Gaetano Lanzetta

Oncologia Medica
I.N.I. - Grottaferrata (RM)

SIMULTANEOUS CARE:

DAL SOGNO ALLA REALTÀ

Modulo dichiarazione conflitto di interessi

Tutti i rapporti finanziari intercorsi negli ultimi due anni devono essere dichiarati.

☐ Non ho rapporti (finanziari o di altro tipo) con le Aziende del farmaco

☒ Ho / ho avuto rapporti (finanziari o di altro tipo) con le Aziende del farmaco

Relationship	**Company/Organization**
Advisory Board , Speaker's fee	KYOWA KIRIN
Advisory Board	JANSSEN
Advisory Board	ITALFARMACO
Advisory Board	ASTELLAS

SIMULTANEOUS CARE : DAL SOGNO ALLA REALTA'

LA PROSPETTIVA E LE NECESSITÀ DELL'ONCOLOGO

A Transformative 20 Years

Verso il modello mutazionale

Modello Istologico

Modello Mutazionale

MEAs: 62

AIFA

Registries: 98

Regional oncology centers

MTB

AIFA

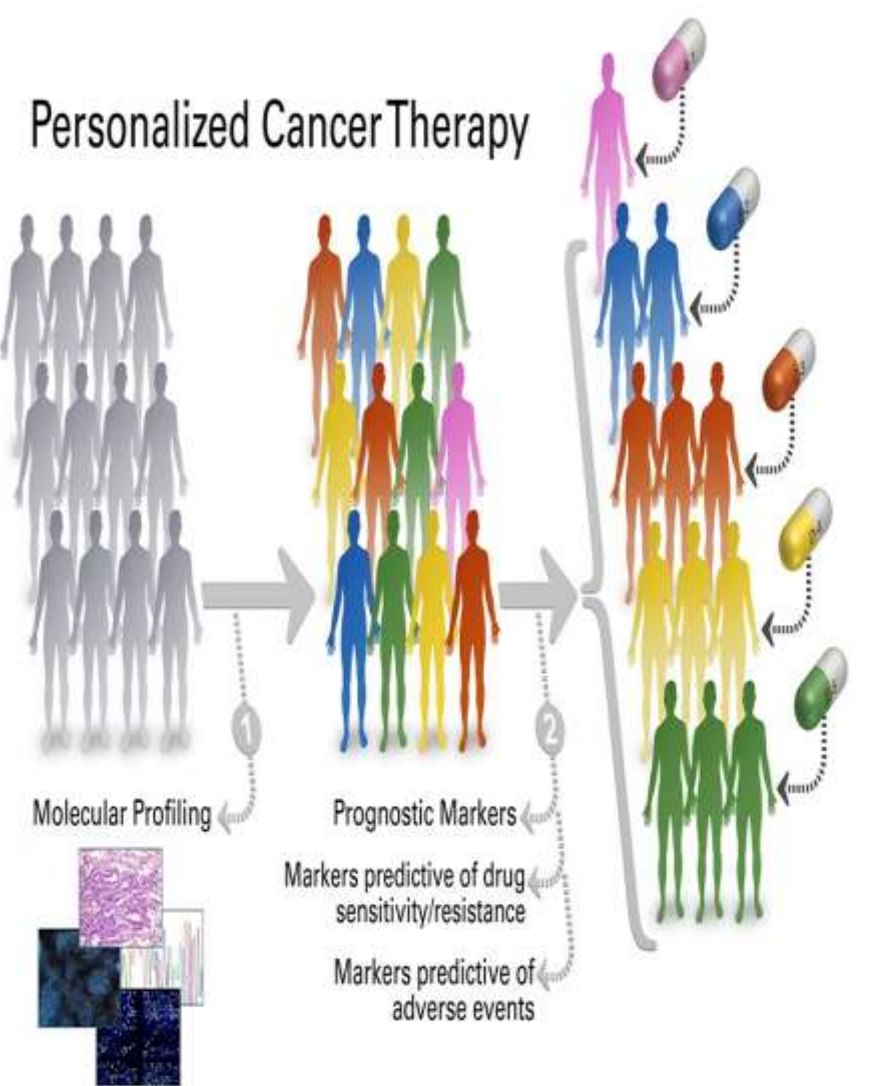
VCS

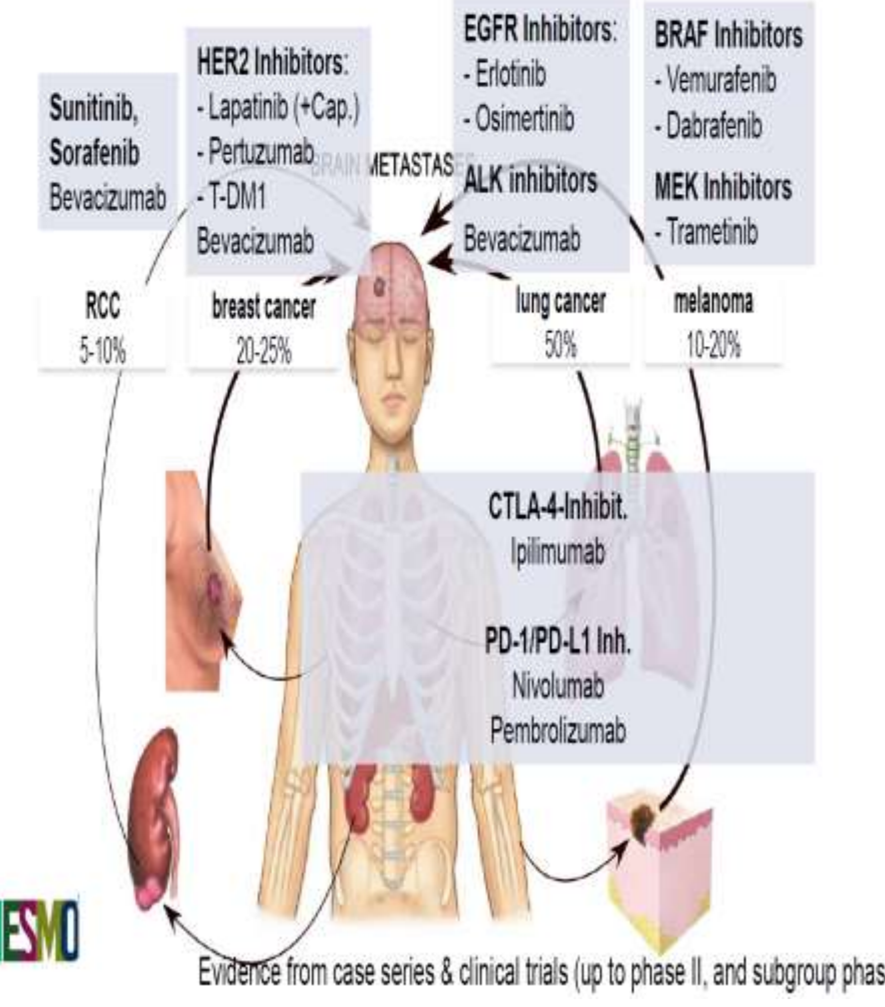
Regional cancer network

University Oncology Hospitals

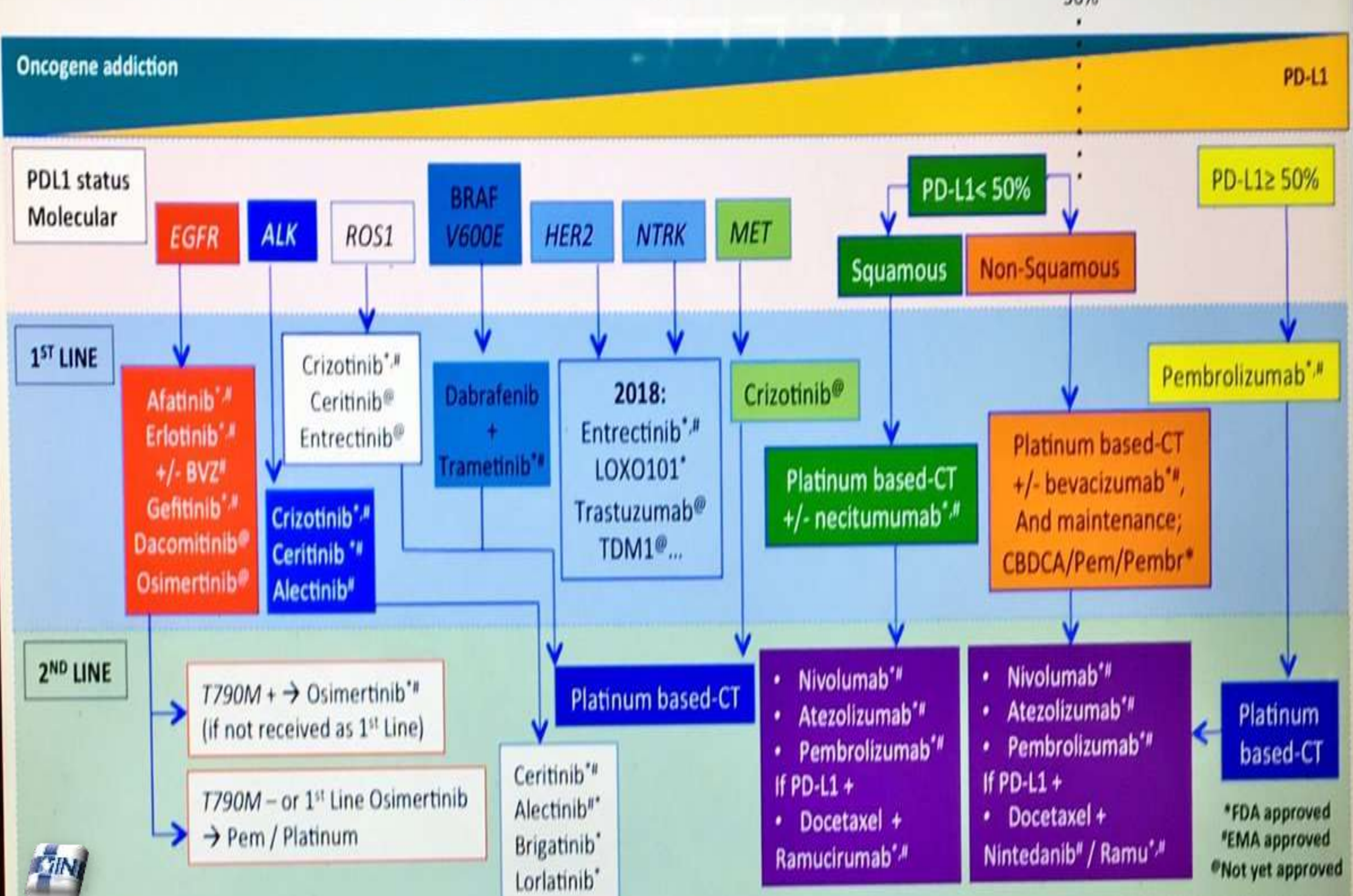
N. Martini, 2019

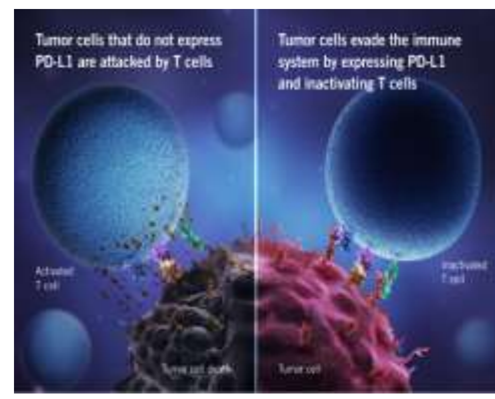
A Systems Approach to Refine Disease Taxonomy by Integrating Phenotypic and Molecular Networks

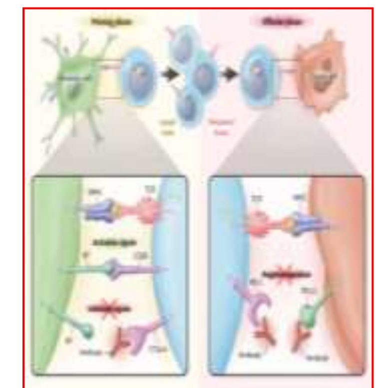

Personalized Cancer Therapy
Molecular Profiling
Prognostic Markers
Markers predictive of drug sensitivity/resistance
Markers predictive of adverse events


Sunitinib,
Sorafenib
Bevacizumab
HER2 Inhibitors:
- Lapatinib (+Cap.)
- Pertuzumab
- T-DM1
Bevacizumab
EGFR Inhibitors:
- Erlotinib
- Osimertinib
ALK inhibitors
Bevacizumab
BRAF Inhibitors
- Vemurafenib
- Dabrafenib
MEK Inhibitors
- Trametinib
BRAIN METASTASES
RCC
5-10%
breast cancer
20-25%
lung cancer
50%
melanoma
10-20%
CTLA-4-Inhibit.
Ipilimumab
PD-1/PD-L1 Inh.
Nivolumab
Pembrolizumab
MUNICH 2018 ESMO
Evidence from case series & clinical trials (up to phase II, and subgroup phase III)

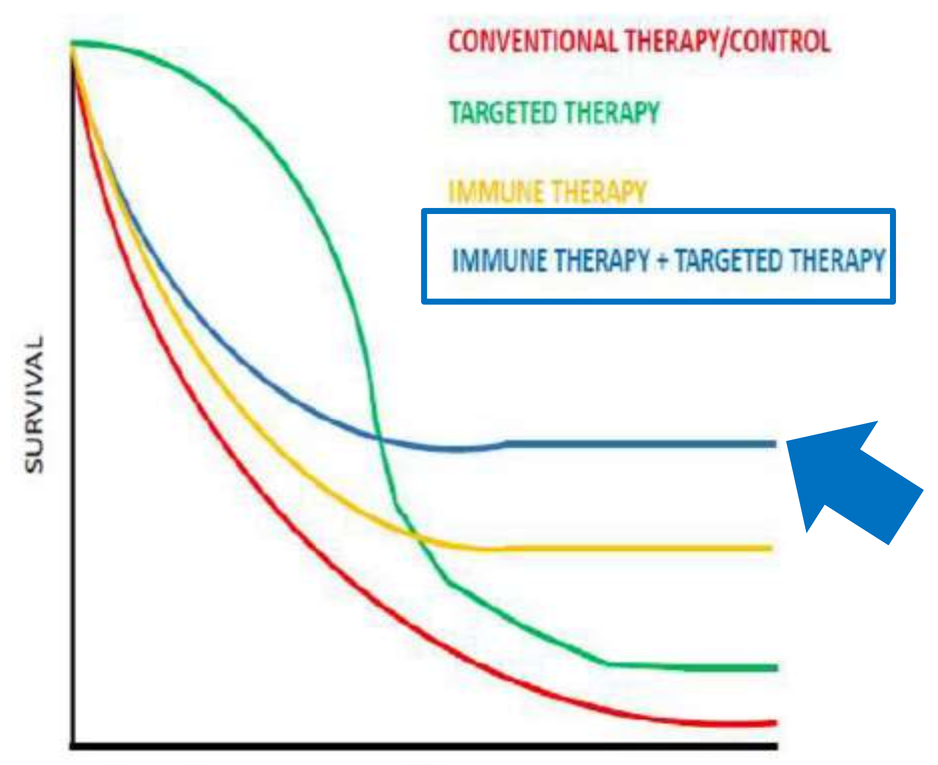
New treatment paradigm in NSCLC







Cambiamenti nell'efficacia delle terapie in oncologia



È in corso una **transizione epidemiologica e demografica**. Lo scenario attuale presenta:

1. **AUMENTO DELL'ASPETTATIVA DI VITA**
   Circa una anno in più ogni 4 anni. Nel 2050 più di un terzo della popolazione dell'UE avrà più di 60 anni
2. **AUMENTO DELLA PREVALENZA MALATTIE CRONICHE**
   In Italia ci si attende un numero di multicronici (chi soffre di almeno 3 malattie croniche) pari a quasi 13 milioni nel 2024
3. **SCARSITÀ DI RISORSE**
   Dal 2010 la spesa sanitaria in Italia è diminuita. Si prevede che nel 2019 scenderà al 6.5% del PIL

W. Ricciardi, L'Arco di Giano, n.89, 2016

FACING AVDVANCED CANCER IS….

