

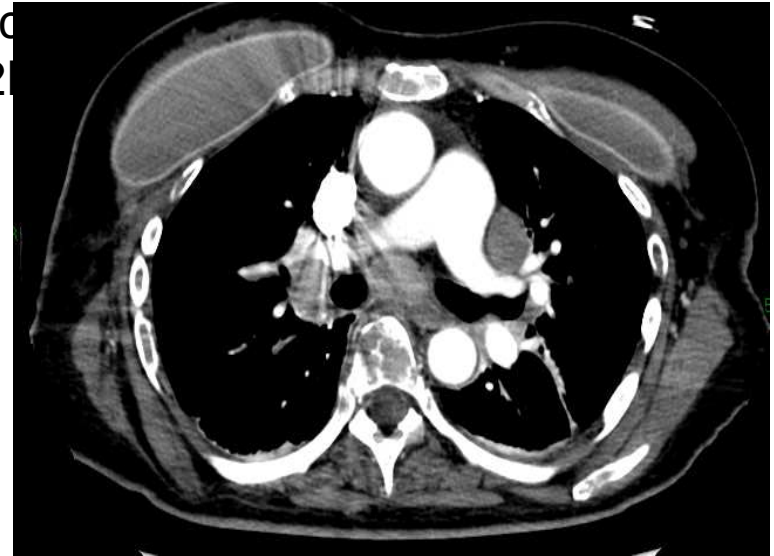


# Scelte difficili

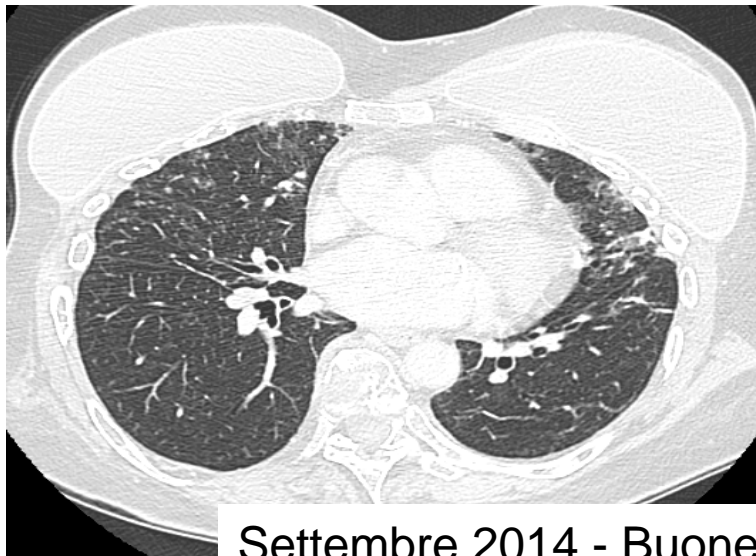


Diagnosi di carcinoma  
lobulare, pT2

Aprile 2013

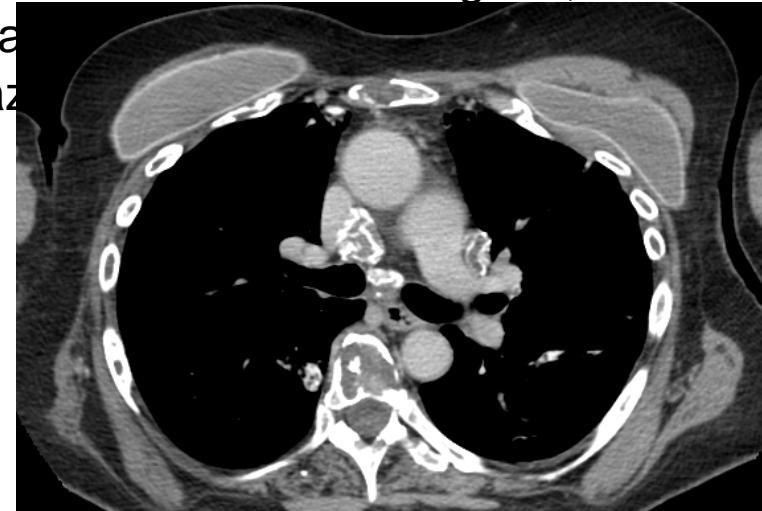


Grave quadro di insufficienza respiratoria ed insufficienza multiorgano,



sferita in terapia  
uta la stabilizzaz

Luglio 2014



Settembre 2014 - Buone condizioni, asintomatica, in terapia ormonale

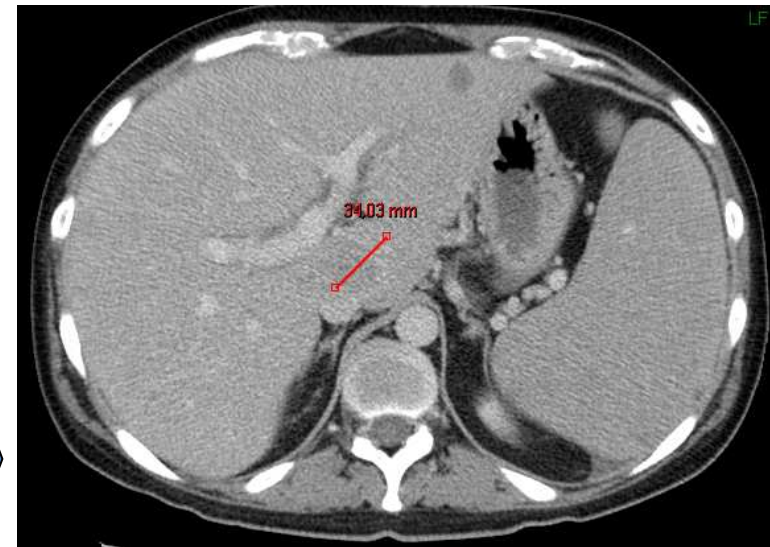
# Scelte difficili



1. Paziente di 31 anni, con melanoma diffuso, BRAF mutato. Inizia terapia con vemurafenib, con rapida risposta clinica

2. Tre mesi dopo, ricovero da PS per comparsa improvvisa di dolore addominale e dispnea. TAC di controllo con apparente risposta clinica delle lesioni target.

Rapido aggravamento (3 gg), e comparsa di arresto cardiaco. Tentativo prolungato di rianimazione, senza successo.

