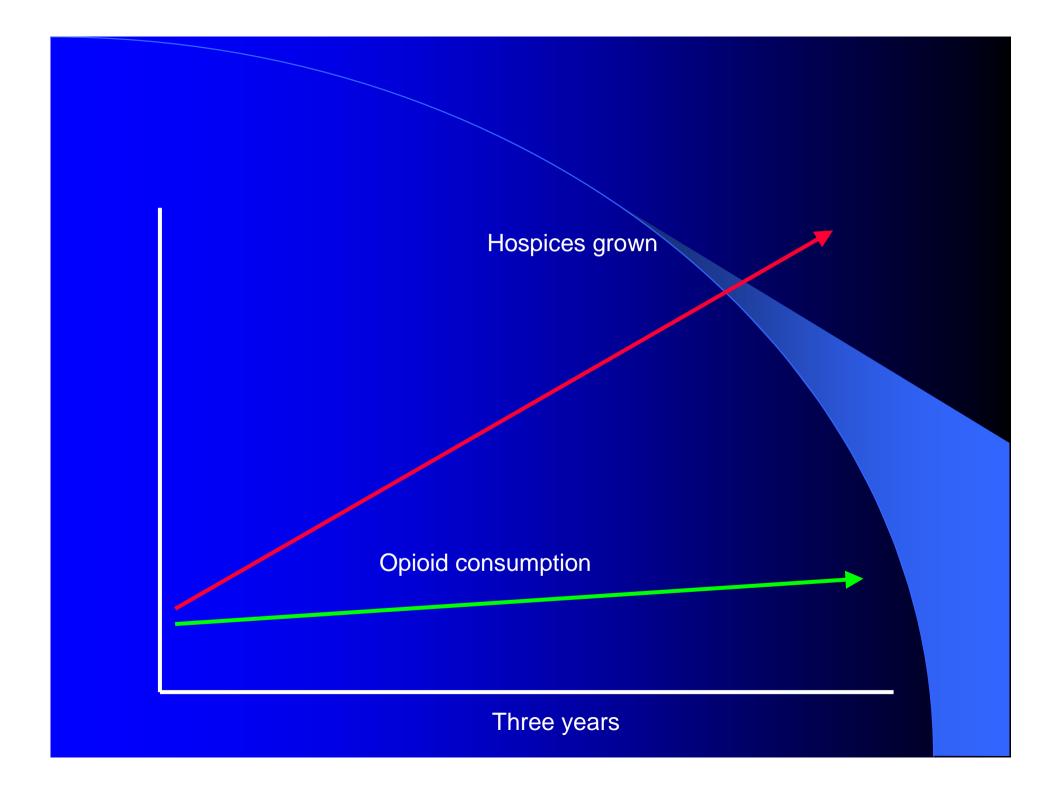


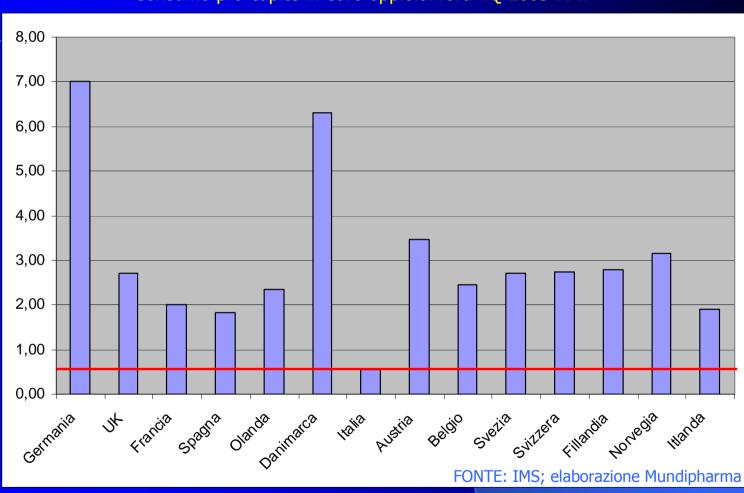
MODELS

HOME CARE
NURSING HOME
HOSPICE CARE
PALLIATIVE CARE SERVICE CONSULTATIONS
ACUTE PALLIATIVE CARE UNIT



Come viene trattato il dolore

Consumo pro-capite in euro oppioidi forti 4Q-2005 MAT





Barriers

- Stigma
- Poor availability
- Poor knowledge
- Costs ?
- Poor organization and patient's network



Conventional continuum of cancer care

Diagnosis

Recurrence

Death

Curative efforts (including life-prolonging therapies)

Palliative care

IS PALLIATIVE CARE END OF LIFE CARE?

