La terapia del dolore in onco-ematologia e le terapie di supporto.

Elena Bandieri
USL Modena

Qual'è lo stato dell'arte sulla gestione del dolore oncologico?

JOURNAL OF CLINICAL ONCOLOGY

REVIEW ARTICLE

Quality of Cancer Pain Management: An Update of a Systematic Review of Undertreatment of Patients With Cancer

Maria Teresa Greco, Anna Roberto, Oscar Corli, Silvia Deandrea, Elena Bandieri, Silvio Cavuto, and Giovanni Apolone

A B S T R A C T

Purpose

Pain is a frequent symptom in patients with cancer, with substantial impact. Despite the availability of opioids and updated guidelines from reliable leading societies, undertreatment is still frequent.

Methods

We updated a systematic review published in 2008, which showed that according to the Pain Management Index (PMI), 43.4% of patients with cancer were undertreated. This review included observational and experimental studies reporting negative PMI scores for adults with cancer and pain published from 2007 to 2013 and retrieved through MEDLINE, Embase, and Google Scholar. To detect any temporal trend and identify potential determinants of undertreatment, we compared articles published before and after 2007 with univariable, multivariable, and sensitivity analyses.

Results

In the new set of 20 articles published from 2007 to 2013, there was a decrease in undertreatment of approximately 25% (from 43.4 to 31.8%). In the whole sample, the proportion of undertreated

J Clin Oncol 32. © 2014 by American Society of Clinical Oncology

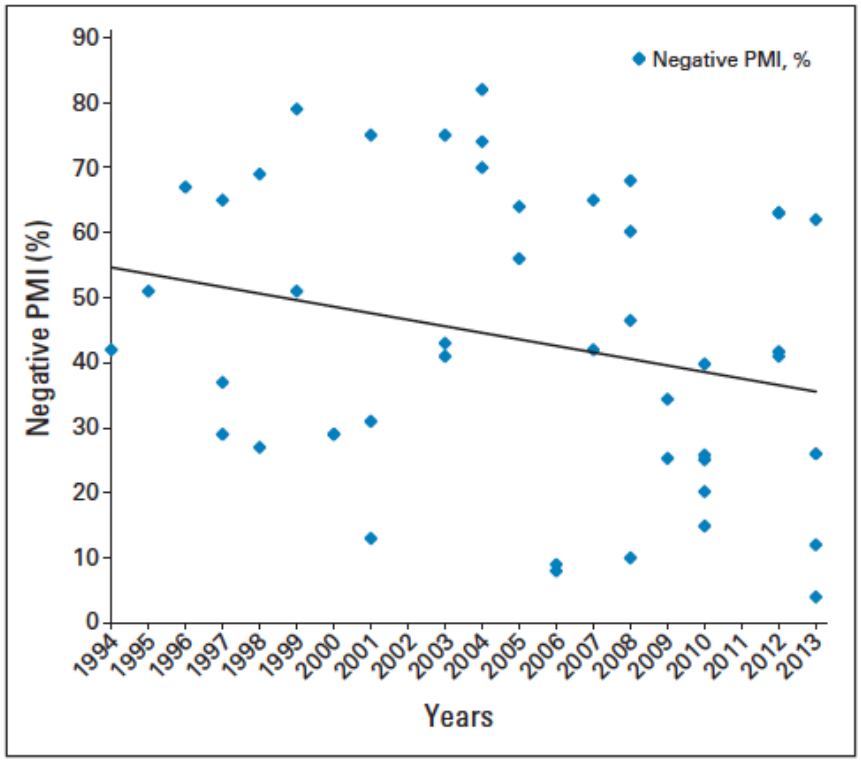


Fig A1. Distribution of undertreatment (Pain Management Index [PMI] negative scores) in relation to time (year) of publication.

Conclusion

Analysis of 46 articles published from 1994 to 2013 using the PMI to assess the adequacy of analgesic therapy suggests the quality of pharmacologic pain management has improved. However, approximately one third of patients still do not receive pain medication proportional to their pain intensity.

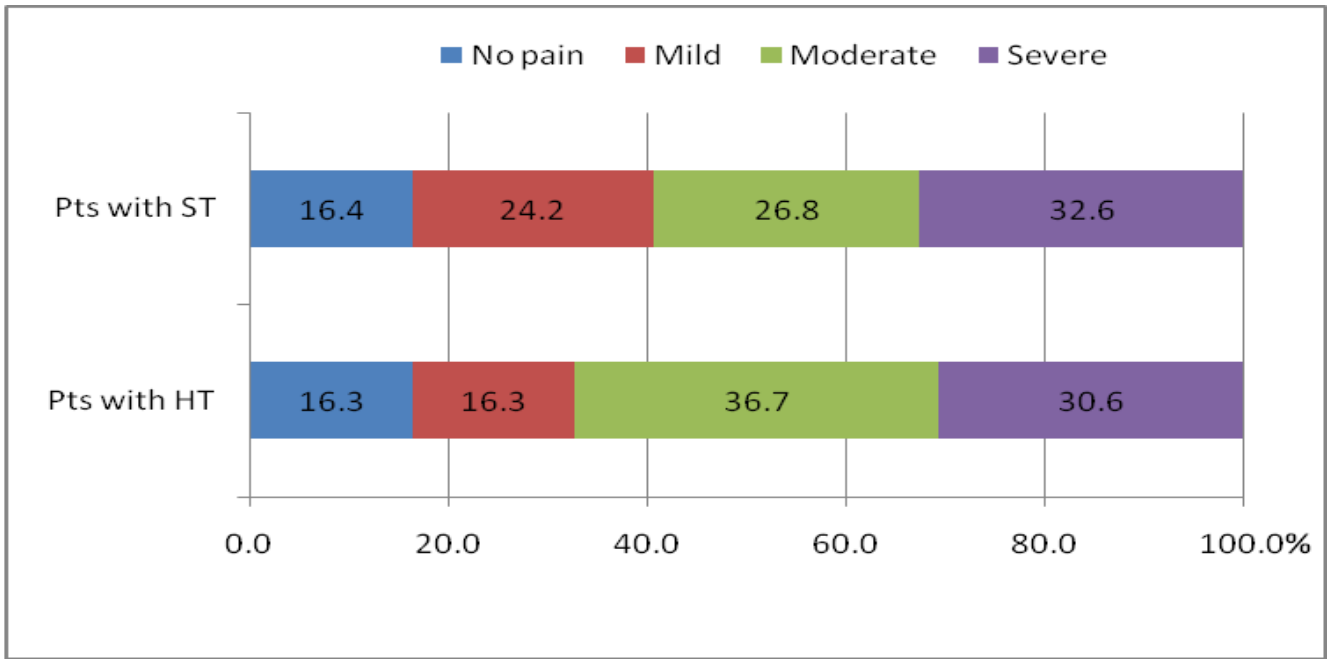
Is pain in patients with haematological malignancies under-recognised? The results from Italian ECAD-O survey

E. Bandieri, D. Sichetti, M. Luppi, C. Ripamonti, G. Tognoni
Leuk Res 2010

Pain intensity

ST 59.4% moderate severe

HT 67.3% moderate-severe



Il setting condiziona l'appropriatezza prescrittiva

original article

Annals of Oncology 21: 2088–2093, 2010
doi:10.1093/annonc/mdq155
Published online 31 March 2010

Impact of setting of care on pain management in patients with cancer: a multicentre cross-sectional study

D. Sichetti[1†], E. Bandieri[2†], M. Romero[1†], K. Di Biagio[1], M. Luppi[3*], M. Belfiglio[1], G. Tognoni[1] & C. I. Ripamonti[4*] for ECAD Working Group

nbaro (Chieti); [2]Palliative Care Unit, Au
University of Modena and Reggio Emi

Table 3. Distribution of patients according to the adequacy/inadequacy of the analgesic treatment received and the pain intensity as reported by the patients (PMI) in the two settings of care

	Non-oncology units (n =393), n (%)	Oncology units (n =426), n (%)	P value
PMI			0.0024
<0 (inadequate)	74 (18.8)	48 (11.3)	
≥0 (adequate)	319 (81.2)	378 (88.7)	

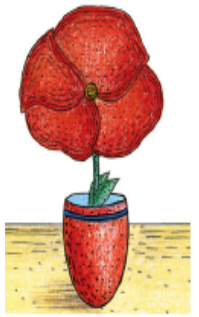
PMI, Pain Management Index.

