Urgent need for integrated oncology and palliative care

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The European Society for Medical Oncology (ESMO) has awarded ESMO Designated Center of Integrated Oncology and Palliative Care accreditation to 16 new oncology centers. The centers will receive the acknowledgment at the ESMO 2012 Congress, in Vienna, Austria, 28 September – 2 October. The ESMO 2012 Congress will also highlight two new Italian studies demonstrating how palliative care works in practice in Italy. The first study explores use of analgesics; the second looks at different models for organization of the integration of palliative care with oncology.

First set up in 2003, this ambitious ESMO project aims to improve the infrastructure for the provision of palliative care globally. The initiative came partly in response to the World Health Organization (WHO) report "Cancer pain relief and palliative care".

"This year's awardees —13 based in Europe, one in Egypt, one in Singapore and one in India—demonstrate the truly international scope of ESMO's work. It shows how ESMO wants to help humanity, not just European oncology patients," says Raphael Catane, one of the founding members of the ESMO Palliative Care Working Group.

"In addition to making efforts to prolong the life of oncology patients, ESMO felt we needed to ensure that quality of life was good. We've made considerable efforts to change the mindset of doctors and patients that taking care of symptoms need not diminish efforts to prolong life. From the outset of diagnosis we wanted to integrate palliative care into

the practice of medical oncology," says Dr Catane, from the Institute of Oncology, Sheba Medical Center, Israel.

The award, judged anonymously by ESMO Palliative Care Working Group members, assesses centers according to 13 rigorous criteria. Any oncology department or cancer centre can apply, with ESMO emphasizing that size is not important, what matters most is the quality and extent of integration of services.

The criteria have come to be regarded as a "roadmap" for how to build palliative care services. Unsuccessful applicants are invited to further develop their programs and reapply. "What's really valuable is that we give feedback which works as a teaching tool, showing centers how they can improve," says Dr Catane. "

Receiving the certification allows centers to use the title "ESMO Designated Center of Integrated Oncology and Palliative Care" and also be eligible to receive fellows in palliative medicine, supported by ESMO grants.

For successful applicants, however, there is no room for complacency, since awards need to be renewed every three years. Of the current 127 (including the 16 new centers) accredited centers, 50 have been reaccredited once (27 this year) and 21 twice (eight this year). "With personnel, policy and financial aspects changing all the time, we want to ensure that integration of palliative care continues," says Dr Catane.

Dr. Matti Aapro, a member of the ESMO Supportive and Palliative Care Faculty, adds, "The program is laid out in a very 'user-friendly' manner which allows many centers to continue to improve their skills while already recognized as a 'designated center'."

Undoubtedly, the much sought after accolade has contributed to

increasing the profile of palliative care within oncology units across the world. "ESMO's initiative has certainly raised a lot of interest, as demonstrated by the growing list of centers that adhere to this program. It's one of many ways to encourage the development of truly multidisciplinary cancer centers which look at the patient's needs in all aspects of cancer treatment," says Dr Aapro, from the Clinique de Genolier, Switzerland.

"While further penetration of ESMO's palliative care policy is still needed, the work of the ESMO Palliative Care Working Group has undoubtedly enhanced the lives of thousands of cancer patients in Europe and beyond," says Dr. Catane.

ESMO 2012 abstracts reveal organization of palliative care in Italy Two Italian abstracts presented at the ESMO 2012 Congress demonstrate the emphasis that Italian oncologists place on monitoring palliative care in a bid to further improve services delivered to patients. As a country, Italy has a strong tradition of palliative care, with 26 centers now awarded ESMO Designated Center of Integrated Oncology and Palliative Care status.

Underuse of adjuvant analgesics is highlighted in the first study, which evaluated the management of pain in eight Italian oncology centers. The study also emphasizes the importance of close patient follow-up.

"We set out to provide a snapshot of the management of cancer pain across Italy to see how we're doing," says Dr Sandro Barni, the principal investigator from Treviglio Hospital, Italy. In the prospective study, 265 consecutive cancer patients seen in eight Italian cancer centers over five days between Monday, 10 January and Friday 14, January 2011 were asked to fill in questionnaires concerning levels of pain experienced in the previous seven days, the site of pain and analgesics used. The questionnaires were then re-administered at one and two weeks later.

