REGIONE DEL VENETO

ESMO Designated Centers of Integrated Oncology and Palliative Care

" LA PERSONA CENTRO DELLA CURA"

Paolo Morandi & Cataldo Mastromauro

Oncologia Medica ULSS 12 " Veneziana"

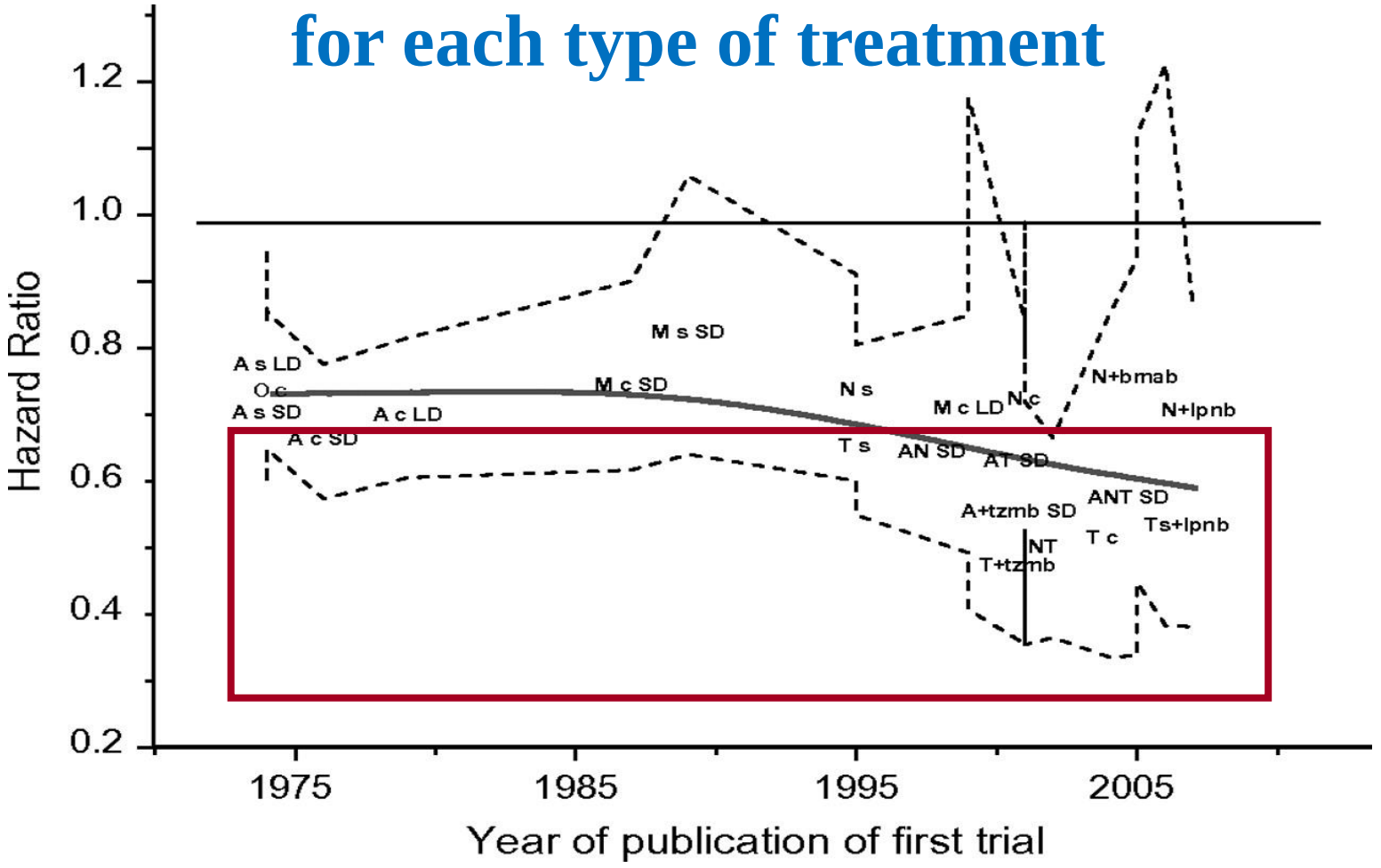
PROGRESSI, INVECCHIAMENTO, NUOVI FARMACI, NUOVI “SINTOMI”…….**NUOVA VISIONE**

- BC Cancer Agency study of stage II/III colorectal cancer.
- Improvement in both rectal and colon ca
- Greater improvement for rectal cancer
- 5Y survival of colon and rectal cancer similar in modern era

Cohort	Rectal Cancer	Colon Cancer
1990	44%	54%
1995/ 1996	59%	62%
2001/ 2002	62%	66%

Renouf ASCO 2008

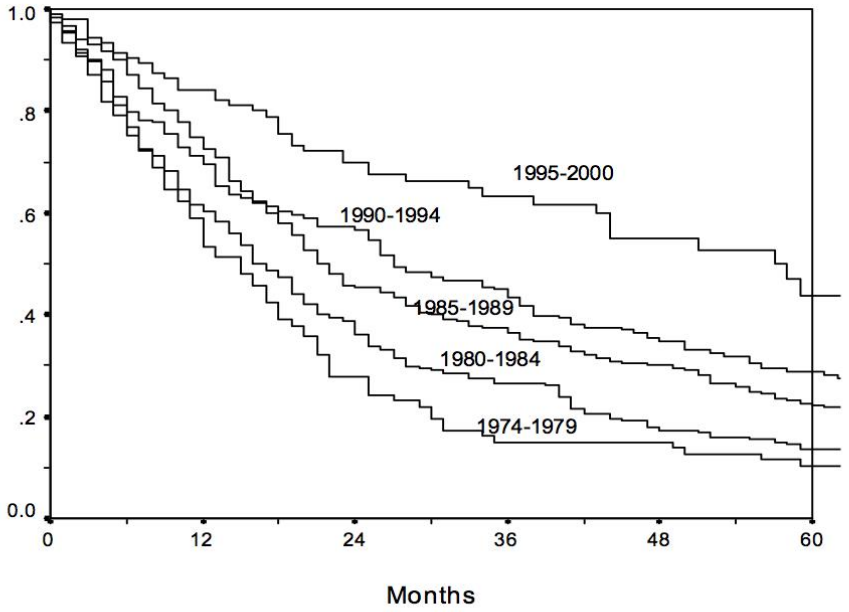
Hazard ratios for mortality using monotherapy, with old agent as the reference comparator as a function of the first year of publication of a trial for each type of treatment



Mauri, D. et al. J. Natl. Cancer Inst. 2008 100:1780-1791; doi:10.1093/jnci/djn414

Giordano SH, et al, *Cancer* 100:44-52, 2004

FROM 1974 TO 2000



Chia et al, Cancer 110:973–9, 2007

FROM 1991 TO 2001

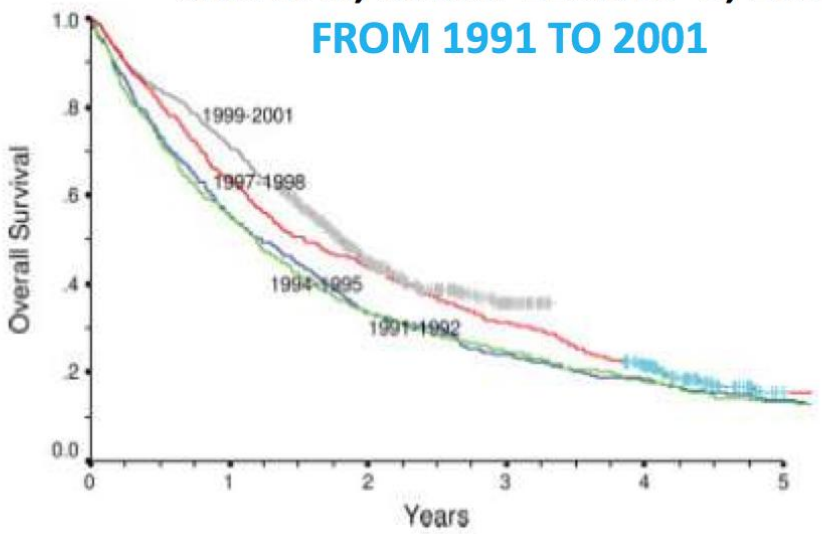


FIGURE 1. Kaplan-Meier curves for overall survival for the 4 time cohorts from date of diagnosis of MBC.

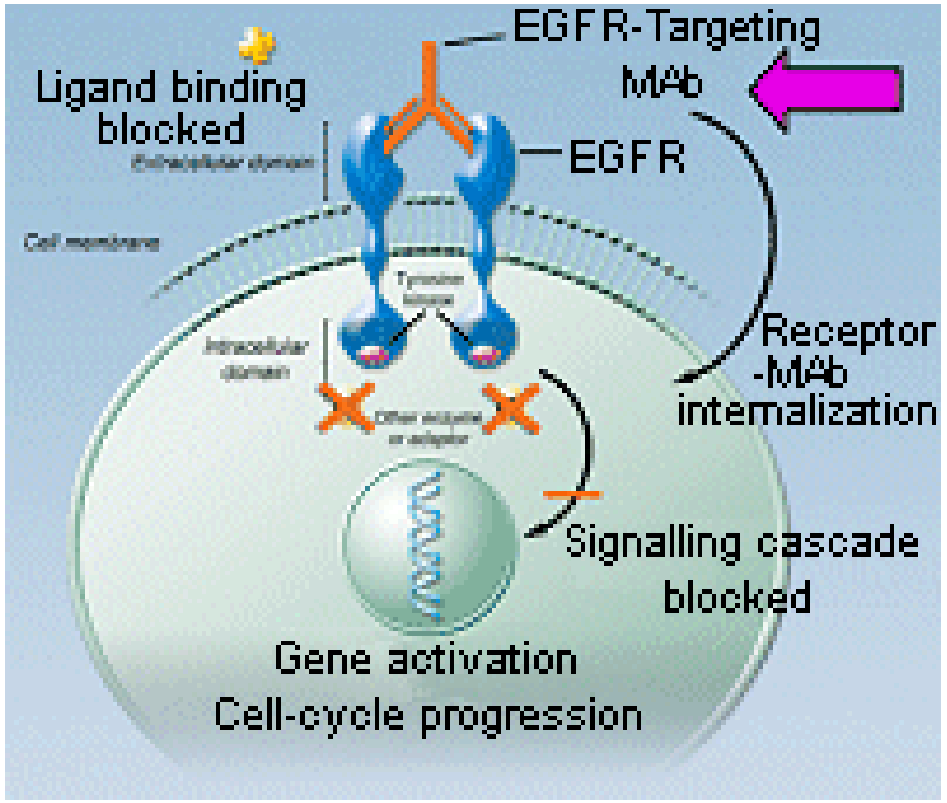
- **Median survival in MBC improved during past decade (14 months in 1991, 22 months in 2001) BUT advances in MBC are measured in days/months and median survival is still 2-3 yrs!**
- **This is NOT a chronic disease!**

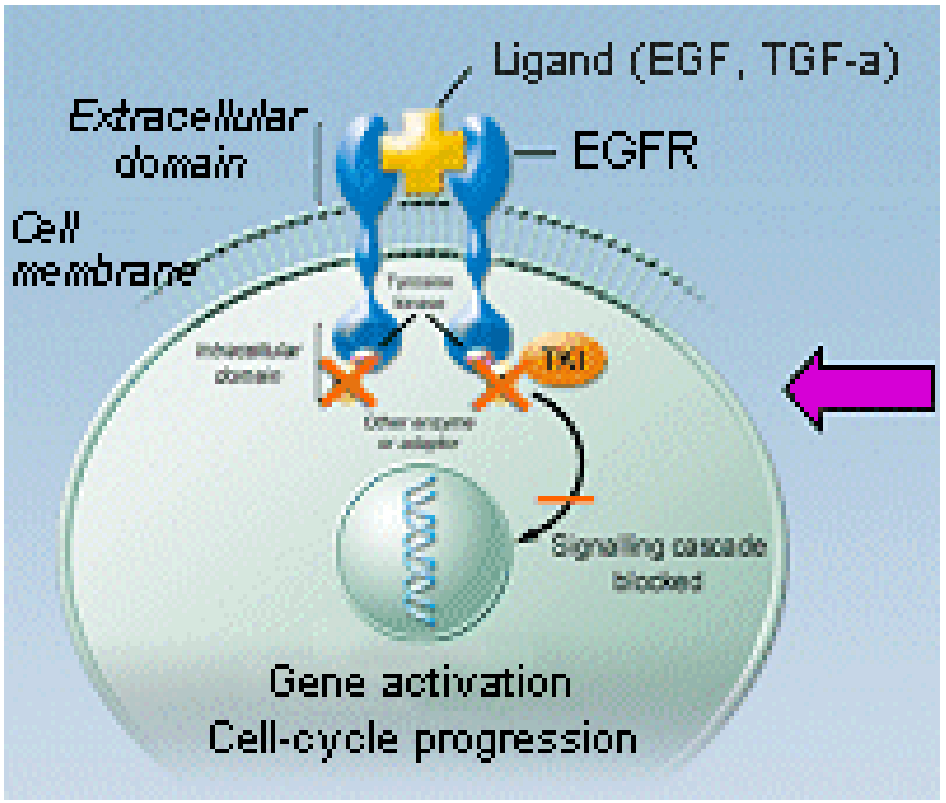
ANTICORPI MONOCLONALI

- colpiscono il dominio extracellulare del recettore
- bloccano il sito di legame con il ligando
- inibiscono i processi di crescita e progressione delle cellule tumorali

PICCOLE MOLECOLE

- Si legano alla porzione tirosin chinasica del recettore,
- Inibiscono l'azione dell'enzima responsabile della trasduzione del segnale





PATIENTS IN ADVANCED DISEASE AT DIAGNOSIS

	M+ (%)	MS(months)
• NSC lung cancer	45	12-15
• Colon cancer	20	20-25
• Breast cancer	18	12-24
• Pancreatic cancer	70	12-15
• Gastric cancer	30	10

Approximately half of all patients with cancer eventually die of their disease, and one-third of cancer deaths happen within 24 months of diagnosis.

VOLUME 27 · NUMBER 35 · DECEMBER 10 2009
JOURNAL OF CLINICAL ONCOLOGY | COMMENTS AND CONTROVERSIES

Incremental Advance or Seismic Shift? The Need to Raise the Bar of Efficacy for Drug Approval

Alberto Sobrero, *Ospedale San Martino, Genova, Italy*
Paolo Bruzzi, *Istituto Nazionale per la Ricerca sul Cancro, Genova, Italy*

				PFS			OS		
Condition	Indication	No. of Patients in the Study	Design	Median Improvement Over Control (months)	*P*	Hazard Ratio	Median Improvement Over Control (months)	*P*	Hazard Ratio
Renal cell carcinoma									
Sorafenib[4]	First-line metastatic	769	Sorafenib *v* placebo	2.7	< .001	0.44	NR*	NR	
Temsirolimus[5]	First-line metastatic with high-risk features	626	Temsirolimus *v* IFN alpha	2.4	< .001	0.66	3.6*	< .001	0.73
Sunitinib[6]	First-line metastatic	750	Sunitinib *v* IFN alpha	6.0	< .000001	0.42	NR*	NR	
Bevacizumab[7]	First-line metastatic	649	IFN alpha + bevacizumab *v* IFN alpha + placebo	4.8	.0001	0.63	NR*	NR	
Breast cancer									
Trastuzumab[8]	First-line metastatic HER-2+	469	Doxorubicin + cyclophosphamide or paclitaxel plus or minus trastuzumab	2.8* (TTP, not PFS)	< .001	0.51	4.8	.046	0.80
Bevacizumab[9]	First-line metastatic	722	Paclitaxel + bevacizumab *v* paclitaxel	5.9*	< .001	0.6	1.5	.16	0.88
Lapatinib[10]	Refractory HER-2+	399	Capecitabine + lapatinib *v* capecitabine alone	1.9*	< .001	0.57	NR	NR	
Colorectal cancer									
Bevacizumab[11]	First-line metastatic	813	IFL + bevacizumab *v* IFL	4.2	< .001	0.54	4.7*	< .001	0.66
Panitumumab[12]	Refractory	463	Panitumumab *v* best supportive care	0.15*	< .0001	0.54	0.0	1	1.0
Non–small-cell lung cancer									
Erlotinib[13]	Second- and third-line metastatic	731	Erlotinib *v* placebo 2:1 randomization	0.4	< .001	0.61	2.0*	< .001	0.7
Bevacizumab[14]	First-line stage IIIB or IV	878	Paclitaxel, carboplatin, bevacizumab *v* paclitaxel and carboplatin	1.7	< .001	0.66	2.0*	.003	0.79
GIST									
Sunitinib[15]	Second line	312	Sunitinib *v* placebo	4.8 (TTP, not PFS)*	< .001	0.33	NR	NR	
Head and neck cancer									
Cetuximab[16]	Locally advanced	424	RT plus or minus cetuximab	9.5* (local control)	.005	0.68	19.7	.032	0.74
Pancreatic cancer									
Erlotinib[17]	First-line metastatic	569	Gemcitabine + erlotinib *v* gemcitabine	0.25	.03	0.76	0.46*	.025	0.81
Hepatocellular carcinoma									
Sorafenib[18]	Pretreated hepatocellular carcinoma	602	Sorafenib *v* placebo	2.7	< .001	0.58	2.8*	< .001	0.69