"…The patient's level of worst pain is subtracted from the most potent level of analgesic drug therapies as prescribed by the physician…"

Gestione del dolore onco-ematologico ancora insoddisfaciente

BISOGNI:

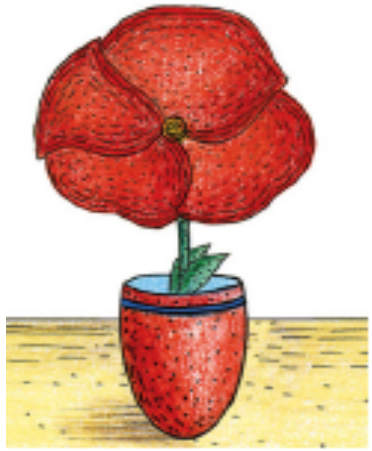
- 1) ottimizzazione della terapia analgesica (cronica ad orari fissi e del BTcP);
- 2) un approccio farmacologico migliore **non è sufficiente *per se*:** il miglioramento della terapia del dolore deve avvenire nel contesto di un **nuovo modello** di cure supportivo/palliative **precoci.**



Gestione del dolore da cancro ancora insoddisfaciente.

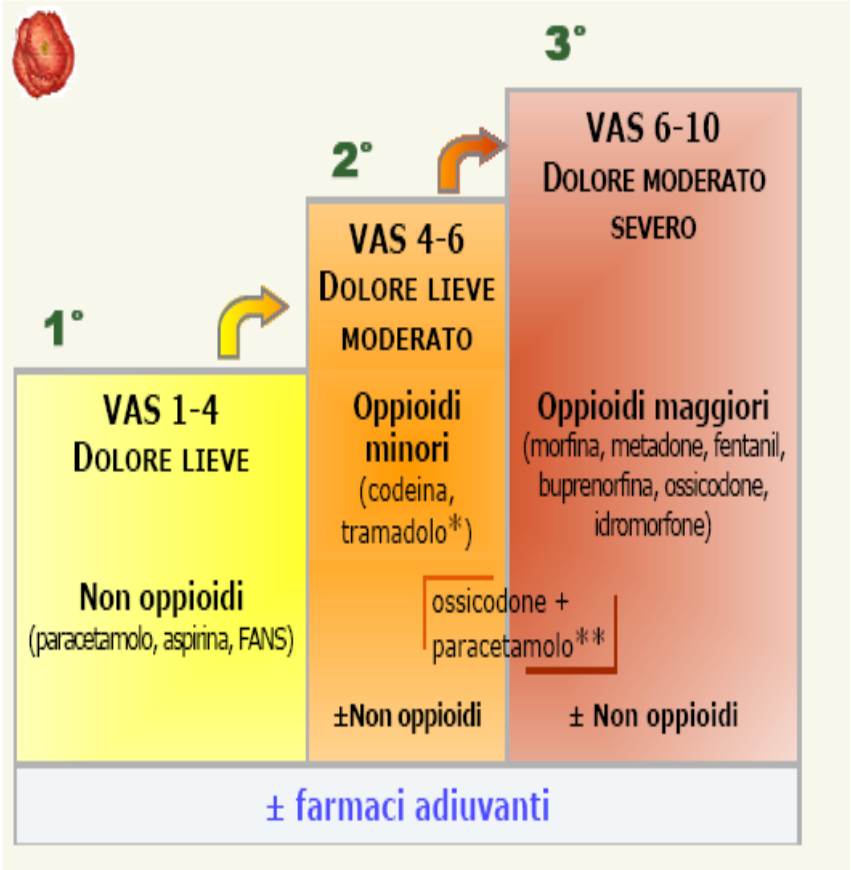
BISOGNI:

- 1) ottimizzazione della terapia cronica ad orari fissi (ATC) (II vs III gradino OMS);
- 2) un approccio farmacologico migliore non è sufficiente *per se*: il miglioramento della terapia del dolore deve avvenire nel contesto di un nuovo modello di cure palliative precoci.



Strategia farmacologica: i “tre gradini” OMS

I “tre gradini” consentono di **controllare** il dolore oncologico **cronico** in circa il **90% dei casi**. Tale approccio, sviluppato nel 1986 da un gruppo di esperti dell’ Organizzazione Mondiale della Sanità (OMS), fornisce specifiche indicazioni per la **scelta della terapia antidolorifica che non va somministrata al bisogno ma a orari fissi.**



La strategia a 3 gradini è validata?
Perché si cambia gradino?

- Numerosi studi sono stati condotti per validare tale approccio metodologico: sono stati osservati oltre 8.000 pazienti in diversi paesi del mondo ed in ambienti clinici differenziati (ospedale e domicilio).
- Le varie casistiche riportano un efficace controllo del dolore nel 71-100% dei pazienti trattati.
- Tra gli studi eseguiti per validare l'approccio OMS quello di Ventafridda et al, (Cancer 1997) condotto su 1.229 pazienti seguiti per 2 anni, ha evidenziato che il passaggio dal 1° al 2° gradino è dovuto in circa la metà dei casi ad effetti collaterali e nell'altra metà all'inefficacia analgesica, mentre il passaggio dal 2° al 3° gradino è soprattutto dovuto all'inefficacia analgesica. Efficacia media dei farmaci del secondo gradino è di 3 settimane.

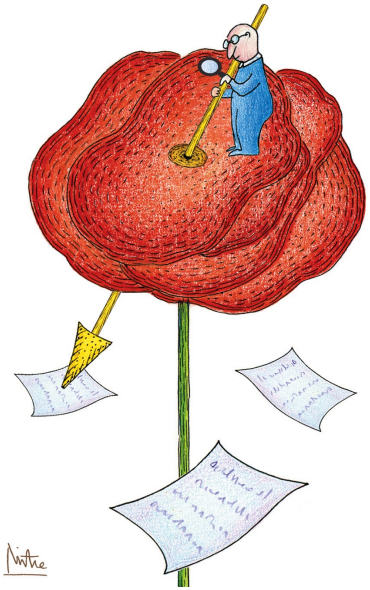
Gradino	Inefficacia	Effetti indesiderati
dal 1° al 2°	52%	48%
dal 2° al 3°	92%	8%

Criticità sul secondo gradino

- **Hanno tutti un "effetto tetto": ciò significa che aumentando la dose di un farmaco oltre una certa soglia l'efficacia non aumenta (ma possono aumentare gli effetti indesiderati).**
- **Le specialità a base di codeina disponibili in Italia non hanno dosaggi ottimali. Non permettono di raggiungere la dose massima efficace di codeina (360 mg/die) senza somministrare dosaggi tossici di paracetamolo (la scheda tecnica indica 3-4 gr/die).**

E le evidenze disponibili?:

- **Non dimostrano una chiara differenza nell'efficacia dei farmaci del 1° e del 2° gradino;**
- **Non permettono di concludere sui benefici dell'aggiunta degli oppioidi minori - in particolare codeina - rispetto al solo paracetamolo o al FANS**



Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC

Augusto Caraceni, Geoffrey Hanks*, Stein Kaasa*, Michael I Bennett, Cinzia Brunelli, Nathan Cherny, Ola Dale, Franco De Conno, Marie Fallon, Magdi Hanna, Dagny Faksvåg Haugen, Gitte Juhl, Samuel King, Pål Klepstad, Eivor A Laugsand, Marco Maltoni, Sebastiano Mercadante, Maria Nabal, Alessandra Pigni, Lukas Radbruch, Colette Reid, Per Sjogren, Patrick C Stone, Davide Tassinari, Giovambattista Zeppetella, for the European Palliative Care Research Collaborative (EPCRC), on behalf of the European Association for Palliative Care (EAPC)*

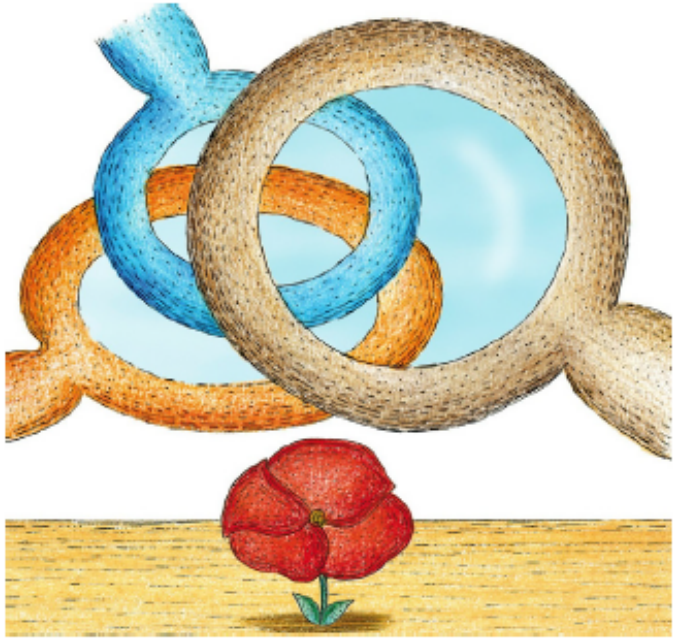
Lancet Oncol 2012; 13: e58–68

.

