fondazione GIMEMA onlus
per la promozione e lo sviluppo della ricerca scientifica sulle malattie ematologiche. FRANCO MANDELLI

Dalle linee guida alla qualità di vita e alle cure palliative precoci e simultanee:

come la storia delle leucemie mieloidi acute sta cambiando

Roma, 2 febbraio 2024 – Starhotels Metropole

Le cure palliative precoci e simultanee in oncologia ed emato-oncologia

Elena Bandieri
Modena

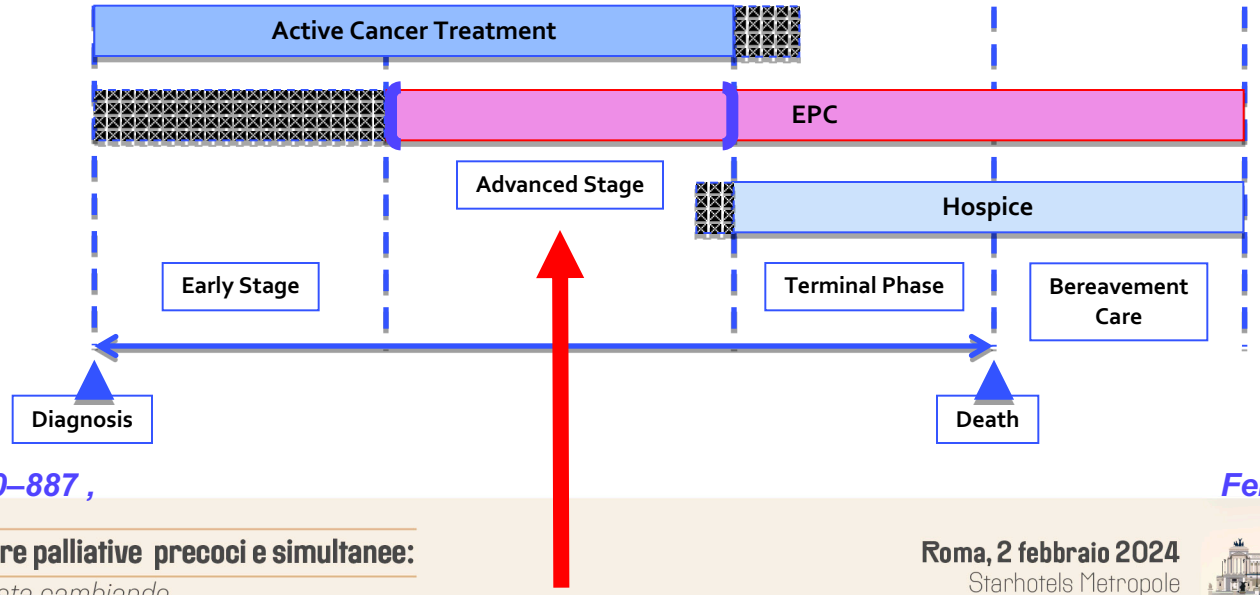
Cicely Saunders (1918- 2005)
Hospice Movement

St. Christopher, 1967

PASSATO:
CURE PALLIATIVE DI
FINE VITA
IMPORTANTI MA NON SUFFICIENTI

Balfourt Mount in 1975, Canada, creò il termine «Palliative Care»

Cure Palliative Precoci in Pazienti Oncologici ed Emato-Oncologici



PRESENTE:
CURE PALLIATIVE PRECOCI (EPC)
DURANTE TUTTA LA TRAIETTORIA DI MALATTIA

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

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

Early Palliative Care:
Quali benefici evidence-based

1. Controllo dei sintomi fisici (in primis il **dolore**) e psicologici (ansia, depressione e disordini di stress post-traumatico)
2. Miglioramento di QoL
3. Promuovono il *coping* adattativo di una malattia inguaribile, costruendo una relazione medico -paziente-caregivers
4. Favoriscono la comprensione della prognosi di malattia, supportano la discussione degli obiettivi EOL care e le scelte dell' astensione dalle terapie attive

Benefici clinici in studi randomizzati e nella pratica clinica in oncologia ed in ematologia

Differenze tra pazienti con neoplasie solide ed ematologiche

Criticità nella implementazione del modello EPC

Obiettivi futuri di ricerca; Monitoraggio dei *PROs, Comunicazione medico-infermiere-paziente, Formazione*

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.

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

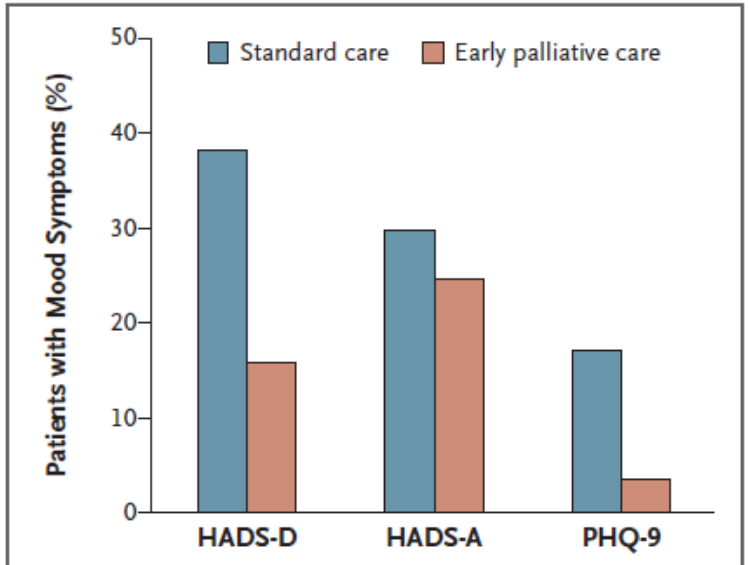


Figure 2. Twelve-Week Outcomes of Assessments of Mood.