Cambiamento della medicina oncologica

In origine

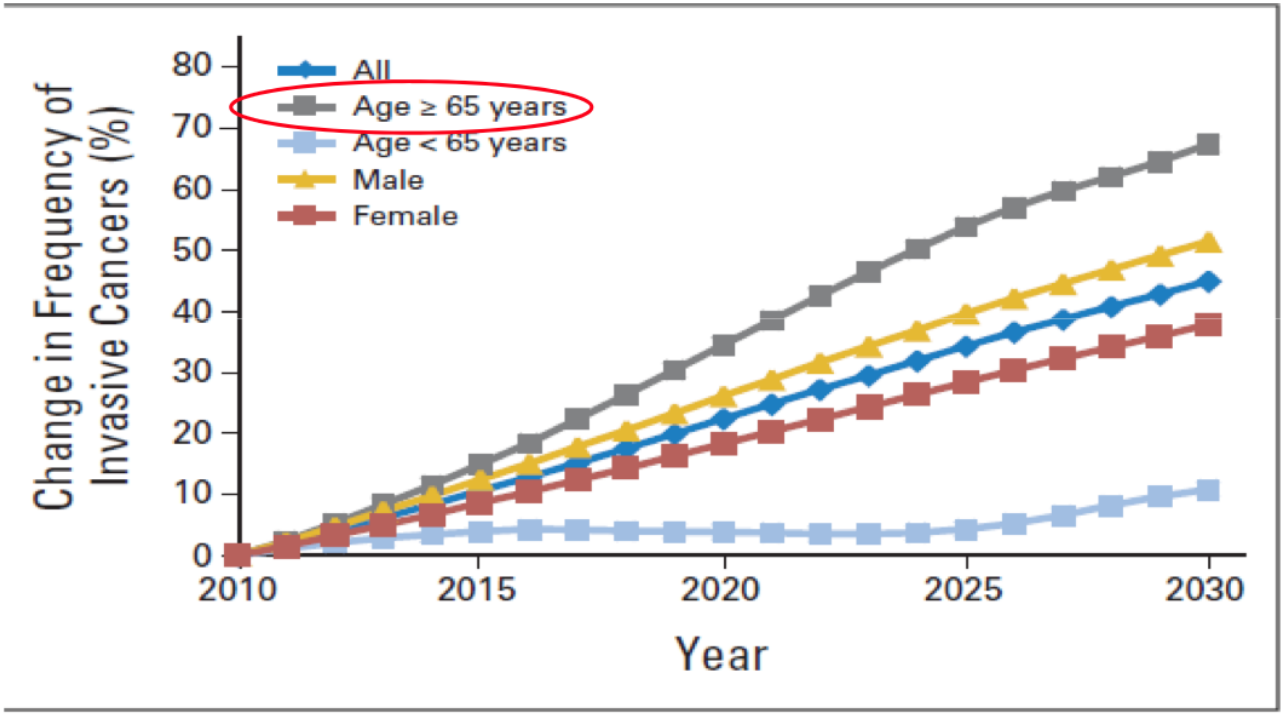
- Diagnosi
- Cura
- Palliazione

Finalità attuali

- Prevenzione
- Diagnosi precoce e accurata
- Cura
- Prolungare la vita
- Riabilitazione
- Palliazione
- End of life care

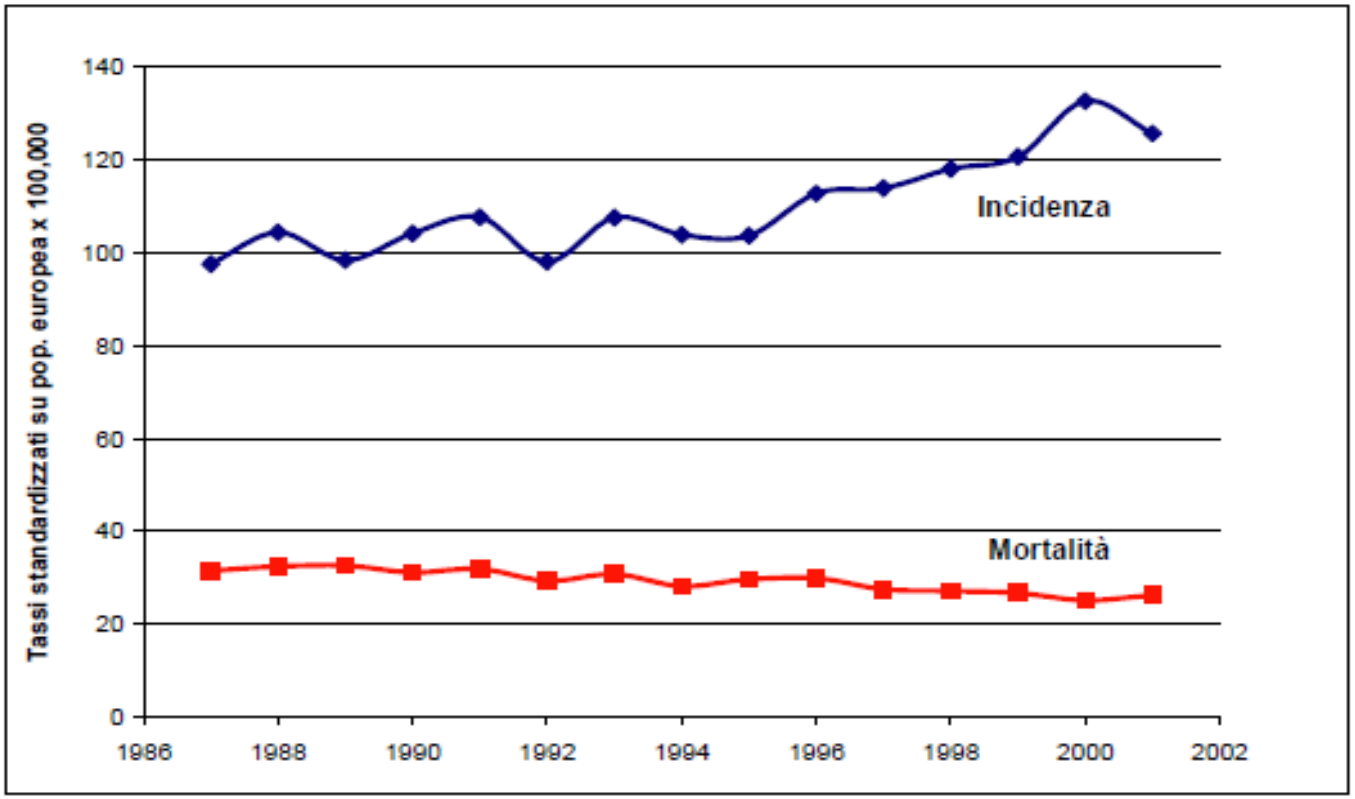
Ahmedzai SH et al. Sem Oncol 27: 1-6, 2000

Projected change in frequency of invasive cancers in USA by age and sex



Kumar S et al. J Clin Oncol 2010

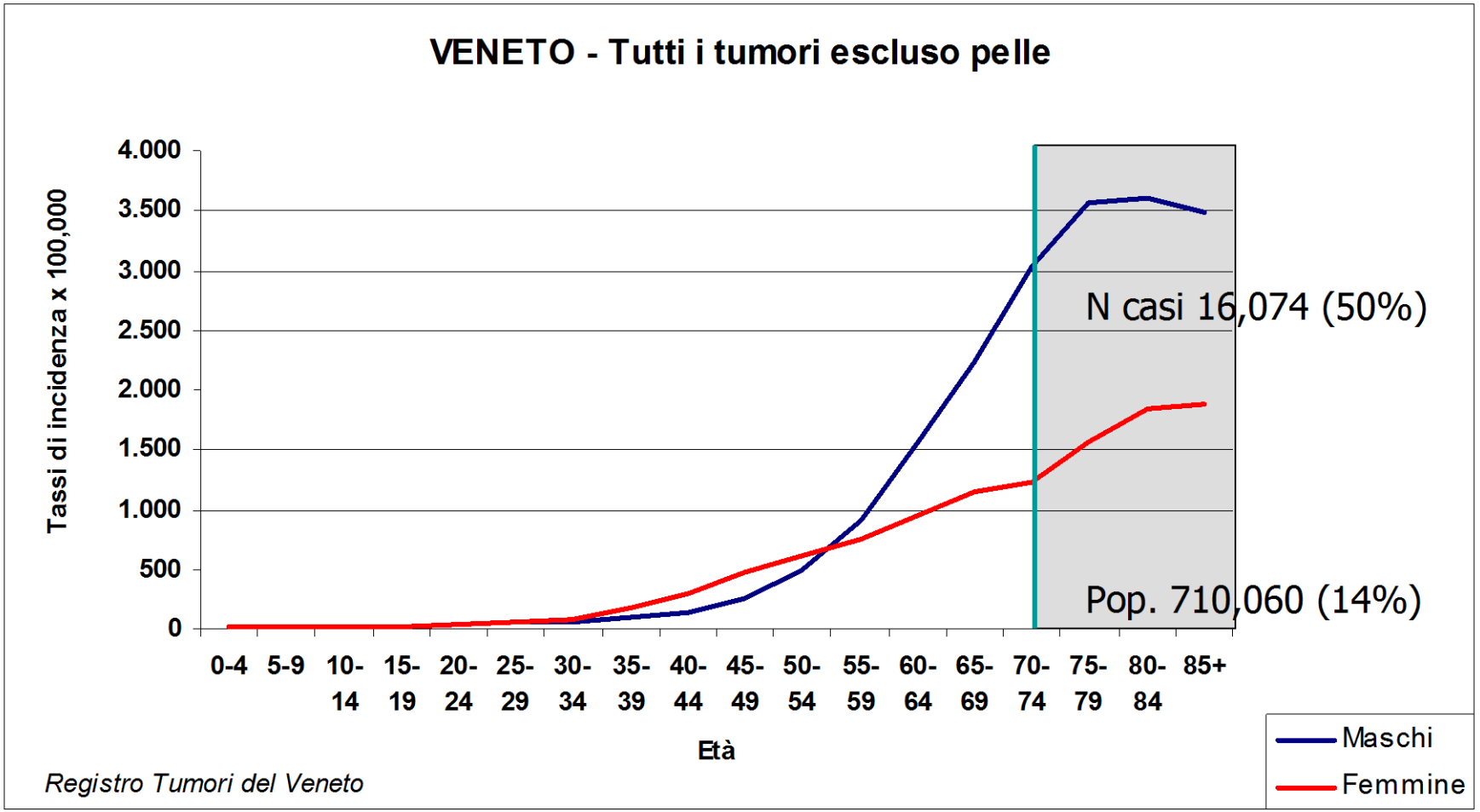
Regione Veneto



Fonti: RTV (dati di incidenza), ISTAT (dati di mortalità)

Un incremento particolarmente accentuato si osserva a carico dell'istotipo lobulare, che è passato da 10.4 casi per 100.000 donne/anno nel periodo 1987/89 a 23.6 per 100.000 nel 1998/2001. Come si evidenzia in Figura 5, l'aumento è stato più precoce, ed è più rilevante, a carico delle donne di età compresa tra i 55 ed i 74 anni. Tale incremento è stato osservato anche in casistiche internazionali (3,4) ed è stato attribuito ad uno specifico aumento di rischio dell'istotipo lobulare in relazione all'utilizzo della Terapia Ormonale Sostitutiva.

TASSI DI INCIDENZA PER CLASSI DI ETÀ E SESSO. PERIODO 2003-2005. VENETO.



Approach to the older patient with cancer

Maxine de la Cruz* and Eduardo Bruera

Box 1 Questions to ask in deciding therapeutic care plan for the elderly cancer patient [6]

Is the patient going to die of cancer or with cancer?
Is the patient going to live long enough to suffer the consequences of cancer?
Is the patient able to tolerate the treatment?
What are the long term consequences of cancer treatment in the elderly?
Will any treatment improve the quality of life?
What are the patient's goals of care?
Is the social network of the patient adequate to support him/her during the treatment?

Approach to the older patient with cancer

Maxine de la Cruz* and Eduardo Bruera

Table 1

Fried's frailty criteria[1] [7]

Abnormalities	Frailty scale
Involuntary weight loss of 10 lbs or more in the last 6 months	Fit (no abnormalities)
Reduced grip strength	Pre-frail (2 abnormalities or less)
Difficulty initiating movements	Frail (3 or more abnormalities)
Reduced walking speed	
Fatigue	

1. Categories of Frailty:

Fit: No abnormalities.

Pre-Frail: 2 abnormalities or less.

Frail: 3 or more abnormalities.

VOLUME 30 · NUMBER 17

JOURNAL OF CLINICA

Under-Represer Registration Tri

Kevin S. Scher and Arti Hurria, *City of*

Table 1. Approved Cancer Agents, 2007 to June 2010: Enrollment of Older Adults As Referenced in Geriatric Usage Sections of Package Inserts

Agent	Total No. of Patients†	Disease Type	Regimen	Age (years) ≥65 No.	≥65 %	≥75 No.	≥75 %
Nilotinib (Tasigna; approved June 17, 2010, and October 29, 2007)	279	New diagnosis Ph-positive CML-CP	Nilotinib	33	12	Not reported	
	458	Resistant Ph-positive CML-CP and CML-AP	Nilotinib	137	30	Not reported	
Cabazitaxel (Jevtana; approved June 17, 2010)	371	Metastatic prostate cancer	Cabazitaxel/prednisone	240	65	70	19
Erlotinib (Tarceva; approved April 16, 2010)	433	NSCLC	Maintenance erlotinib	147	34	Not reported	
	485	NSCLC	Second/third line	189	39	Not reported	
	259	Pancreatic cancer	Erlotinib/gemcitabine	124	48	Not reported	
Rituximab (Rituxan; approved February 18, 2010)	927	DLBCL	Rituximab/chemotherapy	396	43	123	13
	505	Low-grade/follicular lymphoma	Rituximab	123	24	Not reported	
	676	CLL	Rituximab/fludarabine/cyclophosphamide	243	36	100	15
Lapatinib (Tykerb; approved January 29, 2010, and March 13, 2007)	198	Metastatic breast cancer	Capecitabine/lapatinib	34	17	2	1
	642	Metastatic breast cancer	Letrozole/lapatinib	282	44	77	12
Romidepsin (Istodax; approved November 6, 2009)	167	CTCL	Romidepsin	38	23	Not reported	
Ofatumumab (Arzerra; approved October 26, 2009)	181	CLL	Ofatumumab	Not reported		Not reported	
Pazopanib (Votrient; approved October 19, 2009)	586	Metastatic renal cell cancer	Pazopanib	196	33	34	6
Pralatrexate (Folotyn; approved September 24, 2009)	111	PTCL	Pralatrexate	40	36	Not reported	
Bevacizumab (Avastin; approved July 31, 2009, and May 5, 2009)	742‡	Metastatic colon cancer	Fluorouracil/bevacizumab	212	29	43	6
		Metastatic lung cancer	Carboplatin/taxol/bevacizumab				
		Metastatic renal cancer	Ifn/bevacizumab				
		GBM	Bevacizumab				
	1,745	Randomized studies		618	35	Not reported	
Pemetrexed (Alimta; approved July 2, 2009, and September 26, 2008)	839	NSCLC	Pemetrexed/cisplatin	316	38	Not reported	
	438	NSCLC (maintenance)	Pemetrexed	146	33	Not reported	
	265	NSCLC (after prior chemotherapy)	Pemetrexed	79	30	Not reported	
	168	Mesothelioma	Pemetrexed/cisplatin	62	37	Not reported	
Everolimus (Afinitor; approved March 30, 2009)	274	Metastatic renal cell carcinoma	Everolimus	112	41	19	7
Degarelix (Firmagon; approved December 24, 2008)	1,325	Prostate cancer	Degarelix	1,087	82	557	42
Imatinib mesylate (Gleevec; approved December 19, 2008)	1,027	CML	Imatinib	205	20	Not reported	
	553	CML (new diagnosis)	Imatinib	33	6	Not reported	
	1,640	GIST (nonresectable metastatic)	Imatinib	262	16	Not reported	
	713	GIST (adjuvant)	Imatinib	221	31	Not reported	
Plerixafor (Mozobil; approved December 15, 2008)	301	NHL and multiple myeloma	Plerixafor/G-CSF	72	24	2	1
Eltrombopag (Promacta; approved November 20, 2008)	106	ITP	Eltrombopag	23	22	10	9
Bendamustine hydochloride (Treanda; approved October 31, 2008, and March 20, 2008)	153	CLL	Bendamustine	71	46	Not reported	
	176	NHL	Bendamustine	Not reported		Not reported	
Denileukin diftitox (Ontak; approved October 15, 2008)	234	CTCL	Denileukin diftitox	Not reported		Not reported	
Romiplostim (Nplate; approved August 22, 2008)	271	ITP	Romiplostim	55	20	27	10
Bortezomib (Velcade; approved June 20, 2008)	333	Relapsed multiple myeloma	Bortezomib	125	38	Not reported	
Sorafenib (Nexavar; approved November 16, 2007)	297	HCC	Sorafenib	175	59	56	19
	451	RCC	Sorafenib	144	32	18	4
Ixabepilone (Ixempra; approved October 16, 2007)	431	Metastatic breast cancer	Ixabepilone/capecitabine	45	10	3	1
	240	Metastatic breast cancer	Ixabepilone	32	13	6	3
Cetuximab (Erbitux; approved	1,062	Advanced colorectal cancer	With irinotecan or alone	363	34	Not reported	

Aspettative dei pazienti

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Patients' Expectations about Effects of Chemotherapy for Advanced Cancer

Jane C. Weeks, M.D., Paul J. Catalano, Sc.D., Angel Cronin, M.S., Matthew D. Finkelman, Ph.D., Jennifer W. Mack, M.D., M.P.H., Nancy L. Keating, M.D., M.P.H., and Deborah Schrag, M.D., M.P.H.