Overall, the limited evidence provided by these studies shows that oral morphine at low doses can be used in opioid-naive cancer patients and that in some patients pain relief might be better than that achieved with step II drugs…”

QUESITO

E’ possibile abolire il secondo gradino, cioè anticipare il terzo gradino al posto del secondo gradino nella terapia analgesica del dolore moderato da cancro ?



VOLUME 34 · NUMBER 5 · FEBRUARY 10, 2016

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Randomized Trial of Low-Dose Morphine Versus Weak Opioids in Moderate Cancer Pain

Elena Bandieri, Marilena Romero, Carla Ida Ripamonti, Fabrizio Artioli, Daniela Sichetti, Caterina Fani Daniele Santini, Luigi Cavanna, Barbara Melotti, Pier Franco Conte, Fausto Roila, Stefano Cascinu, Eduardo Bruera, Gianni Tognoni, and Mario Luppi

STUDIO INDEPENDENTE NO SPONSOR

Table 1. Characteristics of Patients at Baseline

Characteristics	Weak Opioids (N = 122)	Morphine (N = 118)
Male sex	68 (55.7)	56 (47.5)
Age, years		
Median	68	68
Interquartile range	59-74	58-74
Cancer		
Solid	108 (88.5)	100 (84.8)
Hematologic	14 (11.5)	18 (15.3)
Current antitumor treatment	61 (50.0)	71 (60.2)
Karnofsky performance status, %		
60	9 (7.4)	5 (4.2)
70	48 (39.3)	42 (35.6)
80	28 (23.0)	35 (29.7)
90	23 (18.9)	18 (15.3)
100	14 (11.5)	18 (15.3)
ESAS overall symptom score		
Median	21	19
Interquartile range	14-33	12-29
Pain intensity (NRS)		
Median	5	5
Interquartile range	4-6	5-6
Cause of pain*		
Cancer	117 (95.9)	104 (88.1)
Treatment	8 (6.6)	15 (12.7)
Other†	2 (1.6)	6 (5.1)
Type of pain*		
Visceral	69 (56.6)	59 (50.0)
Somatic	62 (50.8)	61 (51.7)
Neuropathic	5 (4.1)	15 (12.7)
Pain characteristics		
Incidental pain	38 (31.2)	43 (36.4)
Not incidental	84 (68.9)	75 (63.5)
Previous analgesic therapy	100 (82.0)	98 (83.1)
At fixed times	19 (19.0)	21 (21.4)
As needed	81 (81.0)	77 (78.6)
Rescue therapy (prescription)	105 (86.1)	106 (89.8)
Adjuvant therapy	79 (64.8)	78 (66.1)
Duration of pain, days		
Median	30	30
Interquartile range	14-60	15-60

NOTE. Data are presented as No. (%) unless indicated otherwise.
Abbreviations: ESAS, Edmonton Symptom Assessment System; NRS, Numerical Rating Scale.
*Multiple selection possible.
†Associated conditions recorded as other causes of pain in addition to cancer and treatment.

Table 2. Outcomes

Outcome	Weak Opioids (N = 117), No. (%)	Morphine (N = 110), No. (%)	Odds Ratio (95% CI)	*P*	Adjusted Odds Ratio* (95% CI)	*P*
Primary outcome						
Responders†	64 (54.7)	97 (88.2)	6.18 (3.12 to 12.24)	< .001	6.89 (3.33 to 14.25)	< .001
Secondary outcomes						
Patients with a meaningful pain reduction‡	55 (47.0)	91 (82.7)	5.40 (2.92 to 9.97)	< .001	5.74 (3.03 to 10.90)	< .001
Patients with highly meaningful pain reduction §	49 (41.9)	83 (75.5)	4.27 (2.42 to 7.53)	< .001	4.58 (2.52 to 8.33)	< .001

*Adjusted by pain intensity at baseline, age, gender, Karnofsky performance score, adjuvant therapy, rescue therapy, cancer type and anticancer treatment.
†Patients with pain intensity reduction at least 20% from baseline.
‡Patients with ≥ 30% pain intensity reduction from baseline.
§Patients with ≥ 50% pain intensity reduction from baseline.

Lo studio ha mostrato un vantaggio altamente significativo nell' utilizzo della morfina: tra i 118 pazienti che hanno ricevuto la morfina, piu' dell' 88% ha presentato una riduzione del 20% nell' intensità del dolore, laddove tale riduzione si è potuta riscontrare nel solo 57% dei 122 pazienti che hanno ricevuto oppioidi deboli.

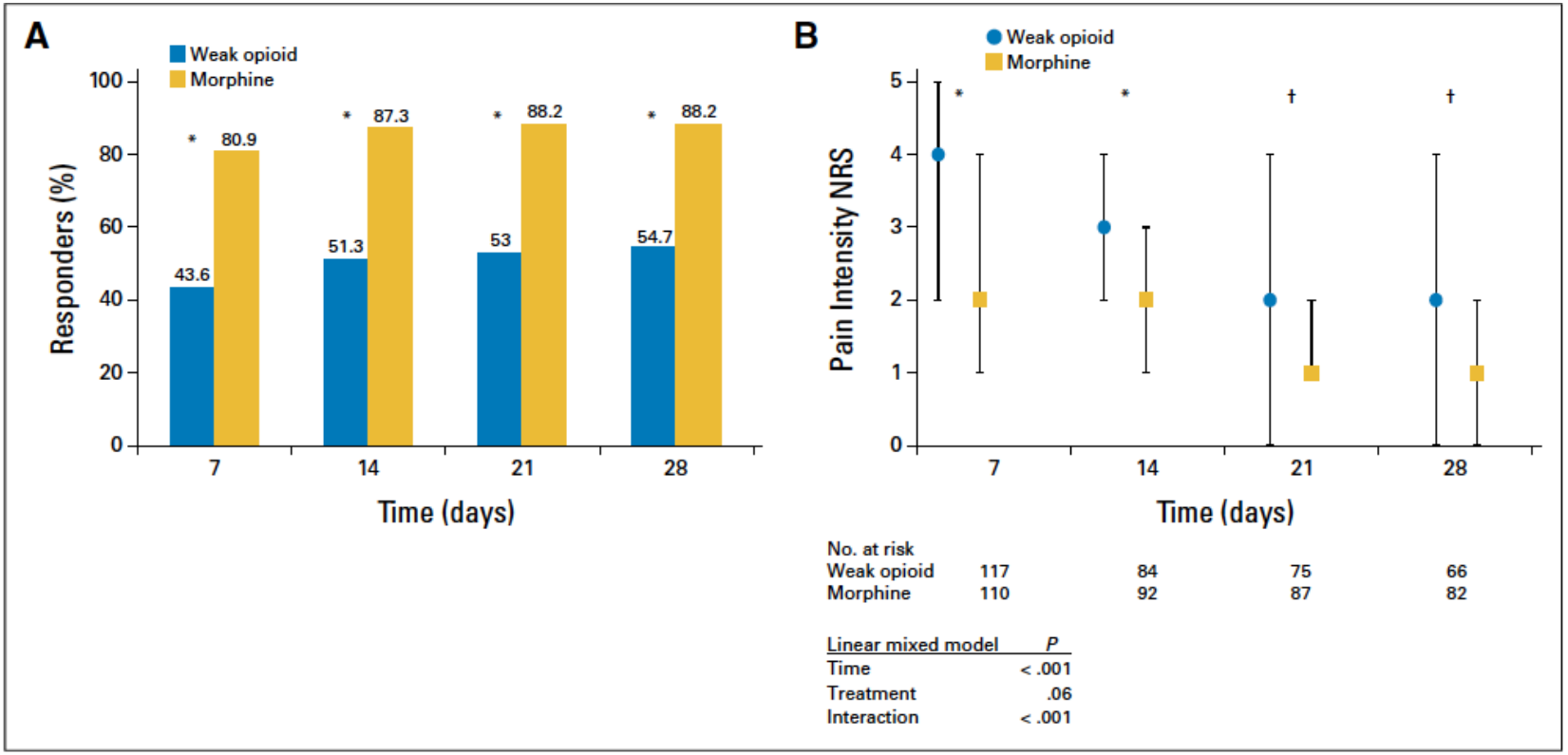


Fig 2. Responder patients and pain intensity (numerical rating scale [NRS]) at different follow-up times by treatment group. (A) Percentage of responder patients (who achieved ≥ 20% pain reduction from baseline) at each follow-up. The *P* value is for the between-group comparison performed using the χ^2 test. (B) Pain intensity evaluated using the NRS at each follow-up. Data are shown as median and interquartile range. A linear mixed mode for repeated measurements was done on pain intensity score. **P* < .001, †*P* = .02 by Mann-Whitney *U* test.