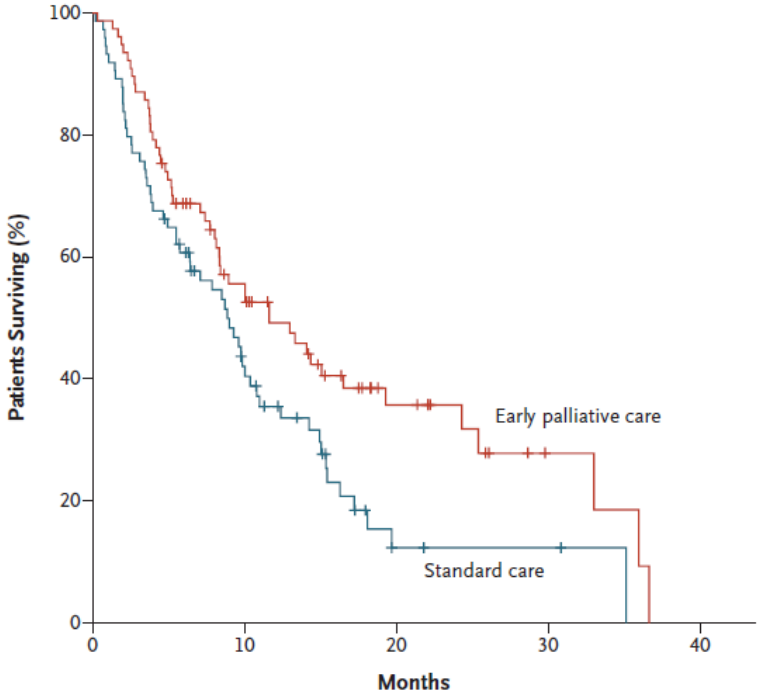


Figure 3. Kaplan–Meier Estimates of Survival According to Study Group.

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

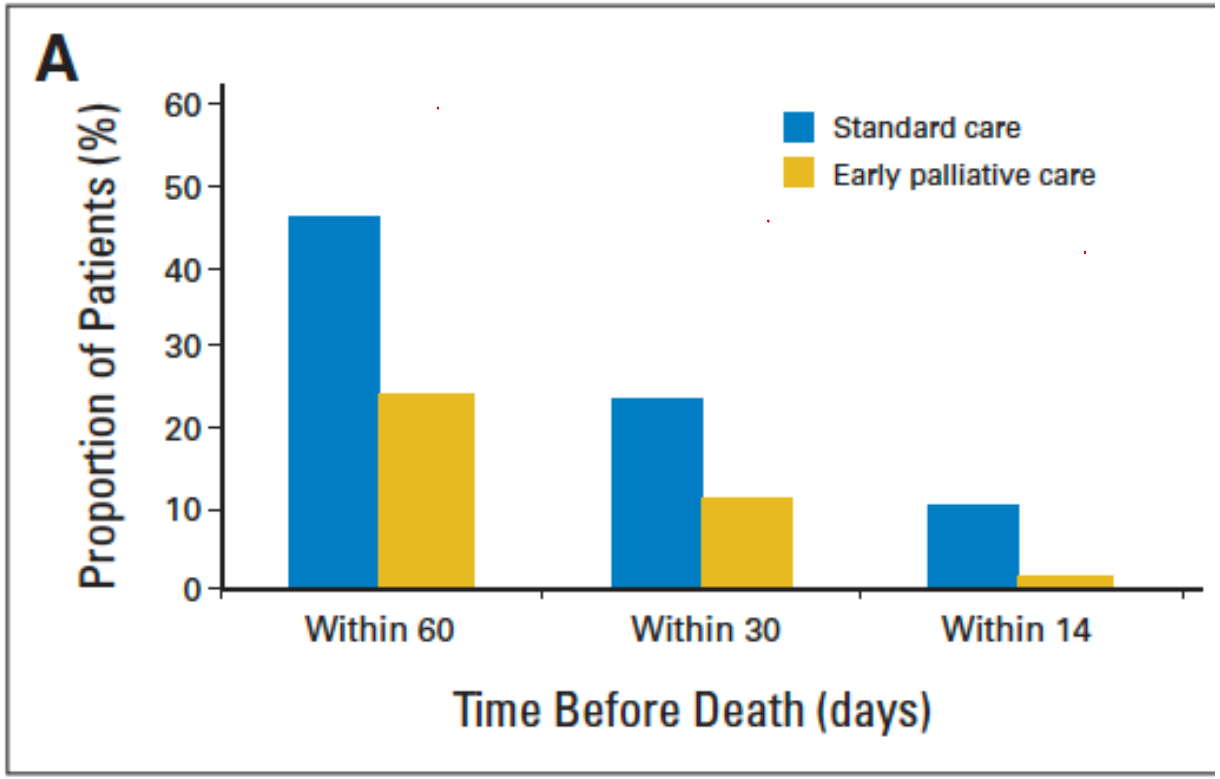
Early Palliative Care: accanimento terapeutico nel fine vita

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. He Emily R. Gallagher, and Jennifer S. Temel



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

VOLUME 33 · NUMBER 13 · MAY 1 2015

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Entro 30-60 giorni

Ritardo di 3 mesi

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

Modello medico infermieristico

Early Palliative Care: OS

Il miglioramento del 15% della sopravvivenza ad un anno in pazienti oncologici,

che ricevono un intervento di cure palliative precoci entro 8 sett. (vs > 3 mesi) è in linea con il vantaggio in studio Temel, NEJM 2010 (11.6 v 8.9 months).