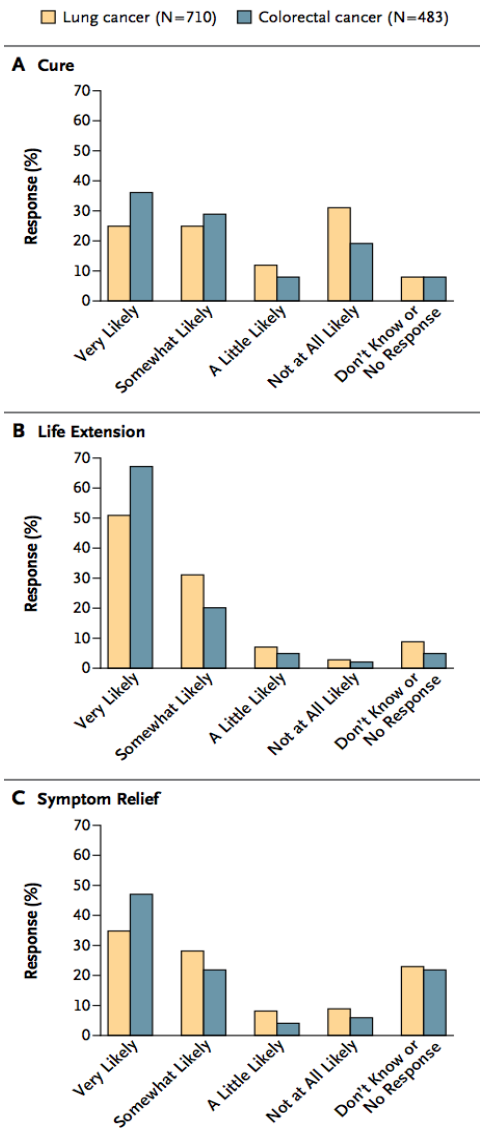
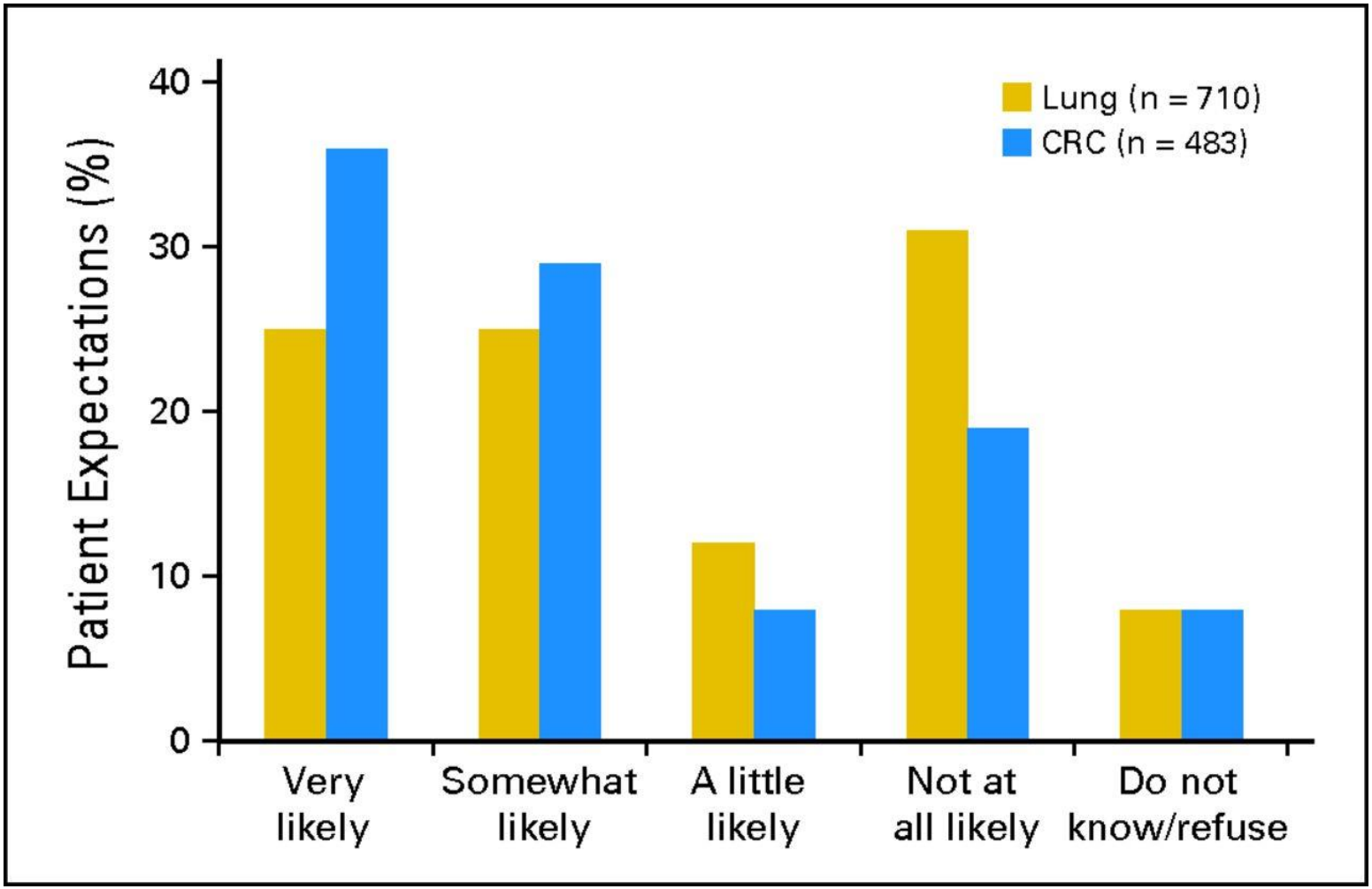


Figure 1. Responses to Questions about the Likelihood That Chemotherapy Will Have an Effect, According to the Type of Effect and Diagnosis.

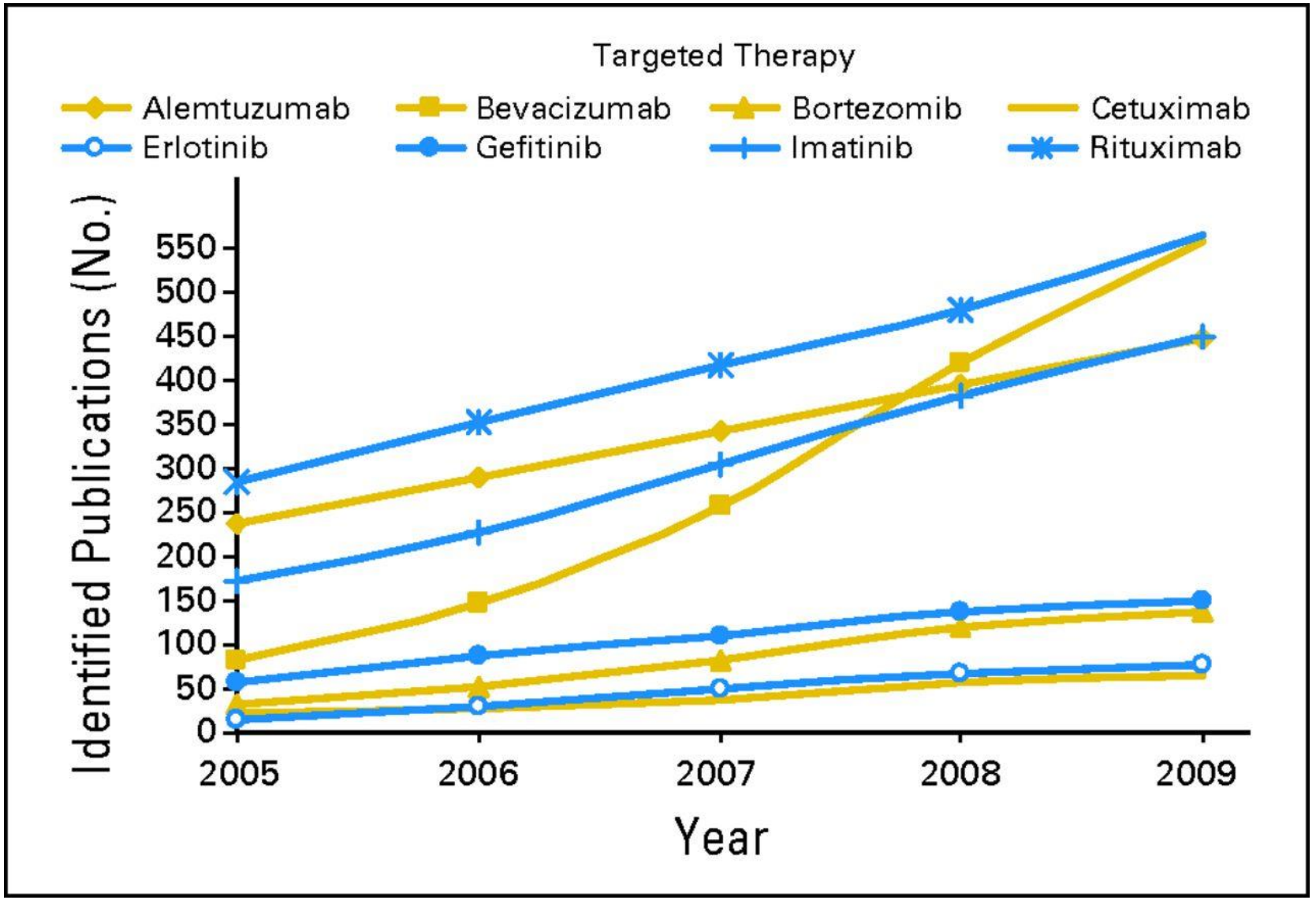
Shown are the responses of patients with advanced lung or colorectal cancer to questions regarding whether chemotherapy will cure their disease (Panel A), extend their life (Panel B), or provide relief of symptoms (Panel C).

Patient expectations of likelihood that chemotherapy will cure cancer.



Shih Y T et al. JCO 2013;31:4151-4157

Number of publications supporting off-label indications, 2005 to 2009.



Shih Y T et al. JCO 2013;31:4151-4157

Aggressiveness of cancer care near end of life: is it a quality-of care issue?

(Earle CC, JCO, 2008; 26: 3860-3866)

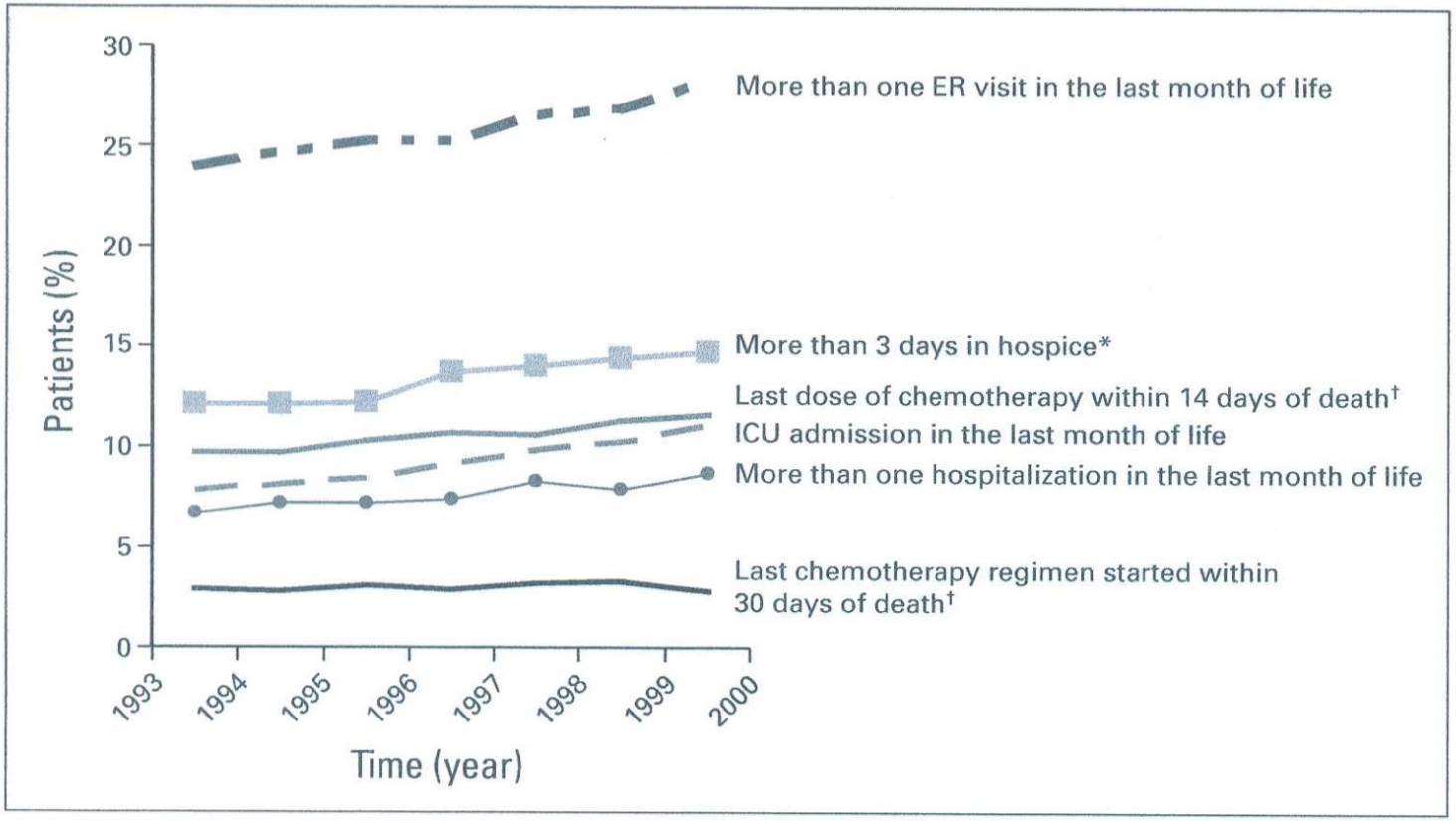


Fig 1. Updated trends in the aggressiveness of cancer care near the end of life, all cancer types, all durations of disease among 215,484 Medicare enrollees in Surveillance, Epidemiology, and End Results (SEER) areas who died as a result of cancer. (*) Among patients admitted to hospice. (†) Among patients who received chemotherapy. ER, emergency room; ICU, intensive care unit.

“Bisogno di conoscere e comprendere….bisogno di essere conosciuto e compreso “

NURSE…..

Saito *et al. BMC Palliative Care* 2011, **10**:14
http://www.biomedcentral.com/1472-684X/10/14

BMC Palliative Care

RESEARCH ARTICLE Open Access

The effect on survival of continuing chemotherapy to near death

Akiko M Saito[1], Mary Beth Landrum[2], Bridget A Neville[3], John Z Ayanian[2,4] and Craig C Earle[5*]

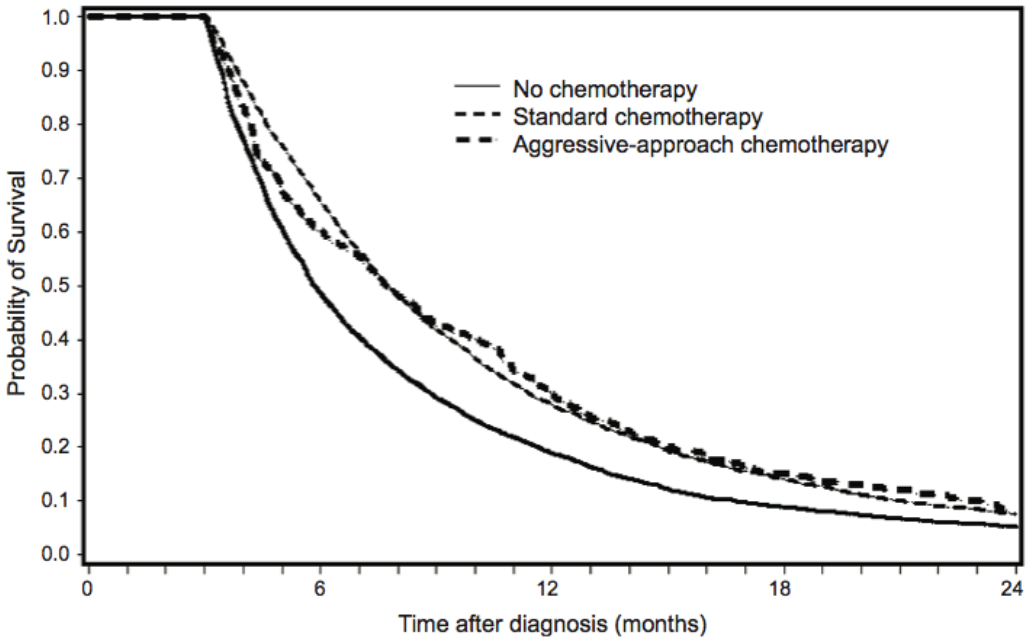


Figure 1 Unadjusted survival among for metastatic non-small cell lung cancer patients by receipt of chemotherapy. Three lines indicate patients who never received chemotherapy (solid line), those who received standard chemotherapy (dashed line), and those who received an aggressive chemotherapy approach continued to within 14 days of death (thick dashed line).

