Mario Luppi, MD, PhD

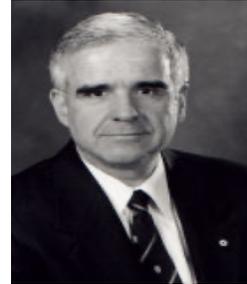| Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
Abbvie						X	
Gilead Sci						X	
Grifols						X	
Jazz Pharma						X	
Novartis						X	
Sanofi						X	

Cicely Saunders (1918- 2005)
Hospice Movement

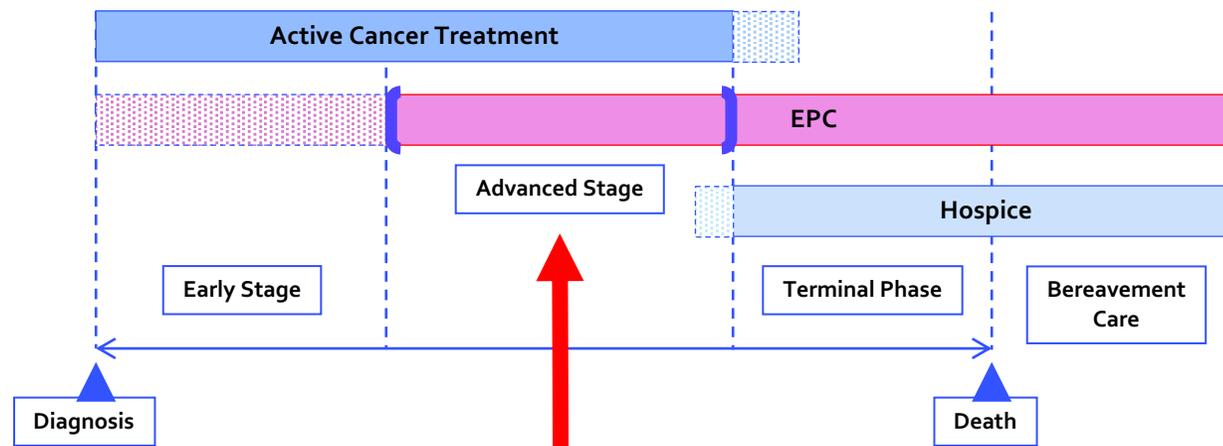
St. Christopher, 1967

END-OF-LIFE CARE INTERVENTIONS ARE IMPORTANT BUT NOT ENOUGH

Balfourt Mount in 1975, Canada, coined the «Palliative Care»

Early Palliative Care in Oncologic (and Hematologic) Patients

PALLIATIVE CARE INTERVENTIONS ARE NECESSARY DURING THE WHOLE ILLNESS TRAJECTORY

Smith et al. J Clin Oncol 2012;30: 880–887 ,

Ferrell et al. J Clin Oncol 2017; 35: 96-112

Q: Why do we need to anticipate palliative care interventions?

A: May be, because patients/primary caregivers have unsatisfied needs, NOT ONLY AT THE END OF LIFE CARE.

Are there any evidences?

Added Value of Early Palliative Care
(as Early as Possibile)

- To provide LONG TERM comprehensive assessment and management of physical symptoms and psycological distress.

- To provide TIMELY AND LONG TERM measurement of physical symptoms and psycological distress (relevance for PROGNOSIS AND THERAPY).

- To implement TIMELY AND LONG TERM goals of care (GOC) discussion:

a) prognostic awareness of patients,
b) decision making-treatment choices-future planning,
c) coping with life-threatening disease and
d) support to primary caregivers, also after bereavement.

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

Bandieri et al., Leukemia Research 34 (2010) e334–e335

Pain in patients with newly diagnosed or relapsed acute leukemia

Adir Shaulov[1,2] · Gary Rodin[1,3] · Gordana Popovic[1] · Valerie B. Caraiscos[1,4] · Lisa W. Le[5] · Anne Rydall[1] · Aaron D. Schimmer[6,7] · Camilla Zimmermann[1,3,8]

Pain intensity

Solid Tumors 59.4% moderate severe
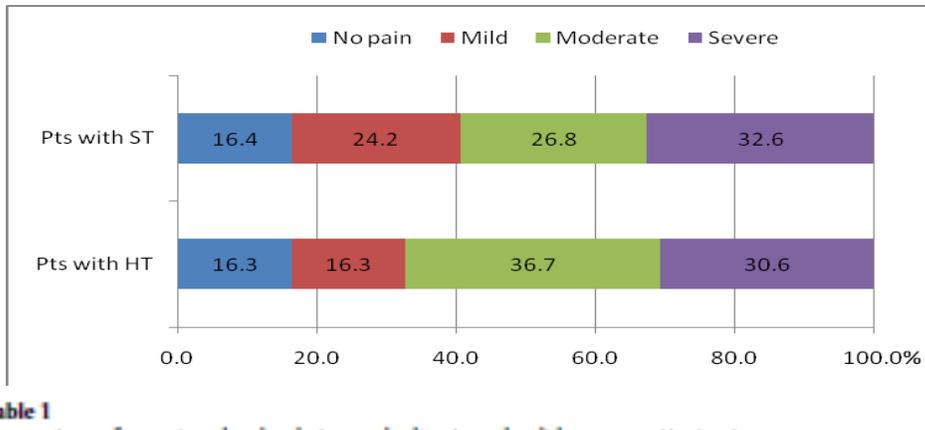
Hematologic Tumors 67.3% moderate-severe

Table 1
Comparison of symptom burden between leukemia and solid cancer patients at diagnosis.

ESAS symptoms	Leukemia		Solid cancer		p
	Median	Range	Median	Range	
Pain	1	0–7	0	0–7	0.1306
Fatigue	3	0–10	1	0–9	0.0370
Nausea	0	0–8	0	0–9	0.0042
Depression	1	0–8	0	0–10	0.7243
Anxiety	1	0–10	2	0–10	0.4477
Drowsiness	2	0–10	0	0–10	0.002
Appetite	1	0–9	0	0–9	0.0039
Well-being	0.5	0–7	0	0–10	0.0692
Dyspnea	0	0–8	0	0–10	0.8096

Table 2 Pain frequency, severity and distress

|	Frequency		Severity		Distress	
	n	%	n	%	n	%
0	161	50.8	161	51.3	169	53.8
1	31	9.8	26	8.3	37	11.8
2	59	18.6	72	22.9	37	11.8
3	42	13.3	42	13.4	36	11.5
4	24	7.6	13	4.1	35	11.2

For frequency, 0 = did not have, 1 = rarely, 2 = occasionally, 3 = frequently, 4 = almost constantly. For severity, 0 = did not have, 1 = slight, 2 = moderate, 3 = severe, 4 = very severe. For distress, 0 = not at all or did not have, 1 = a little bit, 2 = somewhat, 3 = quite a bit, 4 = very much

Missing data: frequency, 1 patient; severity, 4 patients; distress, 4 patients

Pain reported by 49,2% pts; of these 35.3% reported severe pain.

Pain and emotional distress in leukemia patients at diagnosis

Leukemia Research 34 (2010) e67–e68

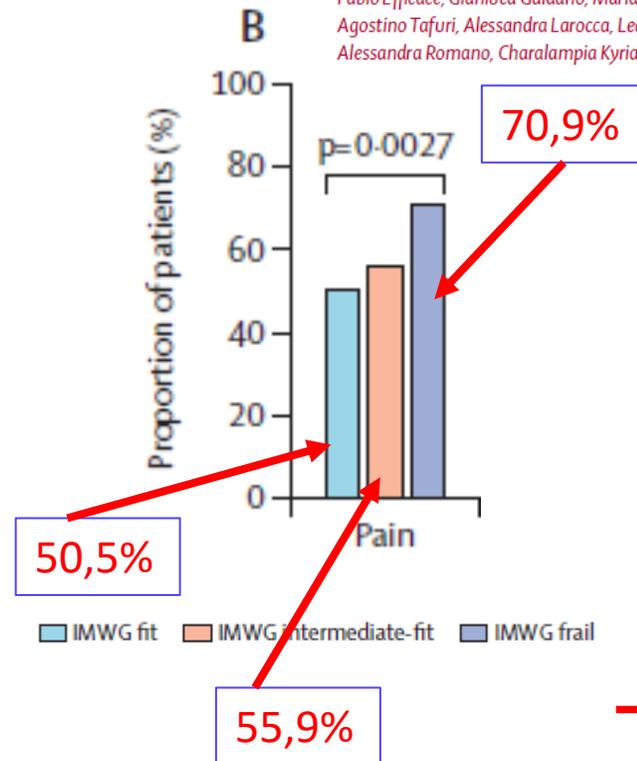# Prevalence and characterization of breakthrough pain in patients with cancer in Spain: the CARPE-DIO study