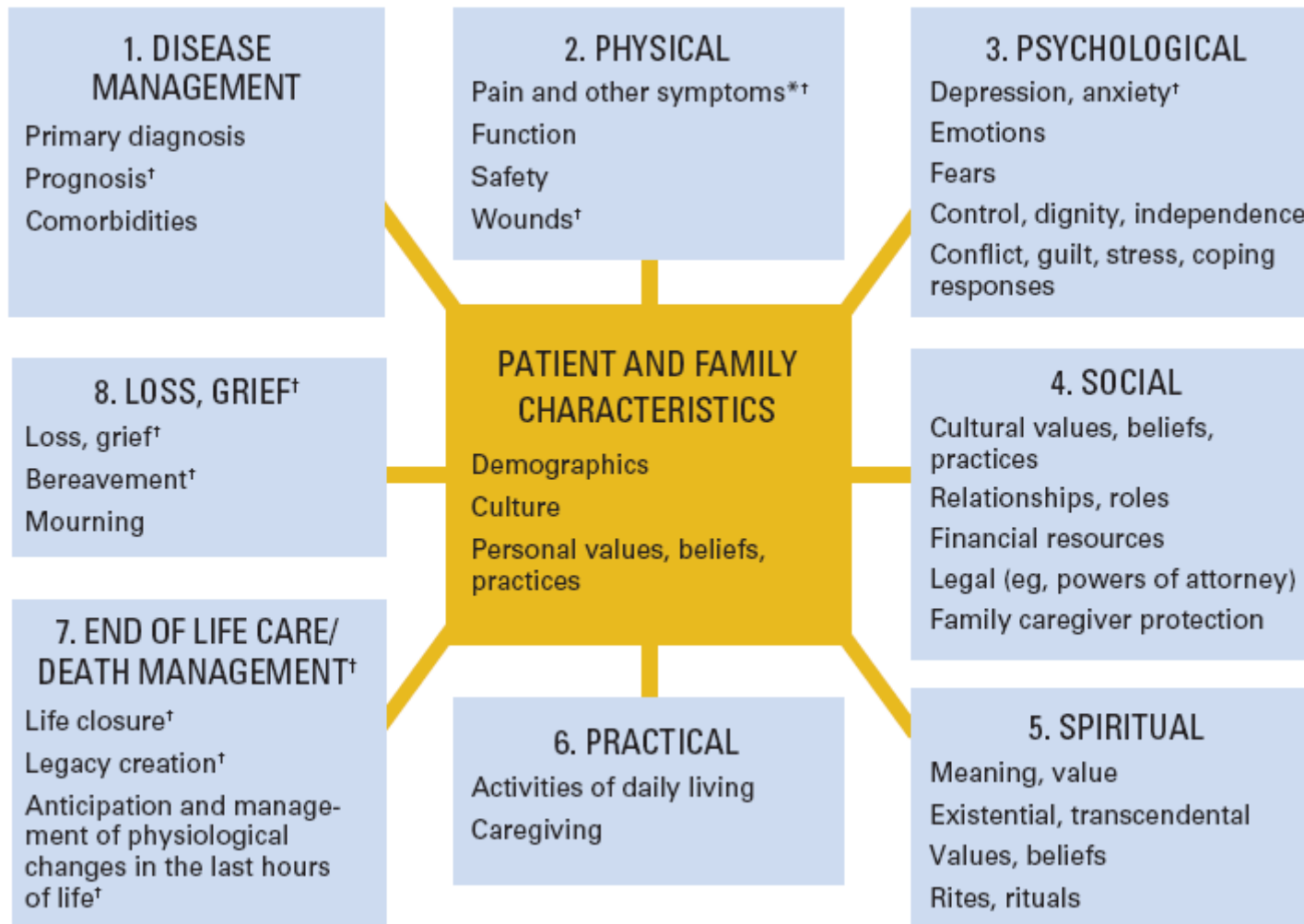


Quadro autoptico: diffusione miliariforme neoplastica a tutti gli organi (cuore ed encefalo compresi)

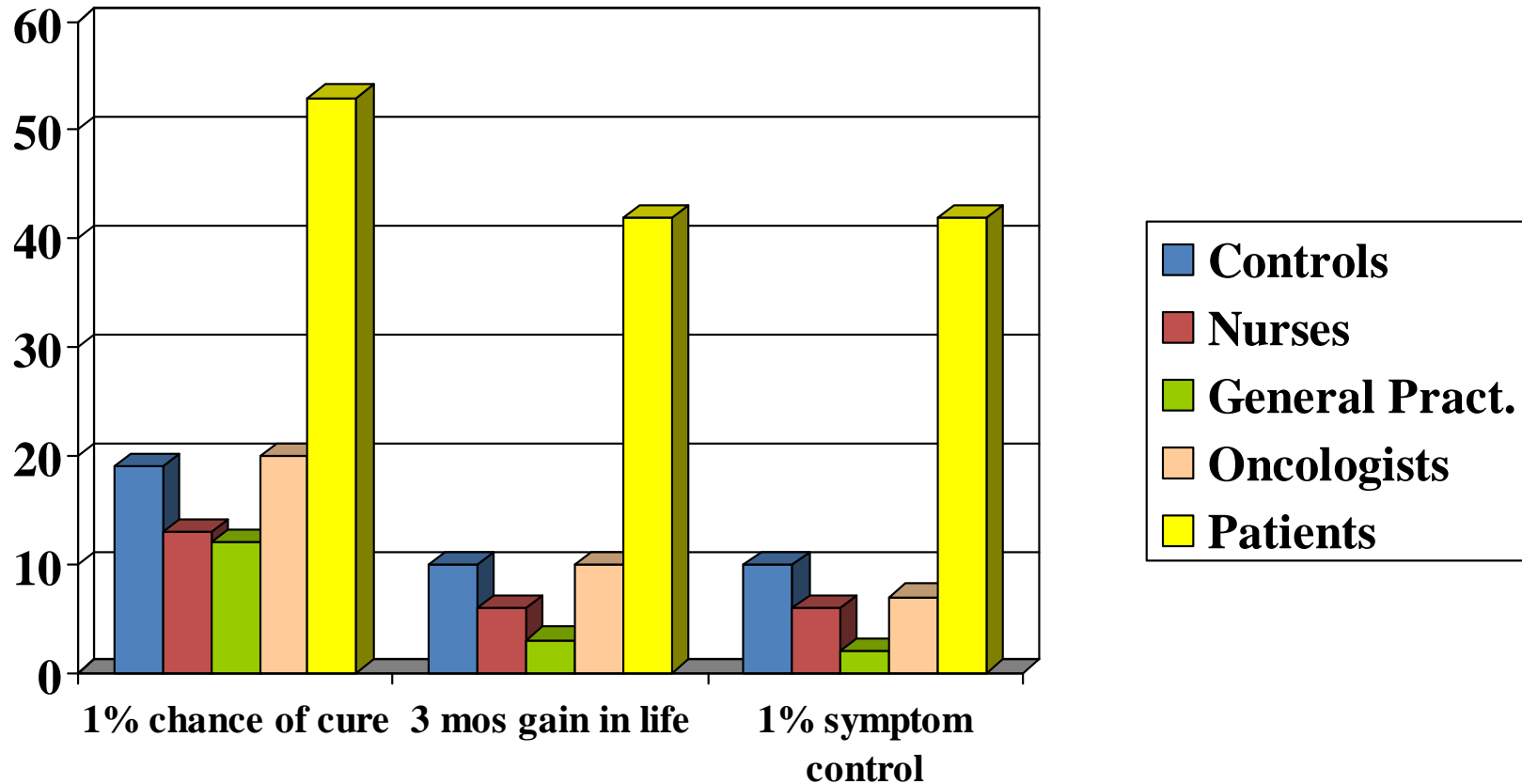
# Obiettivi della terapia oncologica nel paziente con malattia avanzata