Remission or death !!!

Only two options?

A third way should always exist:

living with disease

«..cancer isn't a war, there are no winners or losers..»

«..I can't cure you but I can help you control it..»

October 21, 2016

Identifying patients with advanced chronic conditions for a progressive palliative care approach: a cross-sectional study of prognostic indicators related to end-of-life trajectories

J Amblàs-Novellas,[1,2] S A Murray,[3] J Espaulella,[1,2] J C Martori,[4] R Oller,[4] M Martinez-Muñoz,[5] N Molist,[1,2] C Blay,[2,6] X Gómez-Batiste[2,7]

Time

Death

Function

\+

\-

Good health / non complex health conditions

Terminal care

SITUATIONAL DIAGNOSIS

(A) (B) (C) (D) (E)

KEY TRANSITIONS IN THE EOL

Transition 1

Transition 2

Early End-of-life Identification

END-OF-LIFE TRAJECTORIES associated with advanced chronic illnesses

Cancer Trajectory

Organ Failure Trajectory

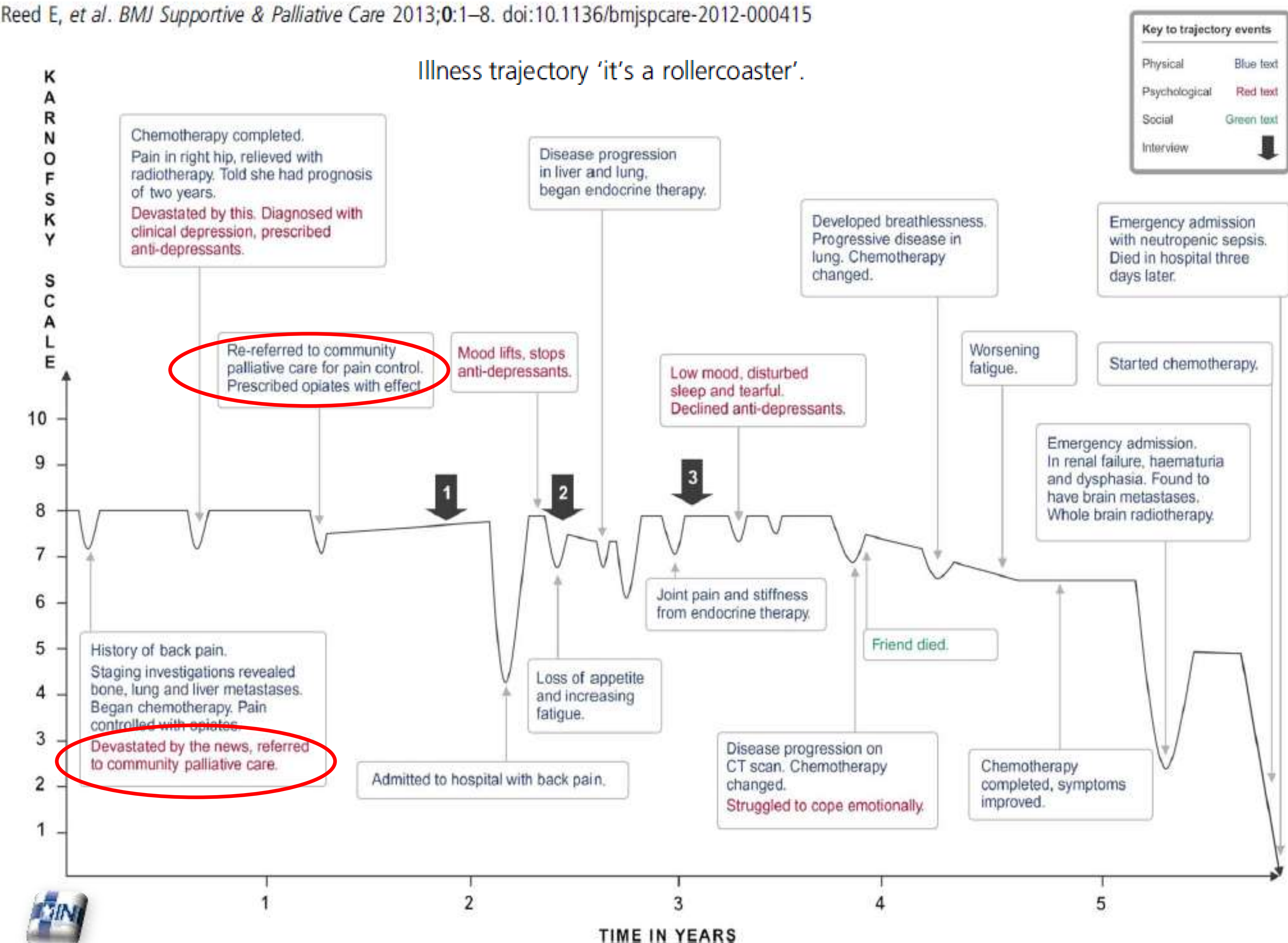
Dementia Trajectory

PROGRESSIVE CARE MODEL

Disease treatment / long term care

Palliative care approach

Reed E, et al. BMJ Supportive & Palliative Care 2013;0:1–8. doi:10.1136/bmjspcare-2012-000415



The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

Early Specialty Palliative Care — Translating Data in Oncology into Practice

Ravi B. Parikh, A.B., Rebecca A. Kirch, J.D., Thomas J. Smith, M.D., and Jennifer S. Temel, M.D.

Traditional Palliative Care

Life-prolonging or curative treatment

Palliative care to manage symptoms and improve quality of life

Diagnosis

Death

Early Palliative Care

Life-prolonging or curative treatment

Palliative care to manage symptoms and improve quality of life

Diagnosis

Death

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A.,
Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H.,
Vicki A. Jackson, M.D. ... Constance M. Dahlin, A.P.N.,
Craig D. Blinderman ... M.D., William F. Pirl, M.D., M.P.H.,
Thomas J. Lynch, M.D.

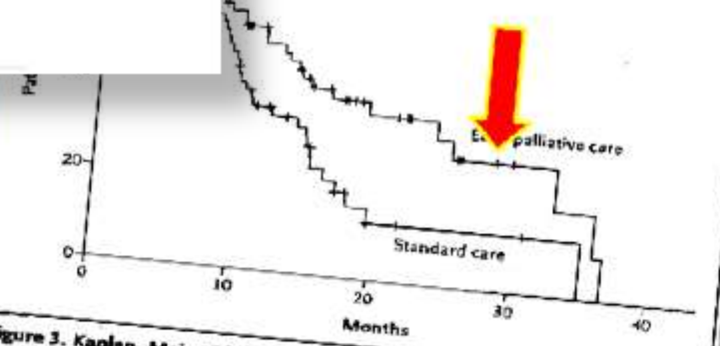
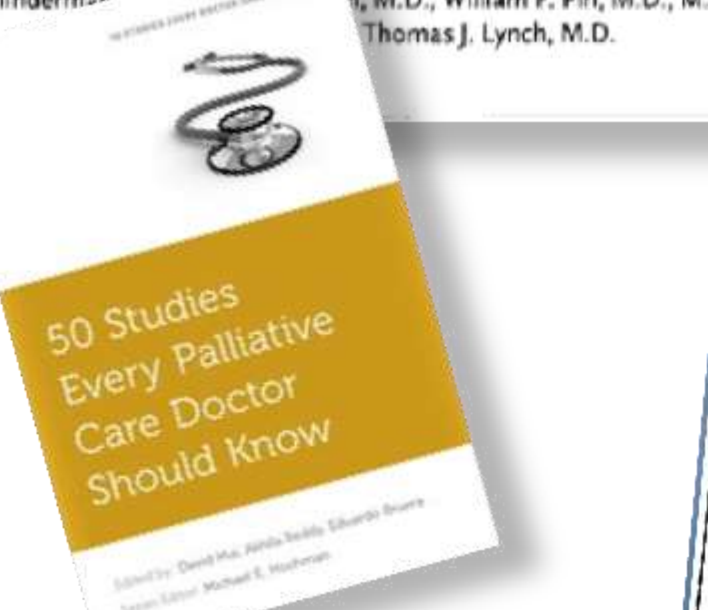


Figure 3. Kaplan–Meier Estimates of Survival According to Study Group.
Survival was calculated from the time of enrollment to the time of death, if it occurred during the study period, or to the time of censoring of data on December 1, 2009. Median estimates of survival were as follows: 9.8 months (95% confidence interval [CI], 7.9 to 11.7) in the entire sample (151 patients), 11.6 months (95% CI, 6.4 to 16.9) in the group assigned to early palliative care (77 patients), and 8.9 months (95% CI, 6.3 to 11.4) in the standard care group (74 patients) (P=0.02 with the use of the log-rank test). After adjustment for age, sex, and baseline Eastern Cooperative Oncology Group performance status, the group assignment remained a significant predictor of survival (hazard ratio for death in the standard care group, 1.70; 95% CI, 1.14 to 2.54; P=0.01). Tick marks indicate censoring of data.



N Engl J Med 363;8 August 19, 2010

The NEW ENGLAND JOURNAL of MEDICINE

N Engl J Med 2010;363:733-42.

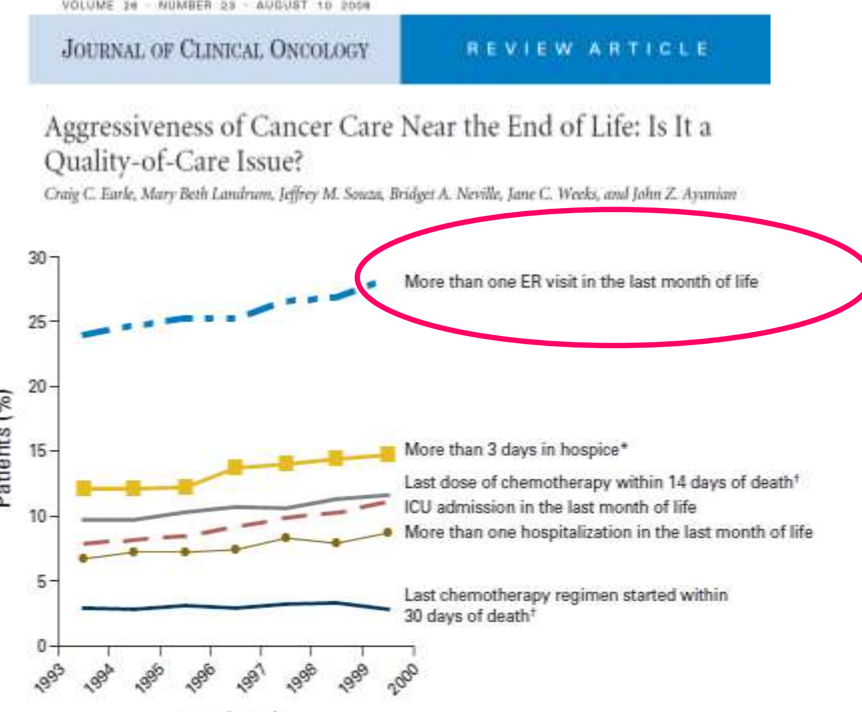
ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

…We hypothesized that patients who received ***early palliative care****, as compared with patients who received standard oncologic care, would have a…*

1. **Better quality of life**
2. **Lower rates of depressive symptoms,**
3. **Less aggressive *end-of-life care*.**



VOLUME 35 · NUMBER 1 · JANUARY 1, 2017

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update

Betty R. Ferrell, Jennifer S. Temel, Sarah Temin, Erin R. Alesi, Tracy A. Balboni, Ethan M. Basch, Janice I. Firn, Judith A. Paice, Jeffrey M. Peppercorn, Tanyanika Phillips, Ellen L. Stovall,† Camilla Zimmermann, and Thomas J. Smith

Recommendations

Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services.

Early palliative care for adults with advanced cancer (Review)

Haun MW, Estel S, Rücker G, Friederich HC, Villalobos M, Thomas M, Hartmann M

Primary outcome: QoL

Figure 4. Forest plot of comparison: 1 Health-related quality of life, outcome: 1.1 Health-related quality of life.

