



# End-of-Life Care Planning in Patients with Recurrent Gynecologic Cancers

Nate L. Jones, MD<sup>1</sup>, Ashley S. Case MD<sup>2</sup>, Ashley Albers, MD<sup>3</sup>, Timothy J. Vanderkwaak, MD<sup>2</sup>, David J. Hetzel, MD<sup>2</sup>, C. Blair Harkness, MD<sup>2</sup>, and Shelley L. Galvin, MA<sup>4</sup>

<sup>1</sup>Department of OB/GYN, MAHEC; <sup>2</sup>Division of Gynecologic Oncology, Hope Women's Cancer Center;

<sup>3</sup>Palliative & Hospice Care Fellowship, MAHEC; <sup>4</sup>Division of Healthcare Innovation, MAHEC; Asheville, North Carolina

## Abstract

**Objectives:** Gynecologic oncologists and associates must provide appropriate, acceptable, patient-centered end-of-life care. Most women with terminal gynecologic cancers do not have do-not-resuscitate (DNR) orders upon hospital admission and many do not receive effective palliative care. Our objective was to assess quality care indicators involving end-of-life care among gynecologic oncology patients treated at our institution.

**Methods:** An IRB-approved retrospective review was performed on all patients with recurrent gynecologic cancers and terminal diagnoses who died from January 2009 through October 2012. Data included intervals to death from: diagnoses, DNR status, Hospice/Palliative Care Medicine (HPCM) involvement, and other factors related to end-of-life care. Chi-squared and discriminate analyses were utilized.

**Results:** Complete data were available for 130 of 345 (37.7%) patients. Disease sites included cervix 28 (21.5%), uterine 37 (28.5%), ovarian 51(39.2%), and vaginal/vulvar 14 (10.8%). Median age at diagnosis and death was 63 and 65 years. Relative to death, diagnoses occurred at a median of 1.65 (0.05-32) years prior. 83 (63.8%) patients were DNR at their last hospitalization, 84(64.6%) had HPCM involvement, and 18(13.8%) had an advance care plan. When HPCM was involved, 83.3% were DNR as compared to 28.3% without involvement (p=0.0001). Patients were also significantly more likely to have DNR status with diagnosis of ovarian cancer and as the duration of time between diagnosis and death increased (p=0.0001). The provider obtaining DNR was most often faculty over residents or HPCM (60.2%, 27.7%, 12%). DNR status was declared by 57 (68.7%) patients and 26 (31.3%) power of attorneys. Median duration from DNR to death was 14 days (0-308) and median duration from HPCM involvement to death was 22 days (0-391).

**Conclusions:** DNR status is associated with ovarian cancer, HPCM involvement, and increasing time from diagnosis to death. Earlier intervention from providers or HPCM could allow for greater patient autonomy and fewer interventions at end-of-life.

## Objective

To assess quality care indicators involving end-of-life care among gynecologic oncology patients treated at our institution.

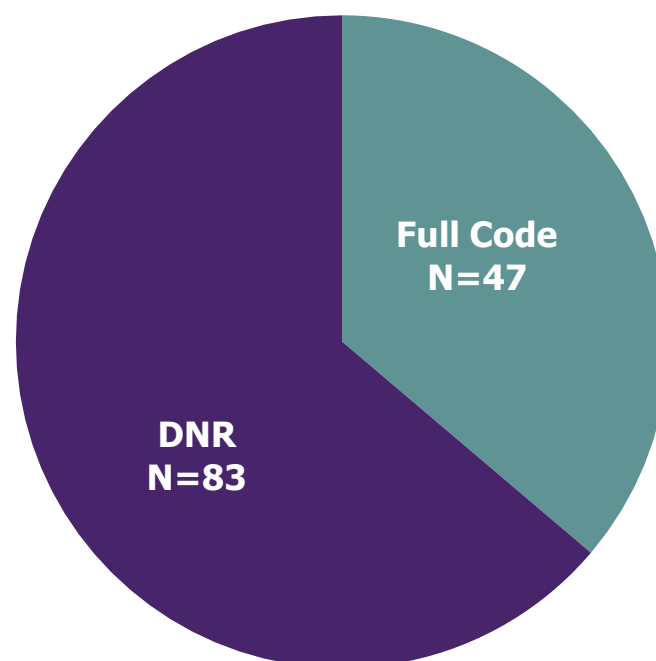
## Methods

- An IRB-approved retrospective review was performed on all patients with recurrent gynecologic cancers who died from January 2009 through October 2012
- Data included intervals to death from: diagnoses, DNR status, HPCM involvement, and other factors related to end-of-life care
- Statistics: Chi square and discriminate analyses used