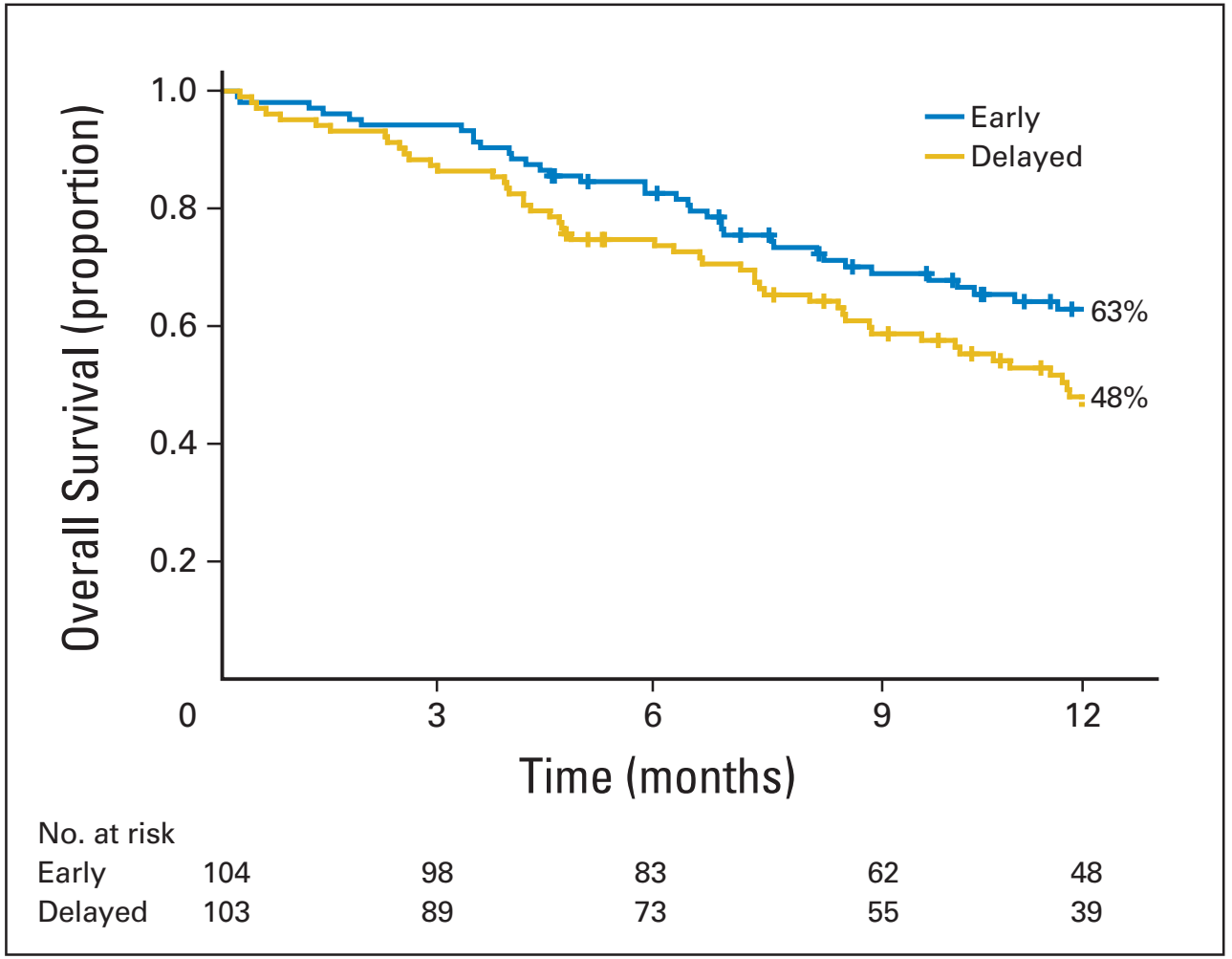


Fig 2. Kaplan-Meier estimates of 1-year survival by treatment group.

Early Palliative Care: i benefici per i caregivers

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: I *caregivers* avevano significativamente minore depressione e *distress* psicologico a 3 mesi da intervento (riduzione del 6%)

Early palliative care for patients with solid tumours

First Author	Bakitas JAMA 2009	Temel NEJM 2010	Zimmermann Lancet 2014	Bakitas J Clin Oncol 2015	Maltoni Eur J Cancer 2016	Temel J Clin Oncol 2016	Groenvold Palliat Med 2017	Vanbutsele Lancet Oncol 2018	Scarpi Support Care Cancer 2019
Country	USA, n=322	USA, n=151	Canada, n=461	USA, n=207	Italy, n=207	USA, n=350	Denmark, n=297	Belgium, n=186	Italy, n=186
Definition of 'early'	Within 8-12 wk of diagnosis	Within 8 wk of diagnosis	6-24 mo clinical prognosis	With 1-2 mo of diagnosis, 6-24 mo prognosis	Within 8 wk of diagnosis, >2 mo prognosis	Within 8 wk of diagnosis	Symptom/prob. (EORTC-QLQ-C30); "earlier"	Within 12 wk of diagnosis, 12 mo prognosis	Within 8 wks of dx, >2 mo prognosis
Setting OUTPATIENT	Telehealth	Outpatient, embedded	Outpatient, freestanding	Telehealth	Outpatient, free-standing	Outpatient, embedded	Outpatient and telehealth	Outpatient and inpatient	Outpatient
QOL	+	+	+	=	+	+	=	+	=
Physical Symptoms	=	+	+	=	+	n/a	=/+ (nausea)	=	=
Depression	+	+	n/a	=	=	+	=	=	=
Satisfaction with care	n/a	n/a	+	n/a	=	n/a	n/a	n/a	=
Caregiver outcomes	= burden	n/a	+satisfaction = QOL	+ mood = QOL	n/a	+ mood =/+ QOL	n/a	n/a	=
EOL care/ service use	=	+	n/a	=	+/=	n/a	n/a	n/a	n/a
Survival	=	+	n/a	+	n/a	n/a	=	=	=