Processes of Discontinuing Chemotherapy for Metastatic Non–Small-Cell Lung Cancer at the End of Life

By William F. Pirl, MD, MPH, Joseph A. Greer, PhD, Kelly Irwin, MD, Inga T. Lennes, MD, MPH, MBA, Vicki A. Jackson, MD, MPH, Elyse R. Park, PhD, MPH, Daisuke Fujisawa, MD, PhD, Alexi A. Wright, MD, MPH, and Jennifer S. Temel, MD

Massachusetts General Hospital Cancer Center; Dana-Farber Cancer Institute, Boston; Harvard University, Cambridge, MA; and Keio University School of Medicine, Tokyo, Japan

Journal of

Table 2. Processes of Discontinuing Chemotherapy

Process	Proportion of Patients (n = 81)		Description
	No.	%	
Definitive decision	16	19.7	Final chemotherapy was followed by documented discussion about permanently stopping chemotherapy
Deferred decision (break)	18	22.2	Documentation of discussion about explicitly discontinuing chemotherapy, with plan to re-evaluate and consider further treatment
Disruption because of radiation treatment	18	22.2	Chemotherapy held for initiation of radiation therapy for brain or bone metastases and hemoptysis, and documentation of intent for potential chemotherapy treatment after completing radiation therapy
Disruption because of hospitalization	22	27.2	Patient hospitalized before next scheduled infusion, and chemotherapy was never restarted
No decision	7	8.6	Patient died before receiving scheduled chemotherapy, and there was no documentation of stopping chemotherapy

EXTENT AND DETERMINANTS OF ERROR IN DOCTORS' PROGNOSES IN TERMINALLY ILL PATIENTS: PROSPECTIVE COHORT STUDY

(Christakis NA et al, BMJ 2000; 320: 469-473)

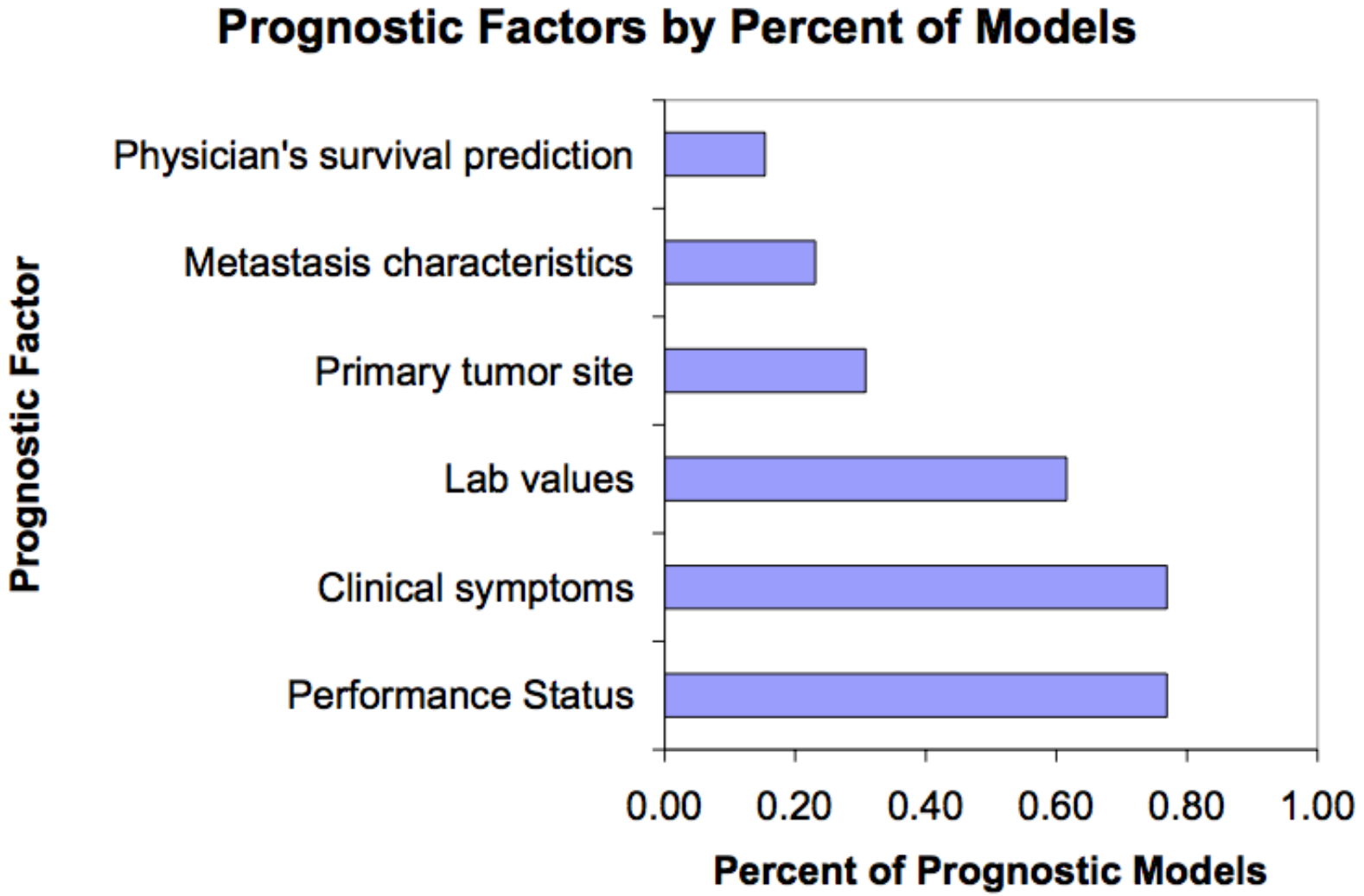
343 doctors' survival estimates for 468 terminally ill patients at hospice referral time

Median survival 24 days

	N°	%
Accurate predictions (± 33% AS)	92	20
Overoptimistic	295	63
Over pessimistic	81	17

Overstimated survival by a factor of 5.3

Non-oncology medical specialists were 326% more likely than general internists to make overpessimistic predictions. As duration of doctor-patient relationship increased and time since last contact decreased, prognostic accuracy decreased.


Prognostic Factors by Percent of Models
Prognostic Factor
Physician's survival prediction
Metastasis characteristics
Primary tumor site
Lab values
Clinical symptoms
Performance Status
0.00
0.20
0.40
0.60
0.80
1.00
Percent of Prognostic Models

THE PALLIATIVE PROGNOSTIC SCORE (PaP Score)

Characteristic	Score	Characteristic	Score
Dyspnea		Karnofsky Performance Status	
No	0	≥50	0
Yes	1	30-40	0
Anorexia		10-20	2.5
No	0	Total leukocytes (cell mm^3)	
Yes	1	4800-8500	0
Clinical prediction of survival (wks)		8501-11000	0.5
>12	0	>11000	1.5
11-12	2.0	Lymphocyte rate (%)	
9-10	2.5	20.0-40.0	0
7-8	2.5	12.0-19.9	1.0
5-6	4.5	0-11.9	2.5
3-4	6.0		
1-2	8.5		

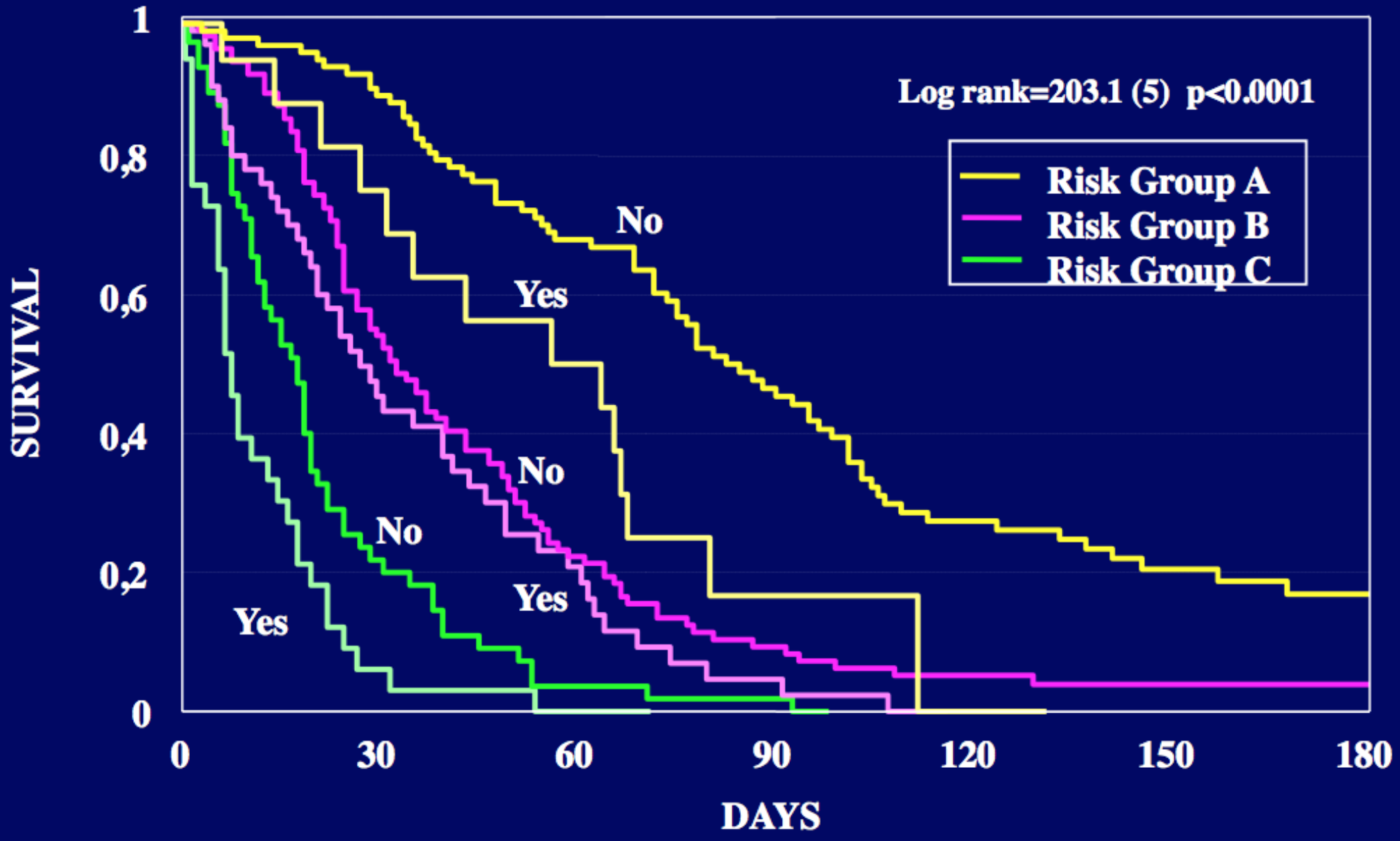
PaP Score groups according to their 30-day survival probability estimate

Risk group		30-days survival (%)	PaP Score
A.	Best prognosis	>70	0.0-5.5
B.	Intermediate prognosis	30-70	5.6-11.0
C.	Worst prognosis	<30	11.1-17.5

Impact of delirium on the short term prognosis of advanced cancer patient

Italian Multicenter Study Group on Palliative Care

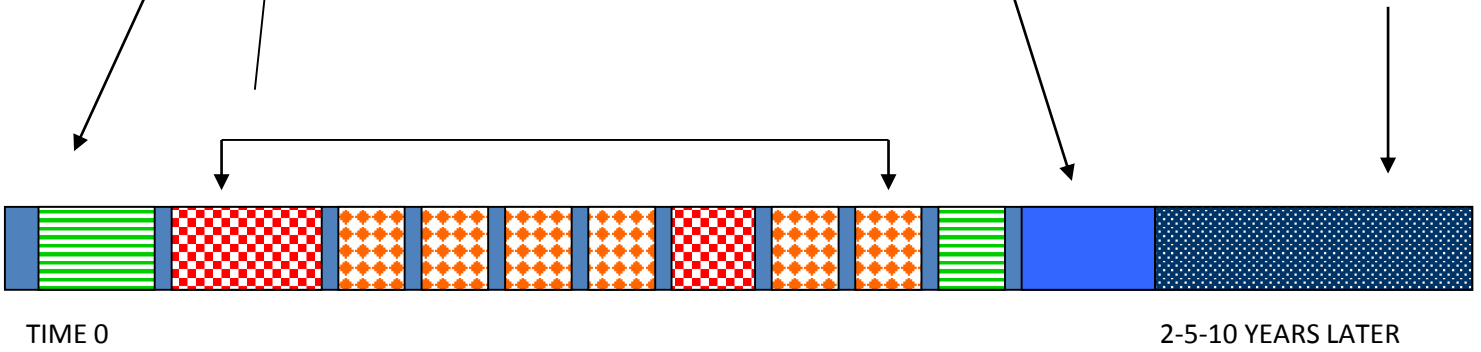
(Caraceni A, Cancer, 2000)



Educazione ….Tempo …. Spazio ….. ….
Comunicazione…. Strumenti & Ricerca

IL PERCORSO DIAGNOSTICO-TERAPEUTICO: ESTENUANTE E FRAMMENTATO

- SCREENING e/o DIAGNOSI
- TERAPIA ANTIBLASTICA (degenza, DH)
- RIABILITAZIONE (??)
- ASSISTENZA DOMICILIARE/HOSPICE (Cure Palliative)



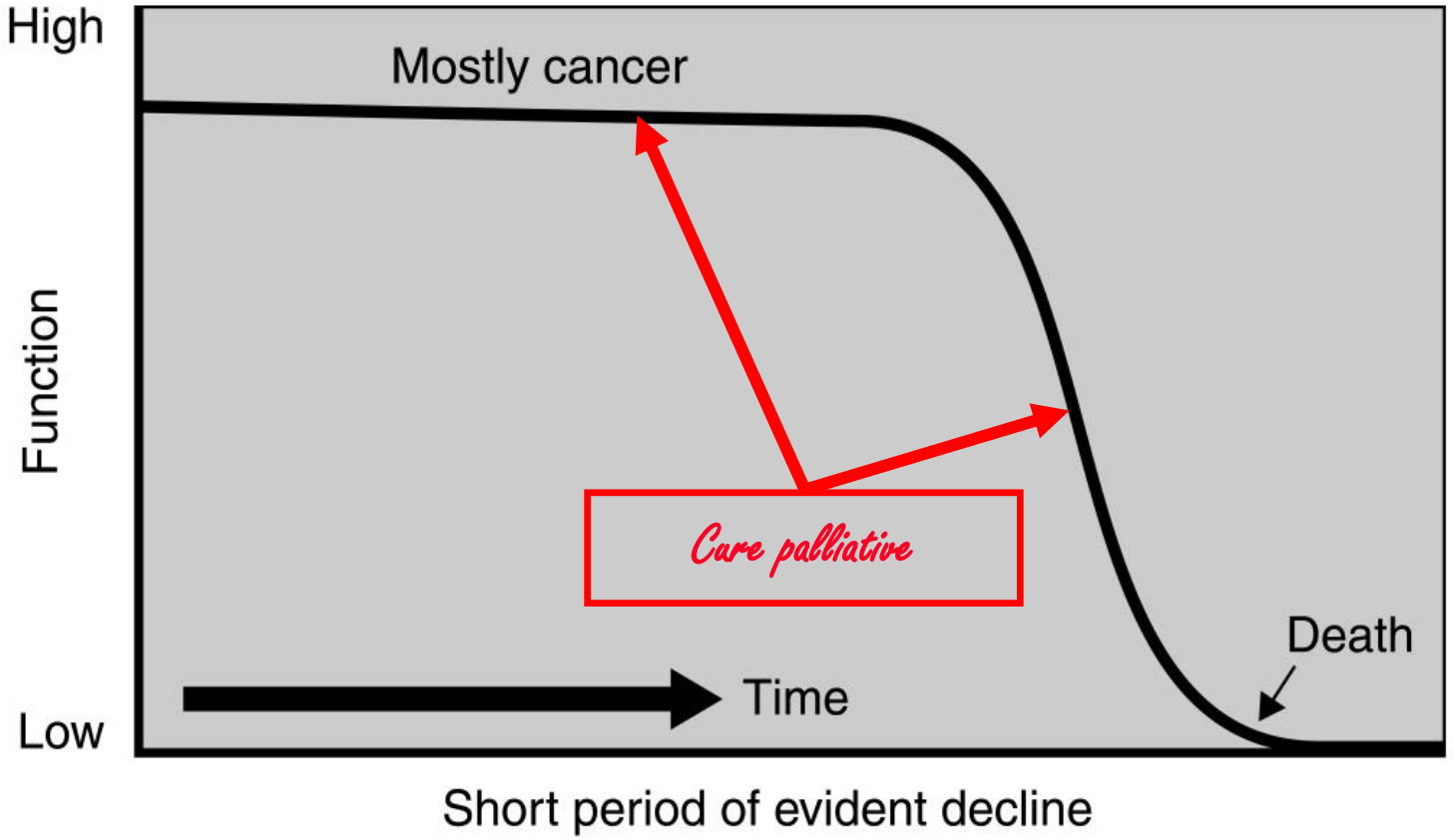
GP
AMBULATORY
HOSPITAL ADMISSION
HOSPITAL DAY
RHEABILITATION CENTER
HOSPICE/HOME CARE

M. Nonis, 2008, modificata.

PROGRESSIONE DELLA MALATTIA ONCOLOGICA:

rapido declino dello stato funzionale negli ultimi mesi di vita

NECESSARIO UN INTERVENTO PRECOCE:
per anticipare i bisogni e controllare i sintomi