In questo studio multicentrico randomizzato, della durata di 28 giorni, la morfina a basse dosi confrontata con gli oppioidi deboli ha ridotto in modo statisticamente significativo l'intensità del dolore, già nei primi 7 giorni di terapia. L'efficacia minore e piu' tardiva degli oppioidi deboli ha portato i clinici a sostituire piu' frequentemente gli oppiodi deboli con quelli maggiori nel trattamento del dolore moderato da cancro nel periodo di studio.

Table S4. Frequency of the main adverse effects			
Adverse effects - no. (%)	**Weak opioids N = 117**	**Morphine N = 110**	**P value**
Vomiting	13 (11.1)	18 (16.4)	0.25
Constipation	24 (20.5)	27 (24.6)	0.47
Dry mouth	6 (5.1)	10 (9.1)	0.24
Itch	3 (2.6)	4 (3.6)	0.64
Dizziness	3 (2.6)	9 (8.2)	0.06
Somnolence	2 (1.7)	3 (2.7)	0.68
Cognitive impairment	1 (0.8)	2 (1.8)	0.61
Pseudo-hallucinations	-	1 (0.9)	0.48
Other	15 (12.8)	22 (20.0)	0.14

Gli effetti collaterali piu' frequentemente associati al trattamento con oppioidi risultavano paragonabili sia come intensità che frequenza tanto nei pazienti che ricevevano morfina a basse dosi quanto nei pazienti che ricevevano oppioidi minori.

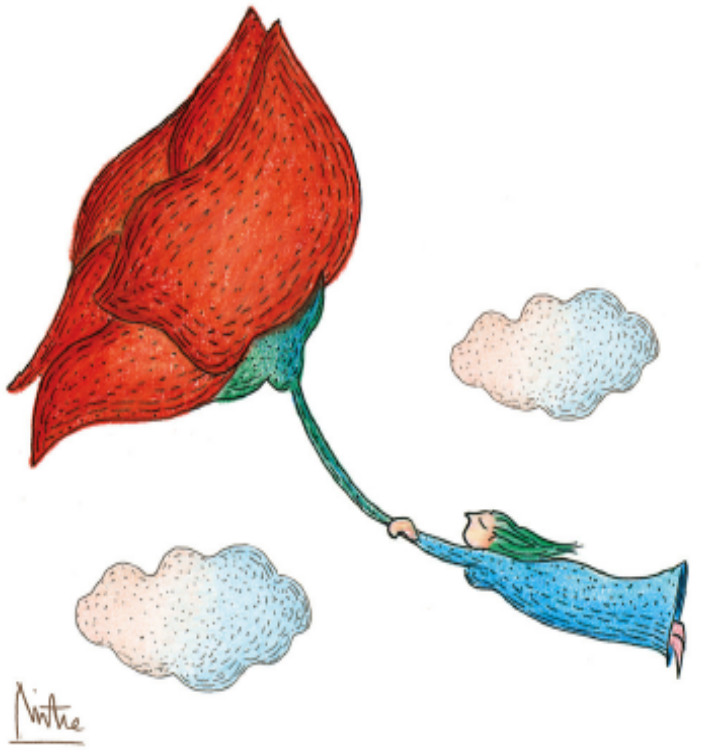
Table 3. ESAS at End of Study

ESAS Item	Weak Opioids	Morphine	*P*
Pain	4 (1-6)	1 (0-3)	< .001
Tiredness	3 (2-6)	2 (1-3)	< .001
Nausea	1 (0-3)	1 (0-1)	.03
Depression	2 (1-4)	1 (0-2)	< .001
Anxiety	2 (0-4)	1 (0-2)	< .001
Drowsiness	3 (1-4)	1 (0-2)	< .001
Appetite	2 (1-5)	1 (0-2)	< .001
Well-being	3 (1-5)	1 (0-2)	< .001
Shortness of breath	0 (0-1)	0 (0-0)	.01
ESAS overall symptom score	19 (10-17)	10 (6-15)	< .001

NOTE. Data are presented as median (interquartile range).
Abbreviations: ESAS, Edmonton Symptom Assessment System.

La condizione generale dei pazienti basata sulla valutazione dei sintomi fisici ed emozionali nel punteggio globale di tutti i sintomi misurati dall' Edmonton Symptom Assessment System (ESAS), era migliore nel gruppo di pazienti trattati con morfina.

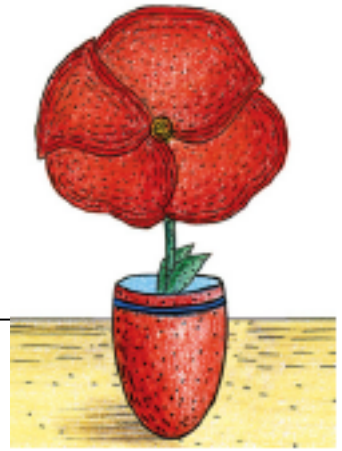
Sebbene gli oppioidi deboli siano efficaci quando usati per brevi periodi, la morfina a basse dosi può essere utilmente anticipata nella terapia del dolore moderato da cancro, per la sua maggiore efficacia e paragonabile profilo di tossicità.



Gestione del dolore da cancro ancora insoddisfaciente, sebbene migliorata.

BISOGNI:

- 1) ottimizzazione della terapia analgesica
- 2) un approccio farmacologico migliore non è **sufficiente *per se***: il miglioramento della terapia del dolore deve avvenire nel contesto di un **nuovo modello di cure supportive/palliative precoci.**



original article

Annals of Oncology
doi:10.1093/annonc/mds103

Impact of early access to a palliative/supportive care intervention on pain management in patients with cancer

E. Bandieri[1†], D. Sichetti[2†], M. Romero[2†], C. Fanizza[2], M. Belfiglio[2], L. Buonaccorso[1], F. Artioli[1], F. Campione[3], G. Tognoni[2] & M. Luppi[4*]

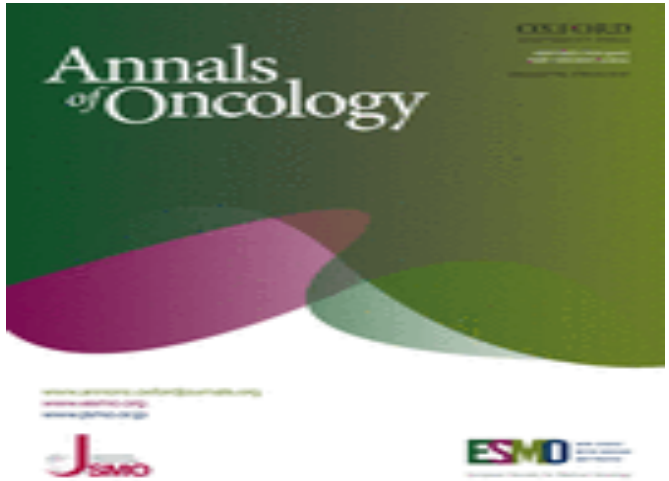
[1]Palliative Care Unit Azienda Unitaria Sanitaria Locale (USL), Modena; [2]Department of Clinical Pharmacology and Epidemiology, Consorzio Mario Negri Sud, Santa Maria Imbaro, Chieti; [3]Institute of Tanatologia, Clinica della crisi, I.A.T.S., University of Bologna, Bologna; [4]Department of Oncology, Hematology and Respiratory Diseases, Azienda Ospedaliera Universitaria, Policlinico, Modena, Italy

Received 18 November 2011; revised 13 February 2012 & revised 20 February 2012; accepted 23 February 2012

Table 5. Factors associated with severe pain prevalence

Variables	Univariate		Multivariate	
	RR (95 % CI)	*P* value	RR (95 % CI)	*P* value
Care model				
SC	1		1	
ePSC	0.69 (0.48–0.99)	0.037	0.69 (0.48–0.99)	0.045
Wards				
Oncology	1.00 (0.75–1.35)	0.98	1.02 (0.76–1.36)	0.91
Non-oncology	1		1	
Metastatic disease				
No	1.12 (0.89–1.41)	0.35	1.16 (0.92–1.46)	0.22
Yes	1		1	
Gender				
Males	0.75 (0.62–0.90)	0.002	0.76 (0.63–0.91)	0.003
Females	1		1	
Age	0.99 (0.99–1.00)	0.016	1.00 (0.99–1.00)	0.25
Analgesic therapy				
Non-opioids	1.00		1	
Weak opioids	1.19 (0.74–1.92)	0.47	1.12 (0.70–1.79)	0.64
Strong opioids	1.38 (0.88–2.17)	0.16	1.00 (0.84–2.05)	0.23

CI, confidence interval; ePSC, early palliative/supportive care; RR, relative risk; SC, standard care.