Courtesy of C. Zimmermann

Early palliative care for patients with solid tumours

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QOL	+	+	+	=	+	+	=	+	=
Physical Symptoms	=	+	+	=	+	n/a	=/+ (nausea)	=	=
Depression	+	+	n/a	=	=	+	=	=	=
Satisfaction with care	n/a	n/a	+	n/a	=	n/a	n/a	n/a	=
Caregiver outcomes	= burden	n/a	+satisfaction = QOL	+ mood = QOL	n/a	+ mood =/+ QOL	n/a	n/a	=
EOL care/ service use	=	+	n/a	=	+/=	n/a	n/a	n/a	n/a
Survival	=	+	n/a	+	n/a	n/a	=	=	=

Courtesy of C. Zimmermann

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QOL	+	+	+	=	+	+	=	+	=
Physical Symptoms	=	+	+	=	+	n/a	=/+ (nausea)	=	=
Depression	+	+	n/a	=	=	+	=	=	=
Satisfaction with care	n/a	n/a	+	n/a	=	n/a	n/a	n/a	=
Caregiver outcomes	= burden	n/a	+satisfaction = QOL	+ mood = QOL	n/a	+ mood =/+ QOL	n/a	n/a	=
EOL care/ service use	=	+	n/a	=	+/=	n/a	n/a	n/a	n/a
Survival	=	+	n/a	+	n/a	n/a	=	=	=

Courtesy of C. Zimmermann

Early palliative care for patients with solid tumours

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Depression	+	+	n/a	=	=	+	=	=	=
Satisfaction with care	n/a	n/a	+	n/a	=	n/a	n/a	n/a	=
Caregiver outcomes	= burden	n/a	+satisfaction = QOL	+ mood = QOL	n/a	+ mood =/+ QOL	n/a	n/a	=
EOL care/ service use	=	+	n/a	=	+/=	n/a	n/a	n/a	n/a
Survival	=	+	n/a	+	n/a	n/a	=	=	=

Courtesy of C. Zimmermann

Benefici clinici in studi randomizzati e nella pratica clinica in oncologia ed in ematologia

Differenze tra pazienti con neoplasie solide ed ematologiche

Criticità nella implementazione del modello EPC

Obiettivi futuri di ricerca; Monitoraggio dei *PROs, Comunicazione medico-infermiere-paziente, Formazione*

EPC E IL CONTROLLO DEL DOLORE

Annals of Oncology Advance Access published May 10, 2012

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*

Studio multicentrico, *cross-sectional* in 32 Ospedali Italiani **1.450 pazienti**, con dolore da cancro: 602 con accesso a terapie standard e 848 con accesso a EPC

Le EPC = fattore indipendente associato alla riduzione del dolore severo da cancro, del 31%.

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.

EPC: dolore, accanimento terapeutico e OS

Research

Early versus delayed palliative/ supportive care in advanced cancer: an observational study

2014-2017

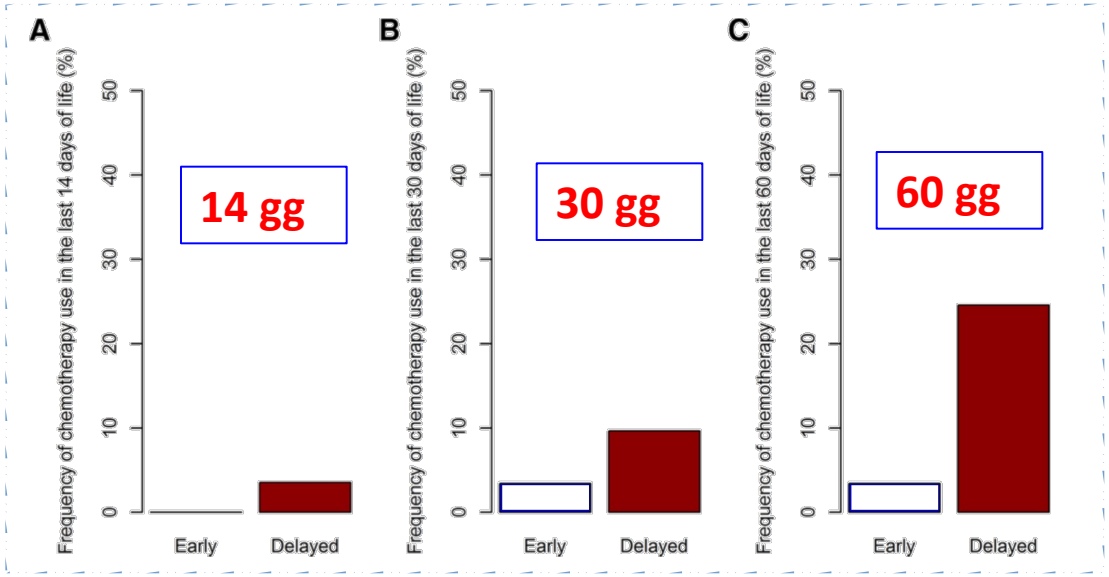
Elena Bandieri,[1] Federico Banchelli,[2] Fabrizio Artioli,[1] Claudia Mucciarini,[1] Giorgia Razzini,[1] Massimiliano Cruciani,[1] Leonardo Potenza,[3] Roberto D'Amico,[2] Fabio Efficace,[4] Eduardo Bruera,[5] Mario Luppi[3]