Study or Subgroup	Std. Mean Difference	SE	EPC Total	TAU Total	Weight	Std. Mean Difference IV, Random, 95% CI
1.1.1 Co-ordinated care model						
Bakitas 2009	0.27	0.12	145	134	24.5%	0.27 [0.03, 0.51]
Bakitas 2015	0.19	0.16	72	83	13.8%	0.19 [-0.12, 0.50]
McCorkle 2015	-0.04	0.28	23	28	4.5%	-0.04 [-0.59, 0.51]
Subtotal (95% CI)			**240**	**245**	**42.7%**	**0.21 [0.03, 0.39]**
Heterogeneity: Tau² = 0.00; Chi² = 1.06, df = 2 (P = 0.59); I² = 0%						
Test for overall effect: Z = 2.33 (P = 0.02)						
1.1.2 Integrated care model						
Maltoni 2016	0.33	0.18	64	65	10.9%	0.33 [-0.02, 0.68]
Tattersall 2014	0.06	0.39	13	13	2.3%	0.06 [-0.70, 0.82]
Temel 2010	0.52	0.2	60	47	8.8%	0.52 [0.13, 0.91]
Zimmermann 2014	0.26	0.1	140	141	35.2%	0.26 [0.06, 0.46]
Subtotal (95% CI)			**277**	**266**	**57.3%**	**0.31 [0.15, 0.46]**
Heterogeneity: Tau² = 0.00; Chi² = 1.77, df = 3 (P = 0.62); I² = 0%						
Test for overall effect: Z = 3.89 (P = 0.0001)						
Total (95% CI)			**517**	**511**	**100.0%**	**0.27 [0.15, 0.38]**
Heterogeneity: Tau² = 0.00; Chi² = 3.44, df = 6 (P = 0.75); I² = 0%						
Test for overall effect: Z = 4.47 (P < 0.00001)						
Test for subgroup differences: Chi² = 0.61, df = 1 (P = 0.44), I² = 0%						

Std. Mean Difference IV, Random, 95% CI

-1 -0.5 0 0.5 1

Treatment as usual Early palliative care

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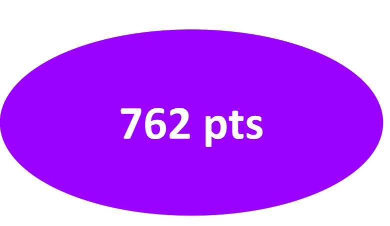

Early palliative care for adults with advanced cancer (Review)

Haun MW, Estel S, Rücker G, Friederich HC, Villalobos M, Thomas M, Hartmann M

Figure 6. Forest plot of comparison: 1 Early palliative care vs standard oncological care, outcome: 1.2 Depression.

Study or Subgroup	Std. Mean Difference	SE	Treatment as usual Total	Early palliative care Total	Weight	Std. Mean Difference IV, Random, 95% CI
1.2.1 Co-ordinated care model						
Bakitas 2009	-0.15	0.12	134	145	39.2%	-0.15 [-0.39, 0.09]
Bakitas 2015	0.06	0.16	83	72	22.1%	0.06 [-0.25, 0.37]
McCorkle 2015	0.11	0.28	56	36	7.2%	0.11 [-0.44, 0.66]
Subtotal (95% CI)			**273**	**253**	**68.5%**	**-0.06 [-0.23, 0.12]**
Heterogeneity: Tau² = 0.00; Chi² = 1.49, df = 2 (P = 0.47); I² = 0%						
Test for overall effect: Z = 0.61 (P = 0.54)						
1.2.2 Integrated care model						
Maltoni 2016	-0.25	0.18	65	64	17.4%	-0.25 [-0.60, 0.10]
Temel 2010	-0.23	0.2	47	60	14.1%	-0.23 [-0.62, 0.16]
Subtotal (95% CI)			**112**	**124**	**31.5%**	**-0.24 [-0.50, 0.02]**
Heterogeneity: Tau² = 0.00; Chi² = 0.01, df = 1 (P = 0.94); I² = 0%						
Test for overall effect: Z = 1.80 (P = 0.07)						
Total (95% CI)			**385**	**377**	**100.0%**	**-0.11 [-0.26, 0.03]**
Heterogeneity: Tau² = 0.00; Chi² = 2.82, df = 4 (P = 0.59); I² = 0%						
Test for overall effect: Z = 1.51 (P = 0.13)						
Test for subgroup differences: Chi² = 1.32, df = 1 (P = 0.25), I² = 24.5%						

Std. Mean Difference IV, Random, 95% CI: -1, -0.5, 0, 0.5, 1 — Early palliative care / Treatment as usual

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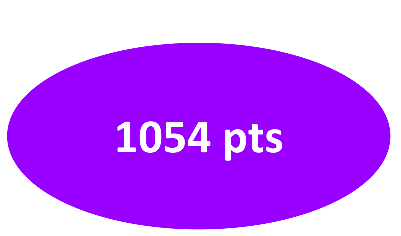


Early palliative care for adults with advanced cancer (Review)

Haun MW, Estel S, Rücker G, Friederich HC, Villalobos M, Thomas M, Hartmann M

Primary outcome: symptom intensity

Figure 7. Forest plot of comparison: 1 Early palliative care vs standard oncological care, outcome: 1.4 Symptom intensity.

Study or Subgroup	Std. Mean Difference	SE	Early palliative care Total	Treatment as usual Total	Weight	Std. Mean Difference IV, Random, 95% CI
1.4.1 Co-ordinated care model						
Bakitas 2009	-0.22	0.12	145	134	27.8%	-0.22 [-0.46, 0.02]
Bakitas 2015	-0.3	0.16	72	83	15.7%	-0.30 [-0.61, 0.01]
McCorkle 2015	0.05	0.33	30	28	3.7%	0.05 [-0.60, 0.70]
Subtotal (95% CI)			**247**	**245**	**47.2%**	**-0.23 [-0.41, -0.04]**
Heterogeneity: Tau² = 0.00; Chi² = 0.92, df = 2 (P = 0.63); I² = 0%						
Test for overall effect: Z = 2.45 (P = 0.01)						
1.4.2 Integrated care model						
Maltoni 2016	-0.38	0.18	64	65	12.4%	-0.38 [-0.73, -0.03]
Tattersall 2014	0.2	0.39	13	13	2.6%	0.20 [-0.56, 0.96]
Temel 2010	-0.42	0.2	60	47	10.0%	-0.42 [-0.81, -0.03]
Zimmermann 2014	-0.13	0.12	151	149	27.8%	-0.13 [-0.37, 0.11]
Subtotal (95% CI)			**288**	**274**	**52.8%**	**-0.23 [-0.43, -0.04]**
Heterogeneity: Tau² = 0.01; Chi² = 3.51, df = 3 (P = 0.32); I² = 14%						
Test for overall effect: Z = 2.37 (P = 0.02)						
Total (95% CI)			**535**	**519**	**100.0%**	**-0.23 [-0.35, -0.10]**
Heterogeneity: Tau² = 0.00; Chi² = 4.42, df = 6 (P = 0.62); I² = 0%						
Test for overall effect: Z = 3.58 (P = 0.0004)						
Test for subgroup differences: Chi² = 0.00, df = 1 (P = 0.95), I² = 0%						

Std. Mean Difference IV, Random, 95% CI

-1 -0.5 0 0.5 1

Early palliative care | Treatment as usual

Early palliative care for adults with advanced cancer (Review)

Haun MW, Estel S, Rücker G, Friederich HC, Villalobos M, Thomas M, Hartmann M

Primary outcome: survival (death hazard ratio)

Figure 5. Forest plot of comparison: 1 Early palliative care vs TAU, outcome: 1.2 Survival.

Study or Subgroup	log[Hazard Ratio]	SE	Treatment as usual Total	Early palliative care Total	Weight	Hazard Ratio IV, Random, 95% CI
Bakitas 2009	-0.22	0.15	161	161	26.8%	0.80 [0.60, 1.08]
Bakitas 2015	-0.45	0.21	103	104	23.7%	0.64 [0.42, 0.96]
Tattersall 2014	0.47	0.19	60	60	24.8%	1.60 [1.10, 2.32]
Temel 2010	-0.46	0.19	74	77	24.8%	0.63 [0.44, 0.92]
Total (95% CI)			**398**	**402**	**100.0%**	**0.85 [0.56, 1.28]**

Heterogeneity: $Tau^2 = 0.14$; $Chi^2 = 15.55$, df = 3 (P = 0.001); $I^2 = 81\%$

Test for overall effect: Z = 0.78 (P = 0.43)

Hazard Ratio IV, Random, 95% CI: 0.5, 0.7, 1, 1.5, 2 — Early palliative care | Treatment as usual

Overall survival results of a randomized trial assessing patient-reported outcomes for symptom monitoring during routine cancer treatment (NCT00578006)

Ethan Basch, Allison Deal, Amylou Dueck, Antonia Bennett, Thomas Atkinson, Howard Scher, Mark Kris, Clifford Hudis, Paul Sabbatini, Dorothy Dulko, Lauren Rogak, Allison Barz, Deborah Schrag

From: Lineberger Comprehensive Cancer Center, University of North Carolina; Memorial Sloan Kettering Cancer Center; Mayo Clinic; Dana-Farber Cancer Institute

ASCO ANNUAL MEETING '17 #ASCO17

Background

- Symptoms are common in advanced cancer
  - Interfere with daily activities
  - Frequently lead to ER and hospital visits
- Symptom management is a cornerstone of oncology practice

Study Design

Patients receiving chemotherapy for metastatic breast, lung, GU, GYN cancer at MSKCC

RANDOMIZE

INTERVENTION ARM
Self-report 12 common symptoms
- Prior to / between visits, by web
- Weekly email reminders to patients
- Alerts to nurses (by email)
- Reports to oncologists (at visits)

CONTROL ARM
"Standard" symptom monitoring

Outcomes
- QOL
- ER visits
- Survival

Stratified by level of prior computer use
Randomized 2:1 for those w/o prior use

Treatment discontinuation, withdrawal, hospice, death

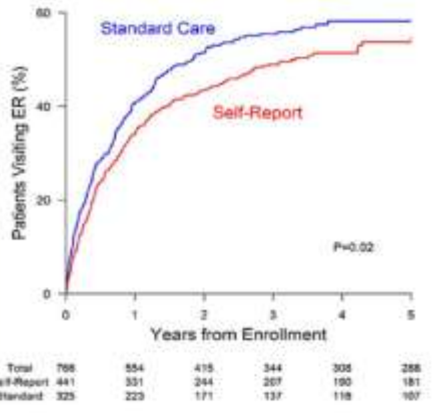
Quality of Life

- Assessed at 6 months, compared to baseline
- Compared to standard care, 31% more patients in the self-reporting arm experienced QOL benefits (*P*<*0.001*)

Basch: J Clin Oncol 2016;34:557-565

Proportion of Patients Visiting Emergency Room

- Compared to standard care, 7% fewer patients in the self-reporting arm visited the ER, with durable effects throughout the study (*P=0.02*)



Overall Survival

- Compared to standard care, median survival was 5 months longer among patients in the self-reporting arm (31.2 vs. 26.0 months) (*P=0.03*)
- Remained significant in multivariable analysis: Adjusted hazard ratio 0.832 (*95% CI; 0.696, 0.995*)

What is the evidence for integrated oncology and palliative care? (1)

- Improved symptom control
- Improved patients' QoL
- Reduced "futile" chemotherapy last 30-60 days of life
- Improved survival

Bakitas 2009-2015
Temel 2010-2017
Zimmermann 2014
Vanbutsele 2018
Basch 2018

What is the evidence for integrated oncology and palliative care? (2)

- Satisfaction with care – patients are more satisfied with the health care delivered
- Family satisfaction and QOL is improved
- Place of care – place of death - more patients are at home

VOLUME 33 · NUMBER 13 · MAY 1 2015

JOURNAL OF CLINICAL ONCOLOGY

EDITORIAL

Palliative Care: If It Makes a Difference, Why Wait?

Barbara Gomes, *King's College London, Cicely Saunders Institute, London, United Kingdom*

See accompanying articles on pages 1438 and 1446

VOLUME 33 · NUMBER 13 · MAY 1 2015

JOURNAL OF CLINICAL ONCOLOGY E D I T O R I A L

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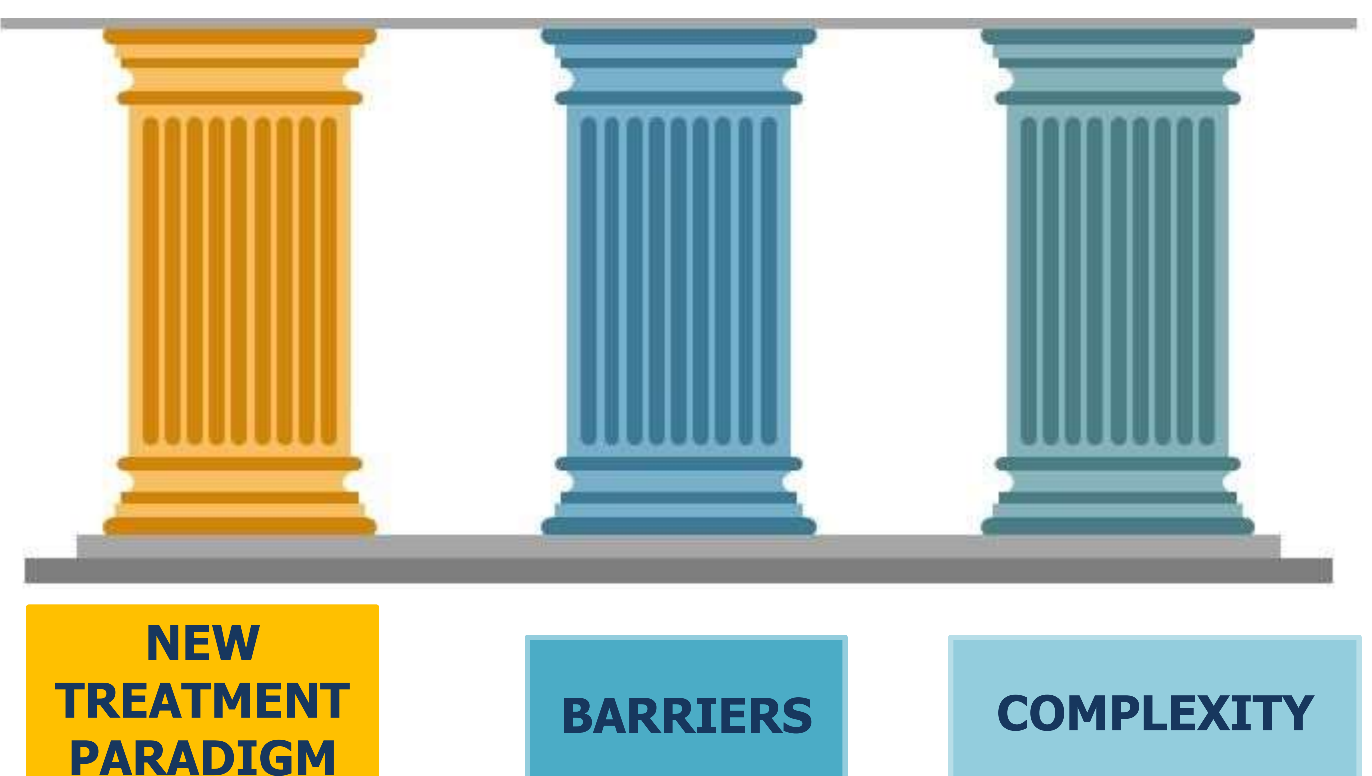
Barbara Gomes, *King's College London, Cicely Saunders Institute, London, United Kingdom*