Concepción Pérez-Hernández[1], Ana Blasco[2], Álvaro Gándara[3], Ana Mañas[4], Manuel Jesús Rodríguez-López[5], Vicente Martínez[6*], Alonso Fernandez-Nistal[6] & Carmen Montoto[6]
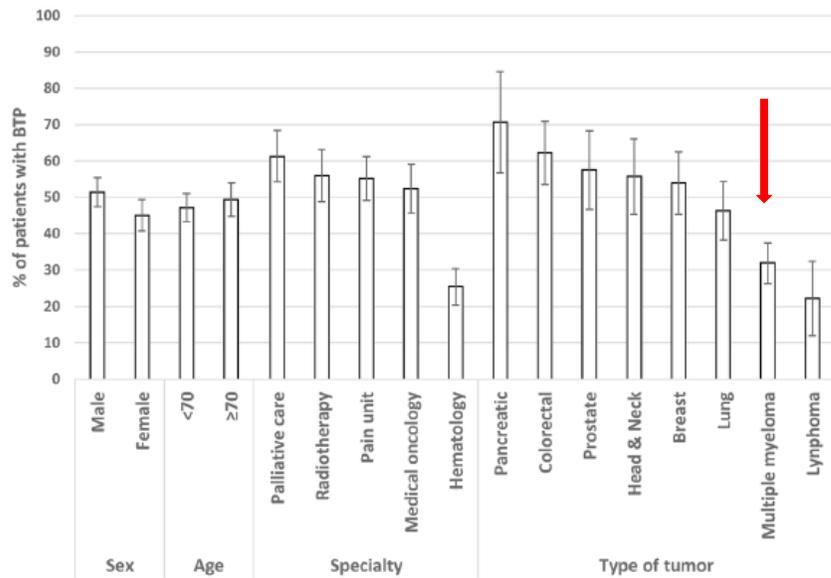
Association of IMWG frailty score with health-related quality of life profile of patients with relapsed refractory multiple myeloma in Italy and the UK: a GIMEMA, multicentre, cross-sectional study

Fabio Efficace, Gianluca Gaidano, Maria Teresa Petrucci, Pasquale Niscola, Francesco Cottone, Katia Codeluppi, Elisabetta Antonioli, Agostino Tafuri, Alessandra Larocca, Leonardo Potenza, Claudio Fozza, Domenico Pastore, Gian Matteo Rigolin, Massimo Offidani, Alessandra Romano, Charalampia Kyriakou, Nicola Cascavilla, Alessandro Gozzetti, Daniele Derudas, Marco Vignetti, Michele Cavo

3765 cancer patients

B

70,9%

50,5%

55,9%

IMWG fit   IMWG intermediate-fit   IMWG frail

p=0·0027

Proportion of patients (%)

Pain

Lancet Healthy Longev 2022; 3: e628–35

	Fit (n=200)	Intermediate-fit (n=112)	Frail (n=103)
EORTC QLQ-C30			
Functional scales and global health status and quality of life			
Physical functioning	71·17 (21·33)	64·75 (26·05)	48·95 (26·95)
Role functioning	69·43 (31·01)	58·93 (35·72)	51·29 (33·31)
Emotional functioning	73·93 (22·13)	72·67 (22·56)	62·94 (25·93)
Cognitive functioning	82·75 (21·03)	79·43 (24·10)	73·62 (26·25)
Social functioning	76·50 (25·13)	71·62 (29·52)	69·42 (29·62)
Global health status and quality of life	61·17 (19·71)	58·33 (21·35)	53·56 (22·43)
Symptoms			
Fatigue	35·94 (22·85)	40·54 (25·63)	54·69 (26·80)
Nausea or vomiting	6·42 (12·80)	9·76 (19·00)	9·71 (18·75)
Pain	27·42 (26·04)	33·18 (30·19)	43·37 (31·60)
Dyspnoea	20·60 (24·27)	27·63 (29·77)	33·33 (31·47)
Insomnia	32·50 (30·23)	33·93 (33·02)	43·23 (35·76)
Appetite loss	10·33 (20·16)	18·02 (25·34)	27·18 (30·87)
Constipation	19·33 (28·23)	23·42 (27·56)	31·39 (38·44)
Diarrhoea	13·83 (22·24)	16·82 (24·97)	16·67 (28·05)

% of patients with BTP

Male Female <70 ≥70 Palliative care Radiotherapy Pain unit Medical oncology Hematology Pancreatic Colorectal Prostate Head & Neck Breast Lung Multiple myeloma Lymphoma

Sex   Age   Specialty   Type of tumor

original article

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

A multicentre cross-sectional study in 32 Italian Hospitals included 1450 patients, receiving analgesic therapy for cancer pain: 602 with access to standard care and 848 with early access to a palliative/supportive care, concomitant with primary oncology care.

Mirandola, USL Modena 2007-2010

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.

Early palliative/supportive care integrated with primary oncologic care was an independent factor associated with a 31 % reduced risk of suffering from severe pain.

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.

Independent, non Sponsored Study
SETTING: EARLY PALLIATIVE CARE

Carpi, USL Modena 2014-2016

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 Fanizza, Daniele Santini, Luigi Cavanna, Barbara Melotti, Pier Franco Conte, Fausto Roila, Stefano Cascinu, Eduardo Bruera, Gianni Tognoni, and Mario Luppi

35% patients in the weak opioid group required switching to a strong opioid.

Adverse effects were similar in both groups

BJHaem
BRITISH JOURNAL OF HAEMATOLOGY

ORIGINAL PAPER

Timing of referral to outpatient palliative care for patients with haematologic malignancies

Sameer Patel[1] | Geordyn Hoge[2] | Bryan Fellman[3] | Sharanpreet Kaur[2] |
Yvonne Heung[2] | Eduardo Bruera[2] | David Hui[2]

> Median time from outpatient care-referral to death is 3,4 ys

TABLE 4 Supportive-care interventions

	Leukaemia	Lymphoma	SCT	Total
Supportive-care topics addressed	N (%)	N (%)	N (%)	N (%)
Physical symptoms				
Pain	112 (78.3)	156 (73.2)	15 (53.57)	283 (73.7)
Fatigue	97 (67.8)	123 (57.8)	17 (60.7)	237 (61.7)
Dyspnoea	9 (6.3)	6 (2.8)	0 (0)	15 (3.9)
Constipation	74 (51.8)	113 (53.1)	12 (42.9)	199 (51.9)
Nausea	28 (19.6)	47 (22.1)	5 (17.9)	80 (20.8)
Anorexia	51 (35.7)	62 (29.1)	7 (25)	120 (31.3)
Insomnia	36 (25.2)	55 (25.8)	9 (32.1)	100 (26)
Others	17 (11.9)	22 (10.3)	6 (21.4)	45 (12)
Psychological symptoms				
Emotional	106 (74.1)	171 (80.3)	19 (67.9)	296 (77.1)
Spiritual	2 (1.4)	5 (2.4)	1 (3.6)	8 (2.1)
Social	12 (8.4)	18 (8.5)	2 (7.1)	32 (8.3)
EOL care plan	58 (40.6)	75 (35.2)	7 (25)	140 (36.5)

ARTICLE

Myelodysplastic syndrome

The IPSS-R more accurately captures fatigue severity of newly diagnosed patients with myelodysplastic syndromes compared with the IPSS index

