**AMICI DELLE CURE PALLIATIVE**
Mariuccia e Giovanni Manera odv

Presso il Teatro Besostri

# La scelta e il dovere dell'assistenza all'ultimo stadio della malattia

## L' offerta delle Cure Palliative

16 OTTOBRE 2021
ORE 9:00 - 13:00

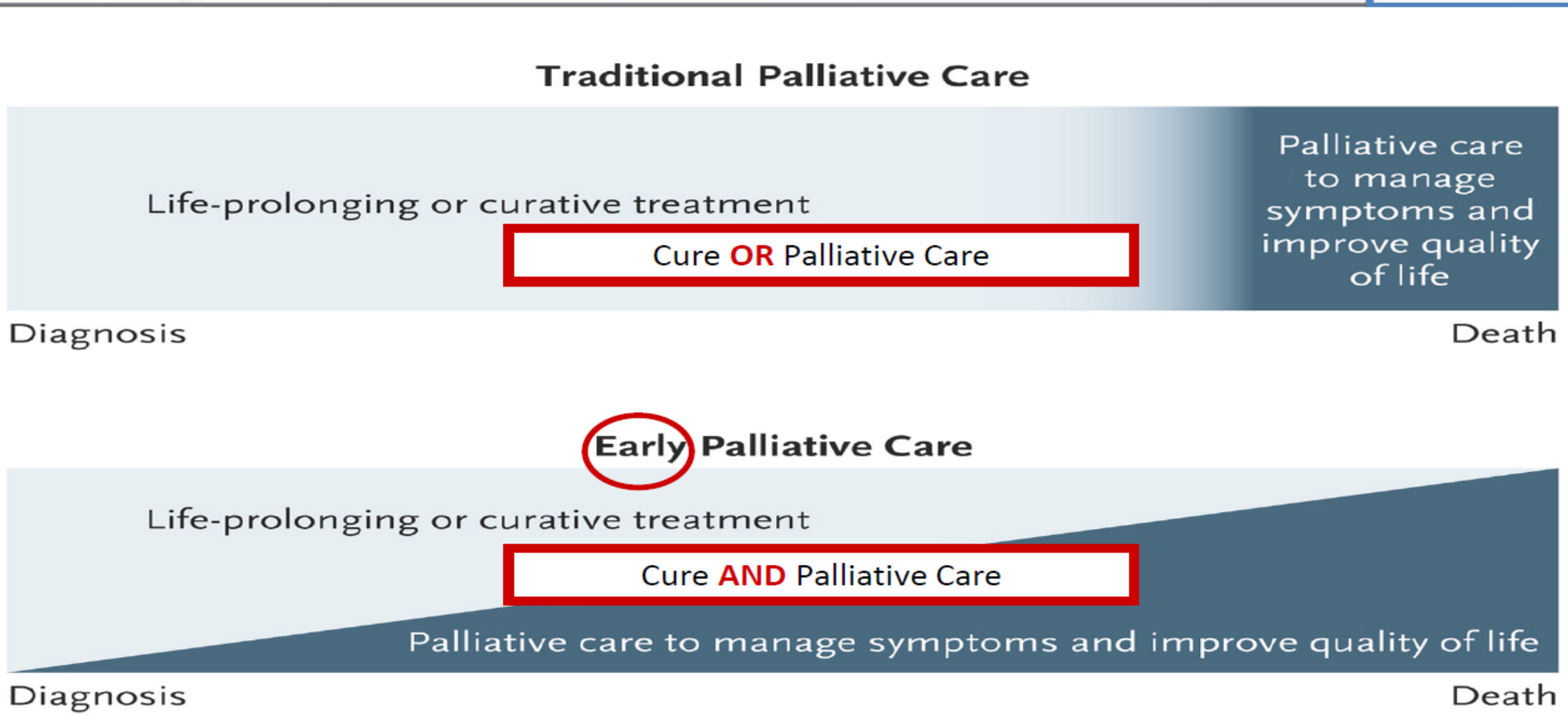
## 16 Ottobre 2021

PROGRAMMA

| | |
|---|---|
| 08:30 – 9:15 | Registrazione |
| 9.15 - 9.30 | Saluto introduttivo Presidente MGM<br>Il supporto della Associazione MGM<br>**Dott. Guido Bertassi** |
| *Moderatori:* | *Dott. Ivan Battistin, Prof. Emilio Bombardieri* |
| 9.30 - 9.50 | Ultimo stadio di malattia: cure intensive o cure palliative? (Grandi insufficienze d'organo "end stage": cure intensive o cure palliative? "Documento condiviso" per una pianificazione delle scelte di cura) - **Dott. Livio Carnevale** |
| 9.50 - 10.10 | Cure palliative: evoluzione dell'opportunità (dalla Legge 38/2010 alla Legge 219/2017) - **Dott. Luciano Orsi** |
| 10.10 - 10.30 | Traiettorie di malattia, fine vita, cure palliative<br>**Dott. Luigi Magnani** |
| 10.30 - 10.50 | Dalle terapie di supporto alla gestione della terminalità: le peculiarità del paziente oncologico - **Dott. Marco Danova** |
| 10.50 - 11.10 | Coffee break |