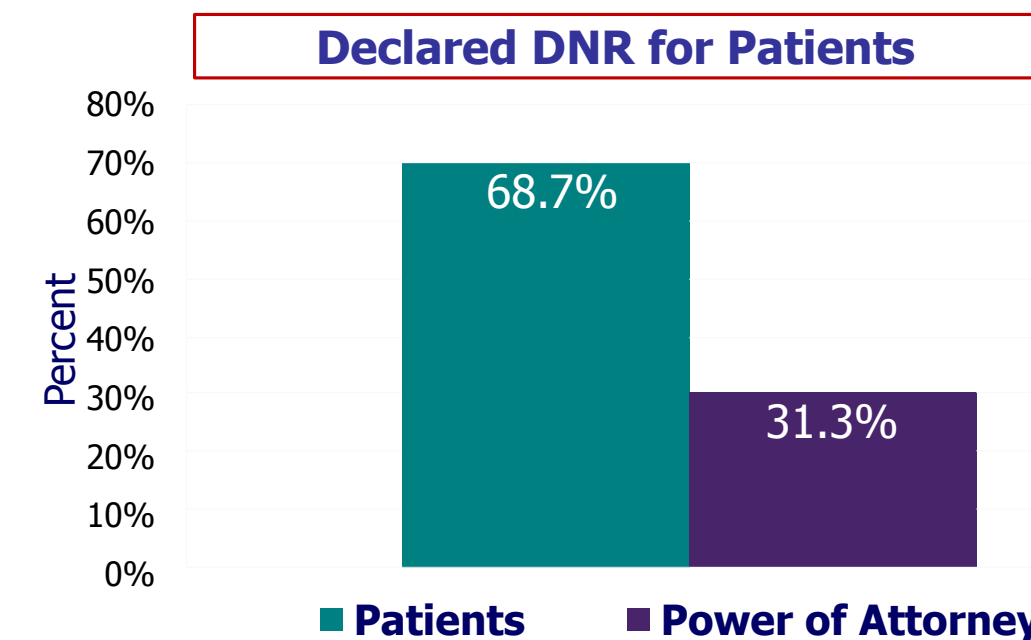
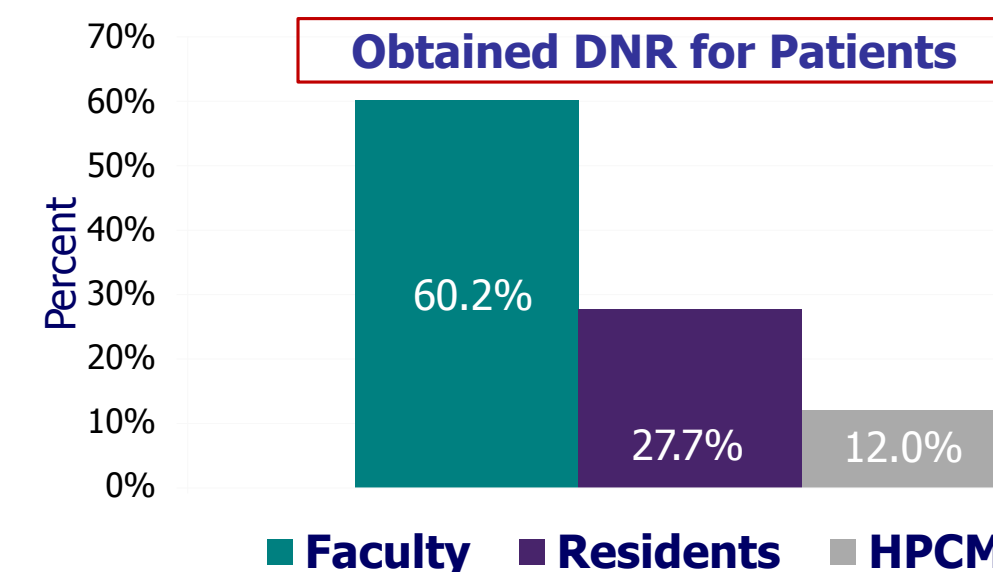
## Results

- A total of 130 patients had complete data (37.7%) and were included in the study
- DNR status was associated with HPCM intervention, diagnosis of ovarian cancer, and increased duration from time of diagnosis to death
- 69% of patients declared their own DNR status, while 31% were declared by their power of attorney
- Median duration from DNR to death was 14 days
- Median duration from HPCM involvement to death was 22 days

## DNR Status at time of Last Hospitalization



## Results



## Increased Likelihood of DNR

- HPCM Involvement
- Ovarian cancer
- Increasing duration from diagnosis to death

## Conclusions

- DNR status is associated with ovarian cancer, HPCM involvement, and increasing time from diagnosis to death.
- Earlier intervention from providers or HPCM could allow for greater patient autonomy and fewer interventions at end-of-life.



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