International Journal of Radiation Oncology biology • physics

www.redjournal.org

BRIEF OPINION

PRADO: A Palliative Care Model for Every Radiation Oncology Practice

Timur Mitin, MD, PhD, Charles R. Thomas, Jr, MD, and Jerry J. Jaboin, MD, PhD

Department of Radiation Medicine, Oregon Health and Science University, Portland, Oregon

Received Jul 3, 2017, and in revised form Jul 20, 2017. Accepted for publication Jul 24, 2017.

During the past few years, large academic radiation oncology programs have uncovered a significant gap in providing palliative care to hospitalized cancer patients. The renowned SPRO (Supportive and Palliative Radiation Oncology) service at Brigham and Women's Hospital (1) has charted the waters since 2011. Similar programs have begun, including, but not limited to, inPROV (Inpatient Palliative Radiation Oncology Service at Vanderbilt) (2) and SOPR (Supportive Oncology and Palliative Radiotherapy at the University of Pennsylvania), which have provided a tremendous benefit to patients, improvements in physician satisfaction, and increases in patient volumes. These academic programs have also incorporated closer follow-up protocols for a subset of patients with metastatic disease, who have a greater risk of requiring additional radiation treatment (RT), such as patients who have received a single fraction of palliative RT (8 Gy $\times$ 1) or patients with central nervous system involvement or oligometastatic disease.

However, the most critical void remains for cancer patients with incurable disease—proactive follow-up care in community radiation oncology clinics. US radiation oncologists are trained to monitor patients who have received definitive RT with curative intent—to monitor toxicity and evaluate for recurrence. However, patients with metastatic disease almost universally have other oncology providers—for the most part medical oncologists and, increasingly, palliative care physicians. US radiation oncologists rarely schedule regular follow-up visits for patients receiving palliative treatment courses and on the final treatment days routinely tell their patients: "Please call us if you have any questions, concerns, or new symptoms; otherwise, continue to follow-up with your main physicians."

It is in the outpatient setting in which a radical change is needed and not just in large academic centers, with a large number of inpatient beds and dedicated physicians and support staff. This change can and should happen across all radiation oncology facilities, including academic and private, hospital-based, community-based, and free standing.

At Oregon Health & Science University, we have built the novel PRADO (Palliative Radiation Oncology) clinic model at one of our community satellite locations. Fundamentally, PRADO establishes regular outpatient palliative support by radiation oncology physicians and support staff by maintaining regular clinic, home, and telephone visits. Thus, new symptoms prompt rapid evaluation with advanced imaging, and palliative RT is offered in a timely fashion, before symptoms become complicated, such as fractured bone, collapsed lung, and spinal cord compression.

Palliative care professionals for the most part have not viewed radiation oncologists as a part of the palliative care team, in large part owing to our unwillingness to actively participate in continuity of care that might not involve the active administration of RT for these patient. As it stands, up to three quarters of these physicians are concerned that radiation oncologists subject terminally ill patients to

Reprint requests to: Timur Mitin, MD, PhD, Department of Radiation Medicine, Oregon Health and Science University, 3181 SW Sam Jackson Park Road, KPV4, Portland, OR 97239. Tel: (503) 494-6159; E-mail: mitin@ohsu.edu

Conflict of interest: none.

Int J Radiation Oncol Biol Phys, Vol. 99, No. 3, pp. 518–519, 2017
0360-3016/$ - see front matter
http://dx.doi.org/10.1016/j.ijrobp.2017.07.032

unnecessary and prolonged treatment (3, 4). This translates to very few palliative care patients ever returning to radiation oncologists for potentially beneficial therapy. Instead, with increasing pain, these patients usually receive additional narcotic medication prescriptions. Skeletal events and obstructive symptoms of the airways, digestive, and circulatory systems and disruption of the central nervous system all become the sentinel events for these patients. This reality can change if we are willing to expand our scope of work and become a preferred provider for palliative care.

Over time, we hope our PRADO clinic will be recognized, not only by patients, but also by other oncology providers, who will realize a tremendous benefit in referring their patients for evaluation and ongoing surveillance even before their patients require palliative intervention.

Our assumption that frequent follow-up examinations and intervention with short-course palliative RT will lead to a better quality of life and perhaps even to improvements in overall survival should be thoroughly studied. Our PRADO model was built in the community and uses the principles of academic medicine, with meticulous data collection of outcomes, including patient-reported quality of life metrics, such that over time we will be able to determine which subsets of patients will benefit the most from this model and how the structure and flow of the outpatient palliative clinic should be altered to deliver the best value to these patients.

As cancer patients live longer with targeted and immunotherapies (5), the role of palliative RT will evolve, with a greater number and complexity of treatment courses required to keep patients comfortable. Only a thorough clinical follow-up program for these patients with constant re-evaluation of treatment intervention benefit will determine how radiation oncologists in the future will be best positioned to lead palliative care services.

We have a remarkably effective tool that we can use to alleviate the suffering of patients with metastatic cancer—RT. Using well-delineated algorithms (eg, National Comprehensive Cancer Network), we can prescribe pain medications and manage patients' complications. We should be proud to assume the manteaux of primary palliative care oncology providers and to have patients proudly call our PRADO clinic their home.

References

1. Tseng YD, Krishnan MS, Jones JA, et al. Supportive and palliative radiation oncology service: Impact of a dedicated service on palliative cancer care. *Pract Radiat Oncol* 2014;4:247-253.
2. Stavas MJ, Pagan JD, Varma S, et al. Building a palliative radiation oncology program: From bedside to B.E.D. *Pract Radiat Oncol* 2017;7:203-208.
3. Lutz S, Spence C, Chow E, et al. Survey on use of palliative radiotherapy in hospice care. *J Clin Oncol* 2004;22:3581-3586.
4. McCloskey SA, Tao ML, Rose CM, et al. National survey of perspectives of palliative radiation therapy: Role, barriers, and needs. *Cancer J* 2007;13:130-137.
5. Mariotto AB, Etzioni R, Hurlbert M, et al. Estimation of the number of women living with metastatic breast cancer in the United States. *Cancer Epidemiol Biomarkers Prev* 2017;26:809-815.