Source: Lynn & Adamson

Palliative care across the continuum of cancer care

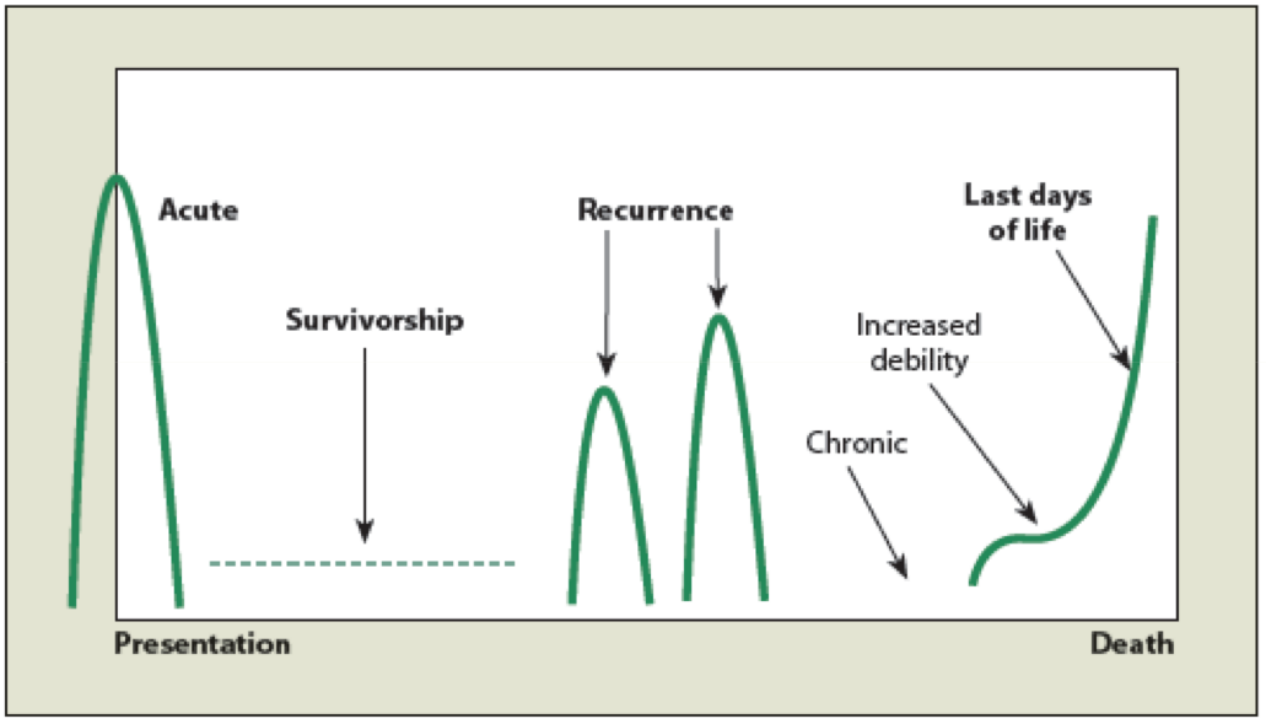


Figure 2: Symptoms across the trajectory of the cancer experience.

Ramchandran K. Oncology 27:1-18, 2013

“fight, win, live” or “quit, lose, die.”

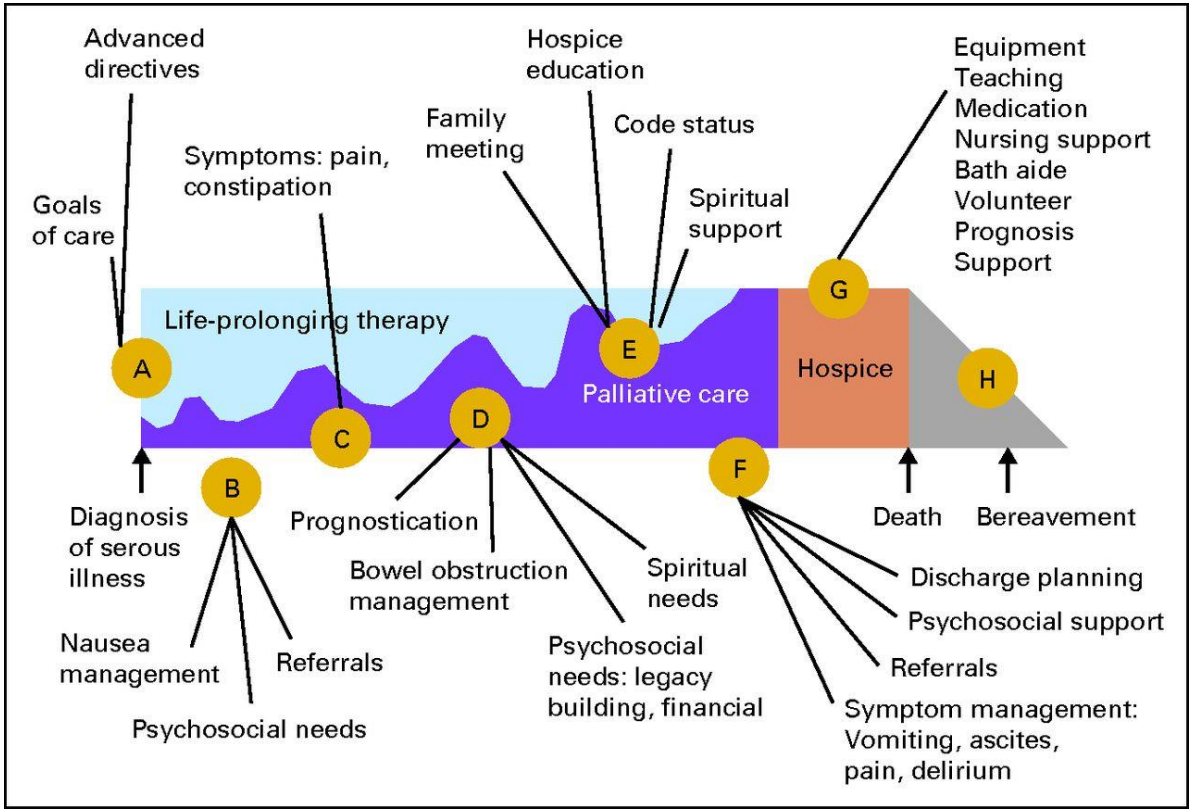
Poor or late timing of intervention, at time of crisis

Framing of the palliative care team as the “stop” team, after all “go” measures have been exhausted

Lack of shared agreement about the treatment plan among providers

Lack of empowerment of every care team member to identify patient and family needs

Lack of respect for complexity of relationships, among both family and providers



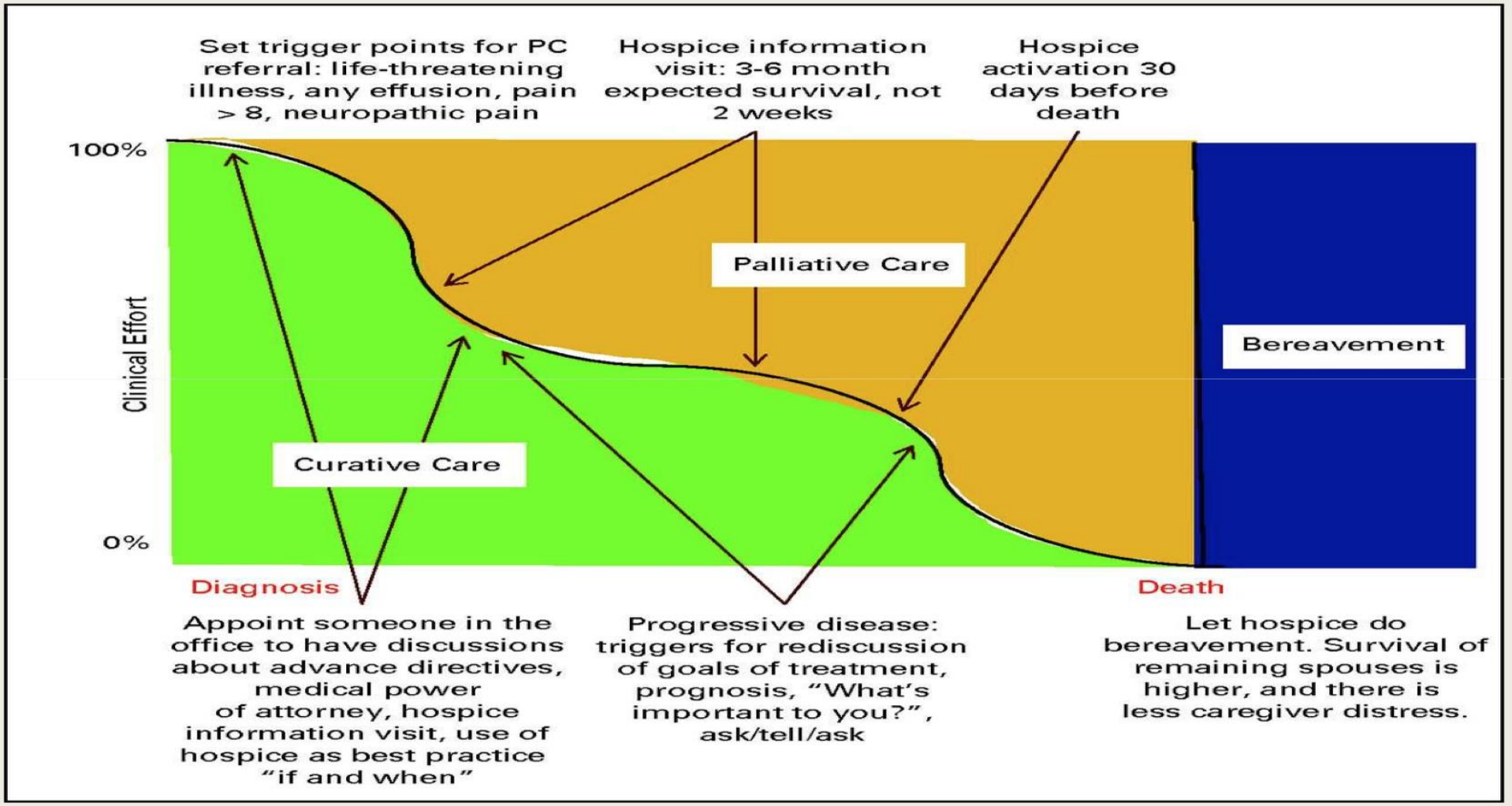
Hennessy J E et al. JOP 2013;9:78-80

CAMBIAMENTO DELL'ATTENZIONE AI SINTOMI

- Nel contesto di cura della malattia avanzata metastatica è necessario la loro rilevazione sistematica così come l'andamento nel tempo

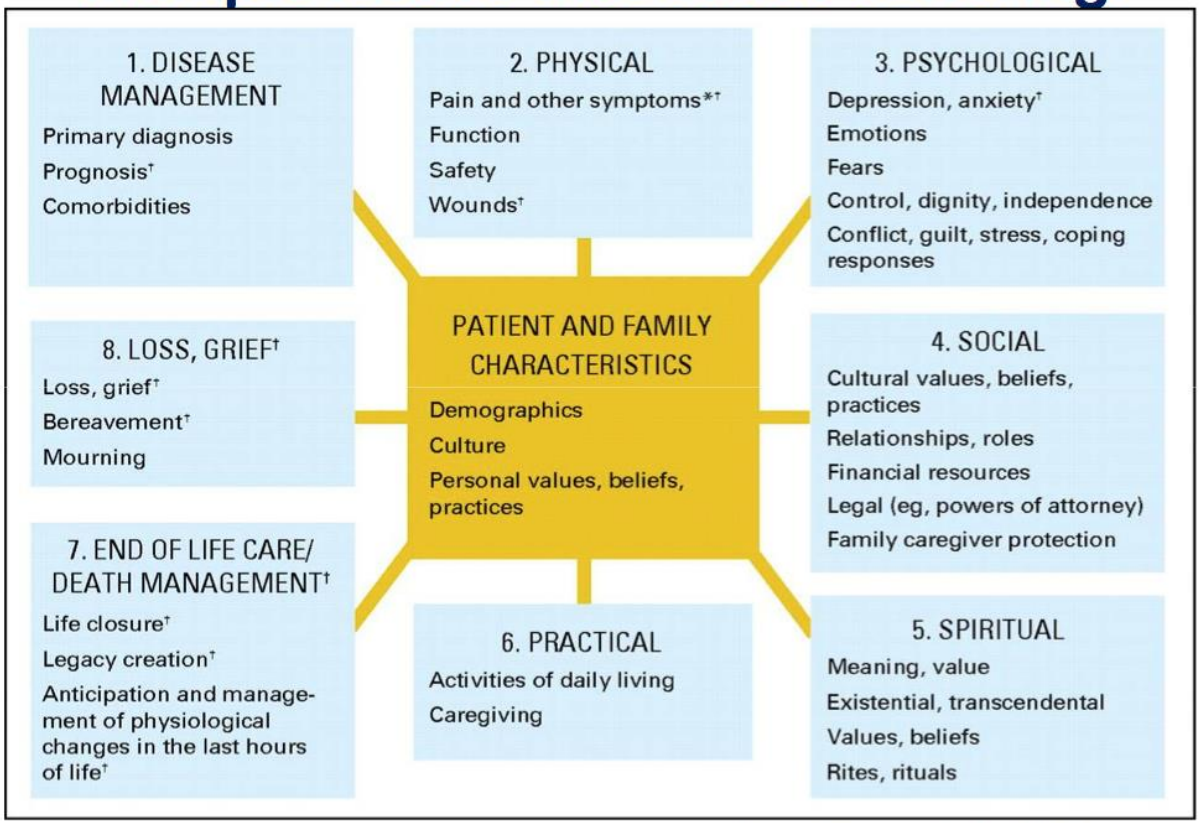
- Informazione adeguata e condivisa
- Adeguato trattamento ed educazione alla gestione
- In quali settings ?
- Oggi….Domani

Palliative care moved upstream.



Cheng M J et al. JOP 2013;9:84-88

Multiple issues that cause suffering.



Ferris F D et al. JCO 2009;27:3052-3058

Sintomi riportati da pazienti ambulatoriali alla prima valutazione oncologica in Ontario

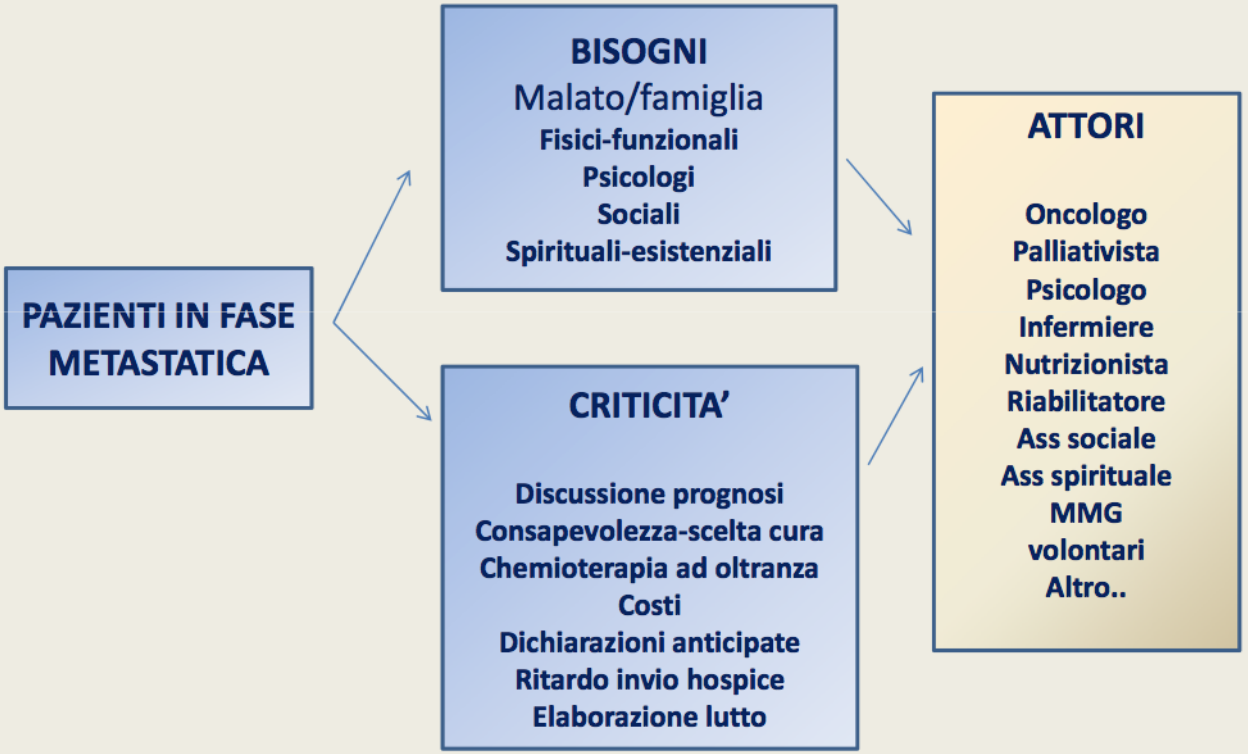
- Fatigue: 76% (66% MS*)
- Appetito: 60% (60% MS)
- Depressione : 44% (45% MS)
- Dolore 53% (60% MS)
- Dispnea 49% (50% MS)

- Paz con prognosi peggiore (2-4 vv il rischio di avere intensita mod sev)
- Paz con comorbidità: sintomi + severi
- Donne riportano maggiore intensità dei sintomi