Fabio Efficace[1,2] · Francesco Cottone[1] · Laura B. Oswald[2] · David Cella[2] · Andrea Patriarca[3] · Pasquale Niscola[4] · Massimo Breccia[5] · Uwe Platzbecker[6] · Giuseppe A. Palumbo[7] · Giovanni Caocci[8] · Reinhard Stauder[9] · Alessandra Ricco[10] · Duska Petranovic[11] · Jo Caers[12] · Mario Luppi[13] · Luana Fianchi[14] · Chiara Frairia[15] · Isabella Capodanno[16] · Elena Follini[17] · Chiara Sarlo[18] · Paola Fazi[1] · Marco Vignetti[1]
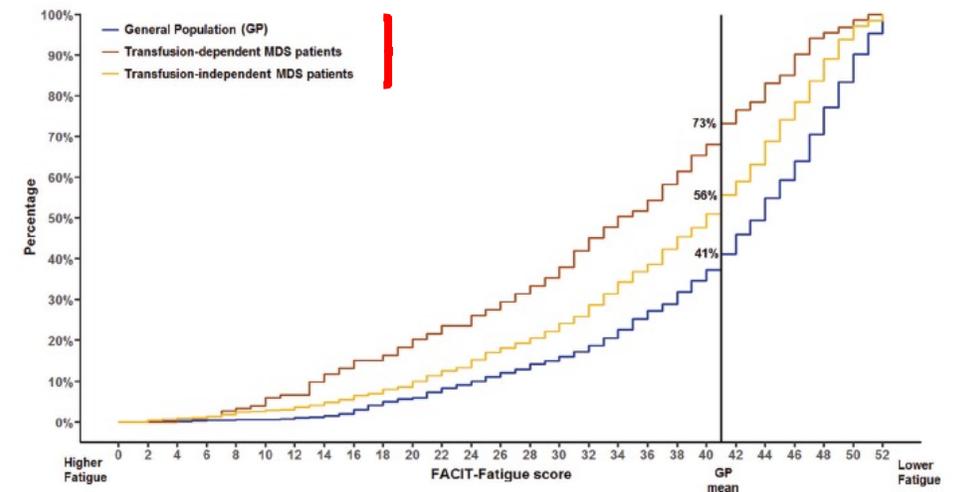
> Fatigue burden of MDS pts WORSE (on average 4,6 points below the mean of the GP).

JAK Inhibition with Ruxolitinib versus Best Available Therapy for Myelofibrosis

Claire Harrison, D.M., Jean-Jacques Kiladjian, M.D., Ph.D., Haifa Kathrin Al-Ali, M.D., Heinz Gisslinger, M.D., Roger Waltzman, M.D., M.B.A., Viktoriya Stalbovskaya, Ph.D., Mari McQuitty, R.N., M.P.H., Deborah S. Hunter, Ph.D., Richard Levy, M.D., Laurent Knoops, M.D., Ph.D., Francisco Cervantes, M.D., Ph.D., Alessandro M. Vannucchi, M.D., Tiziano Barbui, M.D., and Giovanni Barosi, M.D.
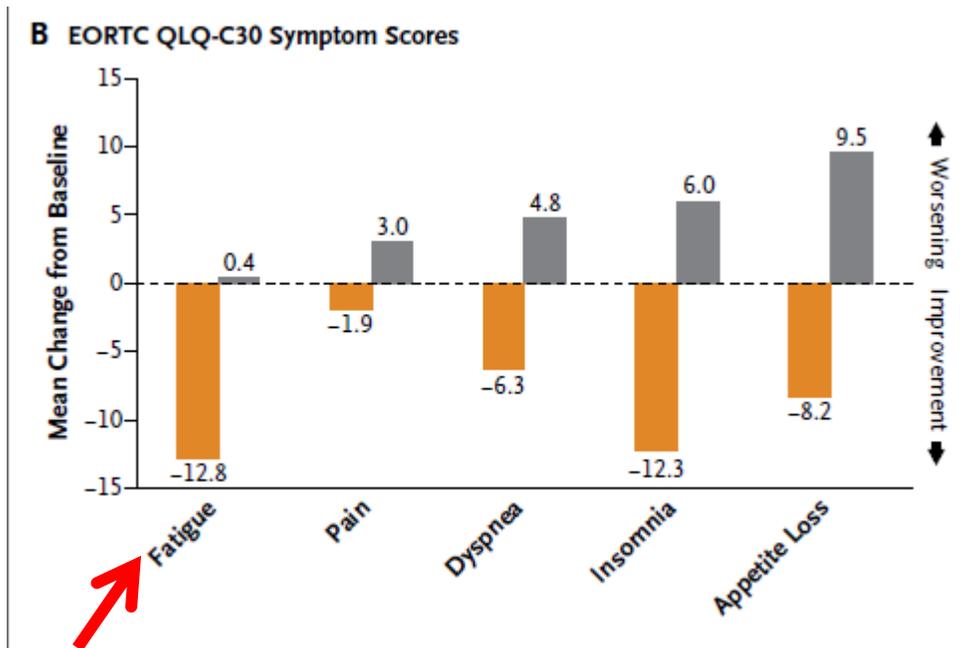
B EORTC QLQ-C30 Symptom Scores

Toward Patient-Centered Drug Development in Oncology

Ethan Basch, M.D.

«Ruxolitinib demonstrates the particular value that PROs provide for understanding clinical benefits when studies are not designed to detect overall survival advantages and instead rely on end points such as tumor response, progression-free survival, or noninferiority.

Although overall, ruxolitinib represents a success story, measurement of fatigue and HRQOL decrements — which are prevalent and widely viewed as important to patients — were not included as key end points because the FDA had methodologic concerns about them; these omissions resulted in a label containing an incomplete picture of the patient experience»

Added Value of Early Palliative Care
(as Early as Possibile)

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- To provide TIMELY AND LONG TERM measurement of physical symptoms and psycological distress (relevance for PROGNOSIS AND THERAPY).

- To implement TIMELY AND LONG TERM goals of care (GOC) discussion:

a) prognostic awareness of patients,
b) decision making-treatment choices-future planning,
c) coping with life-threatening disease and
d) support to primary caregivers, also after bereavement.

BMJ

Edmonton symptom assessment system Global Distress Score and overall survival in acute leukaemia

> 60ys

ESAS

SINCE DIAGNOSIS

Monica Morselli,[1] Federico Banchelli,[2]
Eleonora Borelli ,[1,3,4] Stefano Cordella,[5]
Fabio Forghieri,[1] Francesca Bettelli,[6]
Sarah Bigi,[7] Giuseppe Longo,[8]
Roberto D'Amico,[2] Carlo Adolfo Porro,[9,10]
Fabio Efficace ,[11] Eduardo Bruera ,[12]
Mario Luppi ,[5] Elena Bandieri,[13]
Leonardo Potenza [1,6]

Figure 1. The Edmonton Symptom Assessment System (ESAS)

In the last 24 h on average I have felt:
Please circle the number that best describes your symptoms:

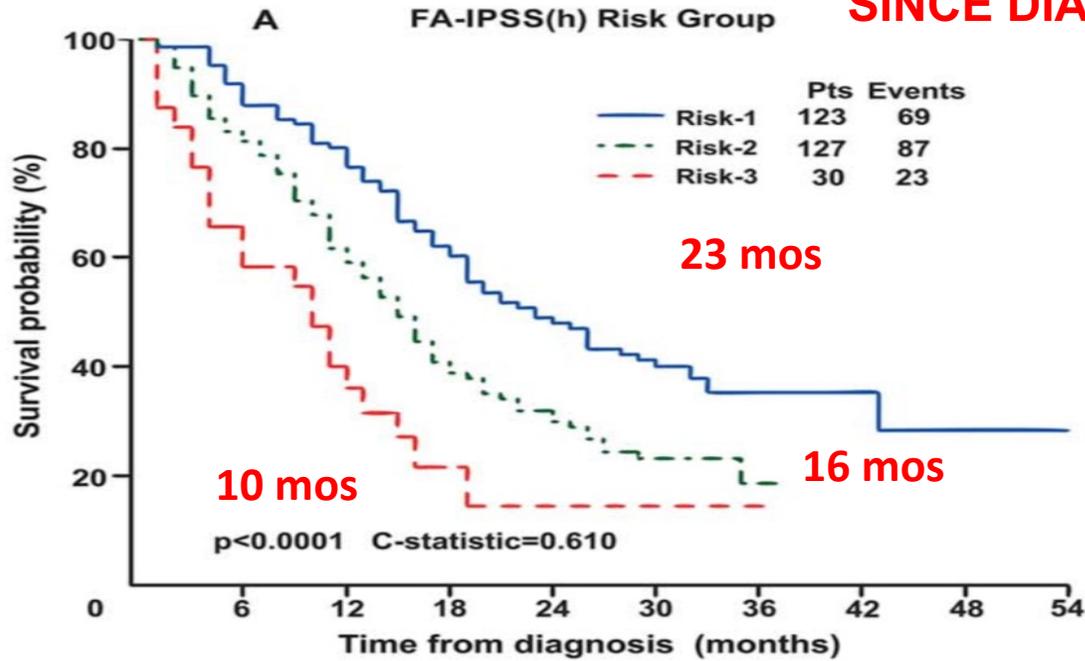|												
No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain
No fatigue	0	1	2	3	4	5	6	7	8	9	10	Worst fatigue
No nausea	0	1	2	3	4	5	6	7	8	9	10	Worst nausea
No depression	0	1	2	3	4	5	6	7	8	9	10	Worst depression
No anxiety	0	1	2	3	4	5	6	7	8	9	10	Worst anxiety
No drowsiness	0	1	2	3	4	5	6	7	8	9	10	Worst drowsiness
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst shortness of breath
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst appetite
Best feeling of well-being	0	1	2	3	4	5	6	7	8	9	10	Worst feeling of well-being
Best sleep	0	1	2	3	4	5	6	7	8	9	10	Worst sleep