See accompanying articles on pages 1438 and 1446



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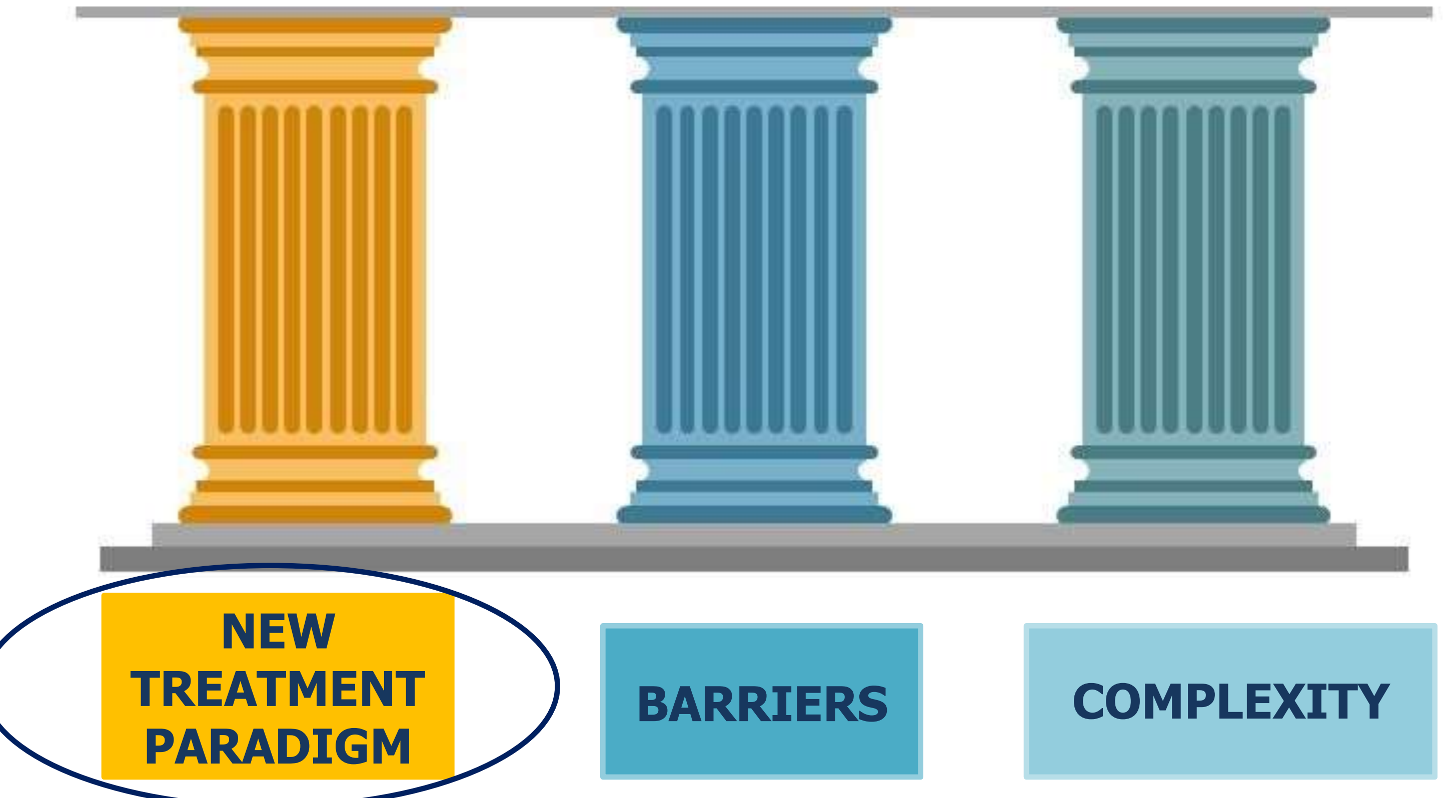
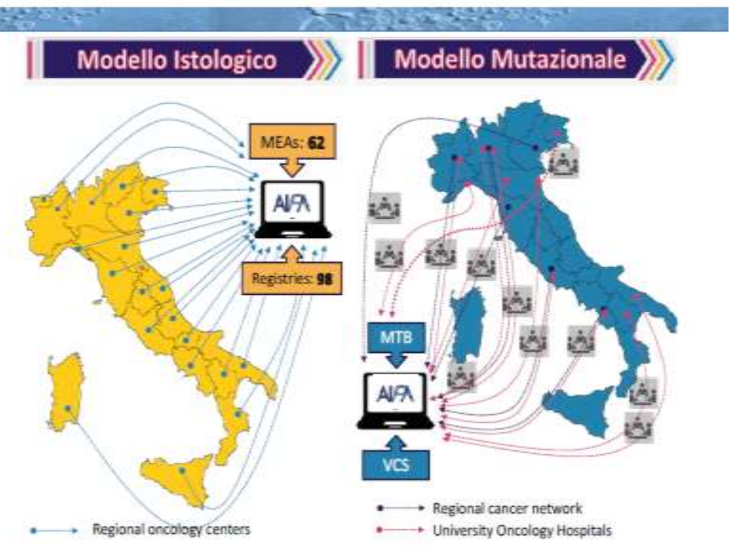


NEW TREATMENT PARADIGM

Verso il modello mutazionale



N. Martini, 2019

Modello Istologico	Modello Mutazionale
Istologia	NGS
Popolazione - Biomarker	Farmaco
Farmaco	Indicazione
Indicazioni	Indipendentemente dalla sede del tumore
Quando un marcatore definisce l'indicazione terapeutica...	

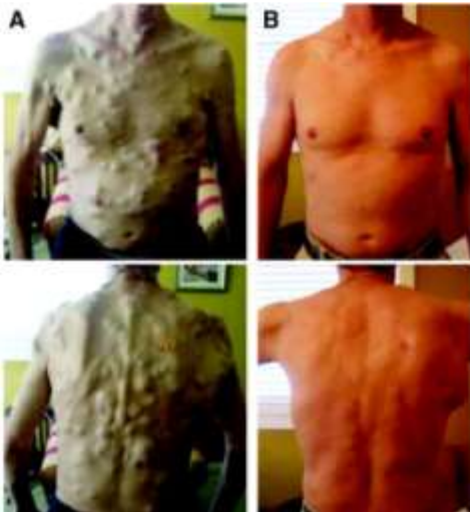
N. Martini, 2019

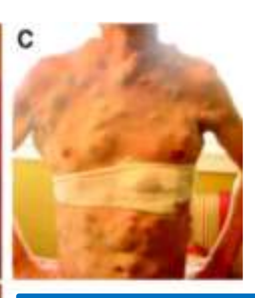
New Challenges in Cancer

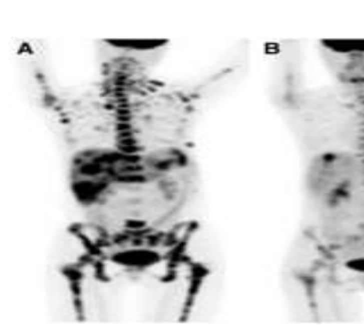
Care It is more complicated and time consuming to care for patients with cancer with "personalized medicine".
Care has simply become more complex as there is not a "standard chemotherapy regimen".
Assessing patients for genotype-directed treatment and immunotherapy and managing patients on complex clinic trials requires significant time.

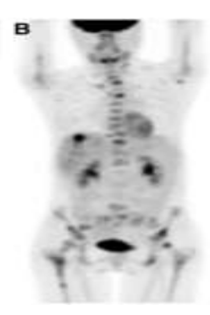
Il *Molecular Tumor Board* in oncologia

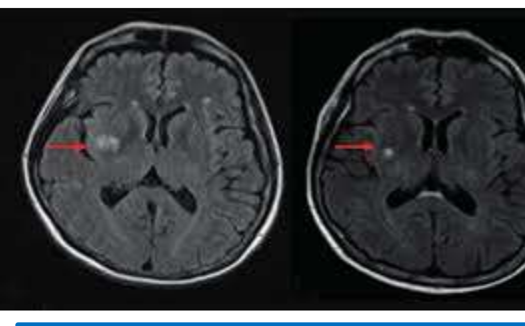
NEW TREATMENT PARADIGM



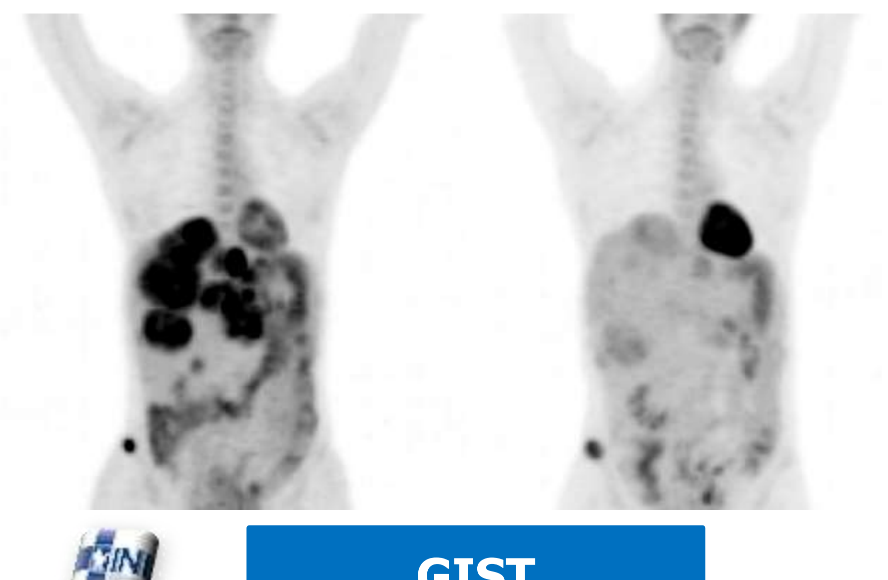




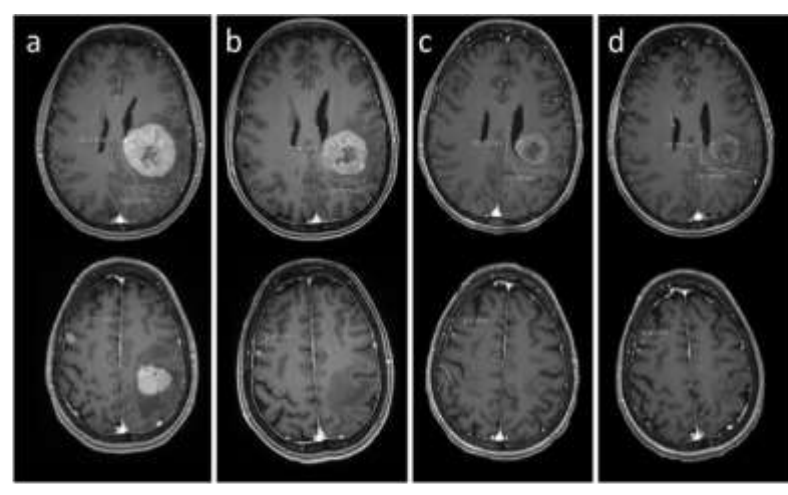




BREAST HER2+

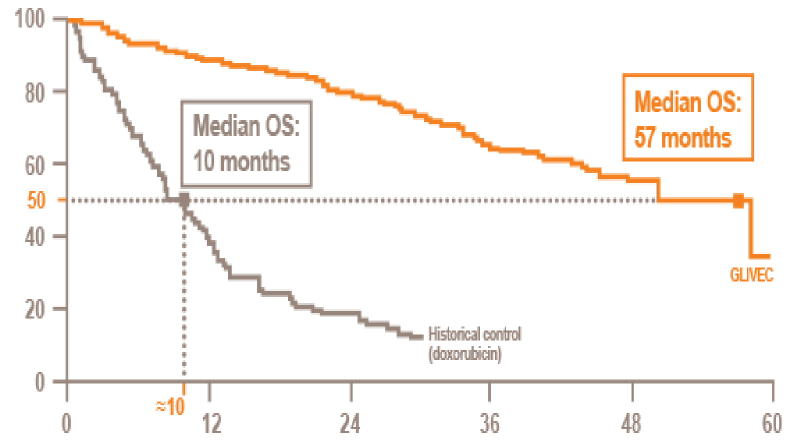


GIST

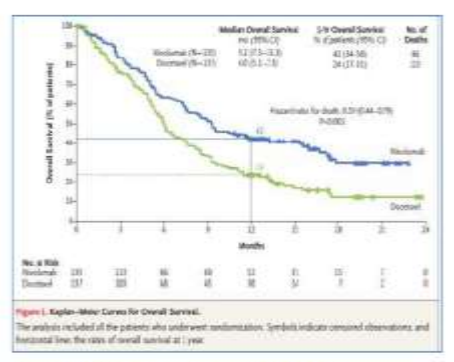


NSCLC

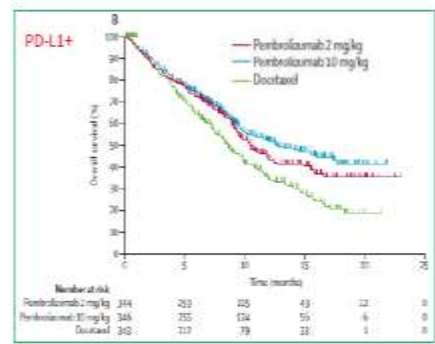
NEW TREATMENT PARADIGM



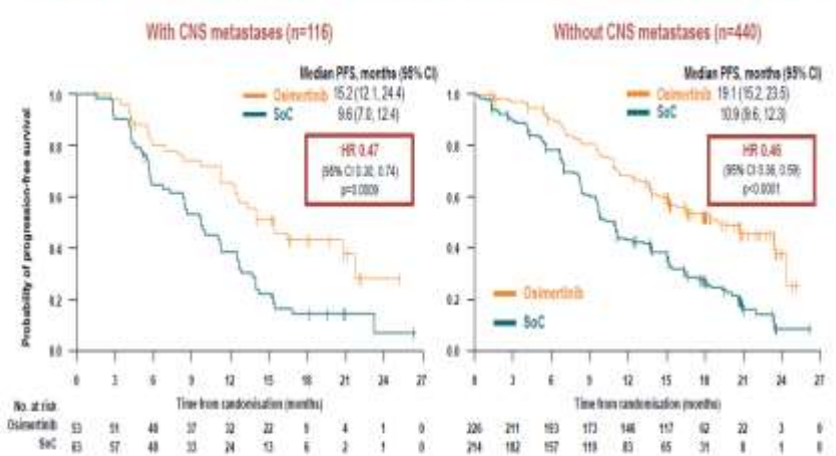
Immune checkpoints inhibitors vs docetaxel for previously treated NSCLC