*MS score: moderato-severo ≥ 4

Barbera L et al Cancer 2010

Cure simultanee:il contesto



BARRIERS

Resources Barriers
Exposure of Oncologists to Palliative Care
Public Exposure
Health Care Policy

PALLIATIVE CHEMOTHERAPY

Four principles guide palliative chemotherapy: therapy (1) with the fewest side effects, (2) with evidence base for relieving cancer symptoms, (3) with the greatest chance for improving quality of life, and (4) with evidence for extending quality of life

THE IMPORTANCE OF EARLY INTEGRATION OF PALLIATIVE CARE FOR ADVANCED CANCER: A MEDICAL ONCOLOGIST'S PERSPECTIVE

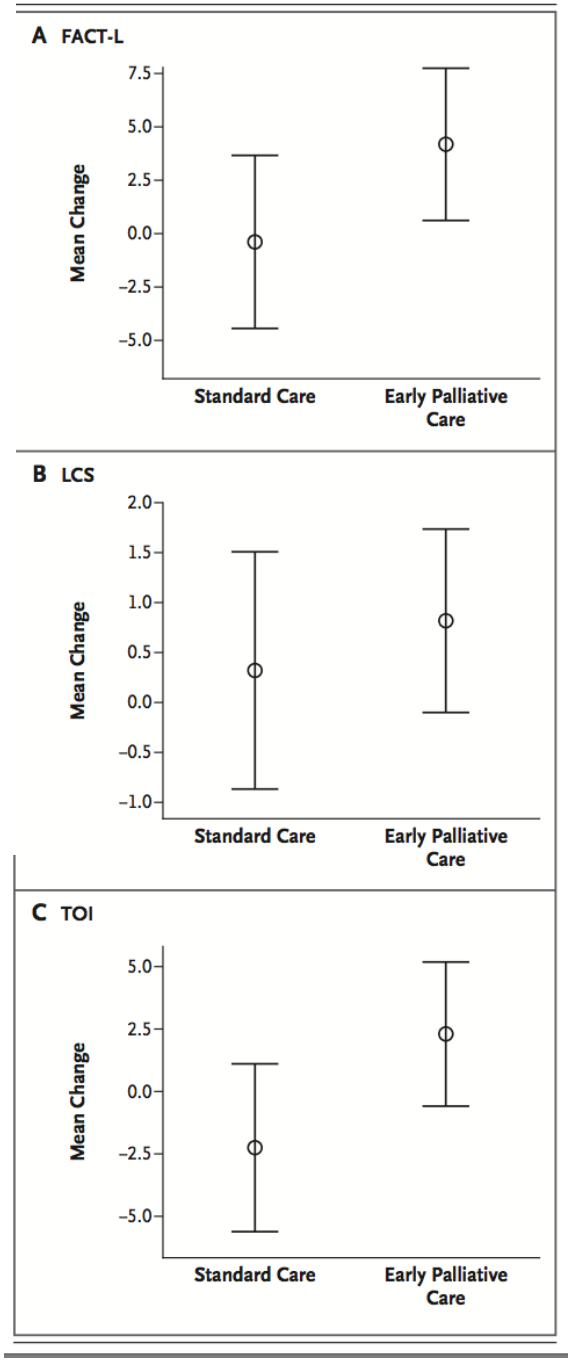
Decreased Time, Increased Demands
A Disconnect between Supply and Demand
Benefits of Early Integration
Harms of Late Referral

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., 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.



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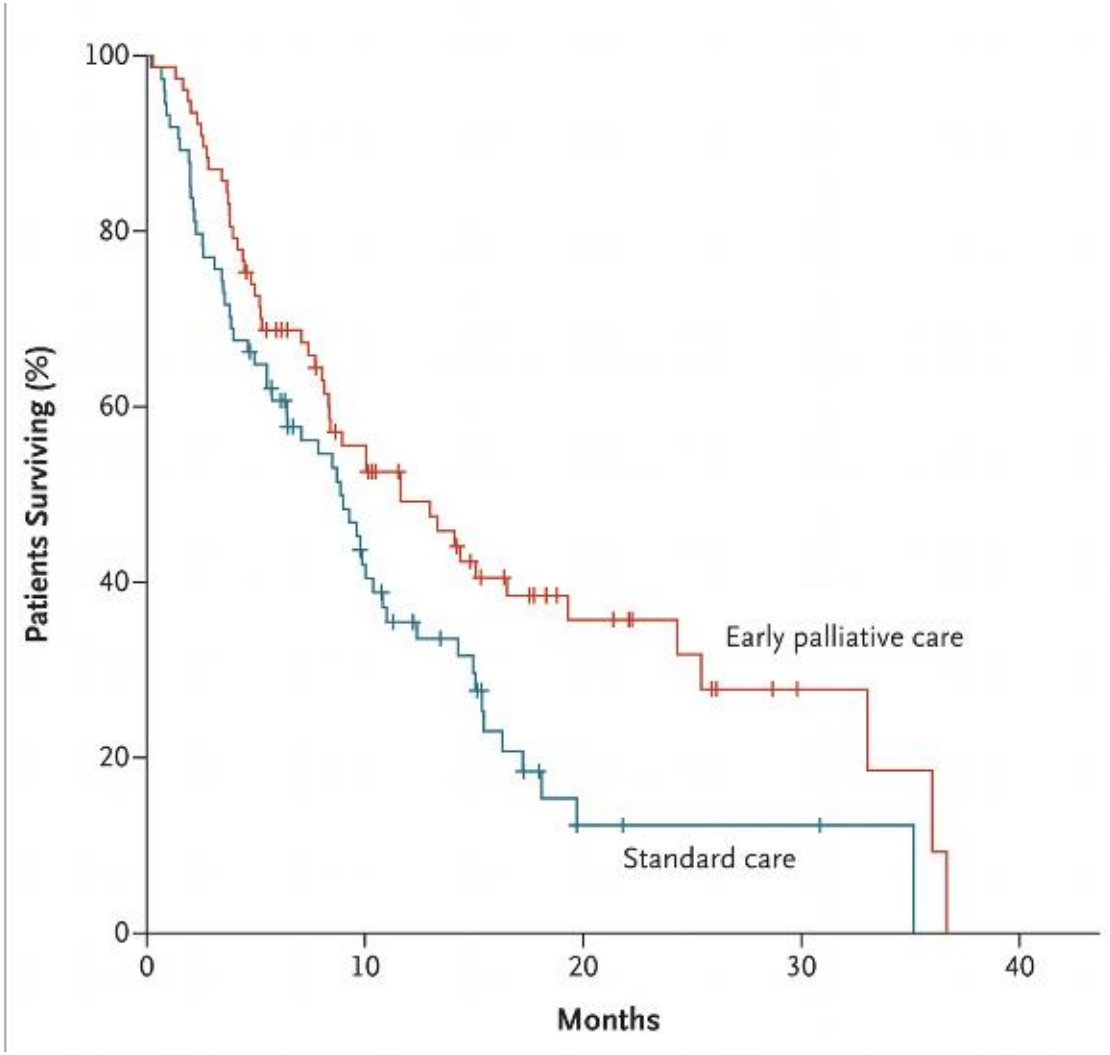
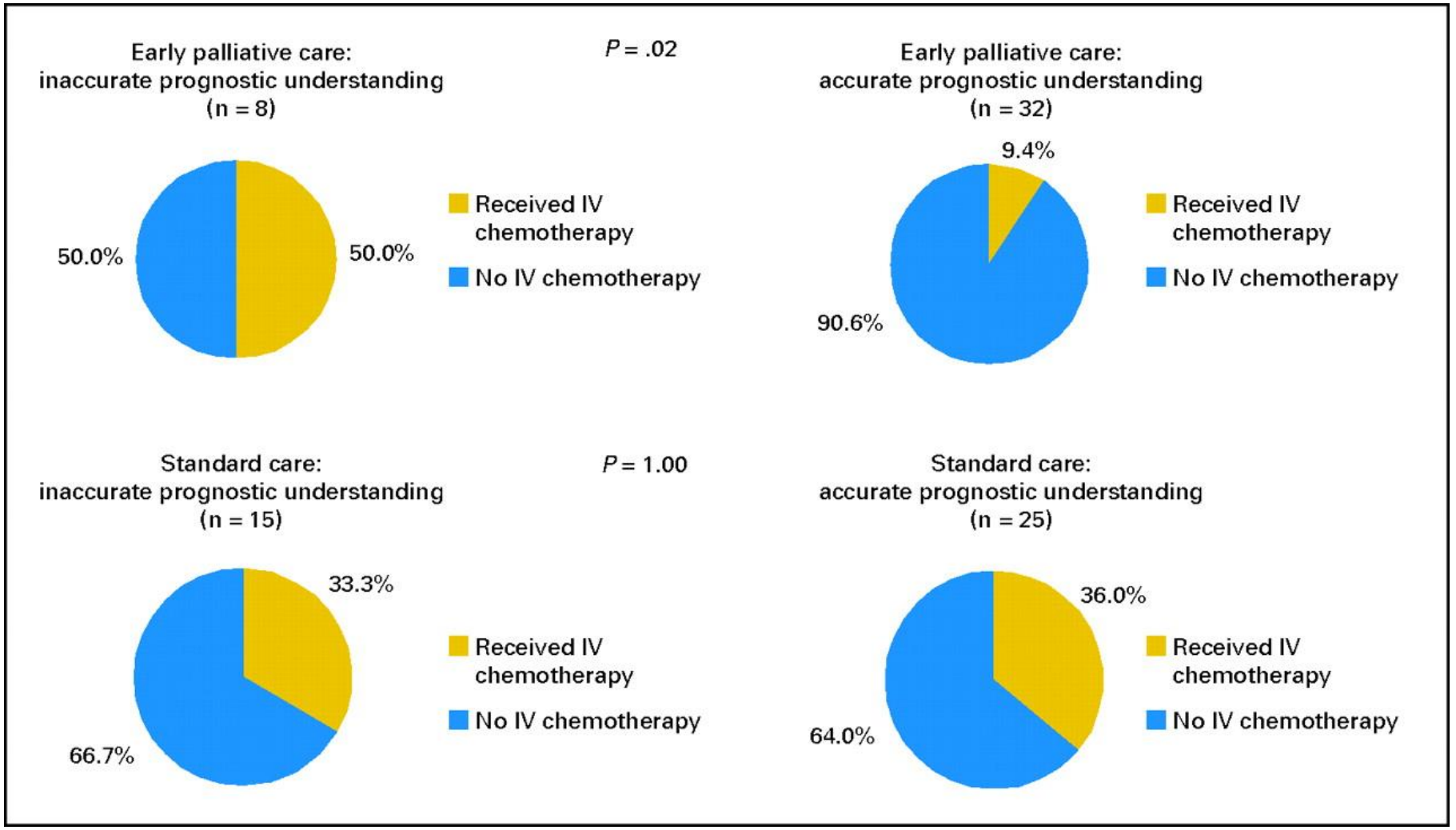
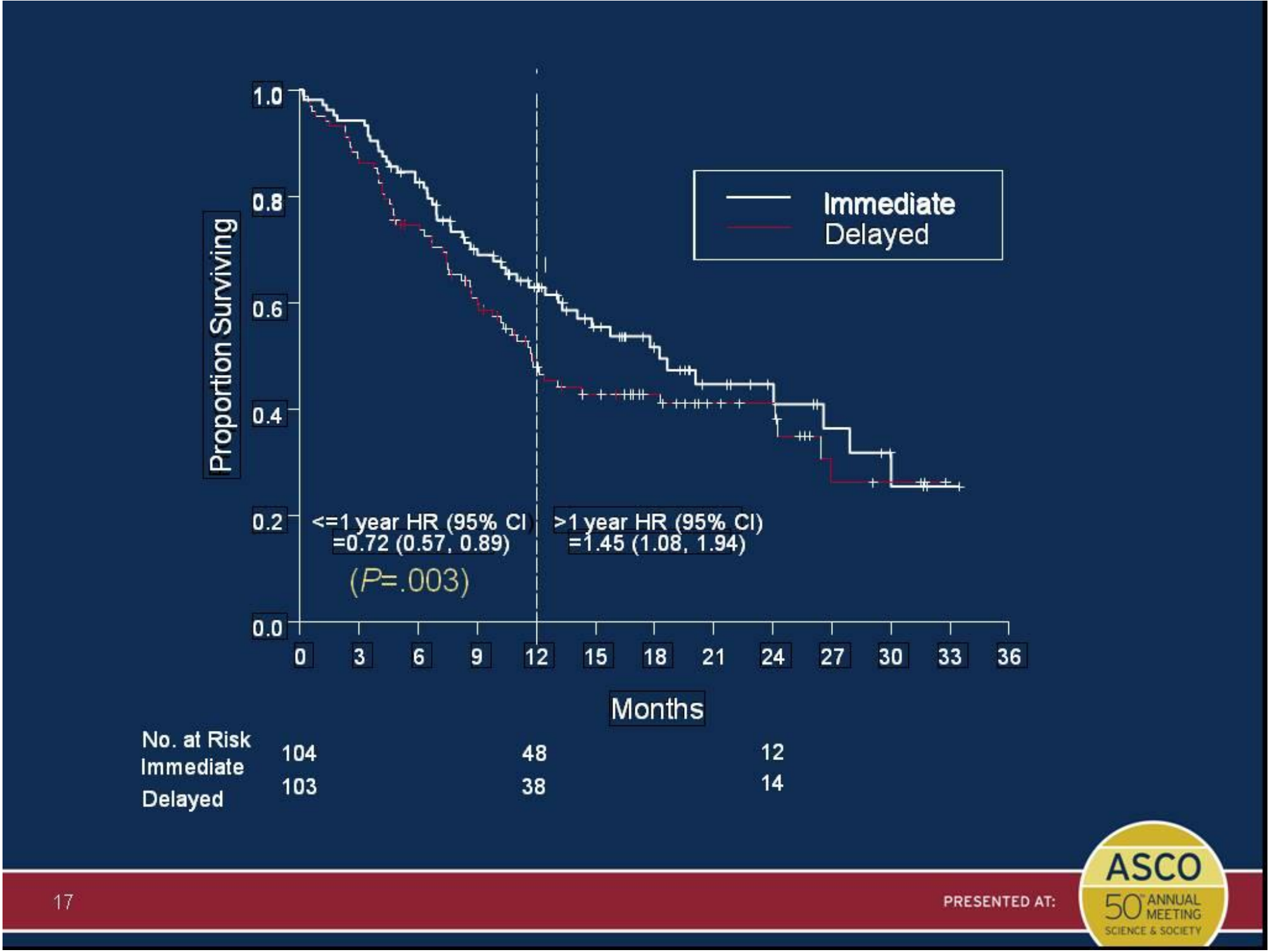
N Engl J Med 2010; 363:733-742A



Chemotherapy near the end of life according to study arm and prognostic understanding.



Temel J S et al. JCO 2011;29:2319-2326



Presented By Jennifer Temel at 2014 ASCO Annual Meeting

VOLUME 30 · NUMBER 8 · MARCH 10 2012

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care

Thomas J. Smith, Sarah Temin, Erin R. Alesi, Amy P. Abernethy, Tracy A. Balboni, Ethan M. Basch, Betty R. Ferrell, Matt Loscalzo, Diane E. Meier, Judith A. Paice, Jeffrey M. Peppercorn, Mark Somerfield, Ellen Stovall, and Jamie H. Von Roenn

Therefore, it is the Panel's expert consensus that combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden. Strategies to optimize concurrent palliative care and standard oncology care, with evaluation of its impact on important patient and caregiver outcomes (eg, QOL, survival, health care services utilization, and costs) and on society, should be an area of intense research

ASCO

American Society of Clinical Oncology

Making a world of difference in cancer care

The five key ASCO opportunities to improve care and reduce costs

Don't use cancer-directed therapy for solid tumor patients with the following characteristics

- Low PS (ECOG >3 Karnofsky < 40);
- No benefit from prior E.B.interventions,;
- Not eligible for a clinical trial;
- No strong evidence supporting the clinical value of further anticancer-treatment

Schnipper l et al J Clin Oncol April 3, 2012

SIMULTANEOUS CARE IN ONCOLOGY

There is a clear evidence for improved outcomes in multiple domains:

1. **Symptoms**
2. **Quality of end-of life care**
3. **Provider satisfaction**
4. **Cost of care**

Ramchandran K et al Oncology 27:1-18, 2013

Definizione/comunicazione
PROGNOSI
Scelta del trattamento

Comunicazione/relazione

Rilievo e trattamento
dei sintomi fisici

Rilievo e trattamento
dei bisogni riabilitativi

Rilievo e trattamento
dei bisogni psicologici

Rilievo e supporto ai
bisogni spirituali

Rilievo e supporto ai
bisogni sociali

CURE SIMULTANEE

Integrazione tra le terapie oncologiche attive e cure per il controllo dei sintomi, (palliative) dal momento della presa in carico del paziente oncologico.

“Le cure palliative iniziano quando inizia la sofferenza del malato e dei familiari”*.