Studio multicentrico in 32 ospedali, 1450 pts.con dolore da cancro: 602 con accesso a standard care (SOC) e 848 con accesso a cure palliativa/ supporto precoci (ePSC).

Un'analisi multivariata ha mostrato che il modello ePSC è un fattore indipendente in grado di **ridurre il rischio di dolore severo del 31%**

Cure supporto/Cure palliative: contenuto

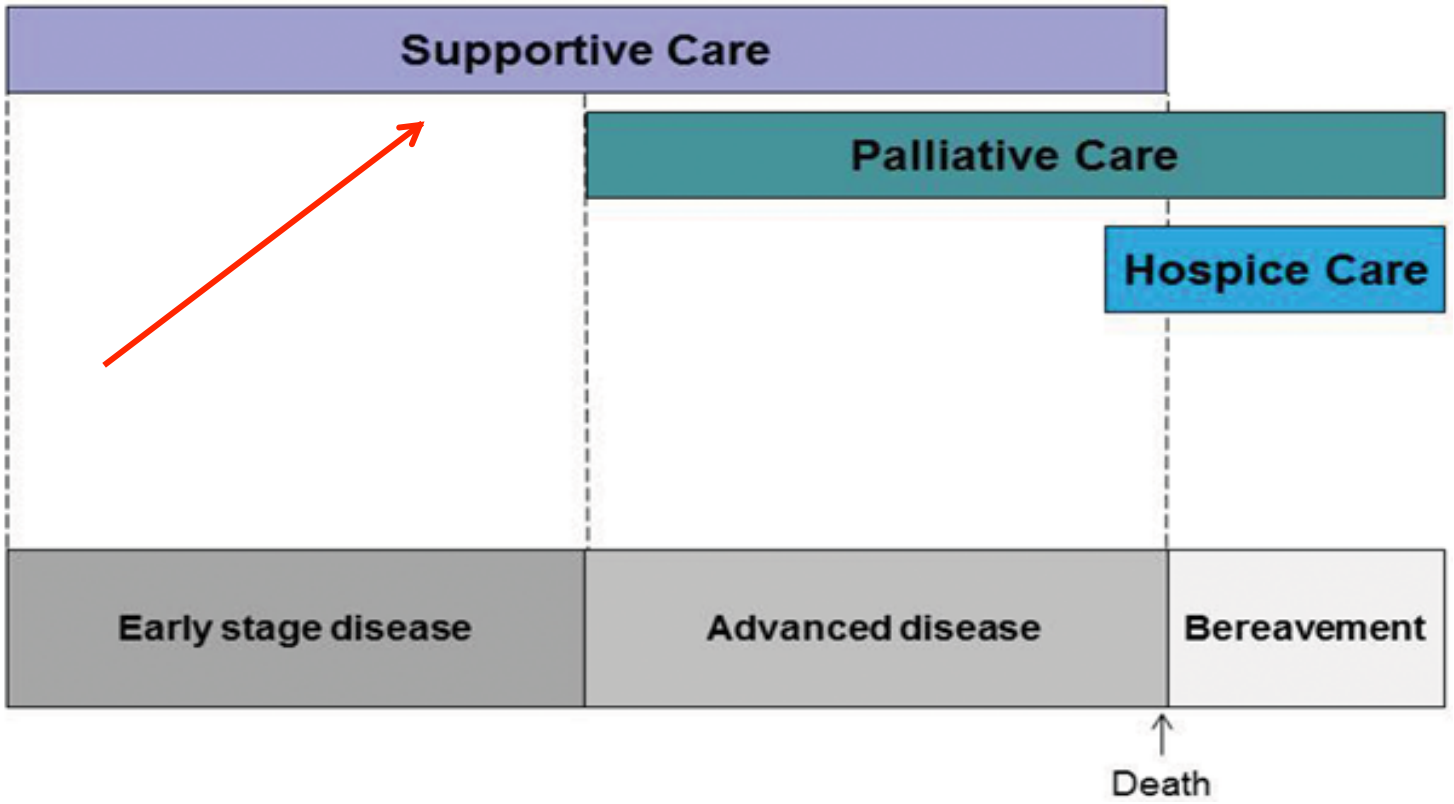
ESMO definisce **Supportive care** la cura che ha come obiettivo di ottimizzare “comfort, function, and social support” a pazienti e famigliari in tutti gli stadi di malattia, inclusa **la malattia curabile.**

ESMO definisce **Palliative Care** la stessa cura rivolta ad una **malattia incurabile**.

I termini descrivono **programmi clinici comuni** con l’obiettivo primario di controllare i sintomi fisici **(in primis il dolore)** psicosociali e spirituali di pazienti con patologia oncologica e loro famigliari.

Early Integration of Palliative and Supportive Care in the Cancer Continuum: Challenges and Opportunities

Mellar P. Davis, MD, Eduardo Bruera, MD, and Daniel Morganstern, MD



E. BOOK ASCO 2013

L’intervento **precoce** di cure supporto/ palliative: quali evidenze?

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.

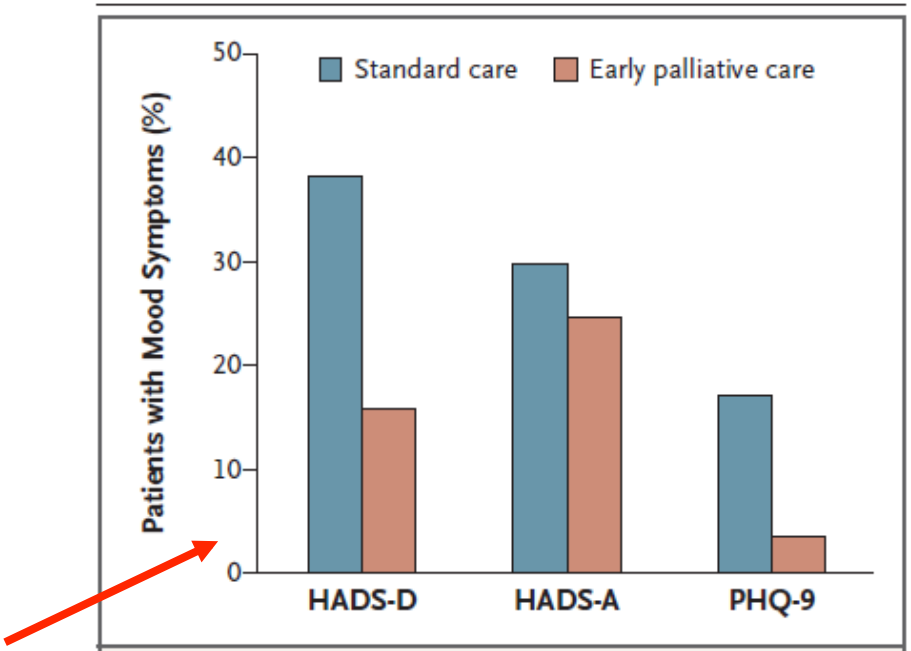


Figure 2. Twelve-Week Outcomes of Assessments of Mood.