1. Prolungare la sopravvivenza
  - Non negare trattamenti
2. Ridurre i sintomi
  - Non indurre o prolungare sintomi
3. Migliorare la qualità della fase terminale
  - Non indurre false speranze

# Le necessità dei pazienti



# Quale grado di accettazione per terapie impegnative?



## Associations between palliative chemotherapy and adult cancer patients' end of life care and place of death: prospective cohort study

## RESEARCH

 OPEN ACCESS

Alexi A Wright *assistant professor of medicine*<sup>1</sup>, Baohui Zhang *research statistician*<sup>2</sup>, Nancy L Keating *associate professor of medicine and health care policy*<sup>3</sup>, Jane C Weeks *professor of medicine*<sup>1</sup>, Holly G Prigerson *professor of medicine*<sup>2</sup>

<sup>1</sup>Harvard Medical School, Department of Medical Oncology, Dana-Farber Cancer Institute, Dana 1133, 450 Brookline Avenue, Boston, MA 02215, USA; <sup>2</sup>Center for End-of-Life Research, Weill Cornell Medical College, New York, NY 10065, USA; <sup>3</sup>Harvard Medical School, Department of Health Care Policy, 180 Longwood Avenue, Boston, MA 02115, USA

Terminally ill patients with advanced cancers who receive chemotherapy a few months before death are more likely to receive intensive care at the end of life, compared with patients who do not.

The use of chemotherapy a median of 4.0 months before death was associated with an increased risk of undergoing mechanical ventilation, cardiopulmonary resuscitation, or both in the last week of life and of being referred to a hospice late, both of which have been associated with worse quality of life for patients at the end of life, more distress in bereaved caregivers and higher costs.

## Alcuni dati...

- In a large community practice, 26% of patients with **NSCLC** received fourth line chemotherapy, including **20% within 2 weeks of their death**
- In **Germany**, **10%** of similar patients received **fourth-line chemotherapy**.
- At a large **university center**, **50%** of patients with solid tumors received **chemotherapy within 14 days of their death**.
- In **Sweden**, **23%** of patients with solid tumors received chemotherapy **in their last 30 days of life**.
- These findings suggest that this practice is driven not by profit, but by the desire to help patients and the inability of patients, families, and their oncologists to make end-of-life transitions

## American Society of Clinical Oncology Identifies Five Key Opportunities to Improve Care and Reduce Costs: The Top Five List for Oncology

*Lowell E. Schnipper, Thomas J. Smith, Derek Raghavan, Douglas W. Blayney, Patricia A. Ganz, Therese Marie Mulvey, and Dana S. Wollins*

- 1.** *Do not use cancer-directed therapy for patients with solid tumors who have the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and with no strong evidence supporting the clinical value of further anticancer treatment.*

# La prognosi e l'utilizzo delle risorse nel paziente oncologico

Accurate prediction of survival helps physicians plan terminal care management and helps administrators properly allocate resources and support services.

Yun HY et al. JCO, 2011

The three main components of medical intervention are diagnosis, therapy and prognosis. Of these, prognosis is the least studied aspect in scientific literature.

Maltoni M et al. The Oncologist, 2012

# Score prognostici

Palliative Prognostic (PaP) Score		
<b>Dyspnea</b>	Yes	1
	No	0
<b>Anorexia</b>	Yes	1,5
	No	0
<b>KPS</b>	≥50	0
	10-40	2.5
<b>Clinical Prediction of Survival (weeks)</b>	>12	0
	11-12	2
	7-10	2.5
	5-6	4.5
	3-4	6
	1-2	8.5
<b>Total WBC (cell/mm<sup>3</sup>)</b>	Normal (4,800-8,500)	0
	High (8,501-11,000)	0.5
	Very high (>11,000)	1.5
<b>Lymphocyte percentage (cell/ mm<sup>3</sup>)</b>	Normal (20%-40%)	0
	Low (12%-19.9%)	1
	Very low (0%-11.9%)	2.5
<b>Total score</b>		<b>Risk group</b>
<b>0-5.5</b>		A. 30-day survival probability >70%
<b>5.6-11</b>		B. 30-day survival probability 30–70%
<b>11.1-17.5</b>		C. 30-day survival probability <30%

Palliative Prognostic Index (PPI)		
<b>Dyspnea at rest</b>	Yes	3.5
	No	0.0
<b>Edema</b>	Yes	1
	No	0.0
<b>Delirium</b>	Yes	4.0
	No	0.0
<b>KPS</b>	10-20	4
	30-50	2.5
	≥60	0
<b>Oral intake</b>	Severely Reduced	2.5
	Moderately Reduced	1.0
	Normal	0
<b>Score</b>	<b>PPV 6-w survival</b>	<b>NPV 6-w survival</b>
<b>&gt;4</b>	0.83	0.71

Morita T et al. Support Care Cancer, 1999

Maltoni M et al. J Pain Symptom Manage, 1999

# Score prognostici

MNA (Mini Nutritional Assessment)	
A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?	0 = severe decrease in food intake 1 = moderate decrease in food intake 2 = no decrease in food intake
B. Weight loss during the last 3 months	0 = weight loss greater than 3 kg 1 = does not know 2 = weight loss between 1 and 3 kg 3 = no weight loss
C. Mobility	0 = bed or chair bound 1 = able to get out of bed / chair but does not go out 2 = goes out
D. Has suffered psychological stress or acute disease in the past 3 months?	0 = Yes 1 = No
E. Neuropsychological problems	0 = severe dementia or depression 1 = mild dementia 2 = no psychological problems
F. Body Mass Index (BMI) (weight in kg) / (height in m <sup>2</sup> )	0 = BMI less than 19 1 = BMI 19 to less than 21 2 = BMI 21 to less than 23 3 = BMI 23 or greater
<b>Screening score (max. 14 points)</b>	12-14 points: Normal nutritional status 8-11 points: At risk of malnutrition 0-7 points: Malnourished