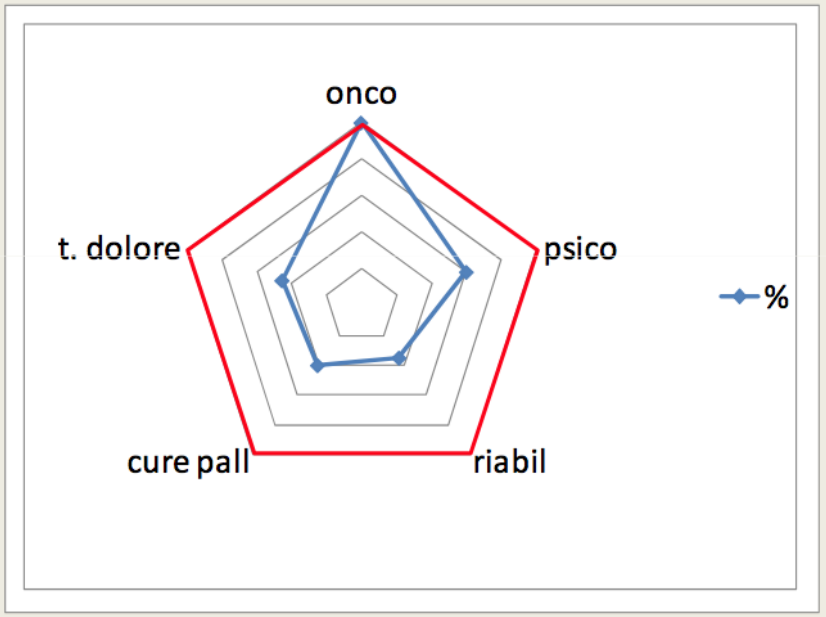
*E. Bruera Lectio magistralis, Bentivoglio 2011

SCREENING FOR PALLIATIVE CARE

- **Uncontrolled symptoms** or
- **Moderate-severe distress** related to cancer diagnosis and cancer therapy or
- **Serious comorbid physical and psychosocial conditions** or
- **Life expectancies <-12 months** or
- **Por patient/family concerns anbout corse of disease** and decision-making or
- **Patient/family requests for palliative care**

NCCN 2013

Services available at the Medical Oncology Dept



Data from: Libro Bianco AIOM 2012,
5th report of the cancer patient day, FAVO 2013, survey AIOM 2013

Five-Item Palliative Care Screening Tool

SCREENING ITEMS	Points
1. Presence of **metastatic or locally advanced cancer**	2
2. **ECOG PS**	0-4
3. One or more **complication**s usually associated with a prognosis < 12 months (brain metastases, hypercalcemia, delirium, spinal cord compression, cachexia)	1
4. One or more **comorbid conditions** (moderate-severe COPD, CHF, AIDS, dementia, end stage renal fauilure, end stage liver cirrhosis)	1
5. **Presence of palliative care problems**:	
- Symptoms uncontrolled by standard approaches	1
- Moderate -severe distress patient or or family, related to cancer diagnosis or ther.	1
- Patient/family concerns about course of disease and decision making	1
- Patient/family requests palliative care consult	1
- Team needs assistance with complex decision making or determining goals of care	1
TOTAL	0-13

Glare PA JOP; 7:367-370, 2011

Cure Simultanee in Italia

- Di che cosa c'è bisogno per realizzare le CS?
- A che punto siamo ?
- Come selezionare i pazienti che beneficiano delle CS?
- Quale il modello organizzativo migliore?

Aiom

F.A.V.O.
Federazione Italiana delle Associazioni di Volontariato in Oncologia

Nel 2010 più di un terzo dei malati oncologi italiani è deceduto in reparti per acuti.
In alcune Regioni questa percentuale ha superato il 50%

VIII GORNATA NAZIONALE DEL MALATO ONCOLOGICO Roma, 16-19 Maggio 2013
5° rapporto sulla condizione assistenziale dei malati oncologici

I CONFERENZA AIOM di consenso sulle CURE SIMULTANEE

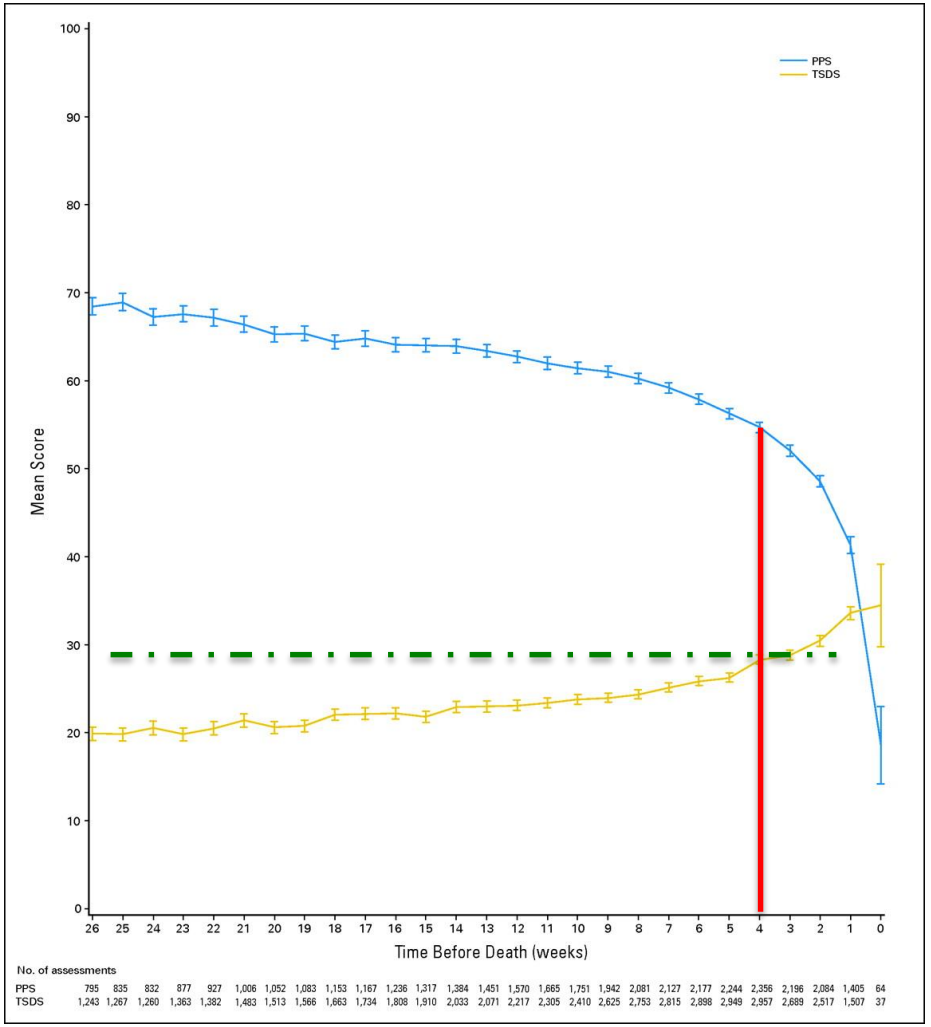
Grazie per l'attenzione……

VOLUME 29 · NUMBER 9 · MARCH 20 2011

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

Trajectory of Performance Status and Symptom Scores for Patients With Cancer During the Last Six Months of Life

Hsien Seow, Lisa Barbera, Rinku Sutradhar, Doris Howell, Deborah Dudgeon, Clare Atzema, Ying Liu, Amna Husain, Jonathan Sussman, and Craig Earle

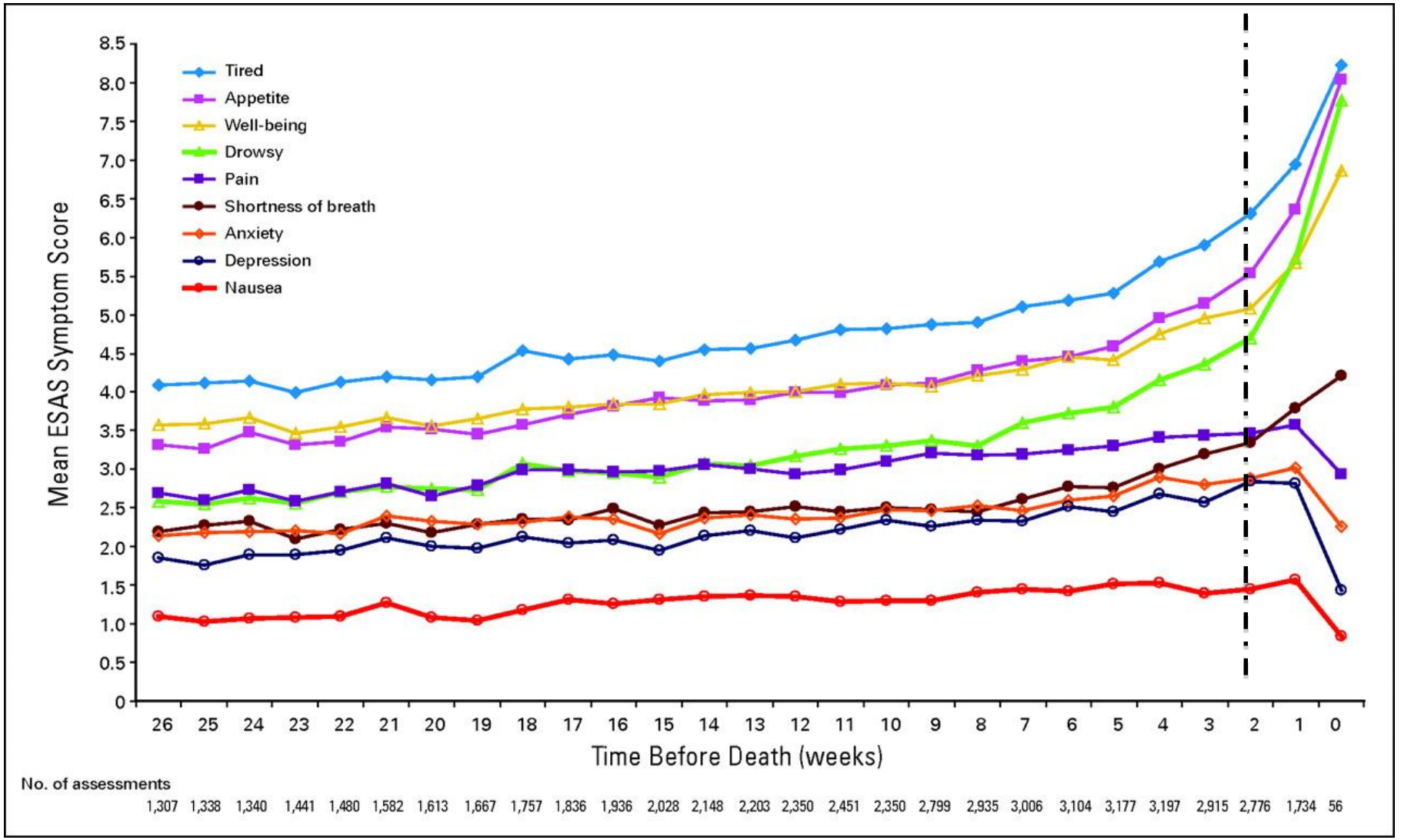


Mean Edmonton Symptom Assessment System (total symptom distress score [TSDS]) and Palliative Performance Scale (PPS) score.

the Edmonton Symptom Assessment System (ESAS) measures severity of nine symptoms (scale 0 to 10; 10 indicates the worst) and the Palliative Performance Scale (PPS) measures performance status (scale 0 to 100; 0 indicates death).

Seow H et al. JCO 2011;29:1151-1158

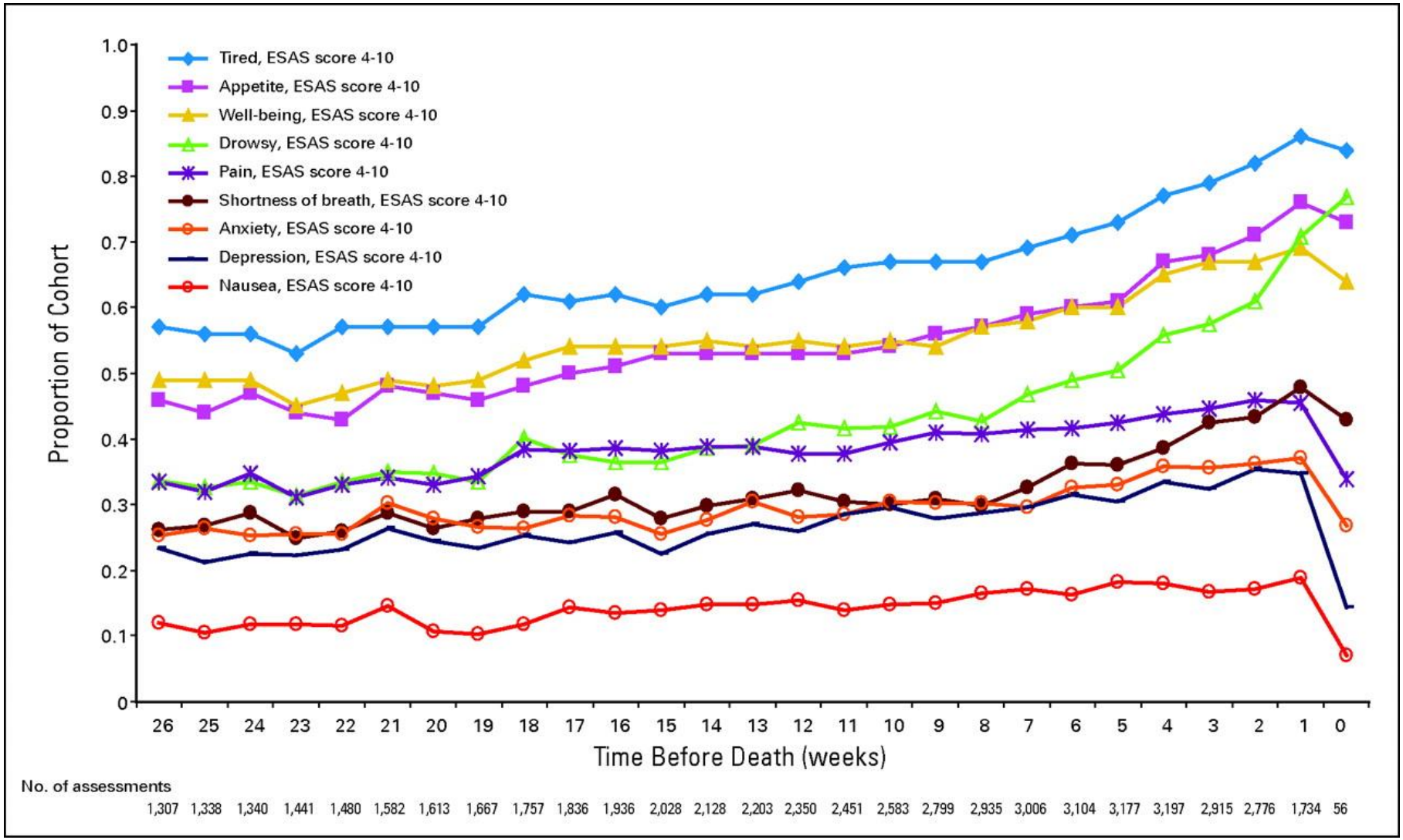
Mean Edmonton Symptom Assessment System (ESAS) symptom scores over time.



Seow H et al. JCO 2011;29:1151-1158

the Edmonton Symptom Assessment System (ESAS) measures severity of nine symptoms (scale 0 to 10; 10 indicates the worst) and the Palliative Performance Scale (PPS) measures performance status (scale 0 to 100; 0 indicates death).

Proportion of cohort reporting severe to moderate Edmonton Symptom Assessment System (ESAS) scores (ie, 4 to 10) over time.