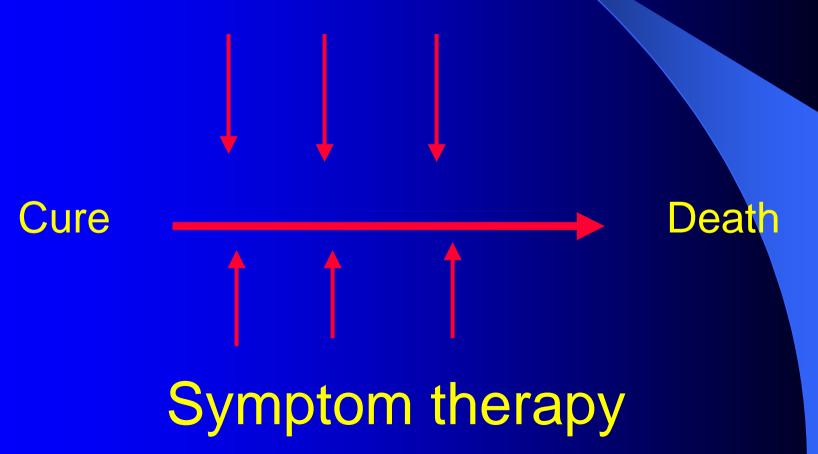
WHEN - WHERE- WHO, HOW?

PAIN AND SYMPTOM MANAGEMENT?

TERMINAL CARE?

PHYLOSOPHICAL APPROACH?

Disease-modifying therapy



A modern continuum of cancer care



Curative efforts

Life-prolonging therapies

Palliative care

Palliative Care – an exercise in prevention

 Genesis of problems at the end of life is often related to symptoms that have unexplored early in the course of disease.

- Pain & physical symptoms
- Psychological issues
- Recognition of cancer stage and prognosis

Oncologic treatment and palliative care

 Palliative care begins at the same time as efforts undertaken to cure the patient

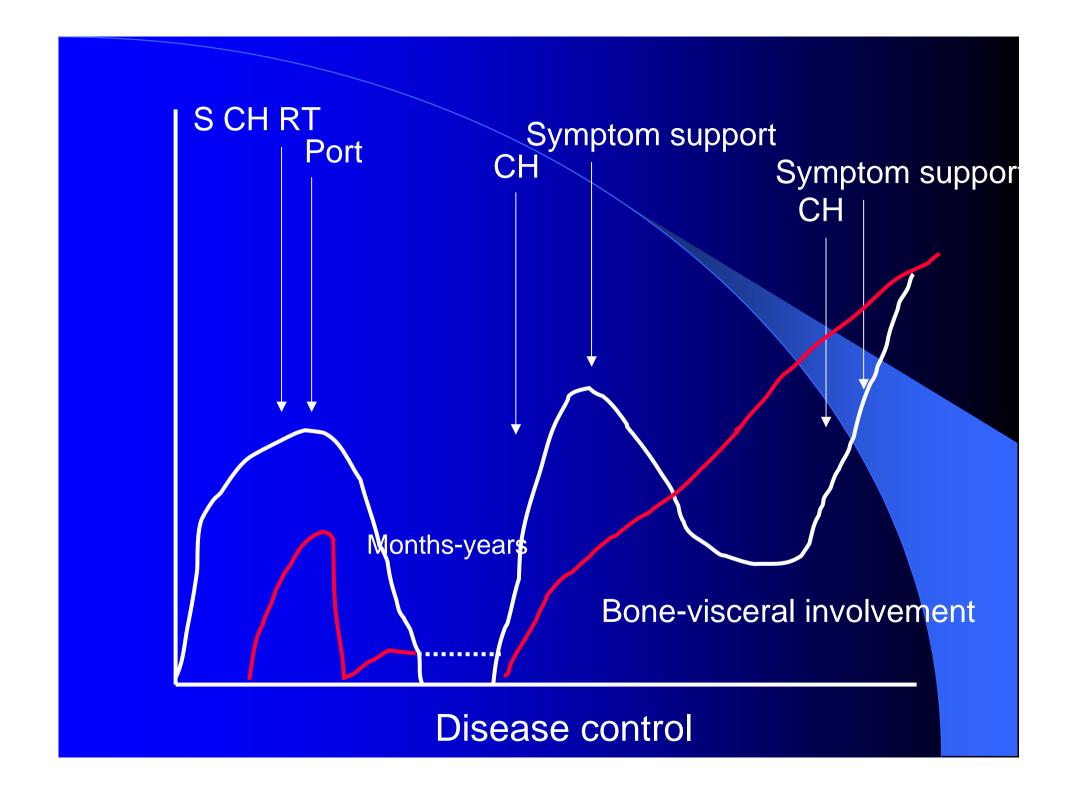
 Palliative care can address symptom early in the disease progression that may cause problems in later stages of the illness