| 11.10 - 11.30 | Prime esperienze di simultaneous care in ASST Pavia<br>**Dott. Vittorio Perfetti** |
| 11.30 - 11.50 | La Rete Locale di Cure Palliative: come attivare l'offerta di cura<br>**Dott. Ivan Battistin** |
| 11.50 - 12.10 | L'offerta di cura dell'UOCP della ASST di Pavia<br>**Dott.ssa Sabina Mediani** |
| 12.10 - 12.30 | Il Medico di Medicina Generale tra domanda ed offerta di cure palliative - **Dott. Vittorio Savini** |
| 12.30 – 13.00 | Discussione |
| 13.00 | Lunch |

The NEW ENGLAND JOURNAL of MEDICINE

# Early Specialty Palliative Care — Translating Data in Oncology into Practice




Parikh RB et al. *N Engl J Med* 2013;369:2347-2351

The NEW ENGLAND JOURNAL of MEDICINE

N ENGL J MED 363;8 NEJM.ORG AUGUST 19, 2010

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.

## Which is the impact?

# BENEFITS OF EARLY PALLIATIVE CARE

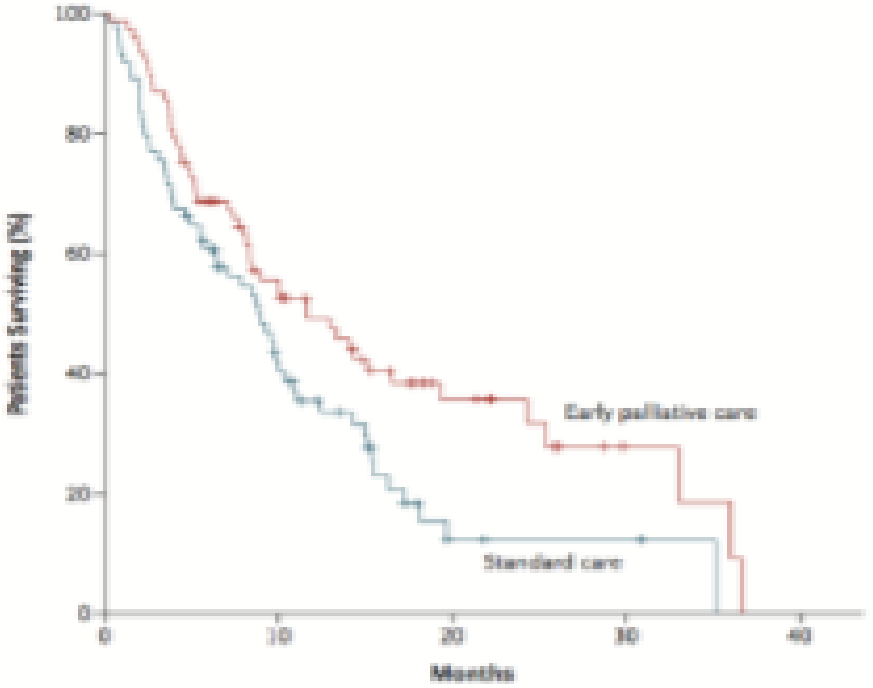
## Study results:

Improved QoL in the intervention group for the total FACT-L scale, the LCS, and the Trial Outcome Index

Lower depression scores in the intervention group measured by HADS and PHQ-9

More aggressive end-of-life care in the control group (54% *vs.* 33%, p = 0.05)