Seow H et al. JCO 2011;29:1151-1158

BMJ

BMJ 2014;348:g3496 doi: 10.1136/bmj.g3496 (Published 6 June 2014)

RESEARCH

Impact of community based, specialist palliative care teams on hospitalisations and emergency department visits late in life and hospital deaths: a pooled analysis

What is already known on this topic

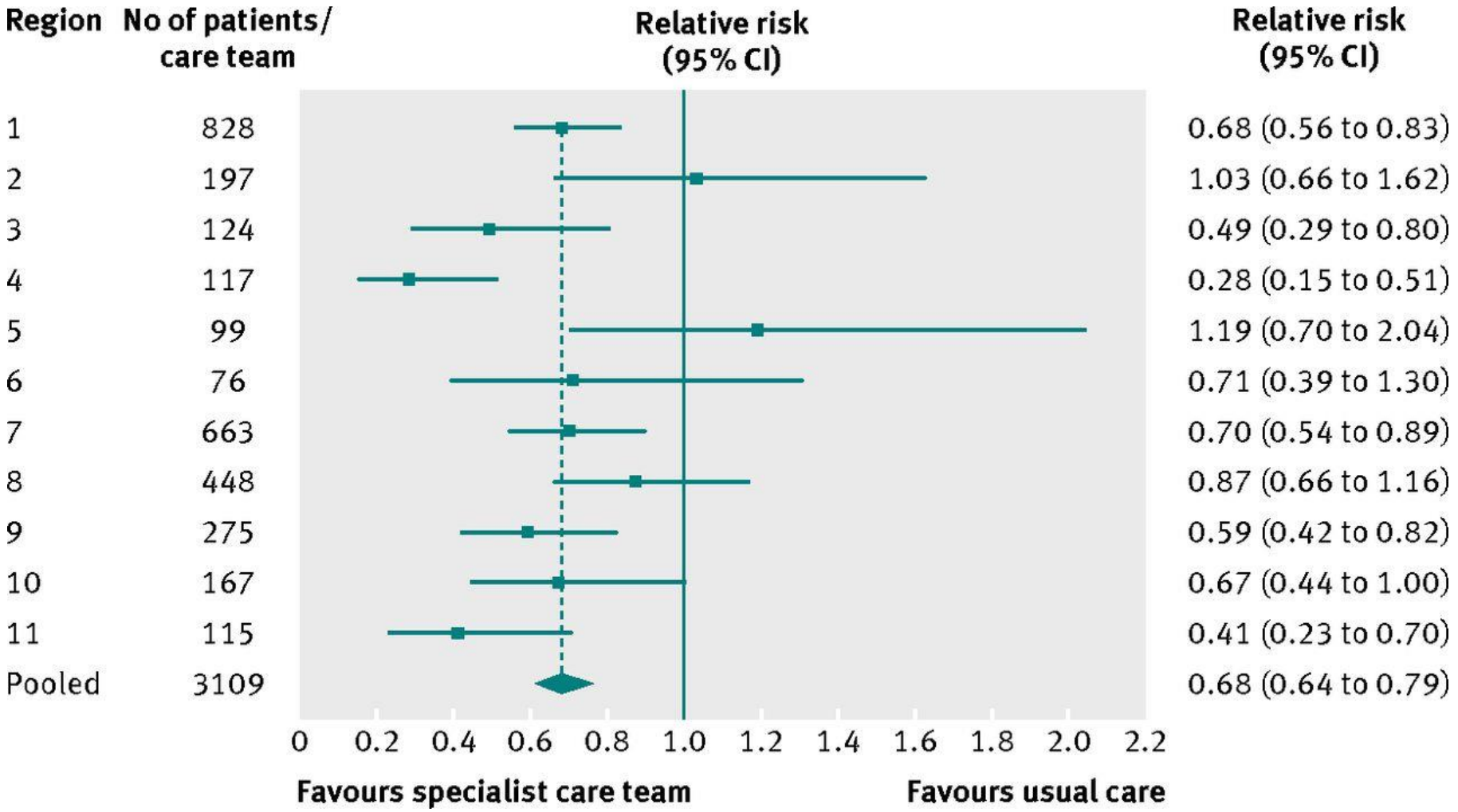
Several randomised trials of community based, specialist palliative care teams have produced mixed evidence as to their efficacy to reduce late life use of acute care and hospital deaths

Team size and composition varied in the trials, which may explain the variation in acute care use, but this has not been studied

What this study adds

A pooled analysis of 11 community based, palliative care teams strongly suggests that—despite variation in team size, composition, and geography served—exposure to the specialist team intervention compared with usual care significantly reduces the risk of: being in hospital (relative risk 0.68 (95% CI 0.61 to 0.76)) or having an emergency department visit (relative risk 0.77 (0.69 to 0.86)) in the last two weeks of life and of dying in hospital (relative risk 0.46 (0.40 to 0.52))

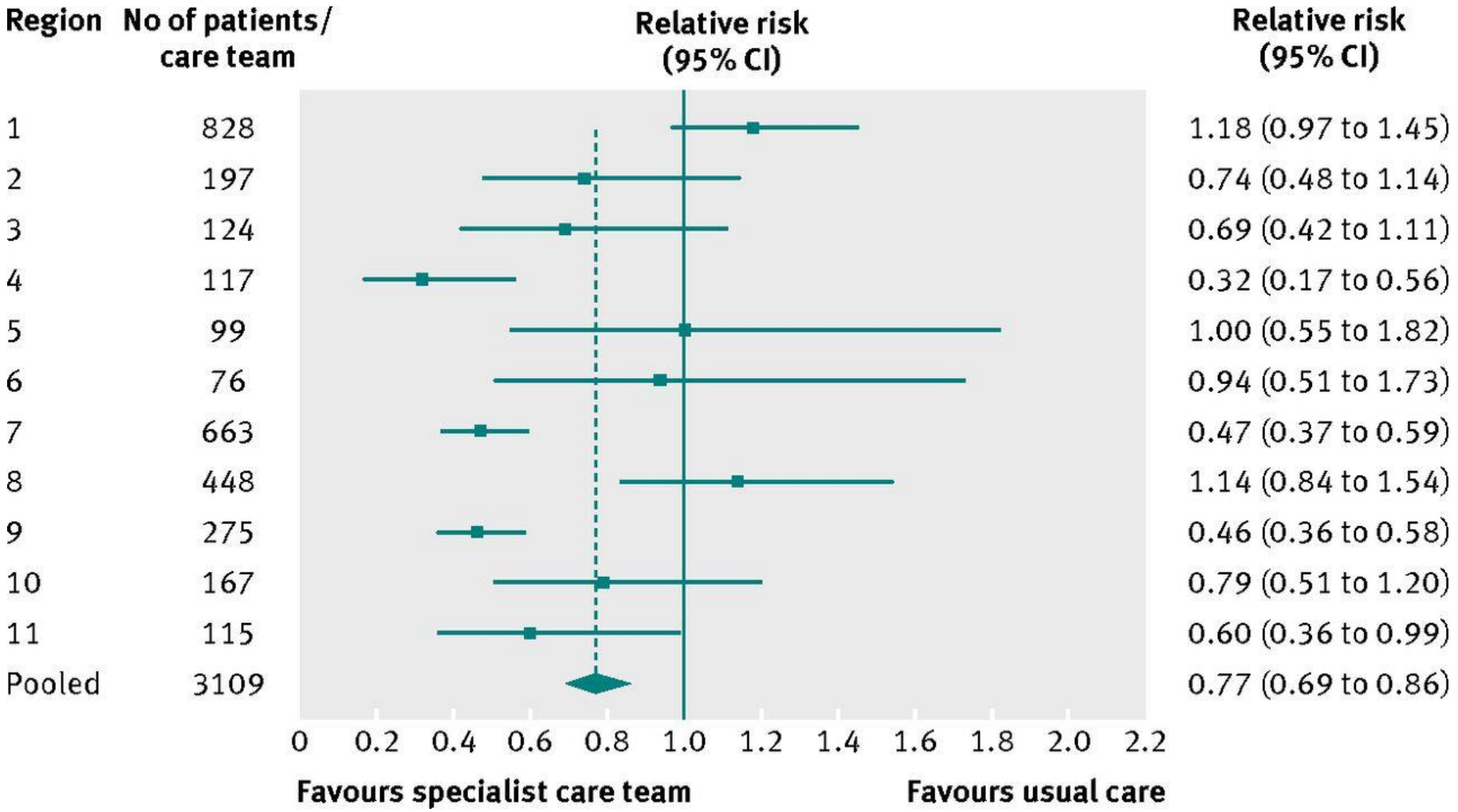
Relative risk of being in hospital in the last two weeks of life for exposed patients (care from specialist palliative care team) and unexposed patients (usual care).



Seow H et al. BMJ 2014;348:bmj.g3496

BMJ

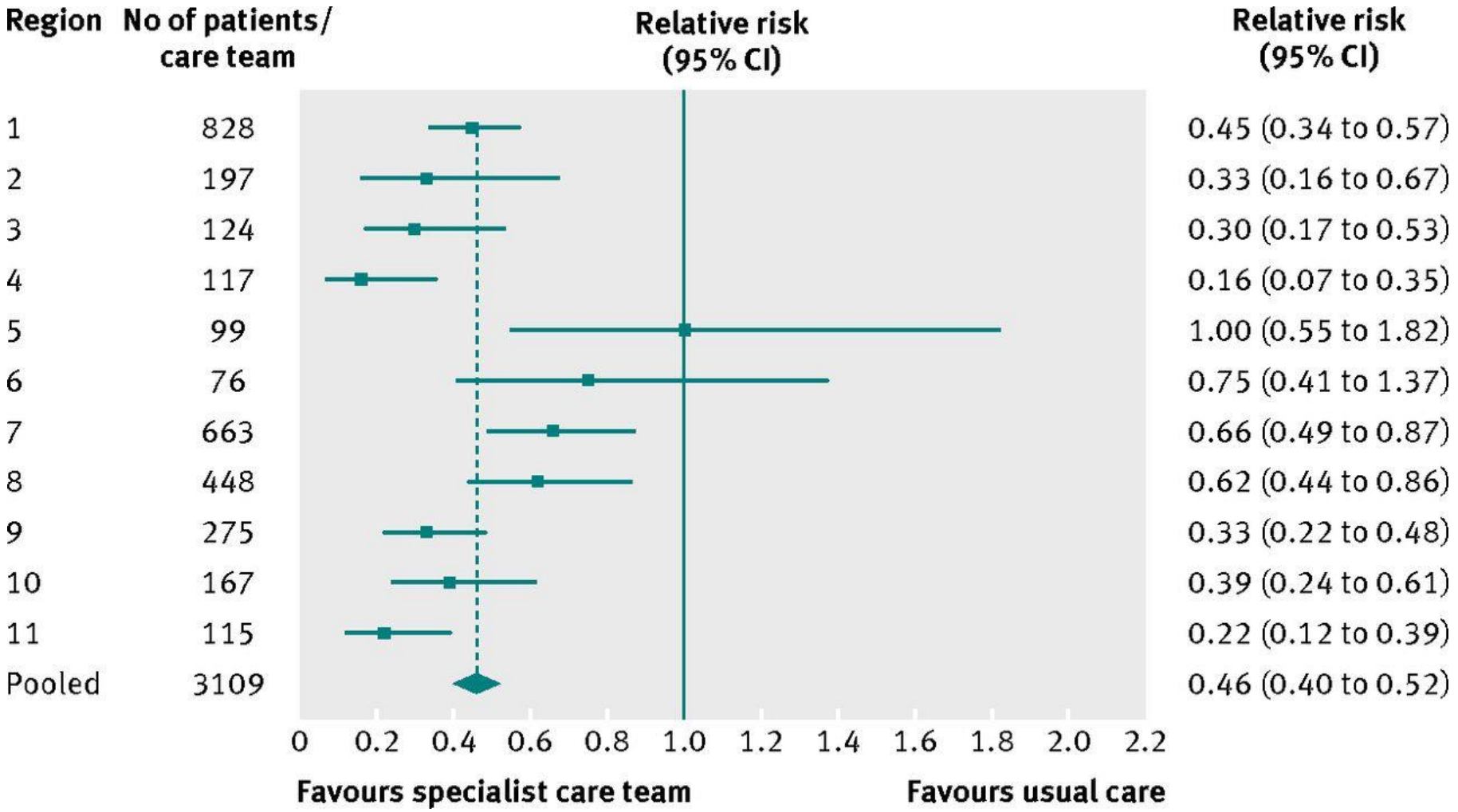
Relative risk of an emergency department visit in the last two weeks of life for exposed patients (care from specialist palliative care team) and unexposed patients (usual care).



Seow H et al. BMJ 2014;348:bmj.g3496

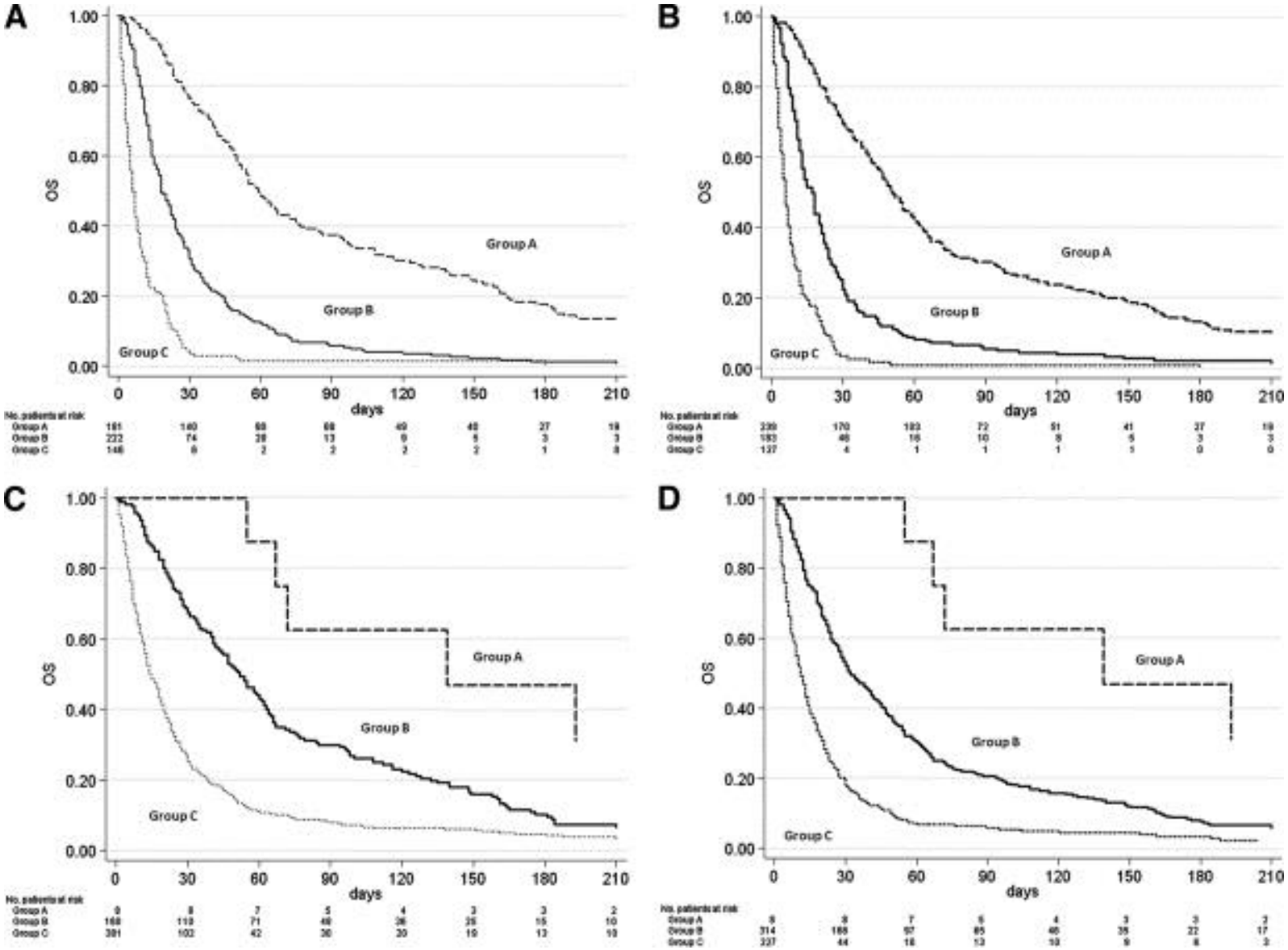
BMJ

Relative risk of dying in hospital for exposed patients (care from specialist palliative care team) and unexposed patients (usual care).



Seow H et al. BMJ 2014;348:bmj.g3496

BMJ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days
Group A
Group B
Group C
1.00
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0.60
0.40
0.20
0.00
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30
60
90
120
150
180
210

Comprehensive Cancer Care

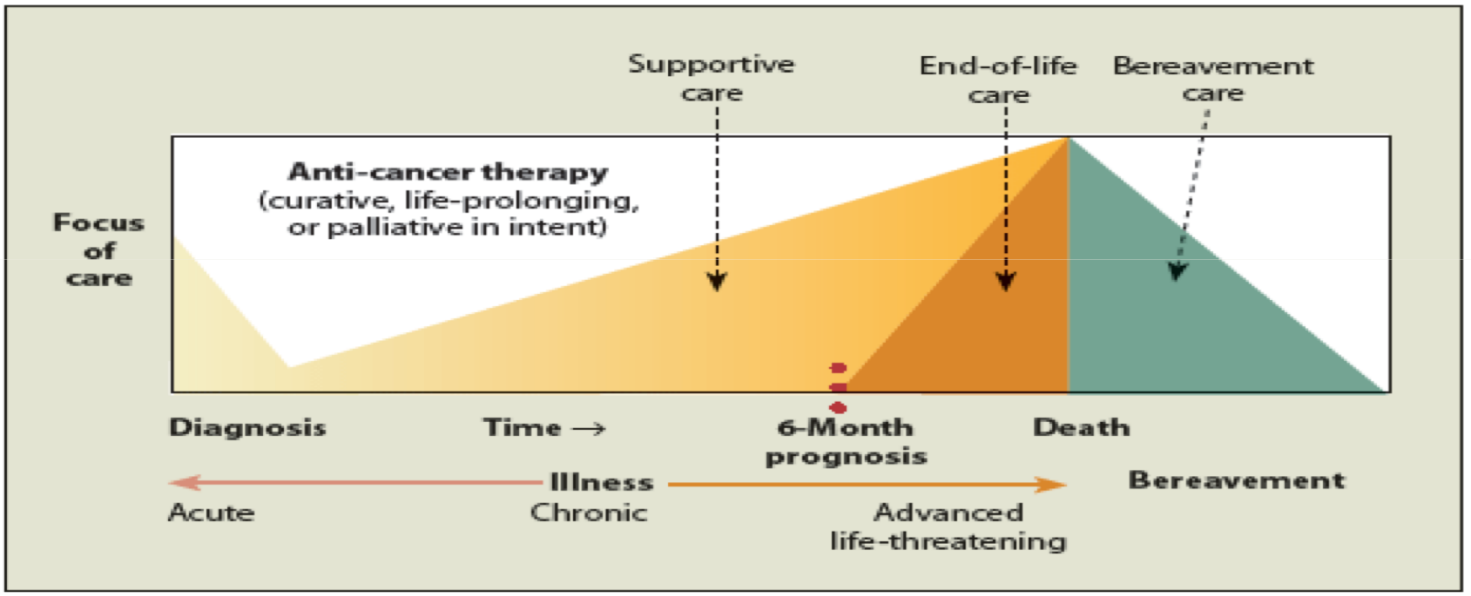

Figure 1: The balance between anti-tumor therapy and palliative care across the continuum of cancer care.

NCI/education in palliative and end-of-life care for oncology. www.cancer.gov