N. at risk						
High GDS	18	4	1	0	0	0
Low GDS	49	30	15	11	8	5
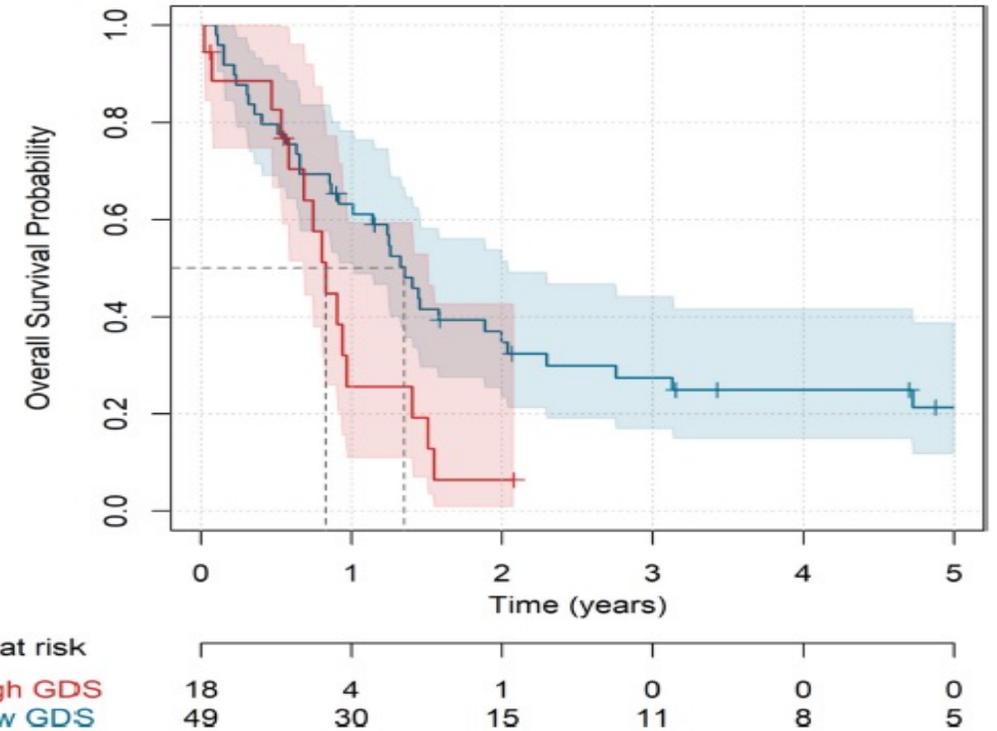
Figure 1 Overall survival curves by Global Distress Score (GDS) score (high vs low).
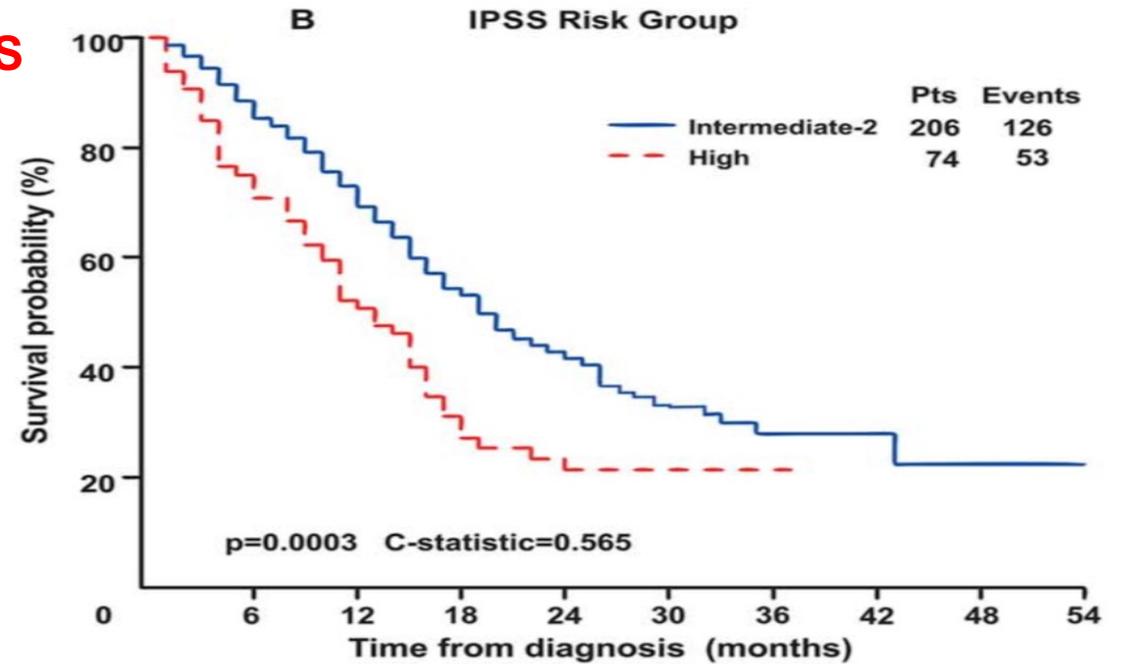
Global Distress Score-GDS- sum of the first 9 ESAS items
ESAS can be completed in less than 1 minute

FATIGUE SINCE DIAGNOSIS

Patient-Reported Outcomes Enhance the Survival Prediction of Traditional Disease Risk Classifications: An International Study in Patients With Myelodysplastic Syndromes

Fabio Efficace, PhD [1]; Francesco Cottone, PhD[1]; Gregory Abel, MD, MPH[2]; Pasquale Niscola, MD, PhD[3]; Gianluca Gaidano, MD, PhD[4]; Franck Bonnetain, PhD[5,6]; Amelie Anota, PhD[5,6]; Giovanni Caocci, MD[7]; Angel Cronin, MS[2]; Luana Fianchi, MD[8]; Massimo Breccia, MD [9]; Reinhard Stauder, MD[10]; Uwe Platzbecker, MD[11]; Giuseppe A. Palumbo, MD, PhD[12]; Mario Luppi, MD, PhD[13]; Rosangela Invernizzi, MD[14]; Micaela Bergamaschi, MD[15]; Lorenza Borin, MD[16]; Anna Angela Di Tucci, MD[17]; Huiyong Zhang, MD[18]; Mirjam Sprangers, PhD[19]; Marco Vignetti, MD[1]; and Franco Mandelli, MD[1]

Cancer   March 15, 2018

- Fatigue measured by EORTC QLQ-C 30
- A new prognostic index was developed: the FA-IPSS(h)
- The predictive accuracy of this new index was higher than that of the IPSS alone.