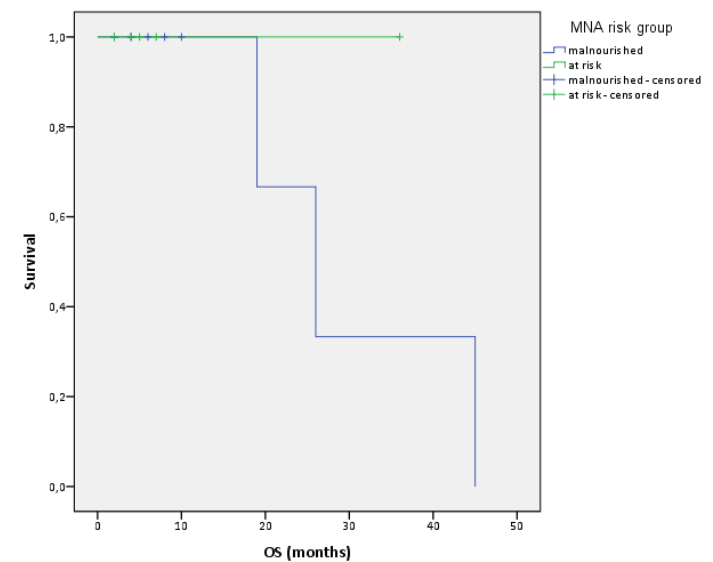
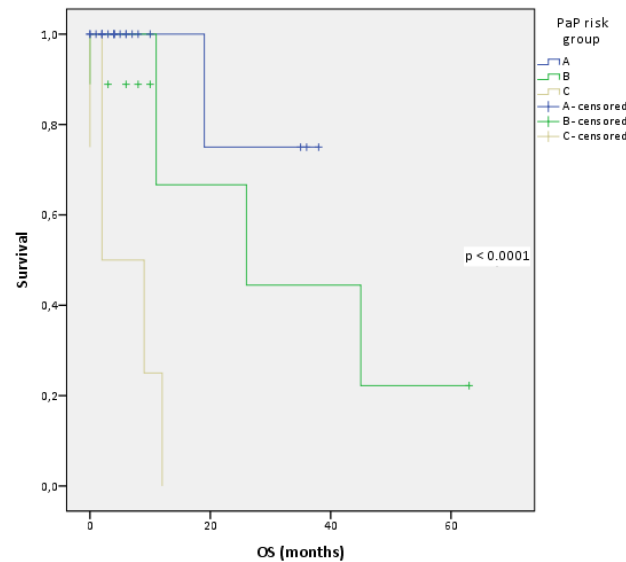
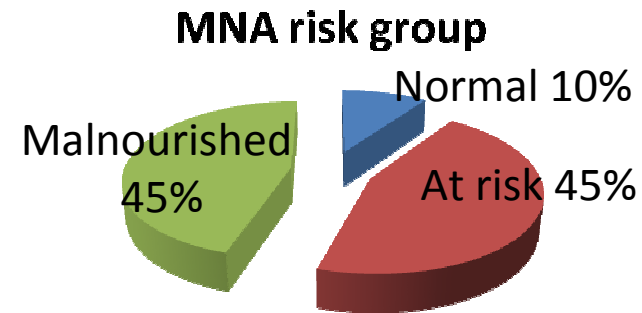
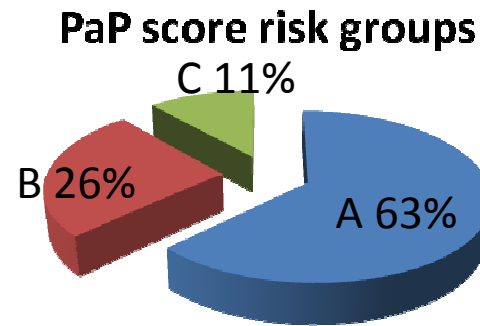
# Approaching the last months of cancer patients: looking for a guide.

Carandina I, Marzola M, Gilli G,  
Bannò E, Moretti A, Nisi C,  
Frassoldati A



35 patients:

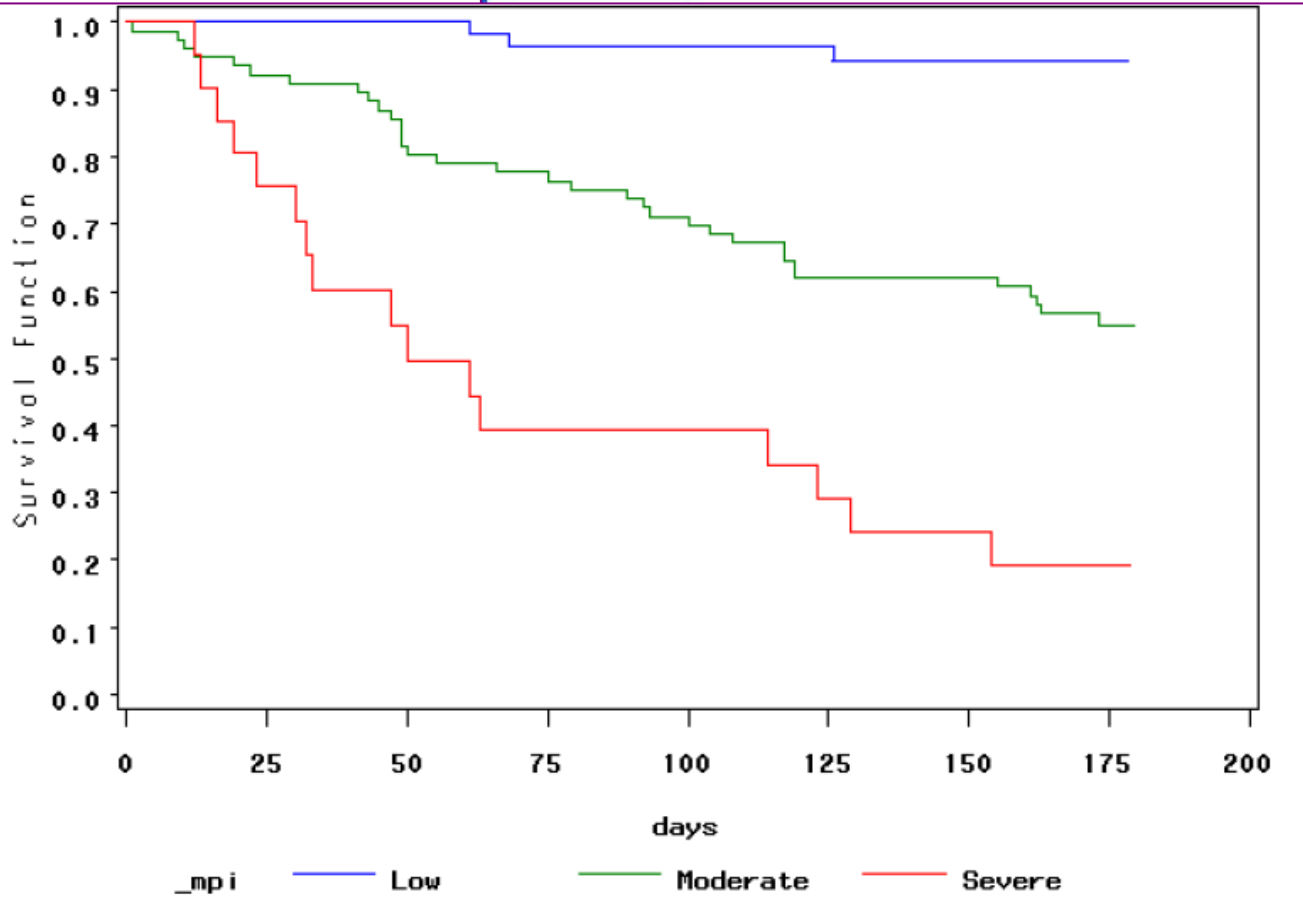
- 54.3% female, 45.7% male
- Median age of 67 (47-83) years
- Digestive tract, breast, and head-neck cancers accounted for the majority of the cases (71.4%).