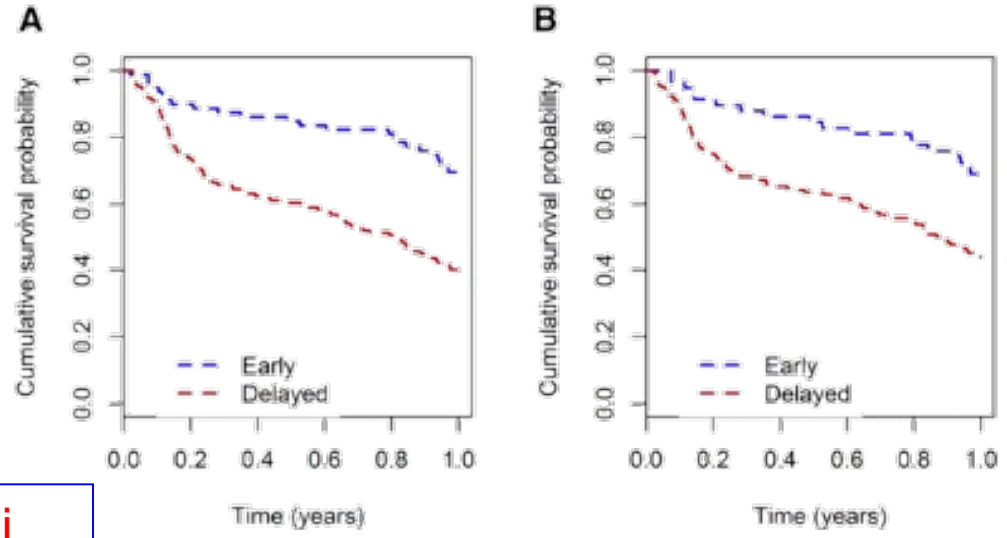
BMJ Bandieri E, *et al. BMJ Supportive & Palliative Care* 2019;**0**:1–10. doi:10.1136/bmjspcare-2019-001794

Table 5 NRS at baseline and over time in the whole sample

	NRS (0–10)*		Comparison with baseline
	Median	IQR	P value
Time 0 (baseline)	7	6–8	NA
Time 1 (after 1 week)	1	0–2	0.000
Time 2 (after 4 weeks)	1	1–2	0.000
Time 3 (after 12 weeks)	1	0–1	0.000

*Data available only for 178 patients.
NA, not applicable; NRS, Numerical Rating Scale.





Early 60 gg dopo la diagnosi

Delayed 90 gg dopo la diagnosi

Benefici clinici in studi randomizzati e nella pratica clinica in oncologia ed in ematologia

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Obiettivi futuri di ricerca; Monitoraggio dei *PROs, Comunicazione medico-infermiere-paziente, Formazione*

JAMA | Original Investigation

Effect of Inpatient Palliative Care on Quality of Life 2 Weeks After Hematopoietic Stem Cell Transplantation

A Randomized Clinical Trial

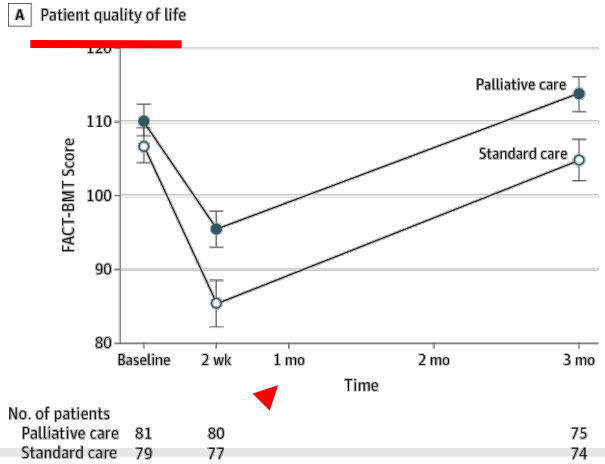
Areej El-Jawahri, MD; Thomas LeBlanc, MD; Harry VanDusen, BS; Lara Traeger, PhD; Joseph A. Greer, PhD; William F. Pirl, MD; Vicki A. Jackson, MD; Jason Telles, NP; Alison Rhodes, NP; Thomas R. Spitzer, MD; Steven McAfee, MD; Yi-Bin A. Chen, MD; Stephanie S. Lee, MD, MPH; Jennifer S. Temel, MD

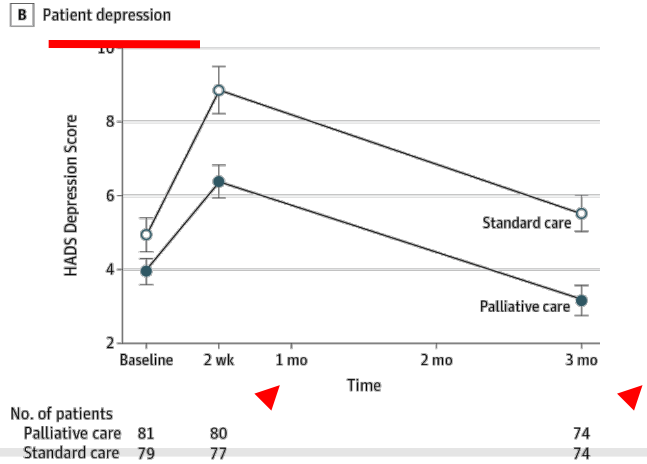
JAMA. 2016;316(20):2094-2103. doi:10.1001/jama.2016.16786