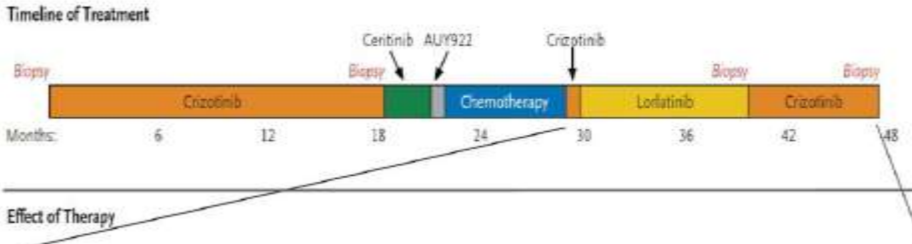


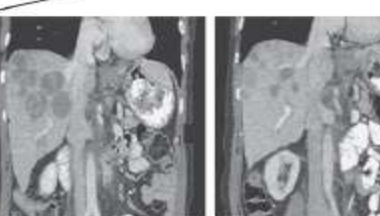
NIVOLUMAB- Brahmer J et al, NEJM 2015



PEMBROLIZUMAB in PD-L1 positive- Herbst RS et al,

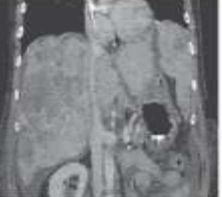




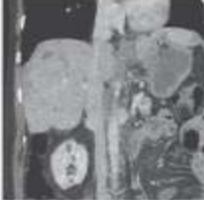


Before Lorlatinib

Response to Lorlatinib



Resistance to Lorlatinib



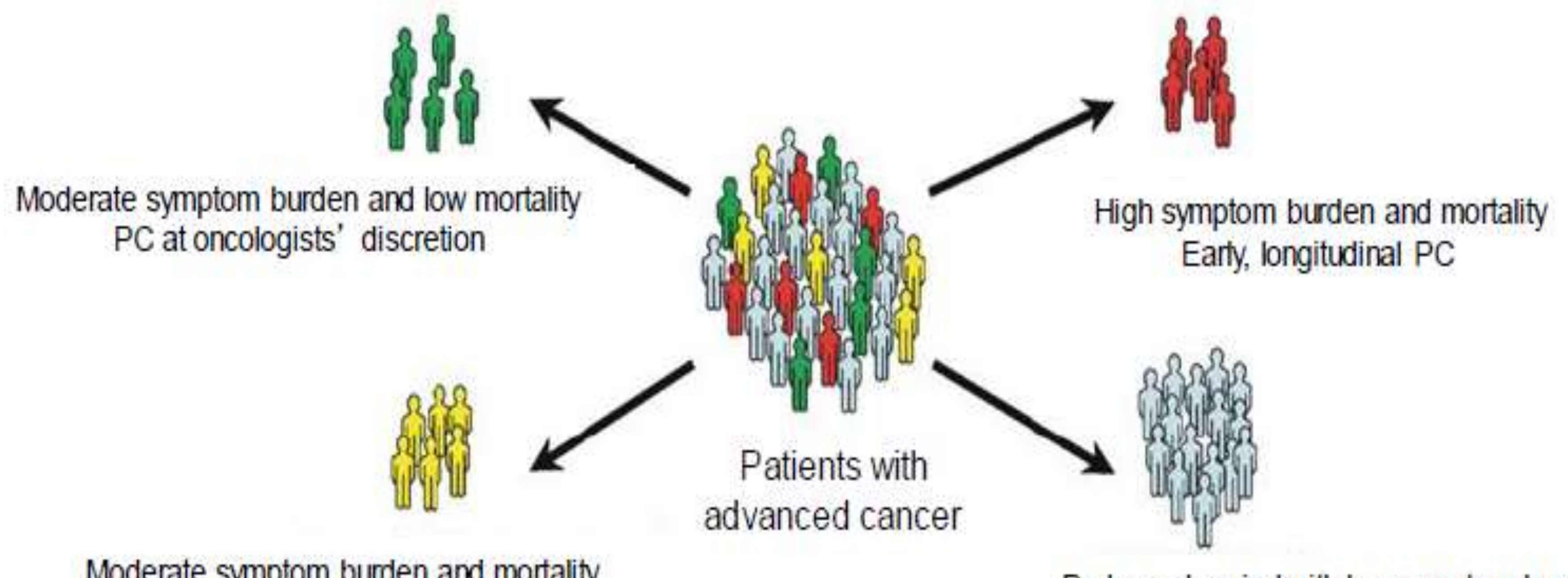
Response to Crizotinib

Resensitization to Crizotinib by the Lorlatinib ALK Resistance Mutation L1198F

Alice T. Shaw, M.D., Ph.D.,

Key Unanswered Questions

Is early palliative care for patients with advanced cancers a one-size-fits all?



VOLUME 33 · NUMBER 13 · MAY 1 2015
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Palliative Care: If It Makes a Difference, Why Wait?

Barbara Gomes, *King's College London, Cicely Saunders Institute, London, United Kingdom*

See accompanying articles on pages 1438 and 1446

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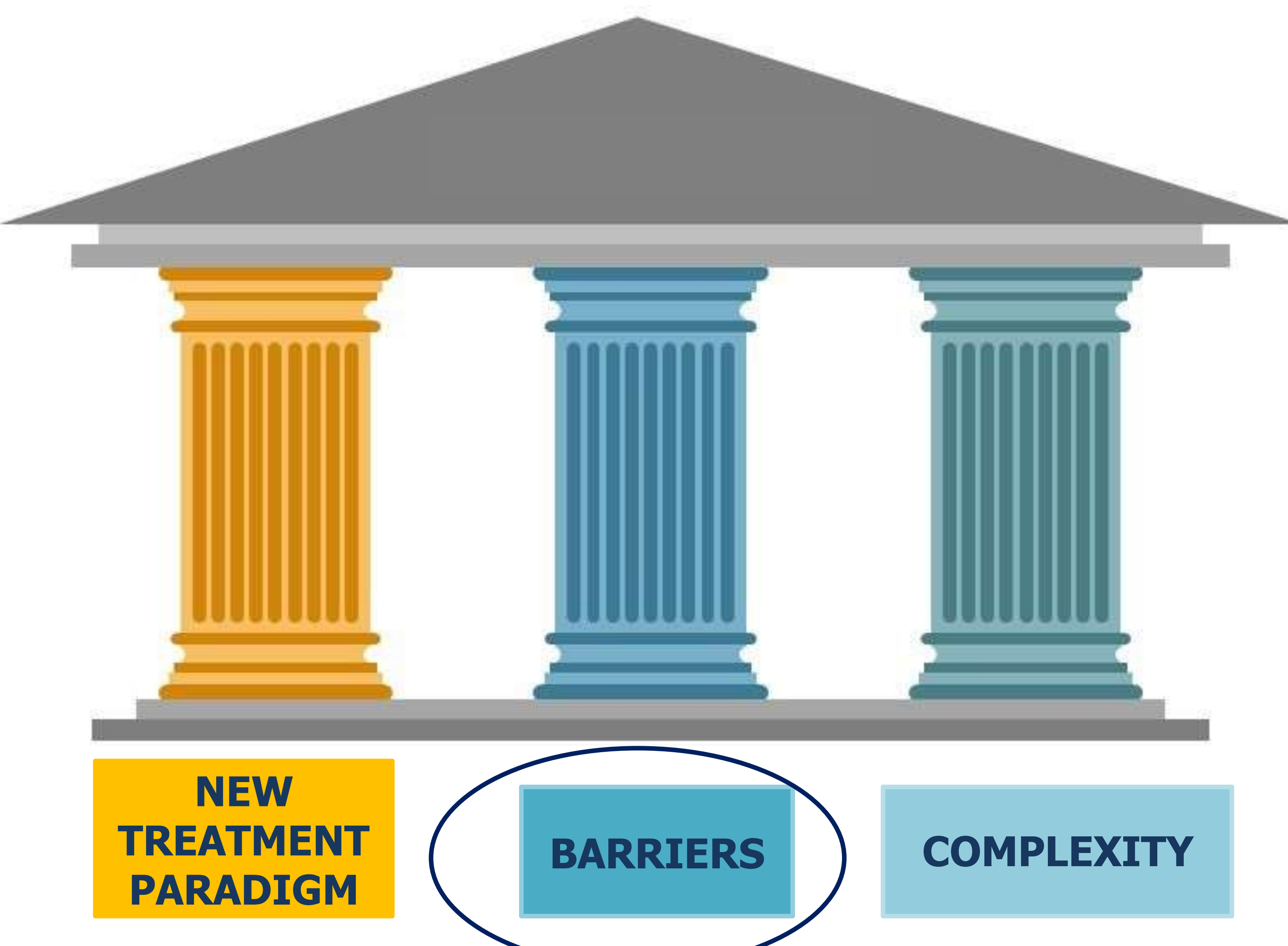

Supportive Versus Palliative Care: What's in a Name?

A Survey of Medical Oncologists and Midlevel Providers at a Comprehensive Cancer Center

Nada Fadul, MD, Ahmed Elsayem, MD, J. Lynn Palmer, PhD, Egidio Del Fabbro, MD, Kay Swint, MSN, BSN, Zhijun Li, MS, Valerie Poulter, BSN, OCN, and Eduardo Bruera, MD

JOURNAL OF PALLIATIVE MEDICINE
Volume XX, Number XX, 2019
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DOI: 10.1089/jpm.2018.0338

Original Article

Understanding the Barriers to Introducing Early Palliative Care for Patients with Advanced Cancer: A Qualitative Study

Aline Sarradon-Eck, MD, PhD,[1,2] Sylvain Besle, PhD,[1,3] Jaïs Troian, MSc,[4]
Géraldine Capodano, MD,[5] and Julien Mancini, MD, PhD[6]

Filling the Gap: Creating an Outpatient Palliative Care Program in Your Institution

Esme Finlay, MD, Michael W. Rabow, MD, and Mary K. Buss, MD, MPH

Supportive Versus Palliative Care: What's in a Name?

Cancer May 1, 2009

A Survey of Medical Oncologists and Midlevel Providers at a Comprehensive Cancer Center

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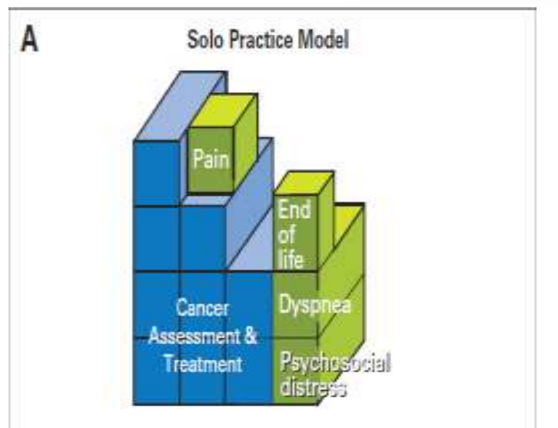
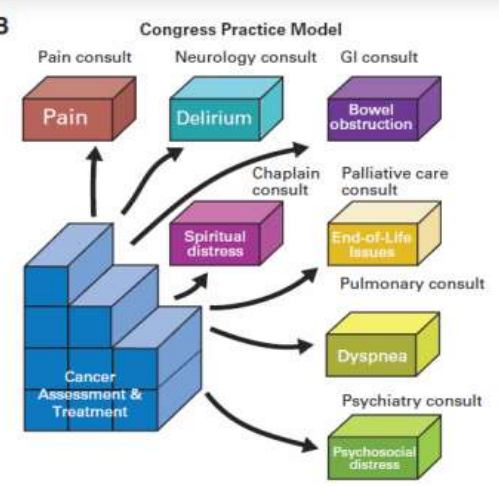
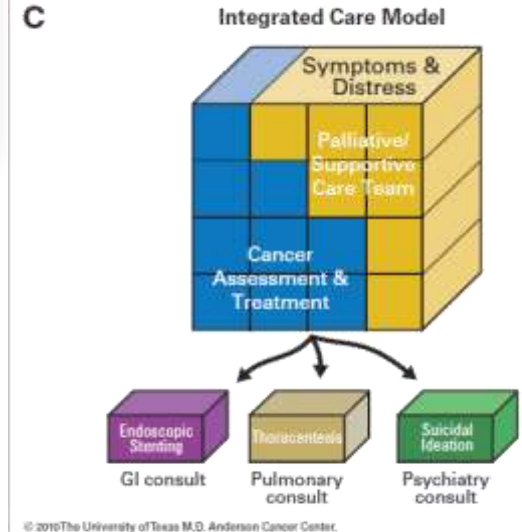
. **RESULTS:** A total of 140 of 200 (70%) participants responded (74 midlevel providers and 66 medical oncologists). Median age was 43 years (range, 34.5-50 years), and there were 83 (60%) women. Midlevel providers and medical oncologists generally agreed in their responses to most of the items. More participants preferred the name *supportive care* (80, 57%) compared with *palliative care* (27, 19% $P < .0001$). Medical oncologists and midlevel providers stated increased likelihood to refer patients on active primary (79 vs 45%, $P < .0001$) and advanced cancer (89 vs 69%, $P < .0001$) treatments to a service named *supportive care*. The name *palliative care* compared with *supportive care* was perceived more frequently by medical oncologists and midlevel providers as a barrier to referral (23 vs 6% $P < .0001$), decreasing hope (44 vs 11% $P < .0001$), and causing distress (33 vs 3% $P < .0001$) in patients and families. There were no significant associations among the perception of the 2 names and age ($P = .82$), sex ($P = .35$), or prior training in palliative care ($P > .99$). **CONCLUSIONS:** The name *palliative care* was perceived by medical oncologists and midlevel providers as more distressing and reducing hope to patients and families. Medical oncologists and midlevel providers significantly prefer the name *supportive care* and stated more likelihood to refer patients on active primary and advanced cancer treatments to a service named *supportive care*. **Cancer 2009;115:2013-21.** **© 2009 American Cancer Society.**