# Indice prognostico multidimensionale

E' un indicatore di mortalità a lungo-termine basato su dati ottenute da Multidimensional

Se l'indice compreso rischio prognostico è basso; se compreso rischio prognostico è considerato un valore è considerato severo.



Calcolatore MPI

Nuovo test MPI Archivio Informazioni

Salva in archivio

Esci

## Impact of Awareness of Terminal Illness and Use of Palliative Care or Intensive Care Unit on the Survival of Terminally Ill Patients With Cancer: Prospective Cohort Study

*Young Ho Yun, Myung Kyung Lee, Seon Young Kim, Woo Jin Lee, Kyung Hae Jung, Young Rok Do, Samyong Kim, Dae Seog Heo, Jong Soo Choi, Sang Yoon Park, Hyun Sik Jeong, Jung Hun Kang, Si-Young Kim, Jungsil Ro, Jung Lim Lee, Sook Ryun Park, and Sohee Park*

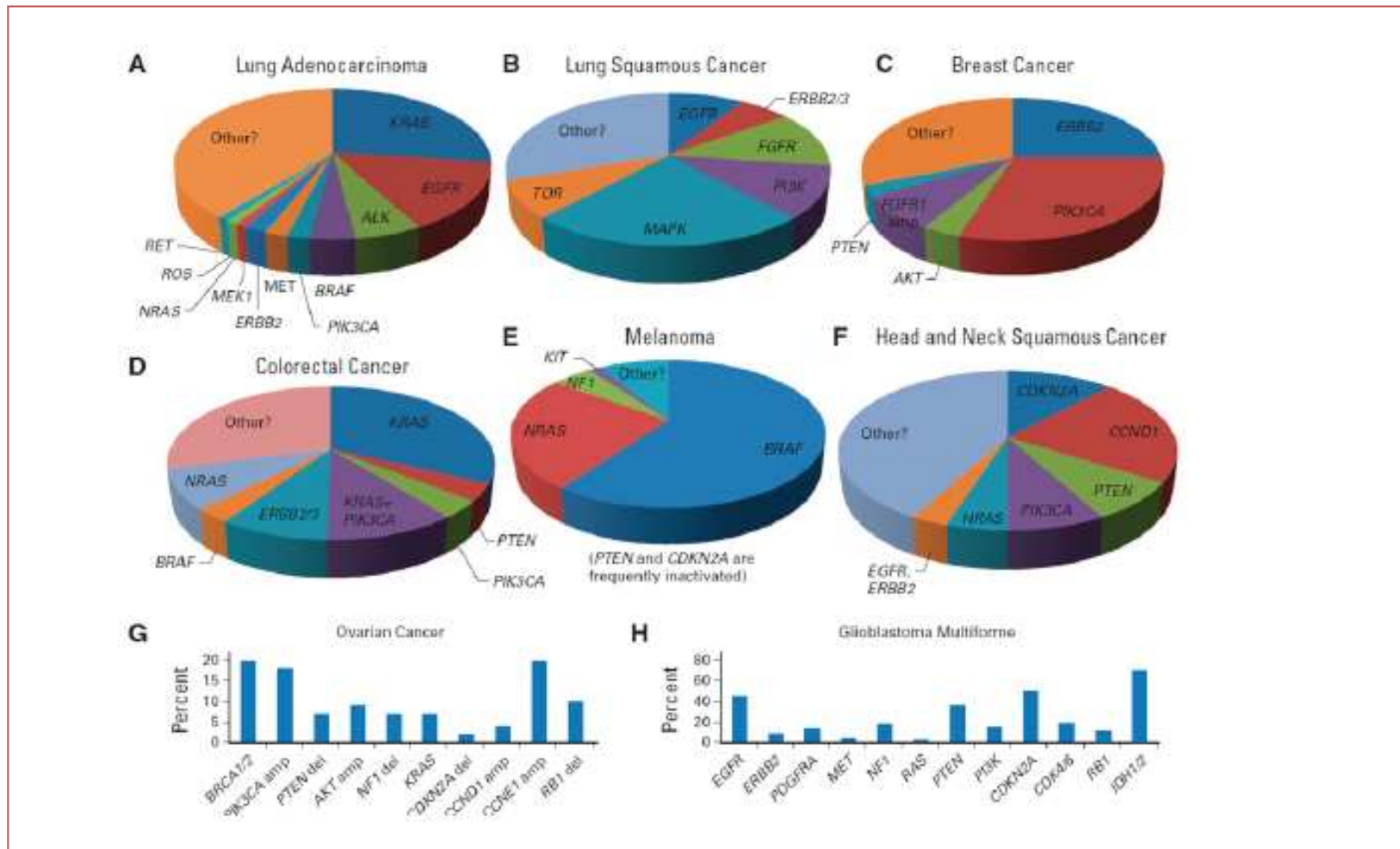
In a prospective cohort study at 11 university hospitals in Korea, we administered questionnaires to 619 consecutive patients immediately after they were determined by physicians to be terminally ill. We followed patients during 6 months after enrollment and assessed how their survival was affected by the disclosure of terminal illness and administration of palliative care or nonuse of the ICU.

A	Variables*	HR	95% CI	Multivariate <i>P</i> †
Overall Survival (probability)	ECOG performance status			
	0-2			
	3-4	1.37	1.10 to 1.71	.006
	Reason for terminal status			
	Refractory to chemotherapy, refusal of further chemotherapy, general prostration	1.23	0.96 to 1.57	.106
D	Aware of terminal diagnosis at diagnosis			
	No			
Overall Survival (probability)	Yes	1.20	0.96 to 1.51	.109
	Used palliative care			
	No			
	Yes	0.96	0.76 to 1.21	.745
	Used ICU			
	No			
	Yes	1.47	1.06 to 2.05	.023

# Cure intensive o palliative nei pazienti oncologici?

- Variabili nella malattia oncologica avanzata
  - Tipo di tumore e fase di malattia
  - Terapie precedenti
  - Disponibilità di farmaci ad alta efficacia
  - Complicanze inattese
  - Consapevolezza
  - La famiglia
- Nuove opzioni terapeutiche
  - Le storie del carcinoma mammario, Melanoma, del carcinoma polmonare
- La complessità della risposta alla terapie
  - Resistenza ai farmaci e possibilità di superarla