The recruiting centers were in Treviglio, Florence, Rome, Pavia, Reggio Emilia and Palermo. Of the enrolled subjects, 59% were female, the median age was 61 years, 72.8% had metastatic disease, 86.4% were undergoing chemotherapy and 88% had ECOG Performance status (0-1), indicating that they were ambulatory.

Results at baseline show 69.4% of patients used NSAIDs, 34% weak opioids, 34% strong opioids and 27.7% adjuvants (24.5% pregabain, 57.1% steroids and 18.4% other drugs). The baseline treatment was confirmed in 57.3%, adjusted in 34% and changed in 8.6%. At one week follow-up analgesic therapy was confirmed in 72.2% and adjusted in 27.8%. New drugs prescribed were NSAIDS in 43.3%, weak opioids in 21.7%, strong opioids in 86.7% and adjuvants in 55%. At two weeks follow-up, therapy was adjusted in 19.1%, with an adjuvant prescribed in 85.7% of these patients.

Adjuvant analgesics (which include antidepressants, corticosteroids and bisphosphonates), are defined as drugs with a primary indication other than pain that have analgesic properties in some conditions.

"Our data suggests not enough cancer patients receive adjuvants. We have the impression that this is especially the case where therapies are not prescribed by oncologists. We'd like both doctors and patients to be better informed about the benefits of these drugs," says Dr Barni. The study, he adds, shows that clinicians frequently change and adjust pain treatments at follow-up visits. "The adjustments demonstrate that you need to follow patients very carefully. Healthcare professionals should be getting cancer patients to assess pain on visual scales every time they see them and adjusting treatments accordingly," concludes Dr Barni.

The integrated care model of palliative care dominates Italian ESMO Designated Centers of Integrated Oncology and Palliative Care, reveals a survey of 20 Italian ESMO designated centers, but organization differs

between centers.

In the second abstract, Dr Vittorina Zagonel and colleagues from the Task Force "Continuity of Care in Oncology" of the Italian Association of Medical Oncology (AIOM), set out to evaluate integration models for oncology and palliative care in the 20 Italian ESMO designated centers that were recognized at the time of the study. The task force, which was set up to bring together the ESMO designated centers in Italy, sent questionnaires to managers at each of the 20 centers.

"The intention was to reveal a picture of the different types of integration models operating in ESMO designated centers. We hope to inspire the Italian oncology units who have yet to be designated to consider applications," says Dr Vittorio Franciosi, one of the investigators from the University Hospital of Parma, who is also secretary of the Task Force.

Results show that the integrated care model operated in 75% of centers. This is the model where the oncologist focuses on the management of the cancer and a supportive care team addresses the vast majority of physical and psychosocial concerns.

The questionnaire revealed that 90% (18) of the centers had an oncologist orientated to palliative care, 90% (18) had guidelines in place for symptomatic treatment, 70% (14) had palliative care beds and 70% (14) had palliative care offices.

Good integration with home care was demonstrated. Home care managed by palliative care physicians (PCPs) occurred in 45% (9), while in 30% (6) it was managed by general practitioners (GPs), in 15% (3) by oncologists and in 10% (2) jointly by PCPs and GPs.

Where home care was not managed by oncologists, the centres achieved

integration through oncologist home visits in 35%, interdisciplinary meetings in 65% and guidelines sharing between oncologists, PCPs and GPs in 35%.

Good integration with hospices was demonstrated. Hospices were managed by PCPs in 79% of cases, PCPs together with GPs in 11%, GPs in 5% and oncologists in 5%. When not managed by oncologists, integration was achieved through hospice visits in 41%, interdisciplinary meetings in 65% and guidelines sharing between oncologists, PCPs and GPs in 41%. The study revealed that 60% (12) centers were based in Northern Italy, 30% (6) in the centre, 10% (2) in the Islands and none in the South.

"Our results show that the type of integration achieved depends to a large extent on local and regional factors. Such information could be useful as a starting point for discussions with other centers showing them how approaches for integration might work in their areas," says Dr Franciosi.

Understanding the different models used in the Italian centers, he adds, opens the way for randomized clinical trials comparing the efficacy of integration of palliative and oncologic care with standard oncologic care. While a study has already shown survival advantages in patients with advanced lung cancer, additional studies could now be undertaken on cancers such as advanced gastric cancer, pancreatic cancer and biliary cancer. The shortage of designated palliative care centers in Southern Italy, he adds, needs also to be addressed.

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