Less advanced care planning documentation in the control group (28% *vs.* 53%, p = 0.05)



# APPROACH TO THE PATIENT WITH INCURABLE CANCER

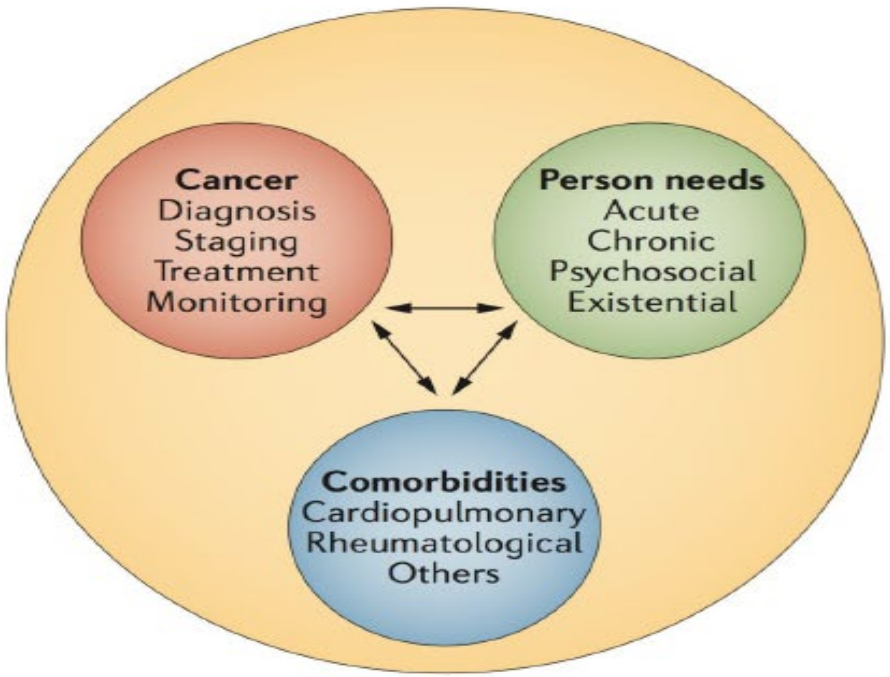
## What matters to people when approaching the End-of-Life (EoL)?

- Being involved in decisions about care
- Being comfortable with controlled symptoms
- Recognition of impending death and a sense of closure
- Affirmation/value of the self, with beliefs and values honoured
- Trust in care providers
- Relationships optimised with family and friends, burden minimised to family
- Family cared for, including bereavement support
- Death in preferred place of care
- Religious prayer or meditation
- Personal affairs in order
- Leaving a legacy

Khan SA, *et al.*, Nat Rev Clin Oncol. 2014 Feb;11(2):100-8

# APPROACH TO THE PATIENT WITH INCURABLE CANCER

## Palliative care needs in oncology




# Clinical Questions

This clinical practice guideline addresses six overarching clinical questions:

(1) What is the most effective way to care for patients with advanced cancers' symptoms?

(2) What are the most practical models of palliative care?

(3) How is palliative care in oncology defined or conceptualized?

(4) How can palliative care services relate in practice to other existing/emerging services?

(5) Which interventions are helpful for Family Caregivers?

(6) Which patients should be offered/or referred to palliative care services, when in their disease trajectory, and are there triggers that should be employed to prompt specialty palliative care referrals?

# Patient and Clinician Communication

- A key component in retrospective analyses has been the performance of a "goals of care" discussion that entails asking about:
  - Knowledge of the illness
  - Realistic options for treatment
  - Planning for the future

- If such discussions are held, care at the end of life improves, and is more consonant with what most people want.

- The stage IV NSCLC guideline also suggests inquiry about psychological and spiritual care, social support, assessing FCG needs, and physician self-care. Please see the Palliative Care and Patient and Clinician Communications sections of the 2015 guideline, as well as its Data Supplement, which includes Sample Talking Points at www.asco.org/guidelines/nsclc

# Multiple Chronic Conditions

- It is important to note that elderly patients most often have multiple chronic illnesses and with the aging population it is expected that this problem will increase.
- In addition, the best available evidence for treating index conditions, such as cancer, is often from clinical trials whose study selection criteria may exclude these patients in order to avoid potential interaction effects or confounding of results associated with MCC.
- As a result, the reliability of outcome data from these studies may be limited, thereby creating constraints for expert groups to make recommendations for care in this heterogeneous patient population.
- As many patients for whom guideline recommendations apply present with MCC, any treatment plan needs to take into account the complexity and uncertainty created by the presence of MCC and highlights the importance of shared decision making regarding guideline use and implementation.