# Nuovi orizzonti in oncologia

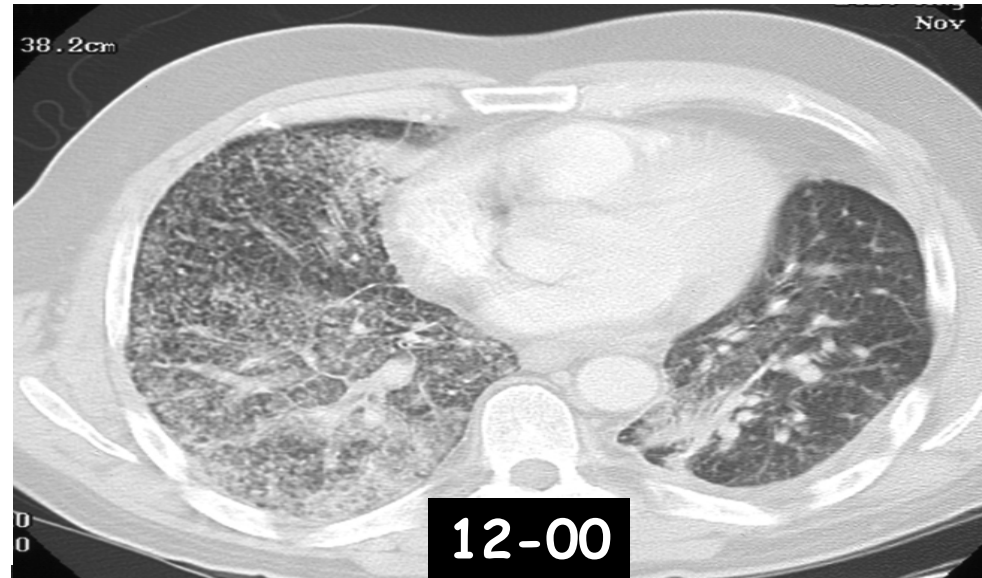


# Tumori “gene-addicted”

*Some cancers that contain multiple genetic, epigenetic, and chromosomal abnormalities are dependent on or ‘addicted’ to one or a few genes for both maintenance of the malignant phenotype and cell survival*

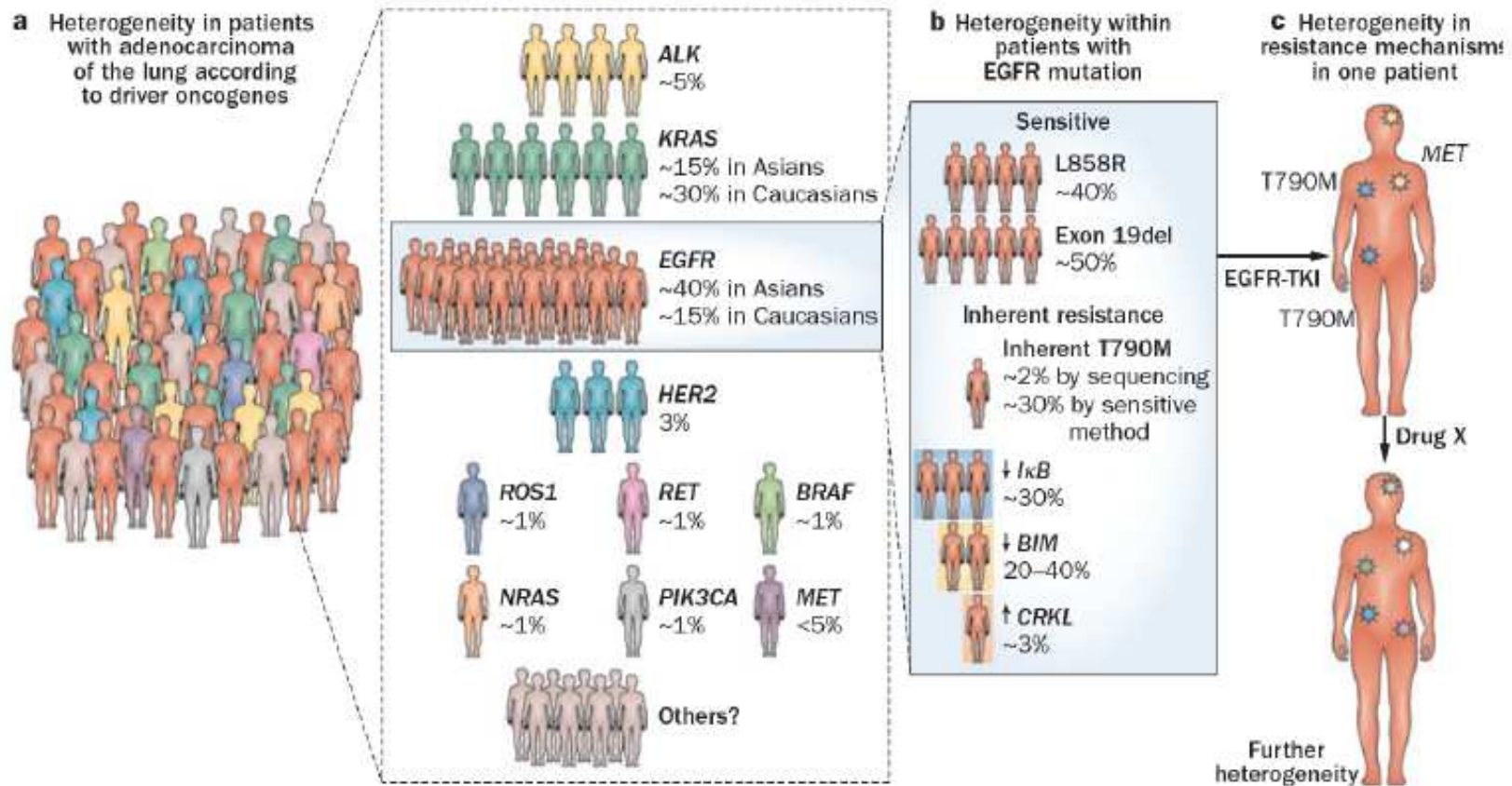
- ErbB-2 in breast cancer
- EGFR (mutant) in NSCLC
- EML4-ALK in NSCLC
- c-Kit in GIST
- BRAF in melanoma
- HIF/VEGF in RCC
- EGFR in colon carcinoma