Palliative care: current relevance to oncology programs

Importance of coordinated programs of cancer control

 It should encopass the continuum of cancer care, including easing the suffering of patients with advanced disease.

 Palliative care, like other aspects of cancer control, should be regarded as an excircise in prevention



Need for implementation of palliative care among oncologists

- Integration with other specialties
- More research in the field of symptom control
- Adequacy of treatment according to the expected survival
- Symptom control and quality of life issues

Toxicity

- Treatment-related deaths are not always reported
- Toxicity is usually additive (doublets, triplets, but also can be very dose-dependent)



Symptom palliation

 Poor assessment of CH-effects on symptoms



Information rarely presented

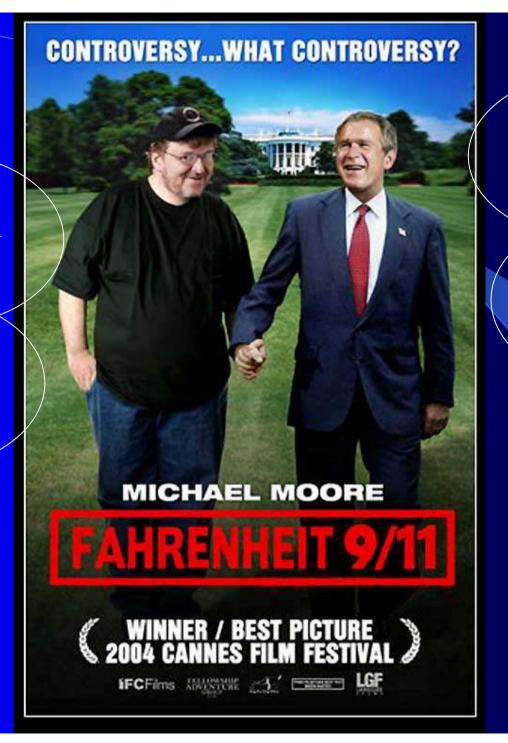


Main problems of failed collaboration

- Unrecognition of expertise
- Patient property
- Presumption
- Bad tempered
- Different scientific levels

palliatori

oncologi



terapisti del dolore

anestesisti



Oncologist

Symptom manager





Main indications for admission

Complex pain and symptom management Evaluation, education for home care Intercurrent supportive care

Terminal care

Permanent central venous access

APRPC

- Education
- Nurse involvement in care processes
- Informal environment
- High opioid consumption
- Research and universitary formation



4th year

47 diplomas for physicians of palliative medicine 29 diplomas for nurses of palliative medicine