# Summary of Recommendations

## CLINICAL QUESTION 1

What is the most effective way to care for patients with advanced cancers' symptoms (palliative care services in addition to usual care, compared with usual care alone)?

### *Recommendation 1*

Patients with advanced cancer should be referred to interdisciplinary palliative care teams (consultation) that provide inpatient and outpatient care early in the course of disease, alongside active treatment of their cancer (Type: evidence based, benefits outweighs harms; Evidence quality: intermediate; Strength of recommendation: strong).

# Summary of Recommendations

## CLINICAL QUESTION 2

What are the most practical models of palliative care? Who should deliver palliative care (external consultation, internal consultations with palliative care practitioners in the oncology practice, or performed by the oncologist her/himself) ?

## *Recommendation 2*

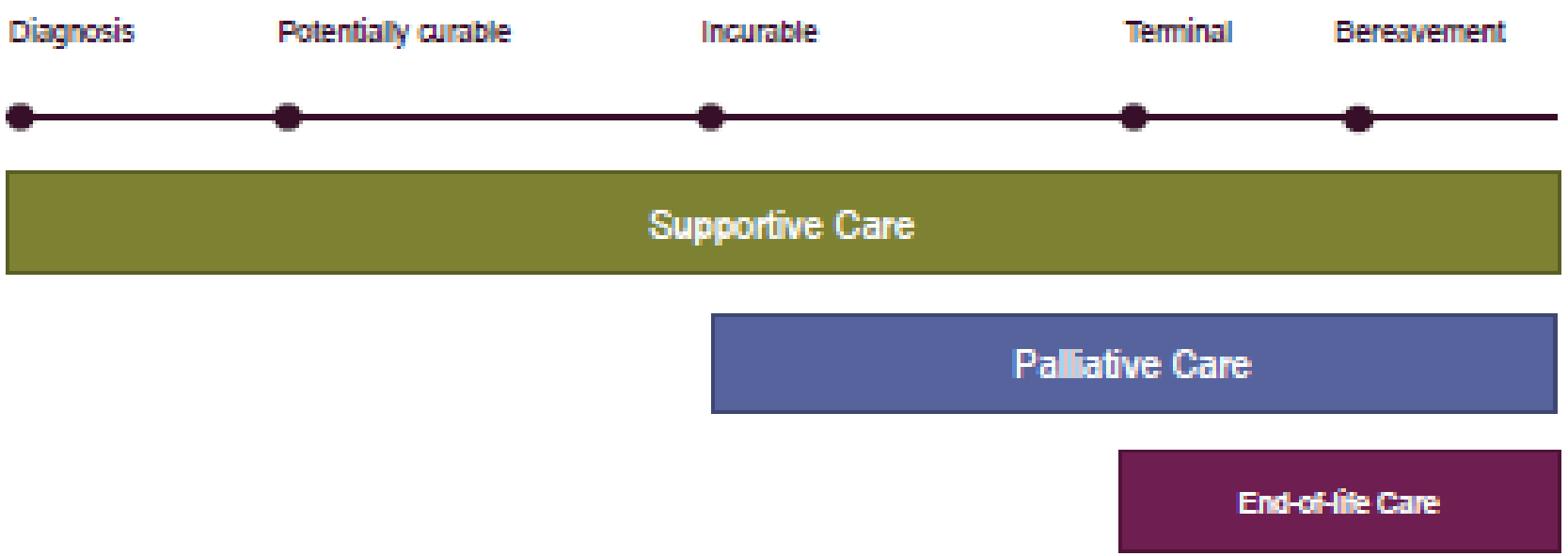
Palliative care for patients with advanced cancer should be delivered through interdisciplinary palliative care teams, with consultation available in both outpatient and inpatient settings (Type: evidence based, benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).

