual, and median survival data often reflects the outlook at the time of diagnosis, not after treatment.

- ✓ Actuarial judgment is generally preferred over subjective judgment in most areas of health care. However, subjective judgments of survival remain relevant in palliative care.

- ✓ There are many tools available to help formulate and communicate survival predictions. In the article they are categorized by survival expectation (less than 3 months or more than three months), disease state, and usage (web-based). See article for specific tools.

- ✓ Because of the lack of consistency amongst prognostic factors between patients, and because of variation in the accuracy of physician's judgments, no single prognostic index has been universally successful in predicting outcomes across patient populations.

- ✓ Just as palliative care has influenced health care with its contributions to pain management and end of life care, it can make prognostication less difficult and stressful for others. Palliative care physicians are at the forefront of predicting death and other outcomes through new work in clinical epidemiology, biostatistical computing, and prognostication concepts.

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Prognostic Tools

Tools for Patients with an Anticipated Survival of Less than Three Months

- National Hospice Study, United States, 1988

- Palliative Performance Scale (PPS), Canada, 1999

- Palliative Prognostic Index (PPI), Japan, 1999

- Palliative Prognostic (PaP) Score, Italy, 1999

- Terminal Cancer Prognostic (TCP) Score, Korea, 2001

- Taiwanese Study, 2004

- Intrahospital Cancer Mortality Risk Model, Turkey, 2004

Tools for Patients with an Anticipated Survival of More than Three Months

- SUPPORT Model, United States, 1995

- Survival Prediction Score (SPS), Canada, 2001

- Good/Bad/Uncertain Index, United States, 1999

- Glasgow Prognosis Score, UK, 2005

- CRP-Vitamin B12 Product and Survival in Terminal Cancer

Disease-Specific Tools for Patients with an Anticipated Survival of More than Three Months

- Lung Cancer

- Breast Cancer

- Colon Cancer

- Prostate Cancer

Web Based Tools

- Prognostigram

- Prognostat

- Adjuvant! Online for Lung, Breast, and Colon Cancer