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(as Early as Possibile)

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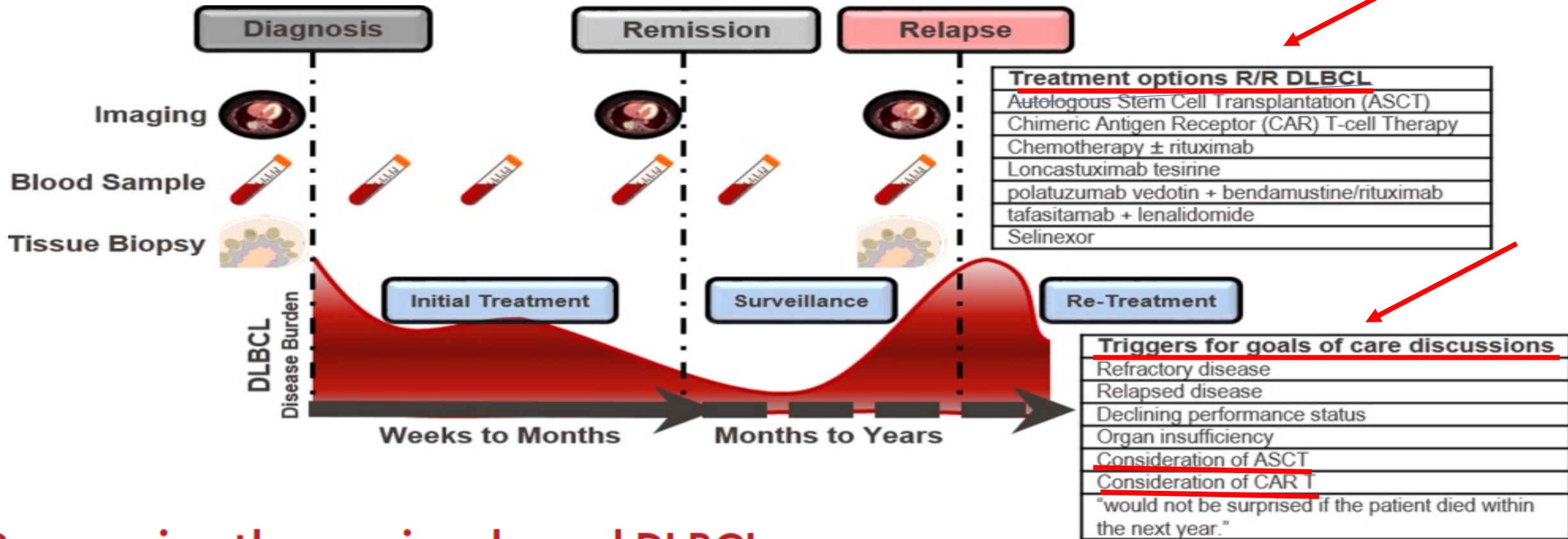
Sequencing therapy in relapsed DLBCL

Christopher R. Flowers[1] and Oreofe O. Odejide[2]

[1]Department of Lymphoma/Myeloma, The University of Texas MD Anderson Cancer Center, Houston, TX; and [2]Lymphoma and Myeloma, Dana-Farber Cancer Institute, Boston, MA

| Hematology 2022 | ASH Education Program

American Society *of* **Hematology**
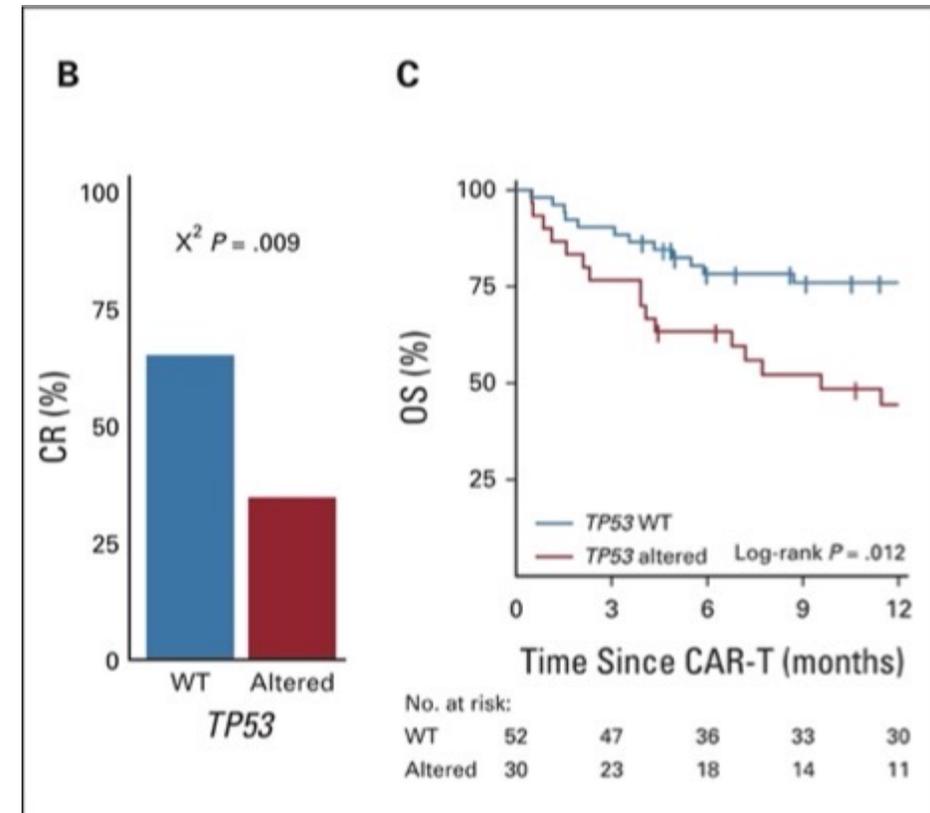Helping hematologists conquer blood diseases worldwide

1. Pretreatment patient clinical features (parameters of lymphoma burden and levels of inflammatory cytokines).

2. *In vivo* CAR T-cell proliferation after infusion

3. T cell immunophenotypic composition of infusion products mediate *in vivo* CAR T-cell expansion and proliferation

CLINICAL RESPONSE TO CAR T-CELL THERAPY

Impact of *TP53* Genomic Alterations in Large B-Cell Lymphoma Treated With CD19-Chimeric Antigen Receptor T-Cell Therapy

Roni Shouval, MD, PhD[1,2]; Ana Alarcon Tomas, MD[1,3]; Joshua A. Fein, MD[4]; Jessica R. Flynn, MSc[5]; Ettai Markovits, MD[6]; Shimrit Mayer, MSc[7]; Aishat Olaide Afuye, BA[1]; Anna Alperovich, MD[1]; Theodora Anagnostou, MD[1,8]; Michal J. Besser, PhD[6,9]; Connie Lee Batlevi, MD[2,10]; Parastoo B. Dahi, MD[1,2]; Sean M. Devlin, PhD[5]; Warren B. Fingrut, MD[1]; Sergio A. Giralt, MD[1,2]; Richard J. Lin, MD[1,2]; Gal Markel, MD, PhD[9,11]; Gilles Salles, MD[2,10]; Craig S. Sauter, MD[1,2]; Michael Scordo, MD[1,2]; Gunjan L. Shah, MD[1,2]; Nishi Shah, MD[1]; Ruth Scherz-Shouval, PhD[7]; Marcel van den Brink, MD, PhD[1,2]; Miguel-Angel Perales, MD[1,2]; and Maria Lia Palomba, MD[2,10]

J Clin Oncol 40:369-381. © 2021

B — Bar chart: CR (%) vs TP53 (WT, Altered), x^2 P = .009

C — OS (%) vs Time Since CAR-T (months); TP53 WT, TP53 altered, Log-rank P = .012

No. at risk:
	0	3	6	9	12
WT	52	47	36	33	30
Altered	30	23	18	14	11

Cellular therapy for multiple myeloma: what's now and what's next

Paula Rodriguez-Otero and Jesús F. San-Miguel

American Society of Hematology
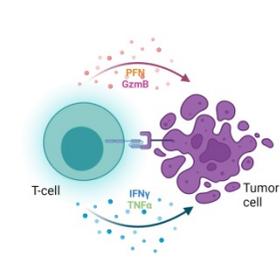Helping hematologists conquer blood diseases worldwide | Hematology 2022 | ASH Education Program