# CONTENTS AND TIMEFRAME OF PALLIATIVE CARE


Lorenz KA, *et al.*, Ann Int Med 2008;148:147–59; Tieman J, *et al.*, J Clin Oncol 2008;26:56-79

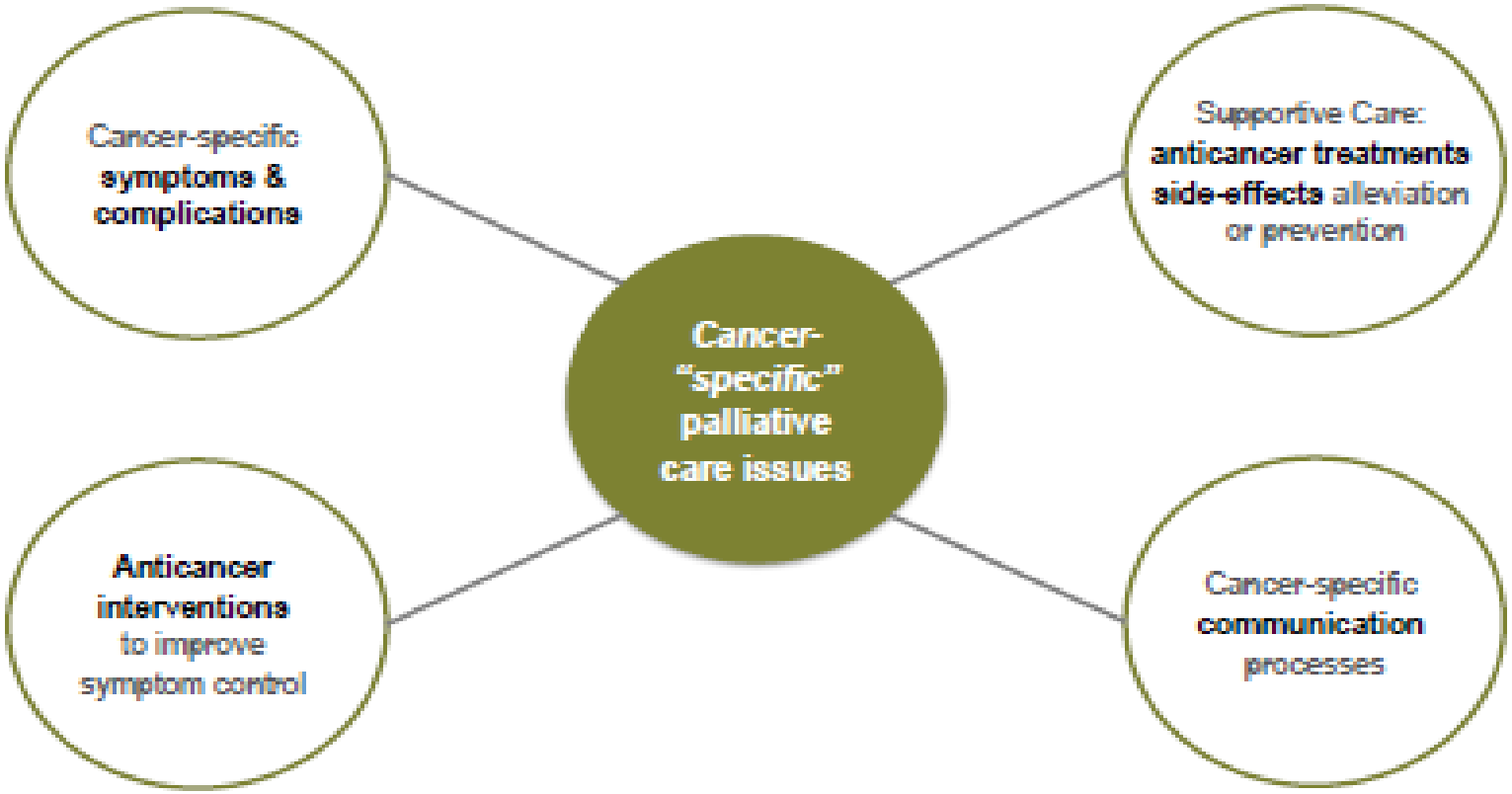
# CONTENTS AND TIMEFRAME OF PALLIATIVE CARE

## ESMO definition (2003)




Cherny NI, et al., Ann Oncol 2003;14(9):1335-1337

# CONTENTS AND TIMEFRAME OF PALLIATIVE CARE



Original Investigation JAMA Oncol. 2015;1(6):778-784.