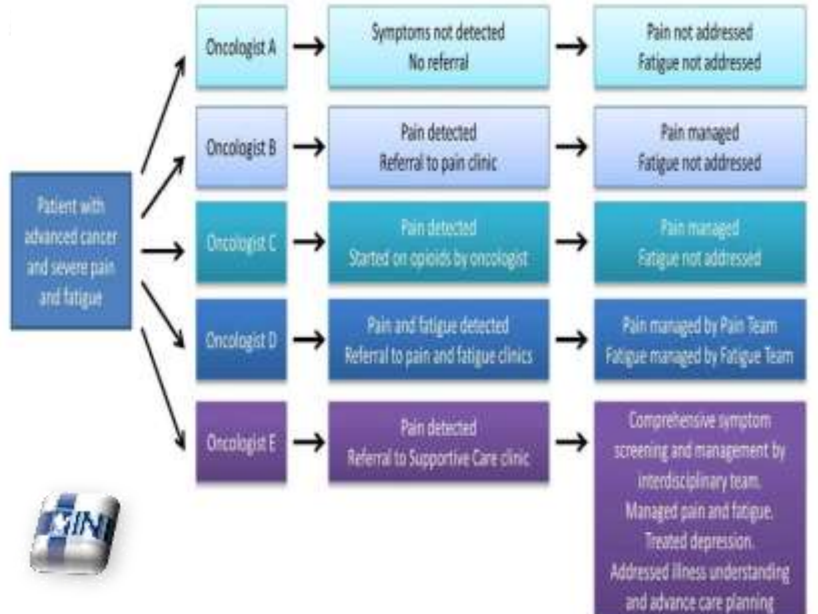
JOURNAL OF CLINICAL ONCOLOGY THE ART OF ONCOLOGY

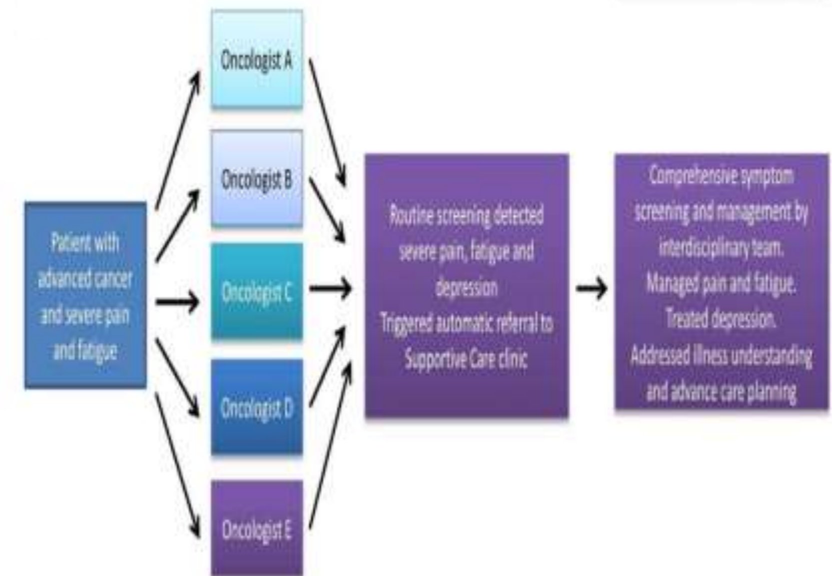
Integrating Supportive and Palliative Care in the Trajectory of Cancer: Establishing Goals and Models of Care





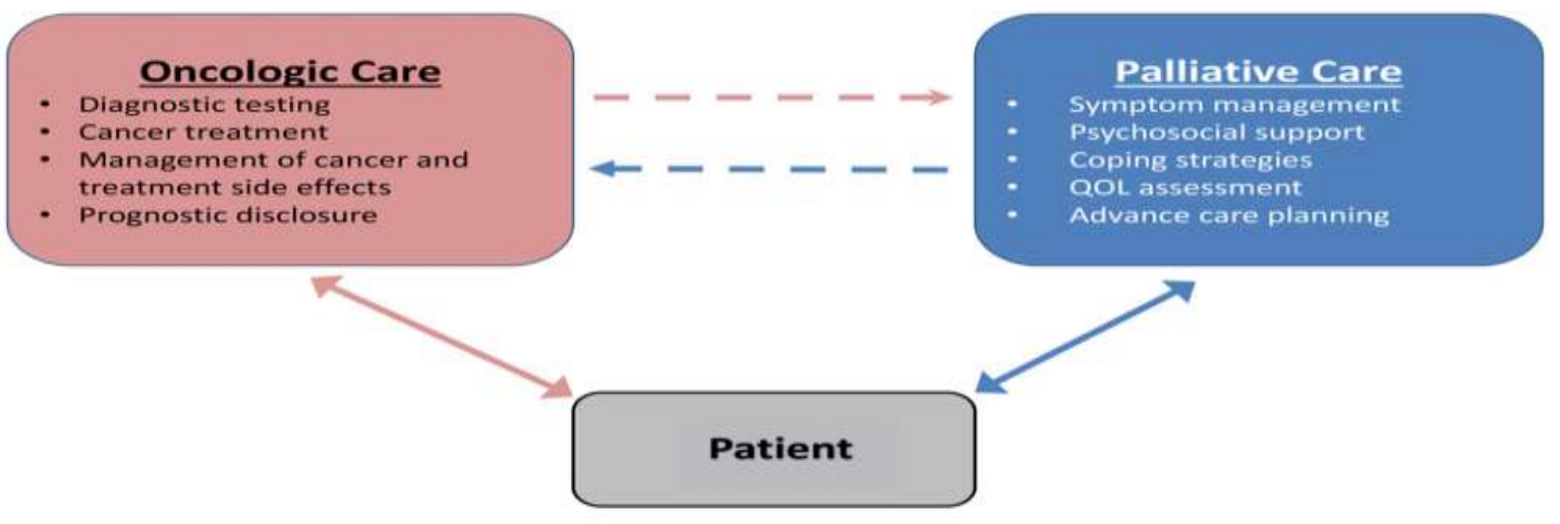






Filling the Gap: Creating an Outpatient Palliative Care Program in Your Institution

Esme Finlay, MD, Michael W. Rabow, MD, and Mary K. Buss, MD, MPH



Embedded Model

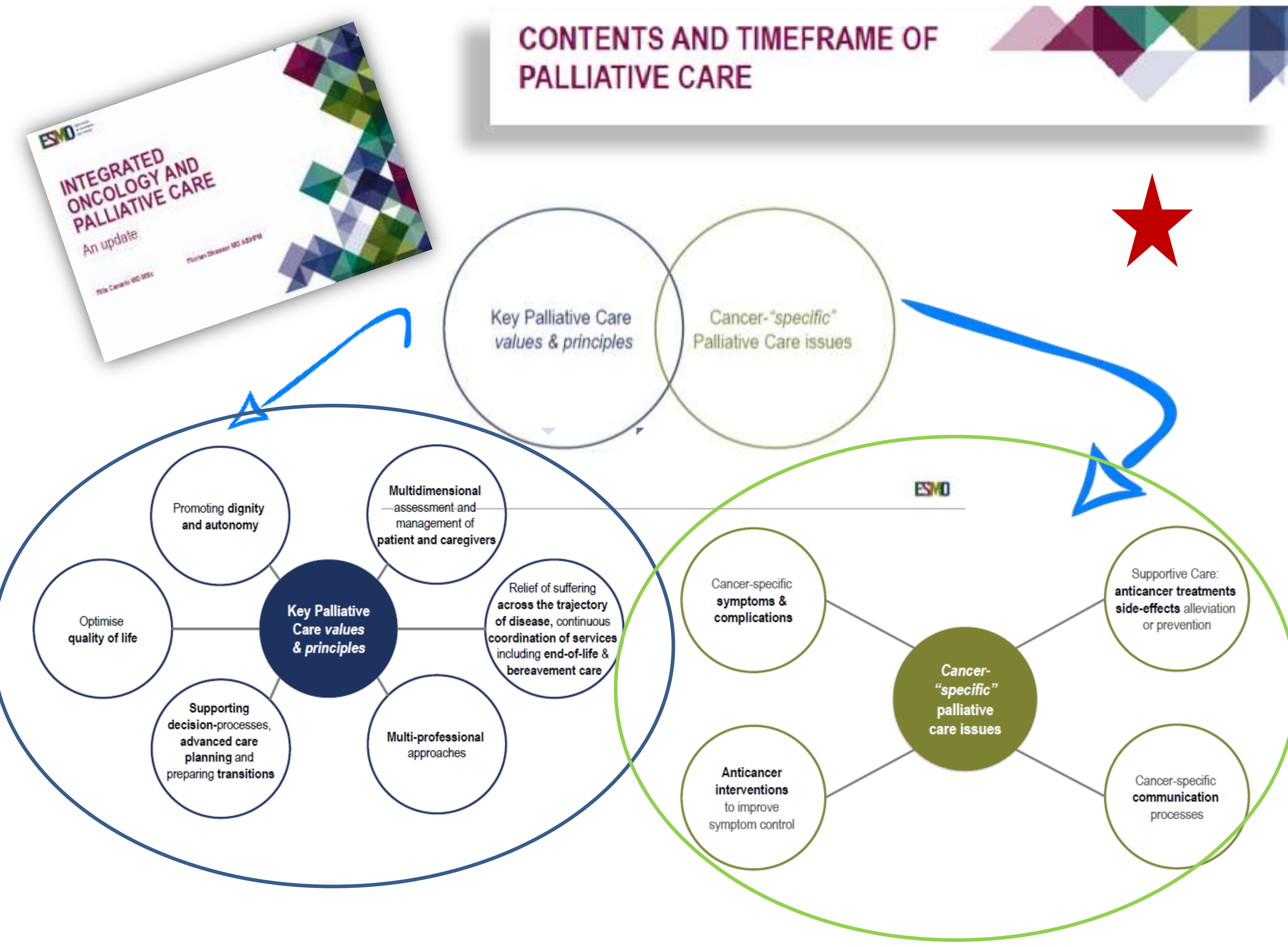
Oncologist educates PC re: cancer-focused care, new therapies, treatment-adjusted prognosis

Oncologic Care
- Diagnostic testing
- Cancer treatment
- Management of cancer and treatment side effects
- Prognostic disclosure

Palliative Care
- Symptom management
- Psychosocial support
- Coping strategies
- QOL assessment
- Advance care planning

PC educates oncology re: symptom management, elicits goals/fears, facilitates communication

Patient



CONTENTS AND TIMEFRAME OF PALLIATIVE CARE
ESMO
INTEGRATED ONCOLOGY AND PALLIATIVE CARE
An update
Key Palliative Care values & principles
Cancer-"specific" Palliative Care issues
Promoting dignity and autonomy
Multidimensional assessment and management of patient and caregivers
Optimise quality of life
Key Palliative Care values & principles
Relief of suffering across the trajectory of disease, continuous coordination of services including end-of-life & bereavement care
Supporting decision-processes, advanced care planning and preparing transitions
Multi-professional approaches
ESMO
Cancer-specific symptoms & complications
Supportive Care: anticancer treatments side-effects alleviation or prevention
Cancer-"specific" palliative care issues
Anticancer interventions to improve symptom control
Cancer-specific communication processes

BARRIERS AND CHALLENGES FOR PC INTEGRATION

Major indicators of integration of Palliative Care into Oncology

1. Presence of palliative care inpatient consultation team
2. Presence of palliative care outpatient clinic
3. Presence of interdisciplinary palliative care team
4. Routine symptom screening in the outpatient oncology clinic
5. Routine documentation of advance care plans in patients with advanced cancer
6. Early referral to palliative care
7. Proportion of outpatients with pain assessed on either of the last two visits before death
8. Proportion of patients with 2 or more emergency room visits in last 30 days of life (negative indicator)
9. Place of death consistent with patient's preference
10. Didactic palliative care curriculum for oncology fellows provided by palliative care teams
11. Continuing medical education in palliative care for attending oncologists
12. Combined palliative care and oncology educational activities for fellows/trainees
13. Oncology fellows have routine rotation in palliative care

Hui D, *et al.*, Annals of Oncology 2015, 26(9): 1953–1959

Early Palliative Care

J. Gaertner, MD

Chapter · January 2015

B. Alt-Epping, F. Nauck (eds.), *Palliative Care in Oncology*,

Bottom Line

In summary, the Latin prefix "Co" (together, jointly) is the basis of the main pillars of an early palliative care "*Co*-ncept":

1. *Co-operation:*
   Patients' and families' palliative care needs are best addressed by close triangular cooperation between (i) cancer specialists, (ii) primary care (family medicine, nursing services, etc.), and (iii) specialist palliative teams.
2. *Co-mmunication and Co-ngruity of care*
   This triangular approach requires close communication about the relevant aspects of care for each patient to (i) avoid contradictory communication of treatment goals and (ii) futile or hazardous medication and to (iii) assure the utilization of synergies of the different disciplines involved.
3. *Co-ordination*
   At all times, patients and their families should know who is primarily responsible for their care and who they should contact in case of questions, concerns, or medical problems.
4. *Co-llegiality* (and *Co-ntracts)*
   Cooperation, communication, coordination, and congruity of cancer care can be facilitated through formal agreements (contracts).