CAR T-cell therapy **TODAY**

CAR T-cell therapy **TOMORROW**

Next-generation CAR T

GPRC5d — BCMA
Cytokines — Antibodies — Receptor

ide-cel   cilta-cel

Newly diagnosed MM
Early relapse
Unmet medical need population

Triple-class exposed RRMM

Table 1. Safety and efficacy data of the 2 FDA- and EMA-approved CARs

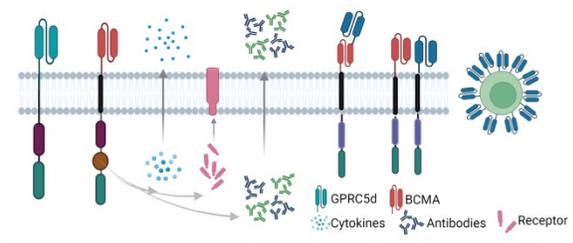|	Idecabtagene vicleucel KarMMa trial[1-3]	Ciltacabtagene autoleucel CARTITUDE 1 trial
ORR, n (%)	94 (73) At 450×10⁶ (n=54): 44 (81%)	95 (97.9)
CR or sCR, n (%)	42 (33) At 450×10⁶ (n=54): 21 (39)	82.5% (sCR)
Time to first response, median (range)	1.0 mo (0.5-8.8)	1.0 mo (IQR 0.9-1.0)
MRD in CR, n (%)	33/42 MRD neg (10^{-5})	61 evaluable 92% MRD negative (10^{-5})
DOR, median (95% CI)	10.7 mo (9.0-11.3)	Not reported
PFS, median (95% CI)	8.8 mo (5.6-11.6) At 450×10⁶: 12.1 mo (8.8-12.3)	NR (16.8-NE) 2-y PFS: 60.5% (48.5-70.4)
PFS in high-risk, median (95% CI)		PFS at 2y, % (95% CI)
ISS 3/R-ISS 3	4.9 mo (1.8-8.2)ᵃ	NE (NE-NE)
High-risk CA	8.2 mo (4.8-11.9)	48.4% (25.1-68.4)
Plasmacytomas	7.9 mo (5.1-10.9)	47.4% (24.4-67.3)
OS, median (95% CI)	24.8 mo (19.9-31.2)	NR (27.2-NE)

Opportunities provided by the EPC setting

- Research in the field of cancer pain management and supportive care measures in hematologic malignancies

- PROs monitoring by digital health

- Multidisciplinary approach to go in depth into the LONG TERM relationship between physician-nurse and patients-caregiver and discuss prognostic awareness, perceptions of hope and death and providing realistic hope

2019

WHO GUIDELINES FOR THE PHARMACOLOGICAL AND RADIOTHERAPEUTIC MANAGEMENT OF **CANCER PAIN** IN ADULTS AND ADOLESCENTS

ORIGINAL ARTICLE

An international, open-label, randomised trial comparing a two-step approach versus the standard three-step approach of the WHO analgesic ladder in patients with cancer

M. Fallon[1*], K. Dierberger[2], M. Leng[3], P. S. Hall[1,2], S. Allende[4], R. Sabar[5], E. Verastegui[4], D. Gordon[1], L. Grant[6], R. Lee[3], K. McWilliams[7], G. D. Murray[2], L. Norris[1], C. Reid[8], T. A. Sande[1], A. Caraceni[9†], S. Kaasa[10,11†] & B. J. A. Laird[1,12†]

UNDERPOWERED, POSSIBLY BECAUSE NOT IN EPC SETTING

«…The original plan was to recruit 400 participants (200 in each arm)…Unfortunately, after 3 years of slow recruitment (about 50 patients per year worldwide), the trial was closed after including 153 patients (76 in the weak opioid group and 77 in the strong opioid group…»
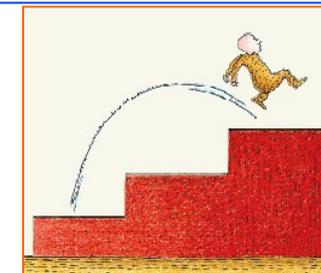
Randomized Trial of Low-Dose Morphine Versus Weak Opioids in Moderate Cancer Pain

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

Use of Opioids for Adults With Pain From Cancer or Cancer Treatment: ASCO Guideline

Judith A. Paice, PhD, RN[1]; Kari Bohlke, ScD[2]; Debra Barton, PhD, RN[3]; David S. Craig, PharmD[4]; Areej El-Jawahri, MD[5]; Dawn L. Hershman, MD, MS[6]; Lynn R. Kong, MD[7]; Geana P. Kurita, PhD, MNSc[8]; Thomas W. LeBlanc, MD[9]; Sebastiano Mercadante, MD[10]; Kristina L. M. Novick, MD, MS[11]; Ramy Sedhom, MD[12]; Carole Seigel, MBA[13]; Joanna Stimmel, PhD[14]; and Eduardo Bruera, MD[15]

Opportunities provided by the EPC setting

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Basch et al. JAMA. 2017;318(2):197-198
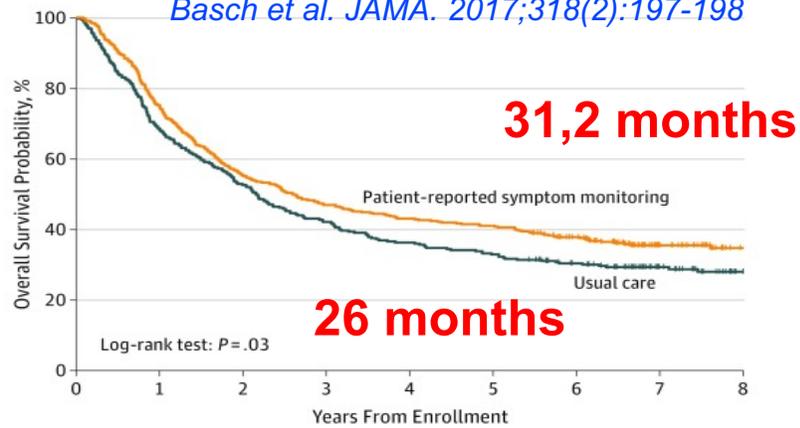
31,2 months

26 months

The <u>systematic monitoring of PROs</u> via web-based platforms, was also found to be <u>associated with improved overall survival</u> in patients with advanced cancers.

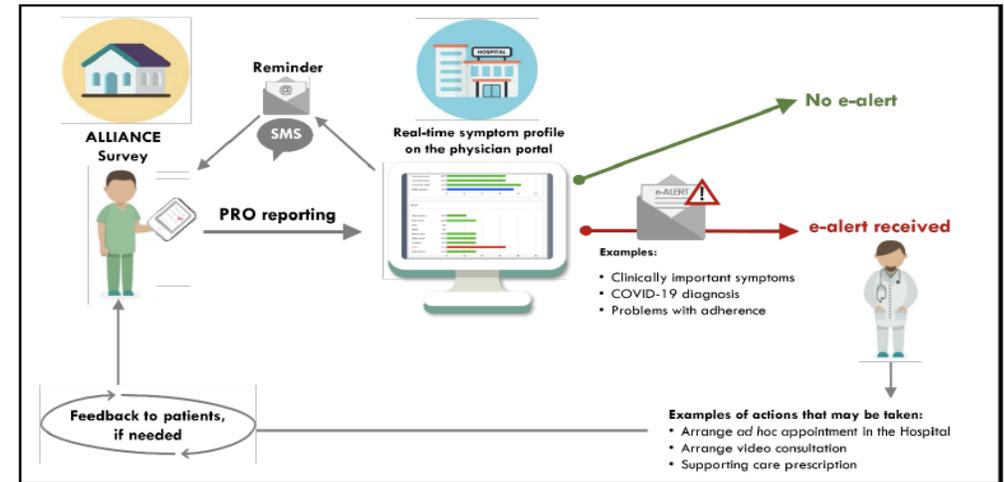Figure 1. Schematic workflow of the patient-generated alerts to the medical team

Physicians' Perceptions of Clinical Utility of a Digital Health Tool for Electronic Patient-Reported Outcome Monitoring in Real-Life Hematology Practice. Evidence From the GIMEMA-ALLIANCE Platform

Fabio Efficace[1*], Andrea Patriarca[2], Mario Luppi[3], Leonardo Potenza[3], Giovanni Caocci[4], Agostino Tafuri[5], Francesca Fazio[6], Claudio Cartoni[6], Maria Teresa Petrucci[6], Ida Carmosino[6], Riccardo Moia[2], Gloria Margiotta Casaluci[2], Paola Boggione[2], Elisabetta Colaci[3], Davide Giusti[3], Valeria Pioli[3], Francesco Sparano[1], Francesco Cottone[1], Paolo De Fabritiis[7], Nicolina Rita Ardu[7], Pasquale Niscola[7], Isabella Capodanno[8], Anna Paola Leporace[5], Sabrina Pelliccia[5], Elisabetta Lugli[8], Edoardo La Sala[1], Luigi Rigacci[9], Michelina Santopietro[9], Claudio Fozza[10], Sergio Siragusa[11], Massimo Breccia[6], Paola Fazi[1] and Marco Vignetti[1]

90% of 201 patients accepted to enter the platform
All hematologists agreed that the platform was easy to use, and (91.3%) agreed that is useful in the clinical management of their patients.