# Chemotherapy Use, Performance Status, and Quality of Life at the End of Life

Holly G. Prigerson, PhD; Yuhua Bao, PhD; Manish A. Shah, MD; M. Elizabeth Paulk, MD; Thomas W. LeBlanc, MD, MA; Bryan J. Schneider, MD; Melissa M. Garrido, PhD; M. Carrington Reid, MD, PhD; David A. Berlin, MD; Kerin B. Adelson, MD; Alfred I. Neugut, MD, PhD; Paul K. Maciejewski, PhD

**CONCLUSIONS AND RELEVANCE** Although palliative chemotherapy is used to improve QOL for patients with end-stage cancer, its use did not improve QOD for patients with moderate or poor performance status and worsened QOD for patients with good performance status. The QOD in patients with end-stage cancer is not improved, and can be harmed, by chemotherapy use near death, even in patients with good performance status.

QOD = Quality Of life near Death

# BARRIERS AND CHALLENGES FOR PC INTEGRATION

## Possible barriers to integration of Palliative Care for haematologic cancers

Unpredictable disease trajectory

Different languages between palliative care and haematologists

Unclear treatment goals / focus on healing

Hyper-Optimistic care / unclear boundaries between curative and palliative

Unawareness of goals of palliative care for haematologic cancers

Auret K, *et al.*, Int Med Journal. 2003; 33: 566-571; Manitta VJ, *et al.*, Journal of Palliative Medicine.2010; 13(8):1021-5

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3

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5

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ESMO RECOMMENDATIONS

# Cancer Patient Management During COVID-19 Pandemic

## Priorities for Supportive Care Patients

### Priorities for Supportive Care

Due to the COVID-19 pandemic, there are different factors that might require changes in therapeutic and prophylactic supportive care interventions for cancer patients. All oncological treatment is a balance of risk and benefit. The presence of COVID-19 adds additional risk that needs to be considered when planning treatment and when pursuing diagnostic and treatment procedures. Intervention options that minimise clinic and chemotherapy visits are preferred. Selected patients are appropriately assessed by telehealth systems to avoid clinic visits. We must consider that there may be reassignment and shortages of resources such as blood products which may limit our supportive strategies. Furthermore, preventing urgent care visits to already crowded emergency departments with many infected patients has special priority at this difficult time. We discuss key aspects of prophylactic supportive care interventions in the following table. Some recommendations are broad and must be adapted to country- and hospital-specific resources and infrastructure.

The need and intensity of treating the malignant disease must be weighed against the possible higher risk of cancer patients of developing severe complications in the course of a SARS-CoV-2 infection. Some early Chinese reports indicated about a doubling of the mortality rate in patients with cancer (especially with lung cancer). Factors identified as playing a crucial role in other community-acquired respiratory virus (CARV) infections include duration of severe neutropaenia, lymphocytopaenia $<0.2 \times 10^9$/L, and age >65 years (as a probable surrogate of comorbidities and lesser reserves in case of severe stress). Most reports with SARS-CoV-2 infection indicate a significantly higher mortality rate for men. The roles of other concomitant illnesses and a high level of immunosuppression associated with many malignancies and treatments doubtless contribute to the greater risk for patients with cancer.

ESMO







ESMO RECOMMENDATIONS

# Cancer Patient Management During COVID-19 Pandemic

## Priorities for Palliative Care Patients

### Priorities for Palliative Care

Practical Suggestions for Treatments

1. Ensure that patients have adequate supply if analgesics or other medication are needed for their symptom control
2. Proactively monitor patients with anticipated high care needs by telemedicine (this can be delegated to the nursing team)
3. When palliative RT is needed for bone metastases or cord compression, single-fraction therapy should be used (if deemed clinically reasonable)
4. Patients with far advanced disease should be managed at home as much as possible
5. Permanent indwelling catheter drainage systems (such as PleurX) should be used for patients needing frequent drainage of pleural effusion or ascites

ESMO

# SUMMARY

- Patients with incurable cancer present palliative care needs throughout the continuum of their disease
- There is increasingly robust level 1 evidence of the benefit of palliative care for patients and caregivers
- Oncologists must acquire core competencies to provide generalist palliative care
- Overlapping roles and unclear goals of care are among the barriers to integration



hospice
palliative
supportive
Hospital-at-home
End-of-life
advanced care planning
terminal
care
home

Sistema Socio Sanitario
Regione Lombardia
ASST Pavia