**FAST FACTS AND CONCEPTS #124**
**THE PALLIATIVE PROGNOSTIC SCORE**
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**Background**     Accurate prognostic information is vital for patients, families and clinicians. This *Fast Fact* reviews the **Palliative Prognostic Score** (PaP); see *Fast Fact* #125 for information on the Palliative Performance Scale (PPS). The PaP uses the Karnofsky Performance Score (KPS) and five other criteria to generate a numerical score from 0 to 17.5 with specific cutoff values to assign patients to three risk groups according to a 30-day survival probability. Unlike many other validated prognostic scales, a significant scoring weight is given to the treating clinician's "gestault" survival prediction. Also, the PaP requires a full blood count for calculation, something which may not always be performed in palliative settings (especially home and inpatient hospice settings).

**Validation and Use of the PaP**     The PaP has been validated in large prospective studies in adult and pediatric oncology settings, as well as patients in inpatient hospices, inpatient palliative care units, and patients seen by palliative care consult teams. It has been shown to be reliable in various non-cancer diagnoses but large-scale validation studies have not been published.

| THE PALLIATIVE PROGNOSTIC SCORE (PaP) | | |
|---|---|---|
| **CRITERION** | **ASSESSMENT** | **PARTIAL SCORE** |
| Dyspnea | No<br>Yes | 0<br>1 |
| Anorexia | No<br>Yes | 0<br>1.5 |
| Karnofsky Performance Status | $\geq 30$<br>$10 - 20$ | 0<br>2.5 |
| Clinical Prediction of Survival (weeks) | > 12<br>11 – 12<br>7 – 10<br>5 – 6<br>3 – 4<br>1 – 2 | 0<br>2<br>2.5<br>4.5<br>6<br>8.5 |
| Total WBC (x10$^9$/ L) | $\leq 8.5$<br>8.6 – 11<br>>11 | 0<br>0.5<br>1.5 |
| Lymphocyte Percentage | 20 – 40 %<br>12 – 19.9 %<br>< 12 % | 0<br>1<br>2.5 |
| **RISK GROUP**<br>**A**<br>**B**<br>**C** | **30 DAY SURVIVAL**<br>**> 70 %**<br>**30 – 70 %**<br>**< 30 %** | **TOTAL SCORE**<br>**0 – 5.5**<br>**5.6 – 11**<br>**11.1 – 17.5** |

**Variant of the PaP Including Delirium (D-PaP)**    Since delirium has been shown to be a significant prognostic contributor, the D-PaP was developed to incorporate the clinical presence of delirium. Patients receive 2 extra points if a clinician determines that delirium is present utilizing the CAM algorithm. Therefore, the maximum score is 19.5 instead of 17.5. In a retrospective analysis of terminally ill cancer patients, the D-PaP performed slightly better than the PaP.

**Comparative Efficacy of the PaP**    There are a few retrospective and prospective studies comparing the PaP to other prognostic scoring systems (PPI, PPS, D-PaP).  These studies suggest that the PPI, D-PaP, and PaP all identify classes of patients with different survival probabilities with good accuracy. The PaP and D-PaP may be slightly more accurate among cancer patients admitted to a hospice unit, but larger studies are needed to validate this finding.

**References**

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**Version History**:  This *Fast Fact* was originally edited by David E Weissman MD and published in October 2004. Version re-copy-edited in April 2009; revised again in July 2015 – section on D-PaP added as well as references 5-8 were added and incorporated into the text.