# Prognosi nell'adenocarcinoma polmonare

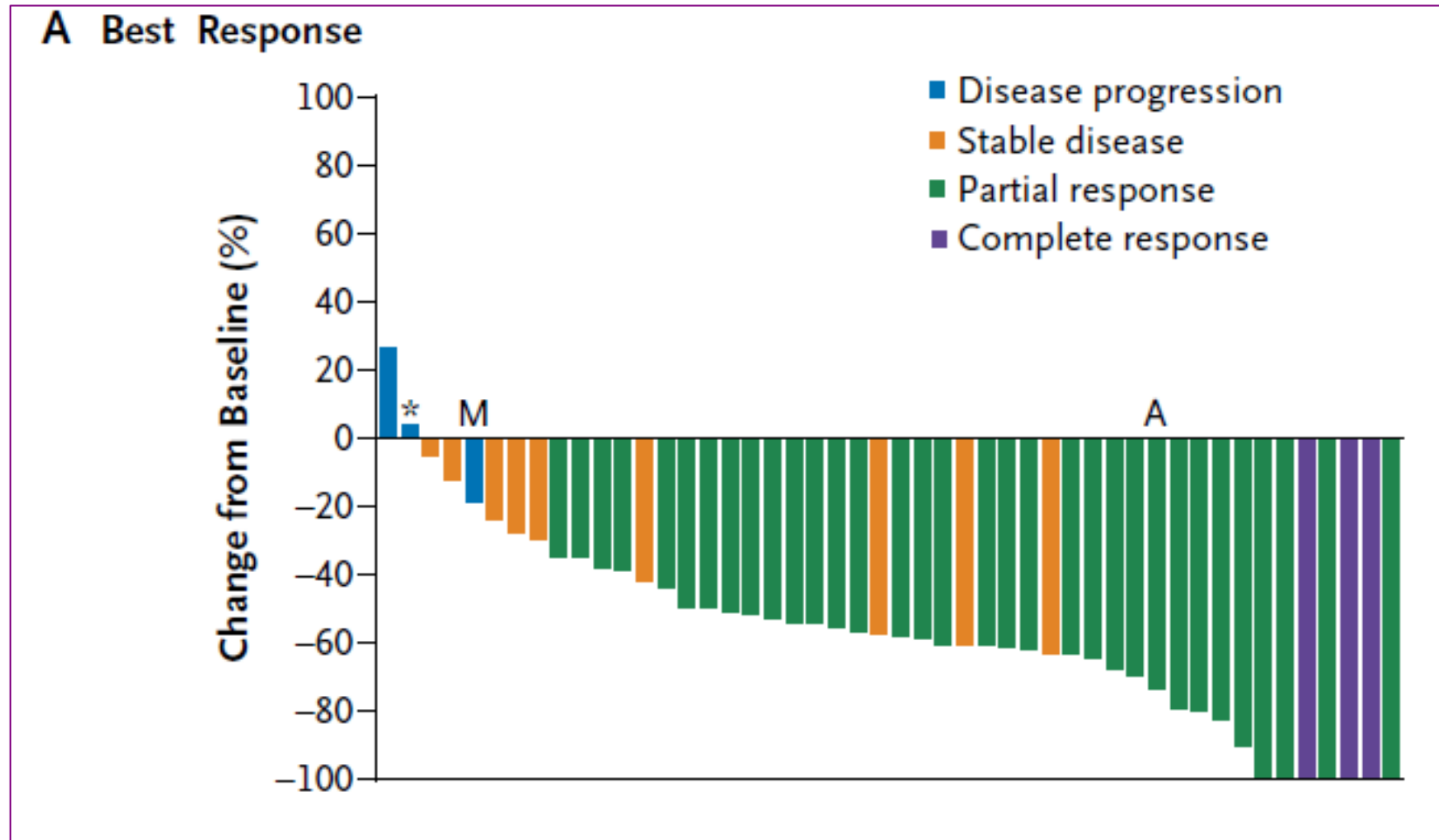


# La malattia cambia nel tempo....

## TUMOR HETEROGENEITY



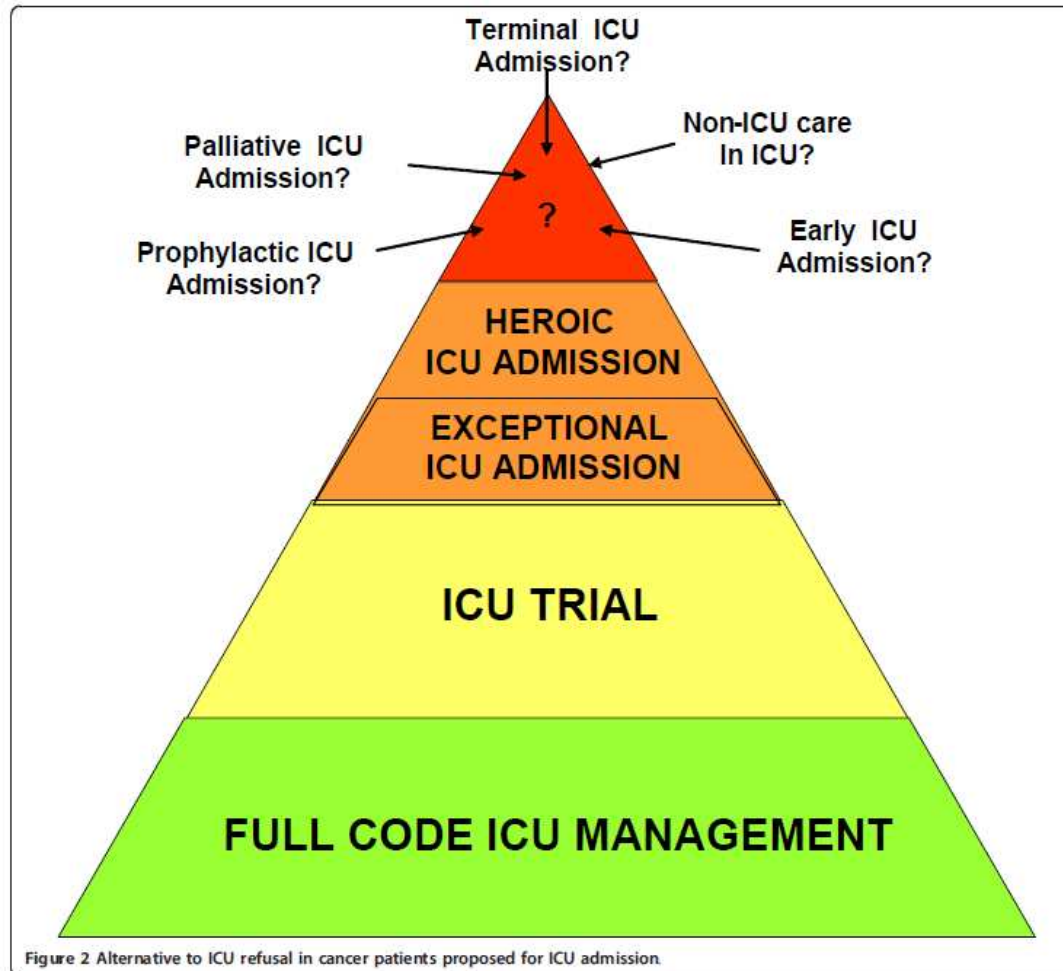
# Risposta a Crizotinib in tumori polmonari con riarrangiamento di ROS-1



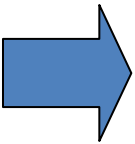
>80% dei pazienti pretrattati con una o più linee di terapia