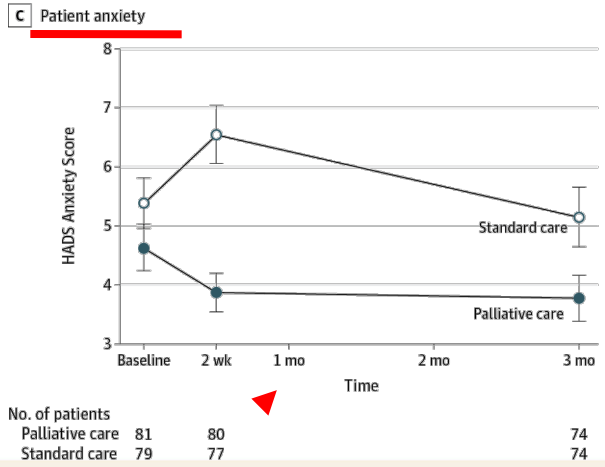
160 pazienti sottoposti a trapianto di cellule staminali emopoietiche randomizzati a ricevere EPC vs esclusivamente il trapianto.

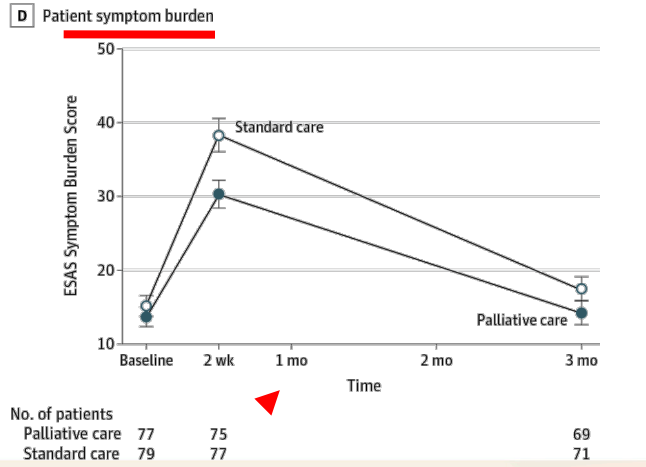
Intervento palliativo: medico o infermiere, due volte alla settimana, durante il ricovero

- Migliore QoL, riduzione di ansia e d depressione dei sintomi invalidanti.
- Caregivers minore depressione









Transplant type, No. (%)		
Autologous HCT	39 (49.4)	41 (50.6)
Myeloablative allogeneic HCT	14 (17.7)	16 (19.8)
Reduced-intensity allogeneic HCT	26 (32.9)	24 (29.6)
Donor type (allogeneic), No. (%)		
Matched related donor	11 (27.5)	11 (27.5)
Matched unrelated donor	23 (57.5)	22 (55)
Haploidentical donor	4 (10.0)	7 (17.5)
Cord	2 (5.0)	0
HCT hospital length of stay, mean (SD), d	21.7 (5.4)	21.9 (11.2)
FACT-BMT score, mean (SD)[a]	107.3 (20.7)	110.3 (19.1)
FACT Fatigue score, mean (SD)[b]	36.9 (10.8)	38.1 (10.3)
PHQ-9 score, mean (SD)[c]	5.4 (4.7)	4.8 (4.4)
HADS Depression score, mean (SD)[d]	4.9 (4.1)	4.0 (3.2)
HADS Anxiety score, mean (SD)[d]	5.4 (3.8)	4.6 (3.6)

Effect of Inpatient Palliative Care During Hematopoietic Stem-Cell Transplant on Psychological Distress 6 Months After Transplant: Results of a Randomized Clinical Trial

Areej El-Jawahri, Lara Traeger, Joseph A. Greer, Harry VanDusen, Sarah R. Fishman, Thomas W. LeBlanc, William F. Pirl, Vicki A. Jackson, Jason Telles, Alison Rhodes, Zhigang Li, Thomas R. Spitzer, Steven McAfee, Yi-Bin A. Chen, and Jennifer S. Temel

VOLUME 35 · NUMBER 32 · NOVEMBER 10, 2017

JOURNAL OF CLINICAL ONCOLOGY | ORIGINAL REPORT

L'effetto dell'intervento era mantenuto anche a 6 mesi con miglioramento della depressione e dell'ansia e riduzione del disturbo post-traumatico da stress.

Table 2. Effect of the Inpatient Palliative Care Intervention on Patient-Reported Outcomes at 6 Months Post-Transplant

Assessment	Adjusted Mean Score*	95% CI	Adjusted Mean Difference Between Groups	95% CI	*P*
HADS-D (n = 141)					
Control	4.66	3.93 to 5.38	−1.21	−2.26 to −0.16	**.024**
Intervention	3.45	2.70 to 4.19			
HADS-A (n = 141)					
Control	4.74	3.99 to 5.49	−0.61	−1.69 to 0.47	.267
Intervention	4.13	3.36 to 4.90			
PHQ-9 depression symptoms (n = 142)					
Control	5.58	4.57 to 6.60	−1.63	−3.08 to −0.19	**.027**
Intervention	3.95	2.93 to 4.98			
PCL (n = 134)					
Control	26.18	23.96 to 28.39	−4.02	−7.18 to −0.86	**.013**
Intervention	22.15	19.91 to 24.40			
FACT-BMT (n = 141)					
Control	109.39	105.38 to 113.41	2.72	−2.96 to 8.39	.346
Intervention	112.11	108.12 to 116.10			
FACT fatigue (n = 143)					
Control	37.38	34.94 to 39.83	0.10	−3.38 to 3.58	.957
Intervention	37.48	35.01 to 39.94			

NOTE. Boldface indicates significant $P < .05$.
Abbreviations: FACT-BMT, Functional Assessment of Cancer Therapy-Bone Marrow Transplant; HADS-A, Hospital Anxiety and Depression Scale anxiety subscale; HADS-D, Hospital Anxiety and Depression Scale depression subscale; PCL, Post-Traumatic Stress Disorder Checklist; PHQ-9, Patient Hospital Questionnaire 9.
*The adjusted mean score is the predicted outcome score at the average baseline value for all participants.

JAMA Oncology | Original Investigation

Effectiveness of Integrated Palliative and Oncology Care for Patients With Acute Myeloid Leukemia
A Randomized Clinical Trial

Areej El-Jawahri, MD; Thomas W. LeBlanc, MD; Alison Kavanaugh, NP; Jason A. Webb, MD; Vicki A. Jackson, MD; Toby C. Campbell, MD; Nina O'Connor, MD; Selina M. Luger, MD; Ellin Gafford, MD; Jillian Gustin, MD; Bhavana Bhatnagar, DO; Alison R. Walker, MD; Amir T. Fathi, MD; Andrew M. Brunner, MD; Gabriela S. Hobbs, MD; Showly Nicholson, BS; Debra Davis, RN, BSN; Hilena Addis, BS; Dagny Vaughn, BA; Nora Horick, MS; Joseph A Greer, PhD; Jennifer S. Temel, MD

JAMA Oncol. 2021;7(2):238-245. doi:10.1001/jamaoncol.2020.6343

Measure (Scale)	Sample size	Group assignment	Adjusted Mean Score (95% CI)	Standardized Mean Difference	P value
Quality of life (FACT-Leukemia	139	Usual care	107.59 (101.45-113.74	0.30	.04
		Integrated palliative and oncology care	116.45 (110.69-122.21)		
Anxiety symptoms (HADS)	147	Usual care	5.94 (5.10-6.79)	0.31	.02
		Integrated palliative and oncology care	4.53 (3.74-5.33)		
Depression symptoms (HADS)	147	Usual care	7.20 (6.26-8.14)	0.34	.02
		Integrated palliative and oncology care	5.68 (4.80-6.56)		
Depression syndrome (PHQ-9)	144	Usual care	8.00 (6.83-9.17)	0.31	.04
		Integrated palliative and oncology care	6.34 (5.23-7.44)		
Symptom burden (ESAS)	146	Usual care	32.82 (28.58-37.06)	0.23	
		Integrated palliative and oncology care			

	Usual care N/Tot (%)	Integrated palliative and oncology care N/Tot (%)	P value
Deceduti	44/73 (60)	43/84 (51)	
Discussion about EOL preferences	12/30 (40)	21/28 (75)	.01

Paz >= 18 anni, *high-risk AML*
Sottoposti a chemioterapia intensiva :

1) *AML* di nuova diagnosi, >= 60 anni;
2) *AML* primariamente refrattaria e recidivata

EPC NEW Standard OF CARE for AML

Intervento palliativo da medico-infermiere, due volte alla settimana, durante il ricovero.
Valutazione indicatori esiti a 2 settimane

Benefici clinici in studi randomizzati e nella pratica clinica in oncologia ed in ematologia

Differenze tra pazienti con neoplasie solide ed ematologiche

Criticità nella implementazione del modello EPC

Obiettivi futuri di ricerca; Monitoraggio dei *PROs, Comunicazione medico-infermiere-paziente, Formazione*

IL DOLORE in EMATOLOGIA

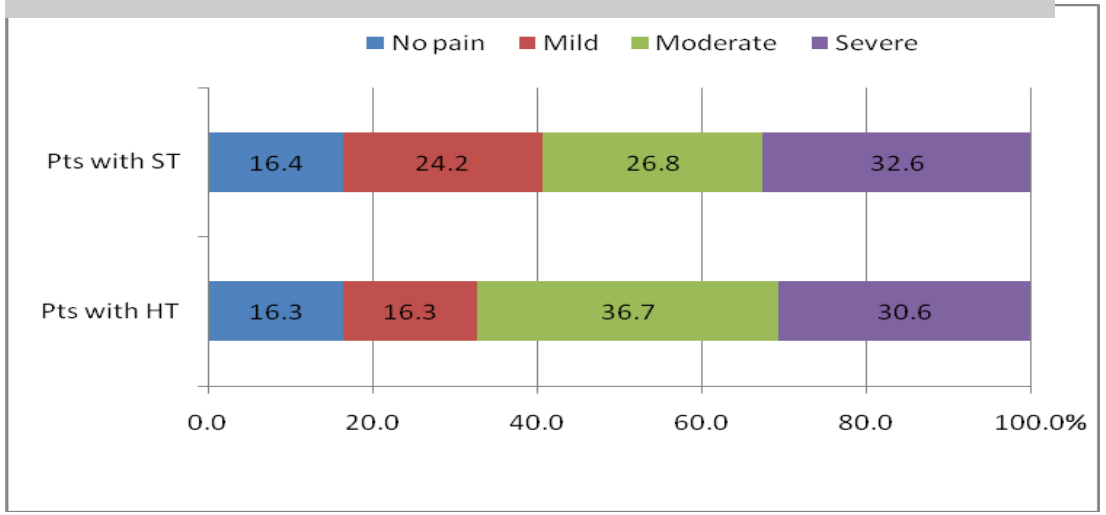
Is pain in patients with haematological malignancies under-recognised? The results from Italian ECAD-O survey