Dipartimento scienze anestesiologiche, Università di Palermo

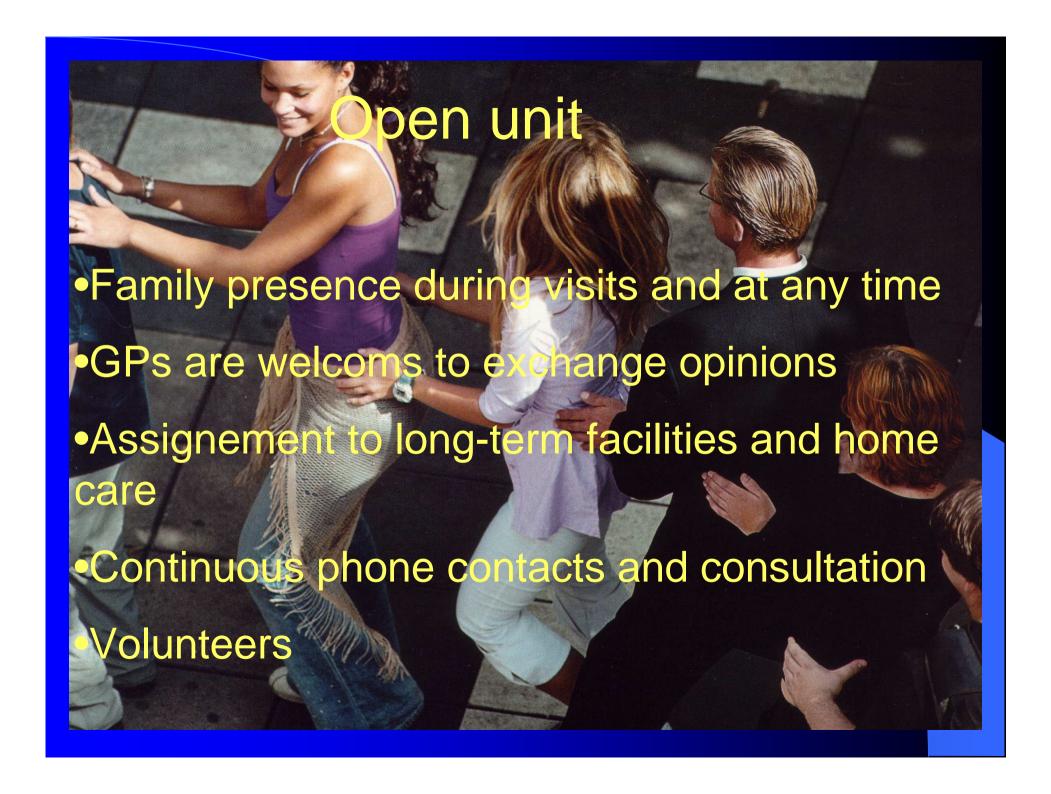
Tel: 091 6552743-31

e-mail: deu@unipa.it

Fields of research



Breakthrough pain
Pharmacokinetics
Opioid responsiveness
Bowel obstruction
Drug comparisons
Difficult symptoms
Route of administration
Multimodal postoperative treatment





Outdoor activity

- Consultation for pain relief
- Procedures (mono-bilumes-port)
- External consultation (phone e-mail)

Painful procedures



Biopsy, mieloaspiration (Mercadante et al, 2007)
Sedation for children
Radio-procedures