# Intensive care of the cancer patient: recent achievements and remaining challenges

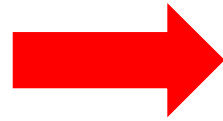
Elie Azoulay<sup>1,2\*</sup>, Marcio Soares<sup>3,4</sup>, Michael Darmon<sup>5</sup>, Dominique Benoit<sup>6</sup>, Stephen Pastores<sup>7</sup> and Bekele Afessa<sup>8</sup>



Alternative to  
ICU refusal at  
Hopital Saint  
Luis, Paris

**Table 3 Different ICU admission policies**

Type of ICU admission	Code status	Clinical situation
1. Full code ICU management	Full code	Newly diagnosed malignancies Malignancies in complete remission
2. ICU trial	Unlimited for a limited time period—at least 3 to 5 days	Clinical response to therapy not available or undetermined
3. Exceptional ICU admission	Same as ICU trial	Newly available effective therapy that should be tested in a patient who becomes critically ill
4. Heroic ICU admission	ICU management until conflict resolution	Both hematologists/oncologists and intensivists agree that ICU admission is not appropriate, but patients or relatives disagree with the appropriate level of care
5. Other admission modalities that are performed but not yet formally evaluated		
a) Prophylactic ICU admission	Full code; intensive clinical and biological monitoring; invasive procedures under safer conditions	Earliest phase of high-risk malignancies. Admission to the ICU is warranted <u>to avoid development of organ dysfunction</u> (acute respiratory failure, tumor lysis syndrome, etc.)
b) Early ICU admission	Full code; intensive clinical and biological monitoring; invasive procedures under safe conditions; no life-sustaining therapies	Admission to the ICU in patients with no organ dysfunction but physiological disturbances. ICU is warranted <u>to avoid late ICU admission</u> (condition associated with higher mortality)
c) Palliative ICU admission	Noninvasive strategies only	Admission to the ICU for the purpose of undergoing noninvasive mechanical ventilation as the ceiling of therapy
d) In-ICU non-ICU care	No life-sustaining therapies	Short ICU admission to help for optimal and prompt management (catheter withdrawal, early antibiotics etc.)
e) Terminal ICU admission	No life-sustaining therapies	ICU admission is required to best provide palliative care and symptom control. Controversial issue



H O W   W E   D O   I T

# Integrating Palliative Care in the Intensive Care Unit

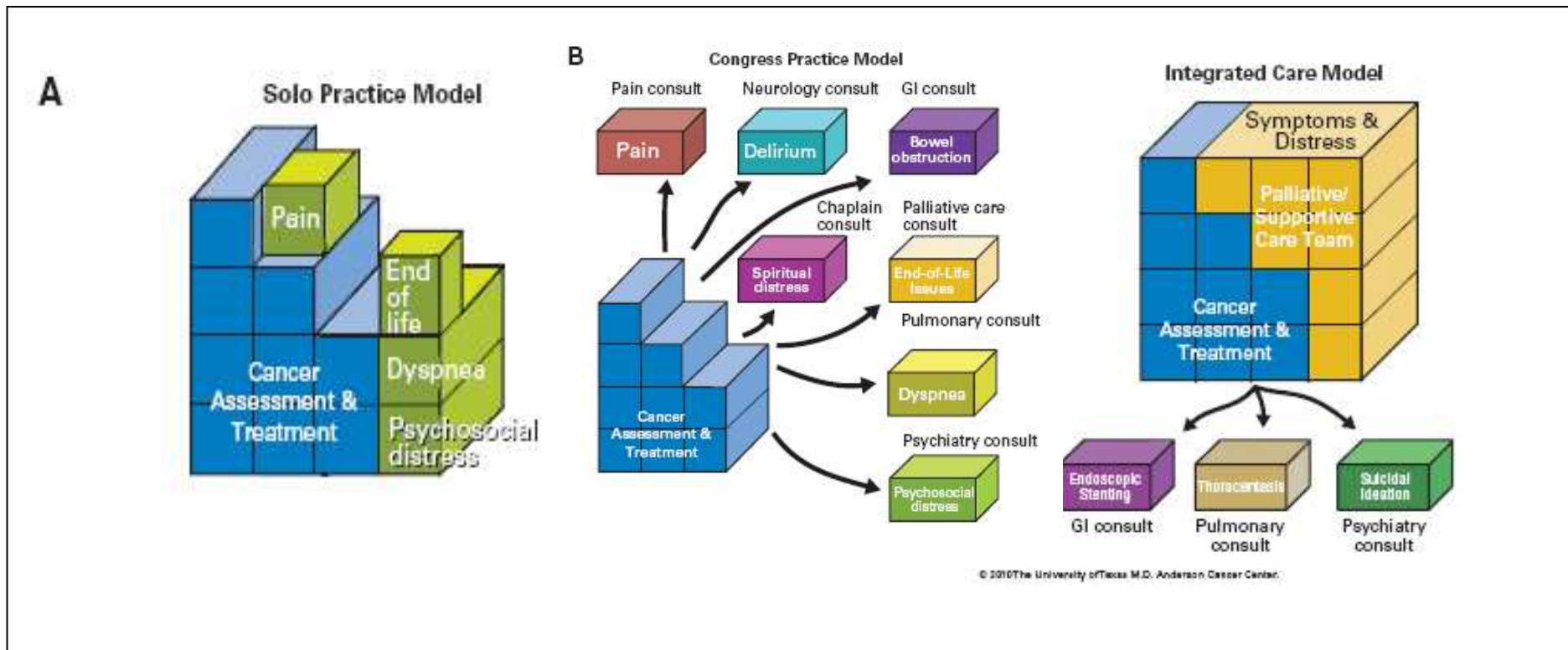
Jacob J. Strand, MD; and J. Andrew Billings, MD

## ABSTRACT

The admission of cancer patients into intensive care units (ICUs) is on the rise. These patients are at high risk for physical and psychosocial suffering. Patients and their families often face difficult end-of-life decisions that highlight the importance of effective and empathetic communication. Palliative care teams are uniquely equipped to help care for cancer patients who are admitted to ICUs. When utilized in the ICU, palliative care has the potential to improve a patient's symptoms, enhance the communication between care teams and families, and improve family-centered decision making. Within the context of this article, we will discuss how palliative care can be integrated into the care of ICU patients and how to enhance family-centered communication; we will also highlight the care of ICU patients at the end of life.

# Integrazione fra oncologo/intensivista/palliativista

Dalla sequenzialità ai modelli di **integrazione** fra oncologo, medico palliativista e medico intensivista



# Conclusioni

Un ricorso ottimale a trattamenti intensivi in pazienti con tumore avanzato richiede la ridefinizione dei criteri di accesso, una comunicazione ottimale fra oncologo e paziente/famiglia, e la integrazione con i servizi di terapia palliativa, per evitare sovra e sottotrattamenti.