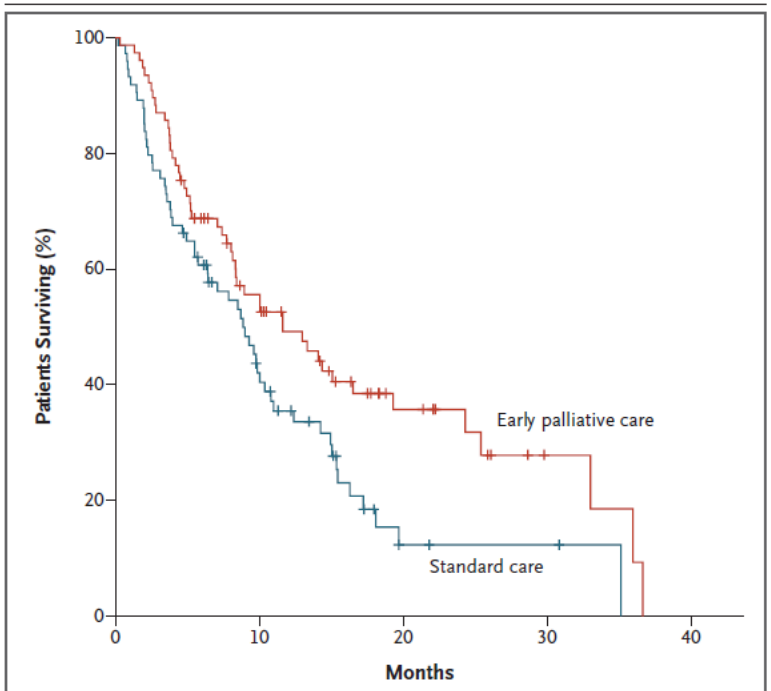


Figure 3. Kaplan–Meier Estimates of Survival According to Study Group.
Survival was calculated from the time of enrollment to the time of death, if it occurred during the study period, or to the time of censoring of data on December 1, 2009. Median estimates of survival were as follows: 9.8 months (95% 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

VOLUME 33 · NUMBER 13 · MAY 1 2015

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

Early Versus Delayed Initiation of Concurrent Palliative Oncology Care: Patient Outcomes in the ENABLE III Randomized Controlled Trial

Marie A. Bakitas, Tor D. Tosteson, Zhigang Li, Kathleen D. Lyons, Jay G. Hull, Zhongze Li, J. Nicholas Dionne-Odom, Jennifer Frost, Konstantin H. Dragnev, Mark T. Hegel, Andres Azuero, and Tim A. Ahles

Within 30-60 days

3-month delay

Table 1. Baseline Demographic and Clinical Characteristics of Patient Participants

Characteristic	Early Group (n = 104) No.	%	Delayed Group (n = 103) No.	%	*P**
Age, years					.68
Mean	64.03		64.6		
SD	10.28		9.59		
Male sex	56	53.85	53	51.46	.78
Diagnosis					.97
Lung	46	44.23	42	40.78	
GI tract	26	25	24	23.3	
Breast	10	9.62	13	12.62	
Other solid tumor	10	9.62	10	9.71	
Genitourinary tract	7	6.73	9	8.74	
Hematologic malignancy	5	4.81	5	4.85	
Disease status at enrollment					.24
New diagnosis	48	46.15	46	44.66	
Recurrence	29	27.88	20	19.42	
Progression	27	25.96	36	34.95	
Do not know	0	0.0	1	0.97	
Brain metastasis at enrollment	17	16.35	18	17.48	.71
Charlson score	6.3	1.62	6.21	1.86	.71
Karnofsky performance status	80.58	10.87	81.46	9.74	.54
Anticancer treatment at enrollment					
Chemotherapy	76	73.08	80	77.67	.52
Radiotherapy	20	19.23	20	19.42	1.00

Initial, standardized consultation by a PC clinician and six structured weekly telephone coaching sessions by an advanced practice nurse.

The finding of a 15% improvement in 1-year survival in patients with advanced cancer of mixed diagnoses receiving early (v 3-month delayed) PC is consistent with the improved survival noted in Temel's study in patients with non–small-cell lung cancer only (11.6 v 8.9 months).

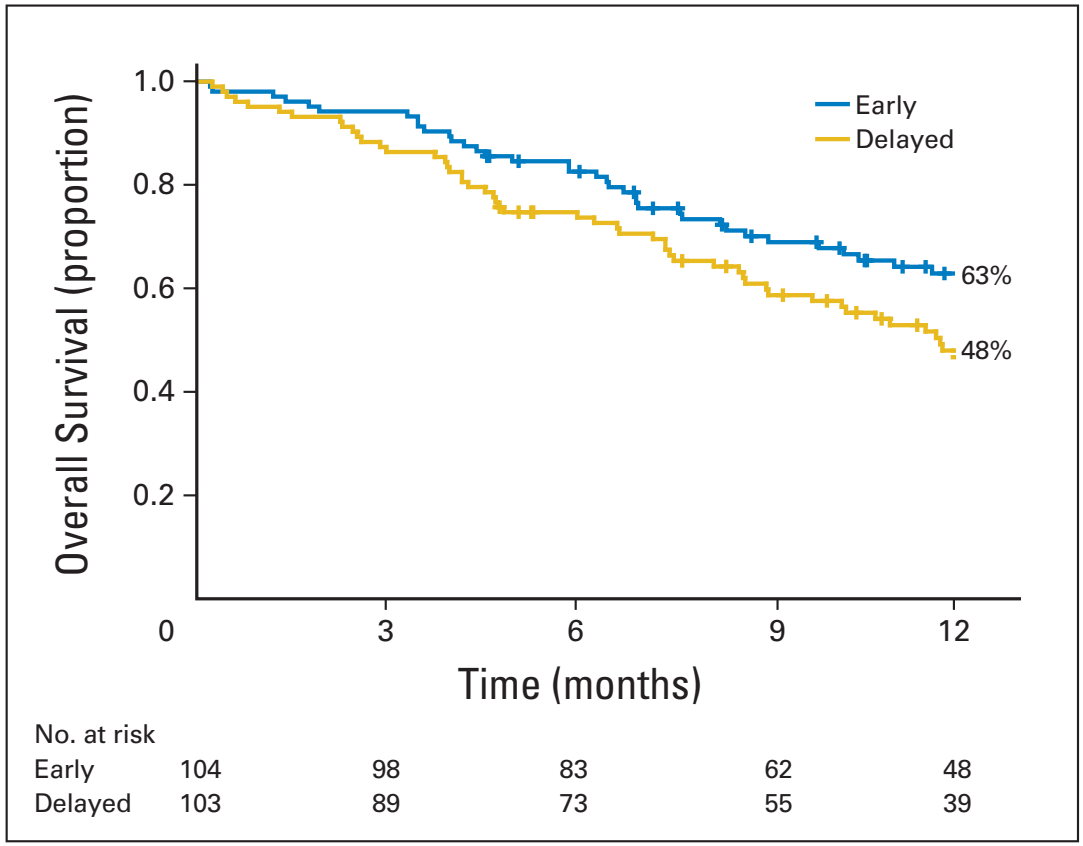


Fig 2. Kaplan-Meier estimates of 1-year survival by treatment group.

L'intervento **precoce** di supporto/cure palliative: quali OBIETTIVI?

Miglioramento:

1. Controllo dei sintomi (dolore), della QoL
2. Dati suggestivi, seppur iniziali, della sopravvivenza
3. Depressione nei care givers
4. Ridefinizione degli obiettivi di cura (Comunicazione)

Riduzione:

5. Cure inappropriate

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VOLUME 33 · NUMBER 13 · MAY 1 2015

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Benefits of Early Versus Delayed Palliative Care to Informal Family Caregivers of Patients With Advanced Cancer: Outcomes From the ENABLE III Randomized Controlled Trial

J. Nicholas Dionne-Odom, Andres Azuero, Kathleen D. Lyons, Jay G. Hull, Tor Tosteson, Zhigang Li, Zhongze Li, Jennifer Frost, Konstantin H. Dragnev, Imatullah Akyar, Mark T. Hegel, and Marie A. Bakitas

Early-group: Care Givers had lower depression (6% decrease) and stress burden in the terminal analysis.

Palliative care for Care Givers should be initiated as early as possible to maximize benefits.

L'intervento **precoce** di supporto/cure palliative: quali OBIETTIVI?