Opportunities provided by the EPC setting

- Research in the field of cancer pain management and supportive care measures in hematologic malignancies

- PROs monitoring by digital health

- Multidisciplinary approach to go in depth into the LONG TERM relationship between physician-nurse and patients-caregiver and discuss prognostic awareness, perceptions of hope and death and providing realistic hope

Oreofe O. Odejide

Dana-Farber Cancer Institute, Boston, MA; and Harvard Medical School, Boston, MA

Conversations and Goals-of-Care Discussions with Patients with DLBCL

Table 1. Barriers to primary and specialty palliative care

Disease-related barriers
High prognostic uncertainty
Rapid decline at the end of life

Physician-related barriers
Misperception that palliative care is synonymous with end-of-life care
Unrealistic physician expectations
Not knowing the right thing to say
Concern that the term "palliative care" will decrease patients' hope

Patient-related barriers
Misperceptions about palliative care
Unrealistic patient expectations

System-related barriers
Lack of universal and systematic symptom screening
Lack of universal and standardized training in primary palliative care
Limited access to specialty palliative care in some clinical settings
Difficulty integrating palliative and oncologic appointment schedules for patients

| Hematology 2020 | ASH Education Program

Barriers:

1. Given recent treatment advances and the potential for cure in R/R settings, the high prognostic uncertainty in DLBCL may lead some clinicians to delay discussions until death is very clearly imminent.

2. Even when clinicians grasp the importance of engaging in goals-of-care discussions, about 40% report that they do not know the right thing to say, which may result in low-quality discussions.

3. Concerns about taking away patients' hope also contribute to hesitancy in conducting these discussions.

Highly interdisciplinary research at the confluence of medical, language and cognitive sciences, studying the affective meaning and semantics of words associated with suffering and hope in hematology patients, including, acute leukemia, multiple myeloma, lymphoma and hemopoietic stem cell transplant patients.

Perceptions of Hope Among Bereaved Caregivers of Cancer Patients Who Received Early Palliative Care: A Content and Lexicographic Analysis

Sarah Bigi[1,*,ID], Vittorio Ganfi[2], Eleonora Borelli[2], Leonardo Potenza[2,3], Fabrizio Artioli[4], Sonia Eliardo[4], Claudia Mucciarini[4], Luca Cottafavi[4], Massimiliano Cruciani[4], Cristina Cacciari[5,6], Oreofe Odejide[7,†], Carlo Adolfo Porro[5,6,†], Camilla Zimmermann[8,9,†], Fabio Efficace[10,†,ID], Eduardo Bruera[11,†], Mario Luppi[2,3,*,†], Elena Bandieri[4,†]

Primary caregivers frequently described a direct link between the truth they were told by the doctors about the clinical conditions of their relative and the trust they developed towards them, which, in turn was linked to hope. A crucial factor in this positive dynamic seems to be the connection between hope, truth, and trust.
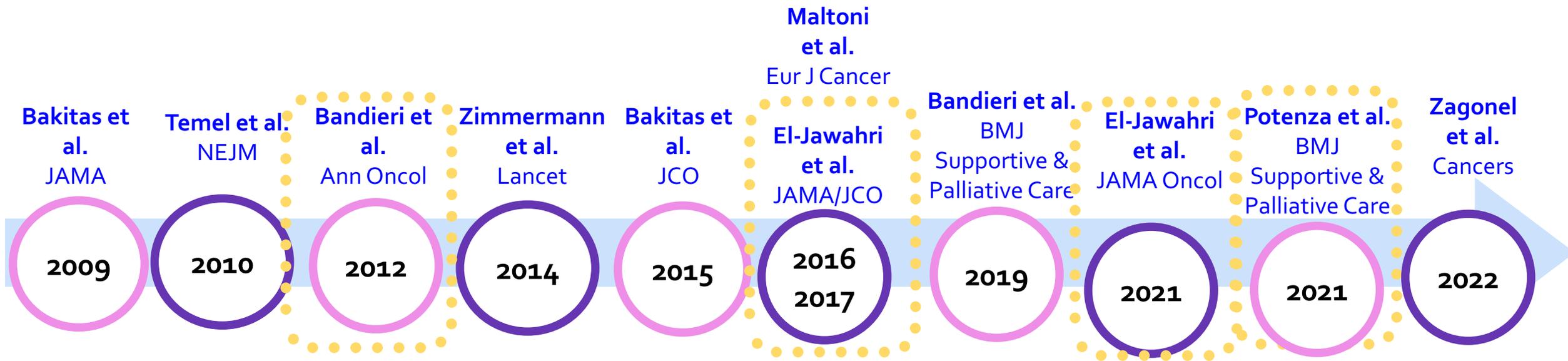
Table 1. Analyzed questions from the questionnaires.

Questions about EPC and hope
1. Per quanto tempo il suo caro ha frequentato l'ambulatorio di cure palliative precoci? *For how long did your relative come to the EPC Unit?*
2. A suo parere, le cure palliative precoci, cosa hanno significato per il suo caro? *What do you think EPC treatments meant for your loved one?*
2.1 E per lei come famigliare? *And what did they mean to you?*
4.1 Come considera il ruolo delle cure palliative precoci per la malattia oncologica? *What do you think is EPC's role in the treatment of oncologic illness?*
5. Ritiene che le cure palliative permettano di tenere accesa la speranza? *Do you think EPC treatments allow keeping hope alive?*
5.1 Che cos'è per lei la speranza? *What is hope for you?*
5.2 C'è un episodio che desidera condividere con noi di questa esperienza di accompagnamento? *Is there an episode you would like to share with us from the period of time when you were caring for your loved one?*
6. Si sente di aggiungere altro? *Would you like to add something else?*

Abbreviation: EPC, early palliative care.

HOW TO IMPROVE AND IMPLEMENT EPC IN HEMATOLOGY SETTINGS?

Bakitas et al.
JAMA — **2009**

Temel et al.
NEJM — **2010**

Bandieri et al.
Ann Oncol — **2012**

Zimmermann et al.
Lancet — **2014**

Bakitas et al.
JCO — **2015**

Maltoni et al.
Eur J Cancer

El-Jawahri et al.
JAMA/JCO — **2016 2017**

Bandieri et al.
BMJ Supportive & Palliative Care — **2019**

El-Jawahri et al.
JAMA Oncol — **2021**

Potenza et al.
BMJ Supportive & Palliative Care — **2021**

Zagonel et al.
Cancers — **2022**

- Improved QoL
- Reduced physical and psychological symptoms burden
- Improved prognostic awareness
- Lower rates of intensive health care utilization near death
- Increased survival

Early, i.e. within 8 weeks, since diagnosis of advanced cancer

ASCO statements
2013 2017

EPC only in hematology

1) SCIENTIFIC EVIDENCES AND CLINICAL RECOMMENDATIONS

Early palliative/supportive care in acute myeloid leukaemia allows low aggression end-of-life interventions: observational **outpatient study**

Leonardo Potenza [1], Miki Scaravaglio,[1] Daniela Fortuna,[2] Davide Giusti,[1] Elisabetta Colaci,[1] Valeria Pioli,[1] Monica Morselli,[1] Fabio Forghieri,[1] Francesca Bettelli,[1] Andrea Messerotti,[1] Hillary Catellani,[1] Andrea Gilioli,[1] Roberto Marasca,[1] Eleonora Borelli [3], Sarah Bigi,[4] Giuseppe Longo,[5] Federico Banchelli,[6] Roberto D'Amico,[6] Anthony L Back,[7] Fabio Efficace [8], Eduardo Bruera [9], Mario Luppi [1], Elena Bandieri[10]

LINEE GUIDA

LEUCEMIA ACUTA MIELOIDE

NON PROMIELOCITICA

NEL PAZIENTE ≥ 60 ANNI

Versione settembre 2022

SIE
SOCIETÀ ITALIANA DI EMATOLOGIA

Società Italiana di Ematologia

	Percentage of Days at Home
Breast Cancer Stage I-III	97%
Lung Cancer Stage I	88%
Azacitidine + venetoclax month 1	51%
Azacitidine + venetoclax month 3	64%
Azacitidine + venetoclax month 6	77%
Intensive Induction month 1	0%
Intensive induction month 2-4	65%
Intensive induction month 5 and beyond	90%