CLINICAL AND FINANCIAL ANALYSIS OF AN ACUTE PALLIATIVE CARE UNIT IN AN ONCOLOGICAL DPT

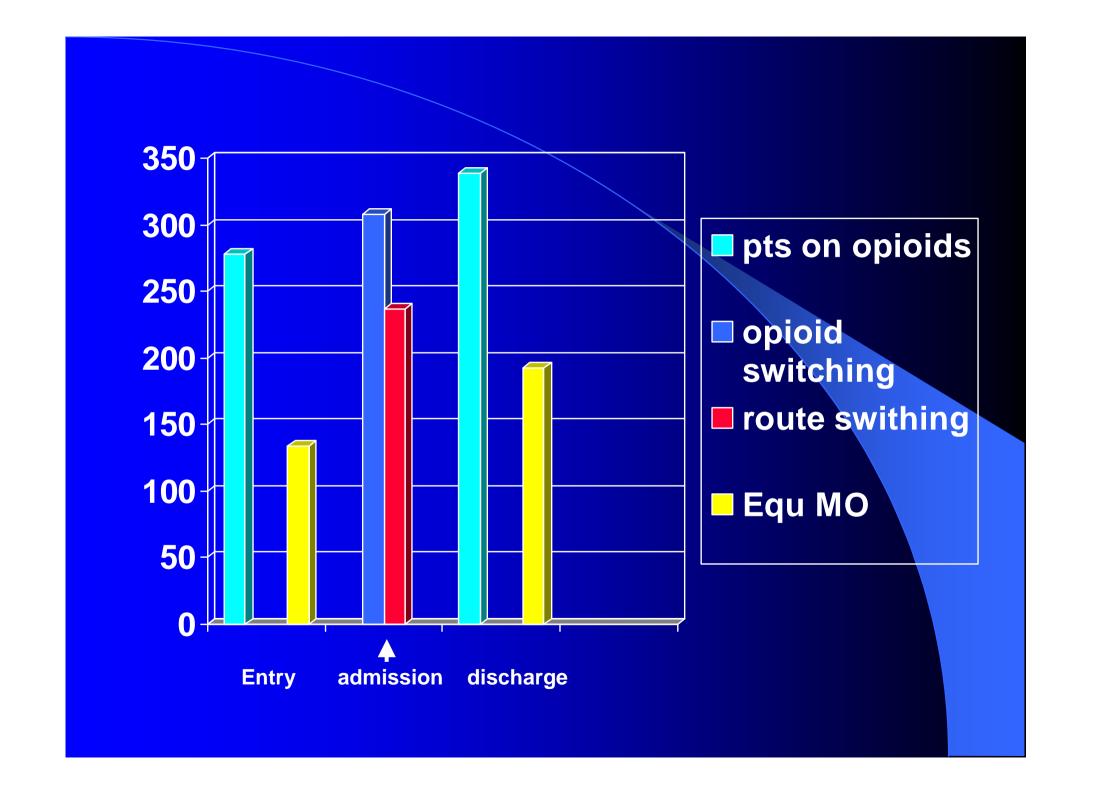
Mercadante S, Intravaia G, Villari P, Ferrera P, David F, Casuccio A, Mangione S.

Palliat Med 2008

- 504 admissions per yr
- 392 pts had been previously followed by other hospital units, 350 of them being directly admitted to APC, and 42 transferred from the oncological ward.
- 25 patients were admitted on emergency basis.
- 102 pts referred from other centres or from primary care physicians without a previous contact with the oncological department.

- Mean hospital stay was 5.4 days.
- Patients often had multiple indications for hospitalization: 348 patients (pain control and/or for other symptoms (232 patients),
- 144 had for port implantation (and pain or other symptoms).
- At admission the mean Karnofsky was 49.2

- All patients had a peripheral IV line and laboratory tests, and 362 of them repeated biochemical examination.
- Instrumental examinations performed during admission for symptom diagnosis or re-staging included:
- 157 lung x-rays,
- 33 MNR,
- 95 TC scan,
- 7 endoscopies,
- 33 ultrasounds,
- 110 EKG
- 2 PET.



59 pts received red cells transfusions Interventional procedures

Venous port	144
Celiac plexus block	2
Peritoneal catheter	12
Central venous access	18
Thoracentesis	1
Intrathecal port-a-cath	5

Discharge

- 460 pts discharged home
- 4 pts transferred to other units (2 patients to surgical ward to be operated, and one patient to ICU and neurology, respectively). Karnofsky status was 51.4 excluding patients who died or were discharged agonic (see below).
- 283 pts were discharged with a prescription of a BP medication, oral morphine being the preferred option.
- 32 pts died in the unit, and 8 pts were discharged agonic, according to a request of relatives.
- Of the 32 pts died in the unit, 11 pts were sedated with IV midazolam (mean dose of 42 mg/day combined with opioids. IV morphine alone was used in one patient (160 mg/day) at time of death.
- Treatment efficacy was considered optimal in 264 pts mild in 226 patients, poor in 2 pts, not assessable in the remaining 12 pts.

- Reimbursements were calculated from the administration registry, according to the DRG system.
- Regardless of the duration of hospital stay, the regional health care system reimbursed a mean of 3,019 euros for admission
- The global reimbursement for the year examined was 1,550,000 (budget assigned by hospital administration being 1,500,000).

After implementation of PC programs, a significant decrease in the number of admissions for symptom problems and cancer death in other acute-care facilities (ICU !!!) can result in a consistent saving in the overall cost

An APC has been found to provide a cost saving of \$760,000 to the health care system if patients would stay in other inappropriate units (Santa-Emma et al. Development and implementation of an inpatient acute palliative care service. J Palliat Med 5:93-100, 2002)

High tech



High touch



CARE