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VOLUME 27 · NUMBER 18 · JUNE 20 2009

JOURNAL OF CLINICAL ONCOLOGY ASCO SPECIAL ARTICLE

Palliative Cancer Care a Decade Later: Accomplishments, the Need, Next Steps—From the American Society of Clinical Oncology

Frank D. Ferris, Eduardo Bruera, Nathan Cherny, Charmaine Cummings, David Currow, Deborah Dudgeon, Nora Janjan, Florian Strasser, Charles F. von Gunten, and Jamie H. Von Roenn

1. DISEASE MANAGEMENT
- Primary diagnosis
- Prognosis[†]
- Comorbidities

2. PHYSICAL
- Pain and other symptoms[†]
- Function
- Safety
- Wounds[†]

3. PSYCHOLOGICAL
- Depression, anxiety[†]
- Emotions
- Fears
- Control, dignity, independence
- Conflict, guilt, stress, coping responses

4. SOCIAL
- Cultural values, beliefs, practices
- Relationships, roles
- Financial resources
- Legal (eg, powers of attorney)
- Family caregiver protection

5. SPIRITUAL
- Meaning, value
- Existential, transcendental
- Values, beliefs
- Rites, rituals

6. PRACTICAL
- Activities of daily living
- Caregiving

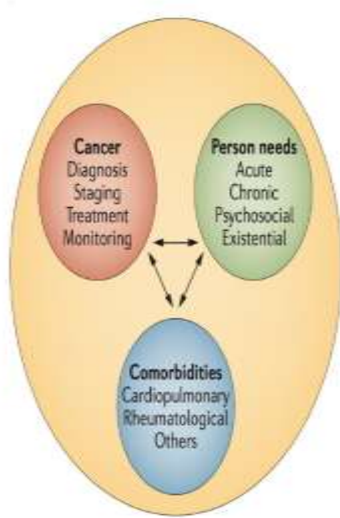
7. END OF LIFE CARE/ DEATH MANAGEMENT[†]
- Life closure[†]
- Legacy creation[†]
- Anticipation and management of physiological changes in the last hours of life[†]

8. LOSS, GRIEF[†]
- Loss, grief[†]
- Bereavement[†]
- Mourning

PATIENT AND FAMILY CHARACTERISTICS
- Demographics
- Culture
- Personal values, beliefs, practices

APPROACH TO THE PATIENT WITH INCURABLE CANCER

Palliative care needs in oncology



Urgency

Acute issues
- Physical symptoms: pain, dyspnea, nausea
- Delirium
- Depression with suicide risk

Chronic issues
- Physical symptoms: fatigue, anorexia–cachexia
- Anxiety, depression
- Declines in physical function

Psychosocial issues
- Advance-care planning
- Family structure and caregiver care
- Financial concerns

Existential and/or spiritual issues
- Meaning
- Hopefulness
- Legacy and dignity
- Religious and spiritual well-being

Meaning

Hui D, and Bruera E, Nat Rev Clin Oncol 2016;13(3):159-171. Reprinted by permission from Mcmillan Publishers Ltd, copyright 2016

Original Article

Ann Palliat Med 2015;4(3):89-98

Models of integration of oncology and palliative care

David Hui, Eduardo Bruera

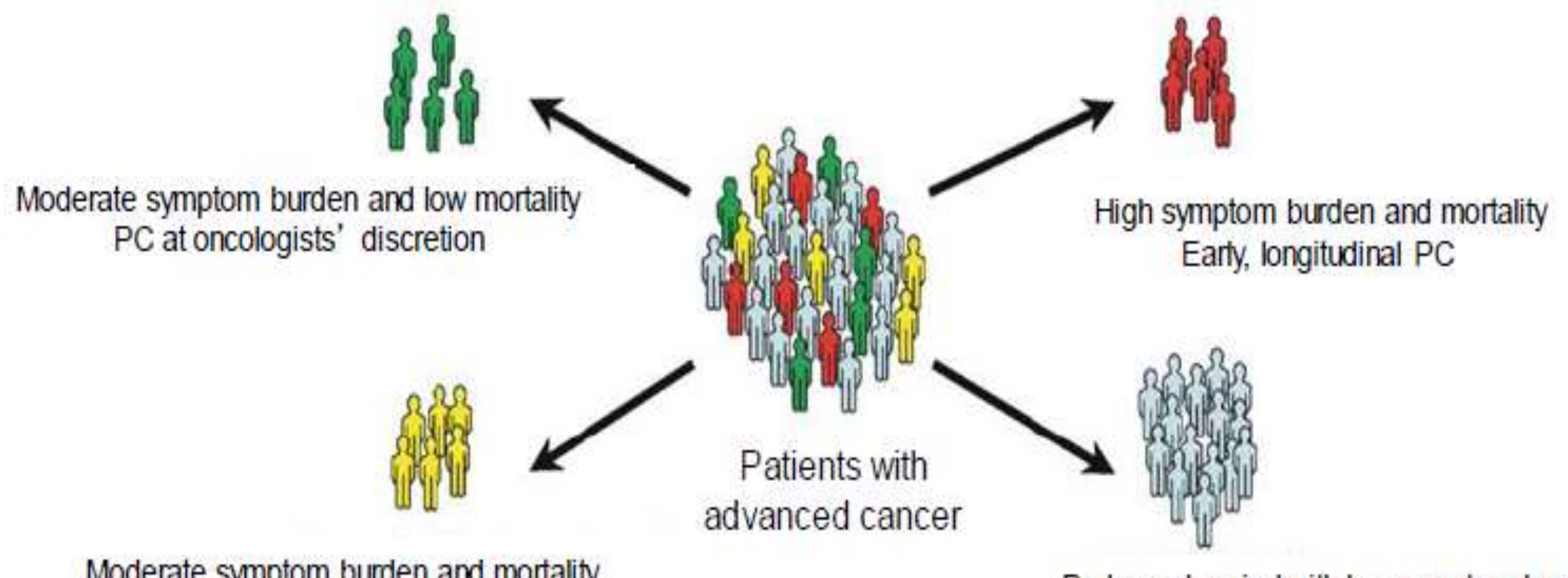
...Thus, the question is no longer whether it is a good idea to integrate palliative care and oncology, but rather HOW...

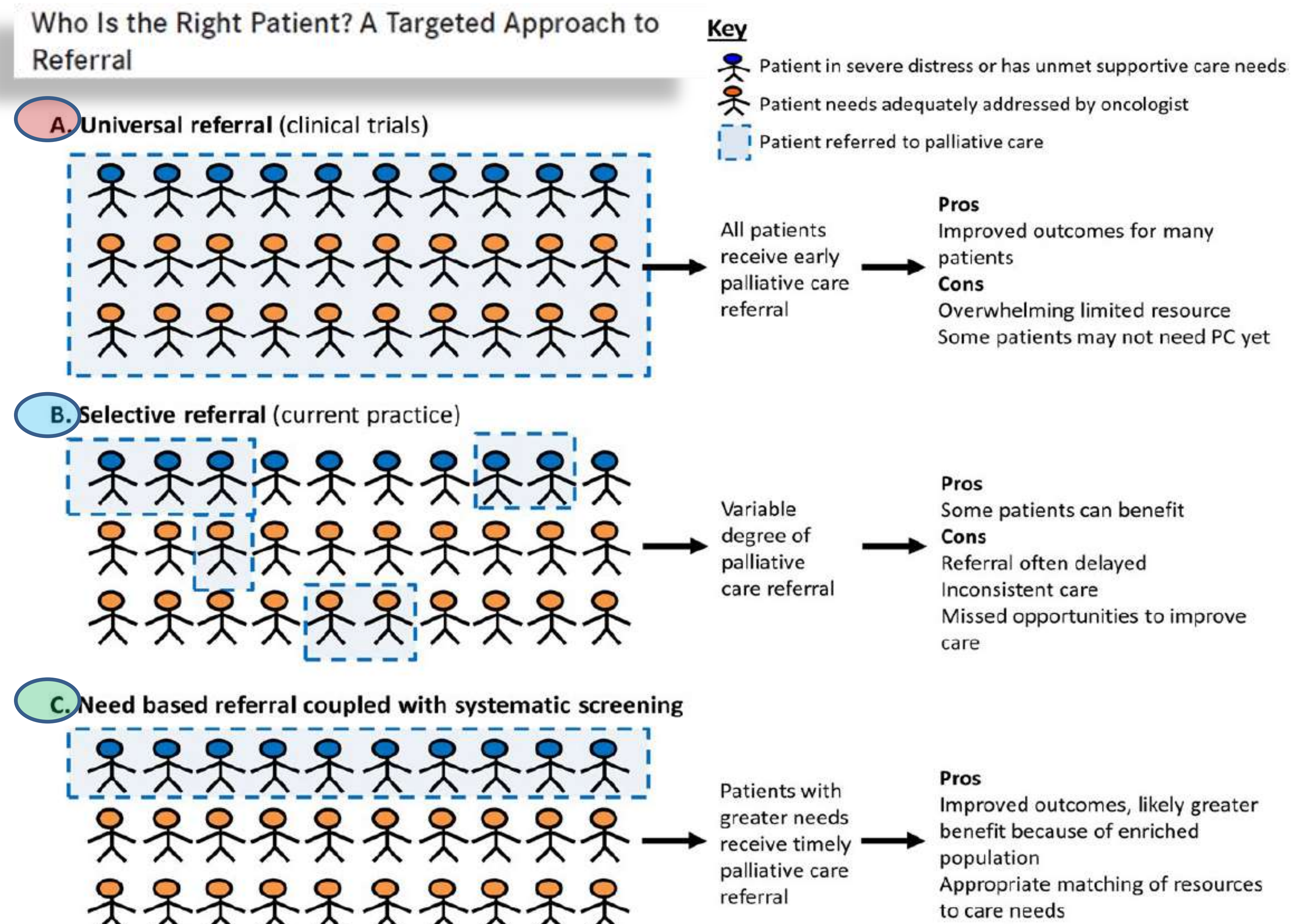
Domande chiave:

- **Qual è il paziente giusto?**
- **Quando è il momento giusto?**
- **Quante e quali CP l'oncologo deve essere preparato ad erogare?**
- **Qual è il modello organizzativo ed il setting migliore?**

Key Unanswered Questions

Is early palliative care for patients with advanced cancers a one-size-fits all?

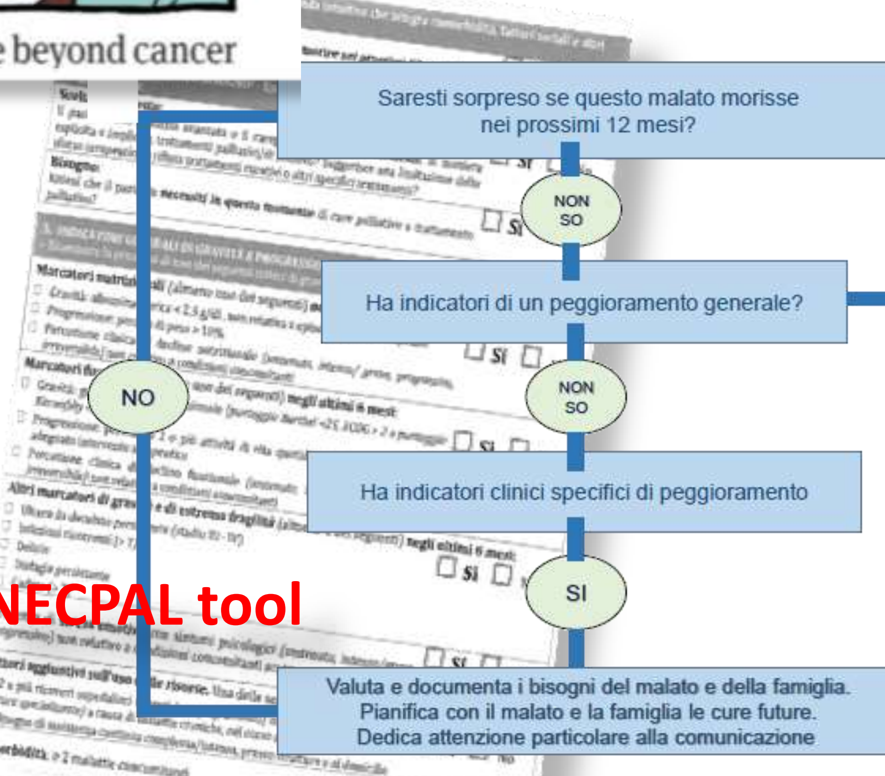




CA CANCER J CLIN 2018;68:356–376

Identificazione precoce

IDC-Pal
Instrumento diagnóstico de la complejidad en cuidados paliativos
Documento de apoyo al PAI Cuidados Paliativos



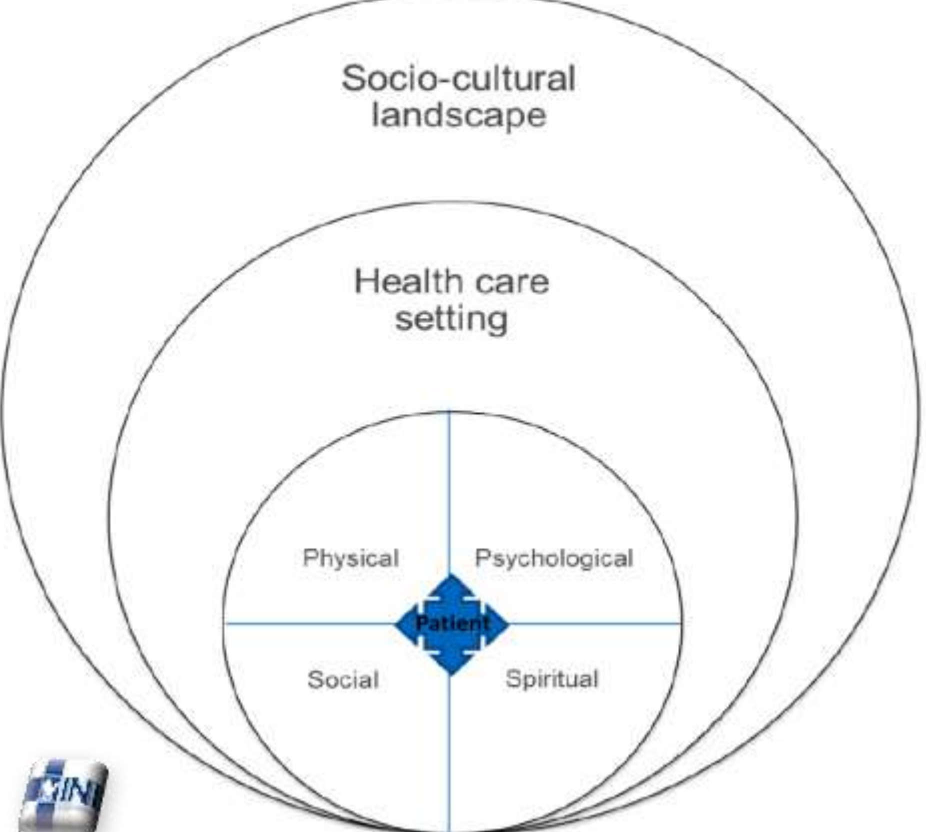
RESEARCH ARTICLE Open Access

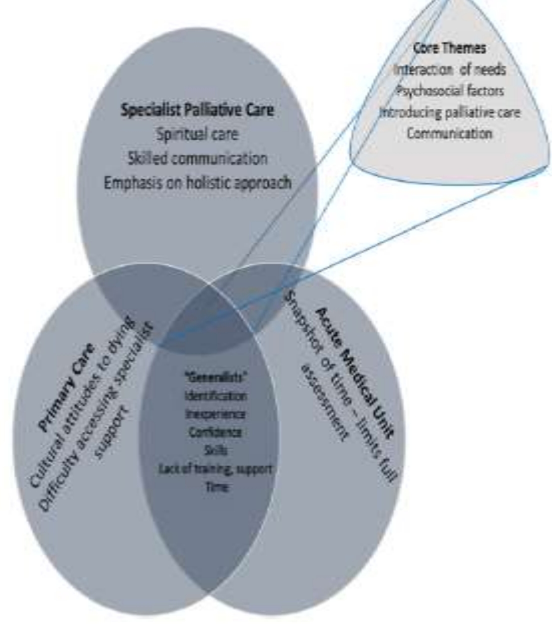
Carduff et al. BMC Palliative Care (2018) 17:12
DOI 10.1186/s12904-017-0259-z

What does 'complex' mean in palliative care? Triangulating qualitative findings from 3 settings

Emma Carduff[1,2*], Sarah Johnston[3], Catherine Winstanley[3], Jamie Morrish[4], Scott A. Murray[5], Juliet Spiller[6] and Anne Finucane[6]

SPICT
GSF-PIG
NECPAL
RADPAC





VOLUME 35 · NUMBER 8 · MARCH 10, 2017

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Effects of Early Integrated Palliative Care in Patients With Lung and GI Cancer: A Randomized Clinical Trial

Jennifer S. Temel, Joseph A. Greer, Areej El-Jawahri, William F. Pirl, Elyse R. Park, Vicki A. Jackson, Anthony L. Back, Mihir Kamdar, Juliet Jacobsen, Eva H. Chittenden, Simone P. Rinaldi, Emily R. Gallagher, Justin R. Eusebio,

Conclusion

For patients with newly diagnosed incurable cancers, early integrated PC improved QOL and other salient outcomes, with differential effects by cancer type. Early integrated PC may be most effective if targeted to the specific needs of each patient population.