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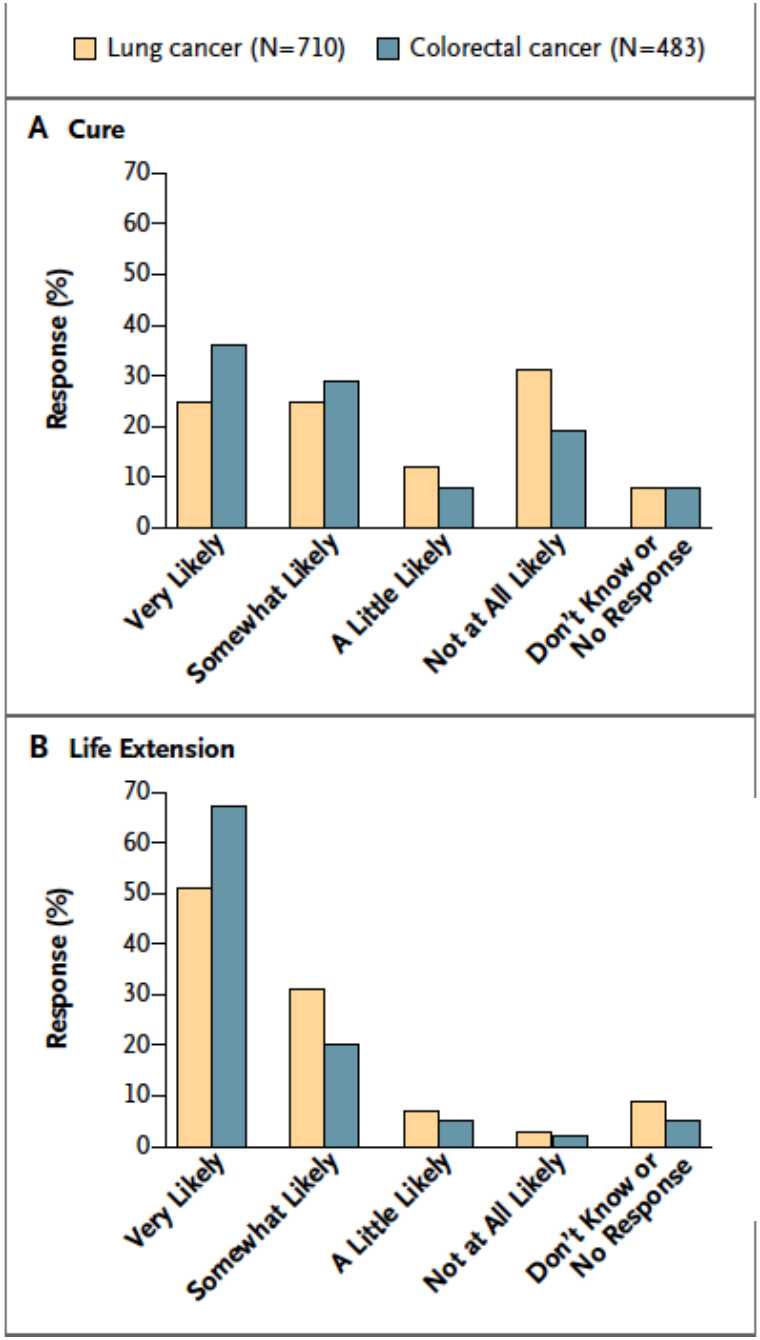
Riduzione:

5. Cure inappropriate



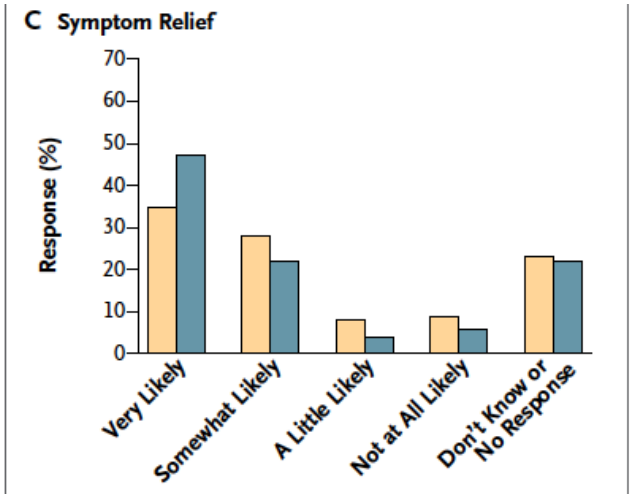


Figure 1. Responses to Questions about the Likelihood That Chemotherapy Will Have an Effect, According to the Type of Effect and Diagnosis.

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).

69% of patients with lung cancer and 81% of those with colorectal cancer did not report understanding that chemotherapy was not at all likely to cure their cancer.

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.

N ENGL J MED 367;17 NEJM.ORG OCTOBER 25, 2012

JOURNAL OF PALLIATIVE MEDICINE
Volume 16, Number 8, 2013

DOI: 10.1089/jpm.2012.0547

The Cultivation of Prognostic Awareness Through the Provision of Early Palliative Care in the Ambulatory Setting: A Communication Guide

Vicki A. Jackson, MD, MPH,[1] Juliet Jacobsen, MD,[1,2] Joseph A. Greer, PhD,[3] William F. Pirl, MD,[3] Jennifer S. Temel, MD,[3] and Anthony L. Back, MD[4]

SPIKES AND NURSE COMMUNICATION ABILITIES

VOLUME 32 · NUMBER 31 · NOVEMBER 1 2014

JOURNAL OF CLINICAL ONCOLOGY

COMMENTS AND CONTROVERSIES

Current State of the Art and Science of Patient-Clinician Communication in Progressive Disease: Patients' Need to Know and Need to Feel Known

Liesbeth M. van Vliet, *King's College London, Cicely Saunders Institute, London, United Kingdom*
Andrew S. Epstein, *Memorial Sloan-Kettering Cancer Center, New York, NY*

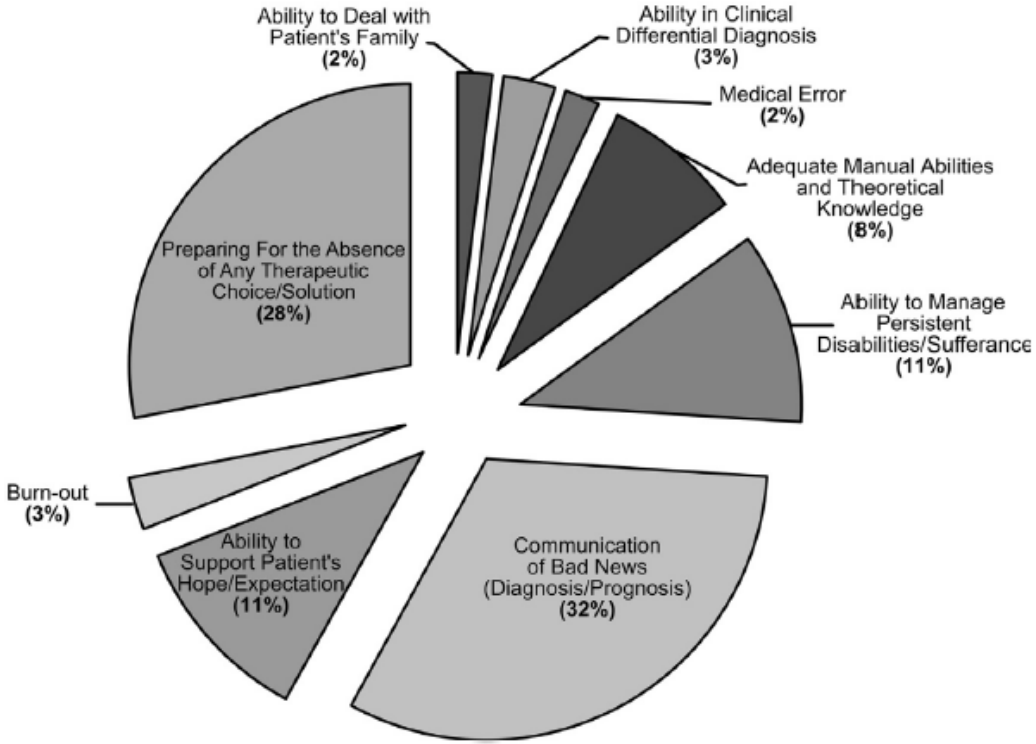


Fig. 1. Description of reported concerns and fears of medical students attending the 5th and 6th years of training at the Faculty of Medicine and Surgery, University of Modena and Reggio Emilia, Modena, Italy.

Potenza, Galli, Bandieri, Luppi et al.

Journal of Pain and Symptom Management 2015

L'intervento **precoce** di supporto/cure palliative: quali OBIETTIVI?