% DAYS AT HOME
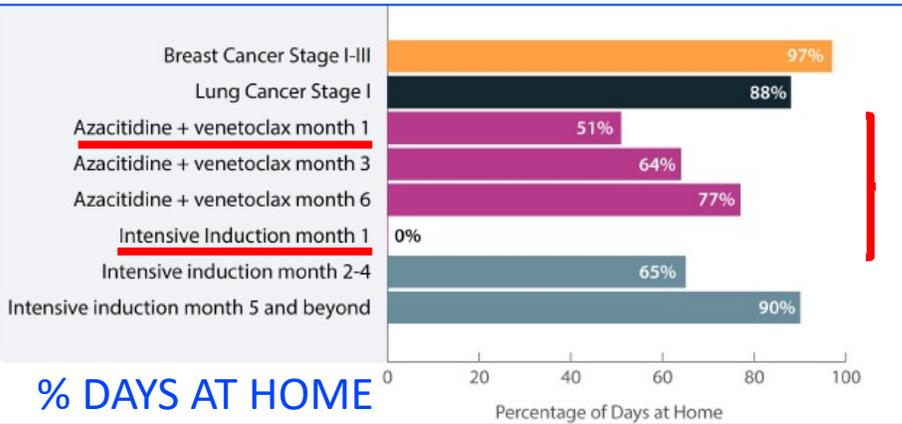
NEW MODELS OF OUTPATIENT EPC FOR AML, SINCE DIAGNOSIS

5. Il panel raccomanda, laddove fattibile, il precoce coinvolgimento del team di cure palliative e l'eventuale servizio di Assistenza Psicologica (istituzionale o supportato dalle Organizzazioni di Volontariato) nell'ottica di promuovere un simultaneo intervento dell'ematologo e del medico palliativista.

EDITORIAL   E. Atallah

Low-intensity induction in acute myeloid leukemia. Always in the patients' best interest?

Haematologica | 108 - April 2023

2) EPC TRIGGERS, SPECIFIC FOR DIFFERENT HEMATOLOGIC MALIGNANCIES, NEED TO BE IDENTIFIED

Early integration of palliative care for patients with haematological malignancies

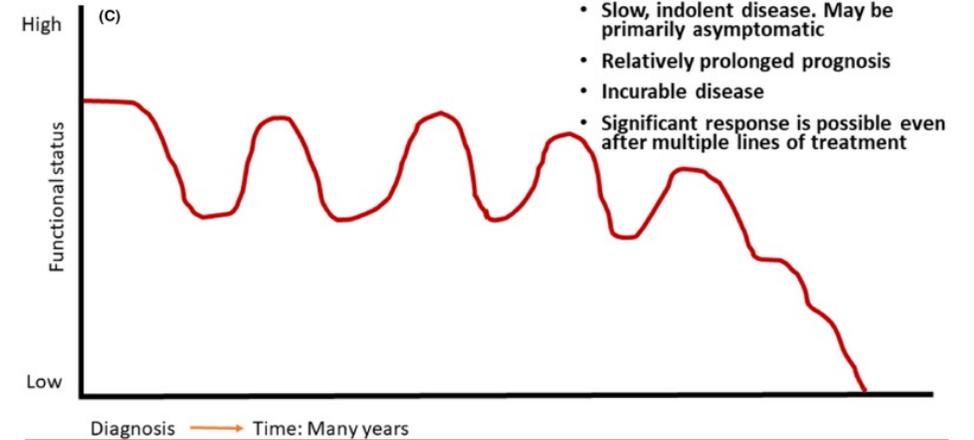Adir Shaulov[1,2] | Ariel Aviv[3] | Jacqueline Alcalde[4,5] | Camilla Zimmermann[4,5,6]

2 — Low symptom burden and low mortality (ie, indolent lymphomas)
PC when disease progresses/prognosis is poor

High symptom burden and mortality (ie, acute leukemias)
Early longitudinal PC — 1

Patients with hematologic malignancies

1 — Moderate symptom burden and mortality (ie, aggressive lymphomas)
Early intermittent PC

Prolonged periods with low symptom burden (ie, myeloproliferative neoplasms)
Identify triggers for PC — 3

Aggressive trajectory

- Dramatic changes over a short time secondary to aggressive treatment as well as disease
- Variable chances of cure vs. high risk of harm

Br J Haematol. 2022;00:1–17.

High / Low — Functional status
Diagnosis → Time: Months until either remission or death. May relapse again in months to years

Acute leukemias, aggressive lymphomas, HSCT, aGHVD

Indolent trajectory

- Slow, indolent disease. May be primarily asymptomatic
- Relatively prolonged prognosis
- Incurable disease
- Significant response is possible even after multiple lines of treatment

High / Low — Functional status
Diagnosis → Time: Many years

Multiple myeloma, indolent lymphomas, CLL

What about PC and EPC in Emilia-Romagna Region, Italy?

L'assistenza nel fine vita ai pazienti oncologici in Emilia-Romagna nel decennio 2010-2019

Outpatient Early Palliative Care (EPC) is under-represented.

Engagement and Education of Policymakers, Stakeholders and the Public

Education and Training of Healthy Professionals in EPC could favour development of PC in Hematology wards.

Tabella 10. Caratteristiche dei pazienti in studio

Caratteristiche dei pazienti	Totale		ADI		Hospice		Cure palliative ambulatoriali		Tutte le tipologie di cure palliative	
	N	%	N	%	N	%	N	%	N	%
Totale	174.658	100,0%	83.686	47,9%	39.945	22,9%	3.443	2,0%	103.770	59,4%
Genere										
Femminile	79.212	45,4%	39.834	50,3%	18.851	23,8%	1.459	1,8%	48.909	61,7%
Maschile	95.446	54,6%	43.852	45,9%	21.094	22,1%	1.984	2,1%	54.861	57,5%
Età										
< 18	202	0,1%	65	32,2%	8	4,0%	6	3,0%	69	34,2%
18 - 49	5.430	3,1%	2.201	40,5%	1.714	31,6%	177	3,3%	3.102	57,1%
50 - 64	19.637	11,2%	8.037	40,9%	6.017	30,6%	617	3,1%	11.341	57,8%
65 - 69	14.501	8,3%	6.096	42,0%	4.146	28,6%	331	2,3%	8.292	57,2%
70 - 74	19.884	11,4%	8.540	42,9%	5.505	27,7%	438	2,2%	11.406	57,4%
75 - 79	27.429	15,7%	12.511	45,6%	6.955	25,4%	563	2,1%	16.014	58,4%
80 - 84	32.921	18,8%	16.231	49,3%	7.356	22,3%	601	1,8%	19.809	60,2%
85 - 89	31.623	18,1%	16.988	53,7%	5.580	17,6%	464	1,5%	19.569	61,9%
≥ 90	23.031	13,2%	13.017	56,5%	2.664	11,6%	246	1,1%	14.168	61,5%
Tipologia di tumore										
Maligni solidi	146.691	84,0%	71.829	49,0%	37.218	25,4%	3.291	2,2%	90.507	61,7%
Maligni ematologici	15.034	8,6%	5.997	39,9%	1.823	12,1%	85	0,6%	6.947	46,2%

3) ENGAGEMENT AND EDUCATION OF POLICYMAKERS, STAKEHOLDERS, AND THE PUBLIC

Palliative Care Is the Umbrella, Not the Rain—
A Metaphor to Guide Conversations in Advanced Cancer

JAMA Oncology   May 2022   Volume 8, Number 5   681

Figure. Illustrated Metaphor of Late vs Early Palliative Care

ecancer 2022, **16**:1377; www.ecancer.org; DOI: https://doi.org/10.3332/ecancer.2022.1377

Camilla Zimmermann, MD, PhD

Jean Mathews, MD

AVOID STIGMA ABOUT PALLIATIVE CARE WHICH SHOULD BE ROUTINE CARE, DURING THE WHOLE ILLNESS TRAJECTORY:

«…referrals are made too late because of misperceptions that palliative care is end-of-life care and palliative care remains synonymous with end-of-life care due to late-referrals…»

ACKNOWLEDGEMENTS