Published Ahead of Print on September 11, 2017 as 10.1634/theoncologist.2017-0227.

Symptom Management and Supportive Care

Effects of Early Integrated Palliative Care on Caregivers of Patients with Lung and Gastrointestinal Cancer: A Randomized Clinical Trial

AREEJ EL-JAWAHRI,[a,b] JOSEPH A. GREER,[a,b] WILLIAM F. PIRL,[a,b] ELYSE R. PARK,[a,b] VICKI A. JACKSON,[a,b] ANTHONY L. BACK,[c]

Implications for Practice: Early involvement of palliative care for patients with newly diagnosed lung and gastrointestinal cancers leads to improvement in caregivers' psychological symptoms. The findings of this trial demonstrate that the benefits of the early, integrated palliative care model in oncology care extend beyond patient outcomes and positively impact the experience of caregivers. These findings contribute novel data to the growing evidence base supporting the benefits of integrating palliative care earlier in the course of disease for patients with advanced cancer and their caregivers.

Improving Patient and Caregiver Outcomes in Oncology: Team-Based, Timely, and Targeted Palliative Care

CA CANCER J CLIN 2018;68:356–376

David Hui, MD, MSc[1,*]; Breffni L. Hannon, MBChB[2]; Camilla Zimmermann, MD, PhD[3]; Eduardo Bruera, MD, FAAHPM[4]

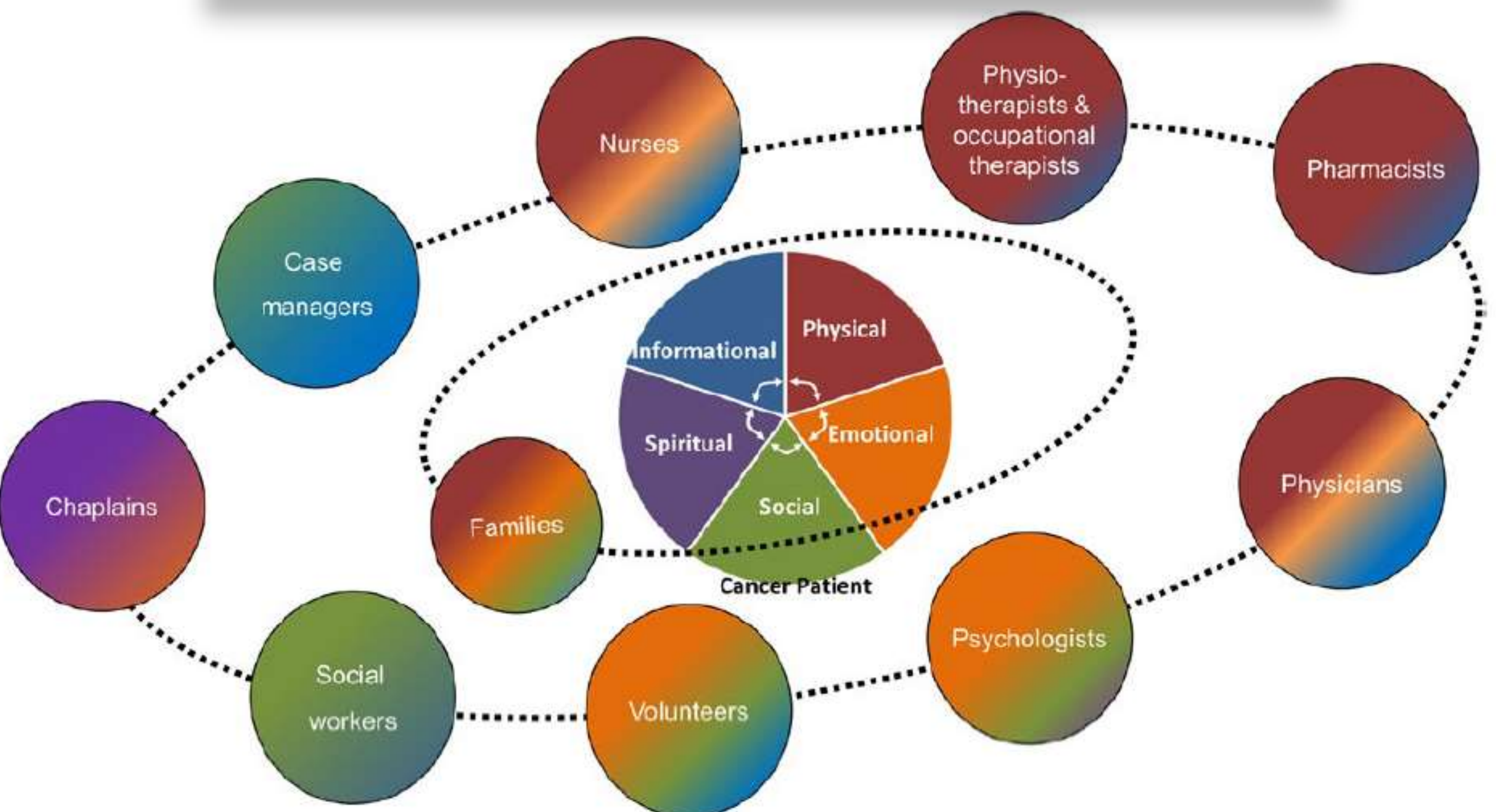
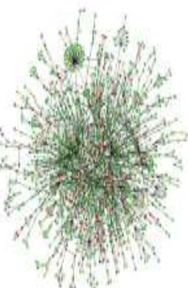


FIGURE 2. The Interdisciplinary Palliative Care Team. One of the most unique aspects of palliative care is its interdisciplinary nature, with different members of the team providing different expertise, thus allowing a patient's needs to be addressed in a holistic and timely fashion, and augmenting the ability of family caregiver(s) to support the patient. Other advantages of an interdisciplinary team include enhanced patient-clinician communication and shared responsibility, work load, decision making, leadership, and stresses while providing care for distressed patients.

Tabella 1. Criteri del PALCOM (*modificata da Tuca A, et al.*[31]).

	SI	NO
Il paziente presenta almeno 5 sintomi con NRS ≥ 4		
Il paziente rientra nello stadio di Dolore 2 (poor prognosis) dell'Edmonton Staging System for Cancer Pain (ESSCP)		
Il paziente presenta un indice di Karnofsky ≤ 50%		
È presente almeno 1 fattore di rischio socio-familiare		
È presente almeno 1 dilemma esistenziale o etico		
Somma punteggio		

"Un sistema complesso non è definito solo dagli elementi che lo costituiscono, ma dalle loro relazioni e modalità di interazione"



MACROSISTEMA
La popolazione e la società

ESOSISTEMA
I servizi e i fattori sistemici
Coordinamento delle cure e possibilità di interazione dei team
Disponibilità dei Servizi specialistici e la loro capacità concreta di attività

MESOSISTEMA
Le interazioni fra la persona, la sua famiglia e il team curante
Discordanza fra pazienti, famiglie e professionisti
Coinvolgimento, pregiudizi e complessità "invisibile"

MICROSISTEMA
I bisogni della persona
Le caratteristiche della persona
La complessità pre-esistente
La complessità Globale

A framework for complexity in palliative care: A qualitative study with patients, family carers and professionals

Sophie Pask[1], Cathryn Pinto[1], Katherine Bristowe[1], Liesbeth van Vliet[1], Caroline Nicholson[2], Catherine J Evans[1,3], Rob George[4], Katharine Bailey[1], Joanna M Davies[1], Ping Guo[1], Barbara A Daveson[1], Irene J Higginson[1] and Fliss EM Murtagh[1,5]

Conceptual transitions in palliative care in the 21st century

Xavier Gomez-Batiste

Building Integrated Palliative Care Programs and Services

Edited by Xavier Gómez-Batiste & Stephen Connor

Change from:	Change to:
Terminalità	Patologia cronica progressiva in fase avanzata
Prognosi di settimane o giorni	Aspettativa di vita limitata
Tumore	Tutte le condizioni croniche progressive
Dicotomia curativo-palliativo	Sincronia, cure condivise e simultanee
Prognosi come criterio per l'intervento dei servizi specialistici	Complessità come criterio
Ruolo passivo del paziente	Pianificazione anticipata delle cure
Servizi specialistici	Attività in tutti i setting di cura
Approccio istituzionale	Approccio di comunità
Cure frammentate	Cure integrate

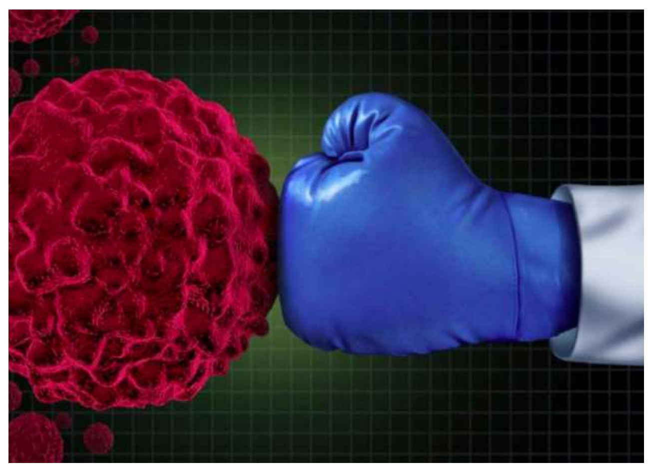
Early palliative care: philosophy *vs.* reality

Gaertner J, Lutz S, Chow E. Ann Palliat Med 2015;4(3):87-88

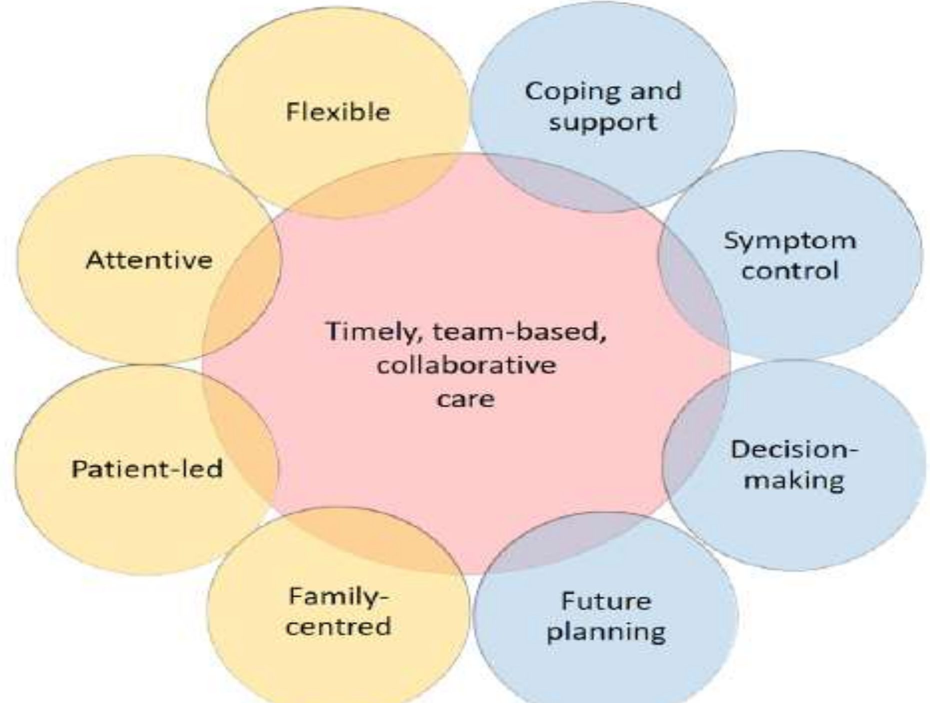
*Therefore, such integration of oncology and palliative care is a key challenge for all of us. Yet, when discussing models of integration with colleagues, the hospital administration or other disciplines, you may frequently encounter **significant misunderstandings** or different views on **how** to accomplish early palliative care and **what it actually is all about***

Ciò che è chiaro è quel che NON E'…

- Non è l'oncologo dedicato alla gestione dei sintomi
- Non è il palliativista in consulenza per pianificare le dimissioni
- (Ovviamente non è l'anestesista per la terapia del dolore)
- Non è l'equipe specialistica di CP domiciliari che fa supporto per gli effetti collaterali dei trattamenti oncologici in corso



Principles of care



Domains of care

Zimmermann C, *et al*. *BMJ Supportive & Palliative Care* 2019;**0**:1–10. doi:10.1136/bmjspcare-2019-001903

Simultaneous Care: dal sogno alla realtà

Simultaneous Care: la realtà di un sogno