Miglioramento:

1. Controllo dei sintomi, della QoL
2. Dati suggestivi, seppur iniziali, della sopravvivenza
3. Depressione nei care givers
4. Ridefinizione degli obiettivi di cura (Comunicazione)
5. Cure inappropriate nel fine vita

VOLUME 30 · NUMBER 4 · FEBRUARY 1 2012

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Effect of Early Palliative Care on Chemotherapy Use and End-of-Life Care in Patients With Metastatic Non–Small-Cell Lung Cancer

Joseph A. Greer, William F. Pirl, Vicki A. Jackson, Alona Muzikansky, Inga T. Lennes, Rebecca S. Heist, Emily R. Gallagher, and Jennifer S. Temel

established guidelines for quality end-of-life care. The American Society of Clinical Oncology Quality Oncology Practice Initiative has delineated several key metrics for determining high-quality treatment near death, such as no chemotherapy within the last 2 weeks of life, referral to hospice, and enrollment in hospice care more than 1 week before death.[26] Palliative care clinicians, who are accustomed to prac-

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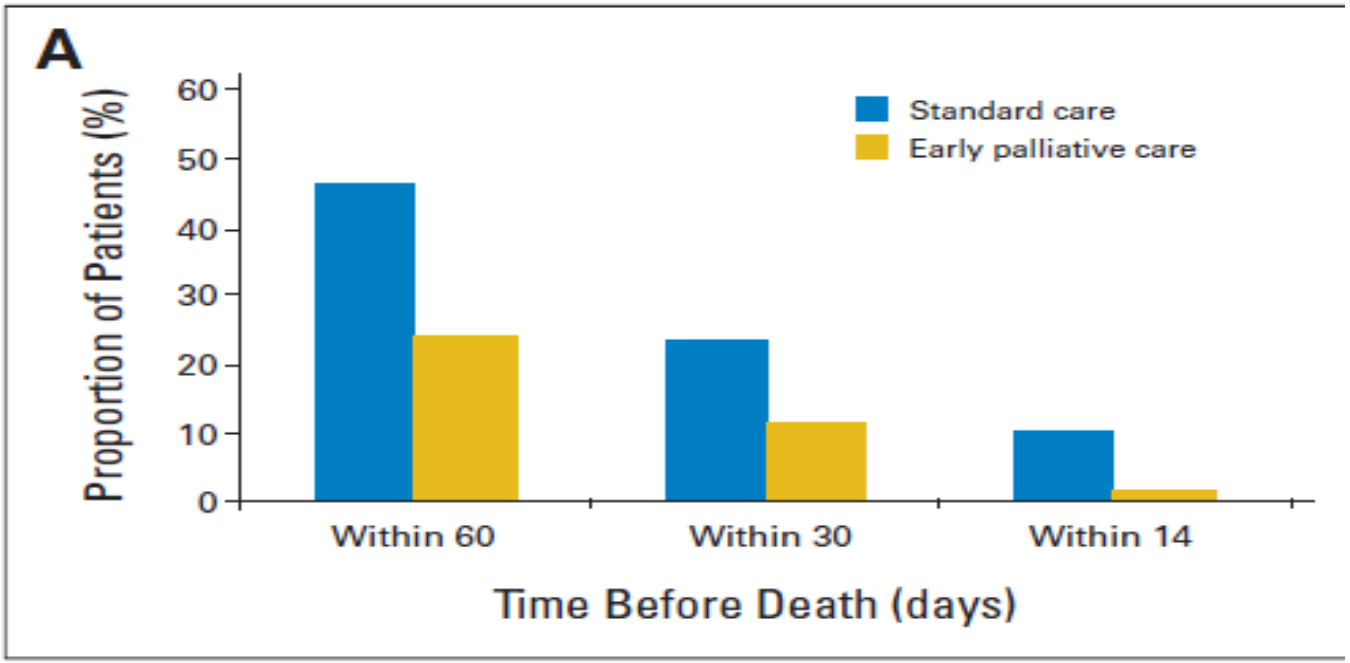


N ENGL J MED 363;8 NEJM.ORG AUGUST 19, 2010

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.,

Early introduction of supportive/palliative care also led to less aggressive end-of-life care, reduced chemotherapy in the last 14 days (17.5%).

VOLUME 33 · NUMBER 13 · MAY 1 2015

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

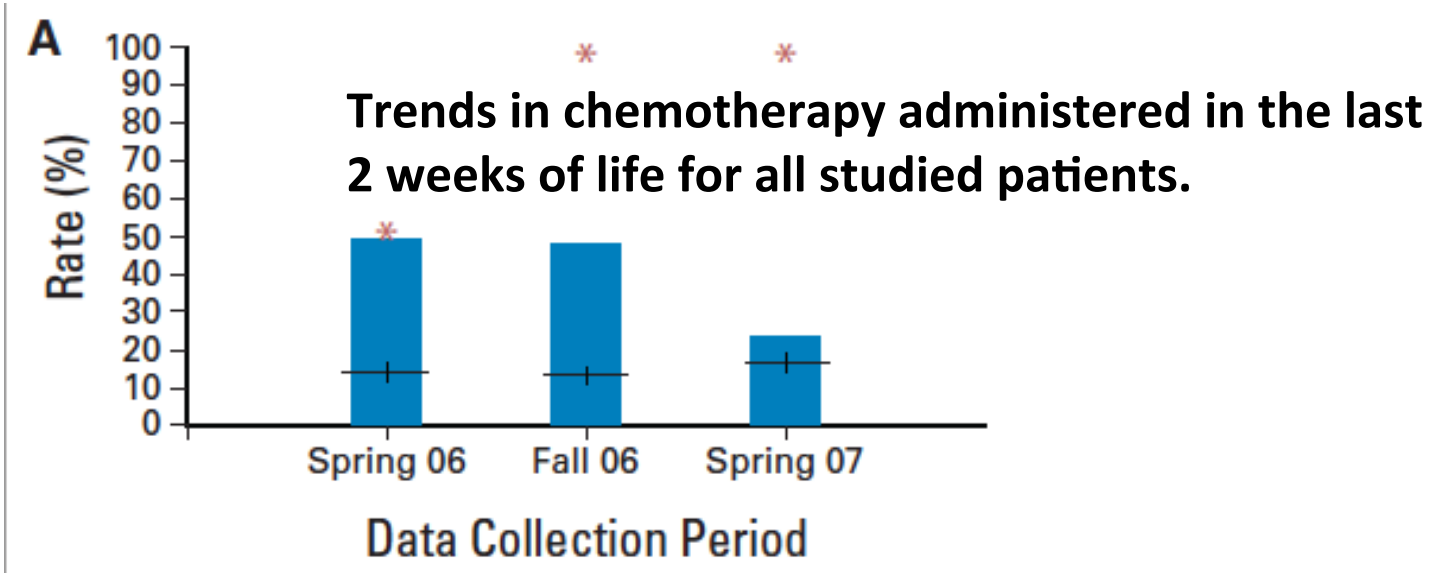
Early Versus Delayed Initiation of Concurrent Palliative Oncology Care: Patient Outcomes in the ENABLE III Randomized Controlled Trial

Marie A. Bakitas, Tor D. Tosteson, Zhigang Li, Kathleen D. Lyons, Jay G. Hull, Zhongze Li, J. Nicholas Dionne-Odom, Jennifer Frost, Konstantin H. Dragnev, Mark T. Hegel, Andres Azuero, and Tim A. Ahles

Chemotherapy use in the last 14 days averaged 7%

FORMAZIONE: ruolo centrale

The University of Michigan reduced chemotherapy use from 50% to about 20% in the patient's last 2 weeks of life by simply initiating of education in palliative care



Trends in chemotherapy administered in the last 2 weeks of life for all studied patients.

Blayney et al., J Clin Oncol 2009

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

J Clin Oncol 34.

Key Recommendation

Patients with advanced cancer, should receive dedicated supportive/palliative care services, **early** in the disease course, concurrent with active treatment.

For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement within 8 weeks of diagnosis.

*“Chiunque **soffre** cerca di **comunicare** la sua **sofferenza**; e solo così facendo, la diminuisce veramente.*
*Coloro che soffrono non hanno, in fondo, bisogno d'altro, che di uomini capaci di prestar loro **attenzione.***
Ma la capacità di dare attenzione a chi soffre è cosa rarissima; quasi un miracolo.”

L'ombra e la grazia- 1943
Simone Weil

: