The Canadian Lung Cancer Conference, held in Vancouver, 8–9 February 2018, was a successful, informative, and well-organized meeting. It was well attended, with its more than 350 participants including many distinguished guests from across Canada. The sessions were engaging and lively with discussion and contemplation. The four women living with lung cancer who shared their personal experiences at the conference were a moving reminder of the importance that advancements in lung cancer management hold not only at a population level, but also at the individual level.

For patients with metastatic lung cancer, the era of long-term survival is becoming a reality. Earlier studies such as the Eastern Cooperative Oncology Group's 1986 prospective randomized trial of the 4 most commonly used chemotherapy regimens for metastatic lung cancer reported a median survival of 24.5 weeks and severe toxicities1. Since then, progress has been made in overall survival for those with metastatic lung cancer—progress that, in part, must certainly be attributed to the use of targeted therapies2. For example, a recent phase III study of nivolumab in patients with previously treated advanced non-small-cell lung cancer showed a 5-year survival rate of 16%, compared with the historical 5-year survival of less than 5%3.

Still, metastatic lung cancer remains a life-limiting diagnosis. How are we managing the people who are not eligible for targeted therapies? How are we caring for all people with metastatic lung cancer, given that most will ultimately die from their disease?

A criticism of an otherwise excellent event was its underappreciation for and underutilization of palliative care. In fact, only one session, attended by few delegates, focused on palliation. It is well-established that early palliative care makes a difference for quantity and quality of life4. The American Society of Clinical Oncology published a special article on palliative care in 19985. Twenty years later, we find ourselves two years away from Society’s vision of “comprehensive cancer care by 2020,” which would include the integration of palliative care into standard oncology practice6. The latest update, published in 2017, outlines the key recommendation in this way7:

Patients with advanced cancer, whether inpatient or outpatient, should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referring patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer caregivers of patients with early or advanced cancer to palliative care services.

Canadian cancer centres must be striving for this same standard of care. In 2006, to better identify symptoms affecting a patient’s cancer care, Cancer Care Ontario launched the use of the Edmonton Symptom Assessment System in Ontario’s regional cancer centres. That initiative has been vital not only in improving symptom management, but also in validating each patient’s experience. However, there have been challenges in its uptake8. The extent of the detrimental effects on patient care that those challenges have engendered remains unclear, but potentially, delayed referral to palliative care is one. Such a delay can in turn mean that conversations about goals of care are being left until too late in the cancer journey. Understanding each patient’s hopes and values for their care is the responsibility of every provider, including the primary treating oncologist. Instead of a discussion focused on the next line of treatment and the associated financial approvals, it is important to listen to what the patient really wants from treatment.

Additionally, all practitioners have to better recognize and act on the social determinants of health, which hold negative consequences for cancer care and cancer survival. From screening to end-of-life care, our current cancer system is not equal for all9.

To provide this truly comprehensive level of care requires a multidisciplinary model. Much as patients benefit from early referral to palliative care, physicians must also make earlier use of their colleagues in allied health fields—social workers, registered dietitians, physiotherapists, occupational therapists, and speech and language pathologists. None of us can accomplish the American Society of Clinical Oncology’s vision alone.

As treatments in metastatic lung cancer continue to expand and improve, so too must the recognition and integration of palliative care.

CONFLICT OF INTEREST DISCLOSURES
We have read and understood Current Oncology's policy on disclosing conflicts of interest, and we declare that we have none.

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