Bandieri et al.,

Leukemia Research 34 (2010) e334–e335

Solid Tumors 59.4% moderate severe

Hematologic Tumors 67.3% moderate-severe



Supportive Care in Cancer (2019) 27:2789–2797
https://doi.org/10.1007/s00520-018-4583-5

ORIGINAL ARTICLE

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]

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

Dolore nel 49,9% dei pazienti con leucemia acuta; dolore severo nel 35.3%.

EPC: IL CONTROLLO DEL DOLORE

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]

BMJ Potenza L, *et al*. *BMJ Supportive & Palliative Care* 2021;**0**:1–8. doi:10.1136/bmjspcare-2021-002898

Table 1 Characteristics of patients with AML enrolled in the study

	ePSC	Late PC
Total, n	131	84
Age, mean±SD (range)	65.5±13.3 (21.0–91.5)	55.8±16.8 (17.1–91.9)
Male, n (%)	75 (57.3)	43 (51)
AML initial therapy, n (%)		
Intensive	80 (61.1)	67 (80)
Non-intensive	31 (23.7)	7 (8)
Supportive care alone	20 (15.3)	10 (12)
Weeks to PC team referral, median (range)		NA
Whole population	5 (0–20.7)	
Delayed referral patients (n=13, 10%)	12 (9.3–20.7)	

AML, acute myeloid leukaemia; ePSC, early palliative supportive care; late PC, late referral to palliative care; NA, not applicable; SD, standard deviation.

Table 4 Pain assessment over time in patients with acute myeloid leukaemia receiving early palliative supportive care intervention

	NRS (0–10)		
	Median	95% CI	P value
Time 0 (baseline)	4	4 to 6	NA
Time 2 (after 1 week)	0	0 to 3	<0.01
Time 3 (after 4 weeks)	0	0 to 1	<0.01
Time 4 (after 12 weeks)	0	0 to 2	<0.01

NA, not applicable; NRS, Numerical Rating Scale.

2014-2019-Modena

BMJ

Potenza L, *et al*. *BMJ Supportive & Palliative Care* 2021;0:1–8. doi:10.1136/bmjspcare-2021-002898

Table 3 Measures of quality indicators for palliative care in patients with acute myeloid leukaemia receiving ePSC intervention or late referral PC

	ePSC, all		Late PC, all		RD, % (95% CI)	P value	ePSC, deceased		Late PC, deceased		RD, % (95% CI)	P value
	n/n	%	n/n	%			n/n	%	n/n	%		
Psychological support*, n (%)	72/131	55	41/84	49	61.5 (–7.5 to 19.8)	0.3781	39/75	52	22/40	55	–3 (–22.1 to 16.1)	0.7588
Assessing and managing pain*, n (%)	131/131	100	39/84	46	53.6 (43 to 64.2)	<0.00001	75/75	100	18/40	45	55 (39.5 to 70.4)	<0.00001
Discussion of GOC/ prognosis*, n (%)	94/131	71.8	36/84	43	28.9 (15.8 to 42)	<0.00001	70/75	93.3	16/40	40	53.3 (37.1 to 69.5)	<0.00001
Promotion of ACP*, n (%)	75/131	57.3	2/84	2.3	54.9 (45.8 to 64)	<0.00001	64/75	85.3	2/40	5	80.3 (69.8 to 90.8)	<0.0001
Discussion of resuscitation preference*, n (%)	16/131	12.2	2/84	2.3	9.83 (3.3 to 16.3)	0.01111	15/75	20	2/40	5	15 (3.7 to 26.3)	0.0309
Home-care service utilisation*, n (%)	57/131	43.5	12/84	14.2	29.2 (17.9 to 40.5)	<0.00001	48/75	64	12/40	30	34 (16.1 to 51.9)	0.0005
Median duration of home care, days (range)	63.5 (3.0–3273.0)		53.0 (1–96)				57.0 (3.0–394.0)		53.0 (1–96)			
Median time from GOC to death, days (range)	NA		NA				106 (4.0–585.0)		149.5 (11–1714)			
Median time from ACP to death, days (range)	NA		NA				25 (4.0–401.0)		5.5 (4–7)			

*Indicators of quality for palliative care.[30]

ACP, advance care planning; ePSC, early palliative supportive care; GOC, goals of care; late PC, late referral to palliative care; NA, not applicable; RD, risk difference.

EVIDENZE SCIENTIFICHE E RACCOMANDAZIONI CLINICHE

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]

BMJ Potenza L, *et al*. *BMJ Supportive & Palliative Care* 2021;0:1–8. doi:10.1136/bmjspcare-2021-002898

NUOVI MODELLI DI CURE PALLIATIVE PRECOCI SIA *INPATIENT* CHE *OUTPATIENT*

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.

EPC: NON SOLO IN LMA

Short report

Early palliative care versus usual haematological care in multiple myeloma: retrospective cohort study

Davide Giusti,[1] Elisabetta Colaci,[1] Valeria Pioli,[1] Federico Banchelli,[2] Monica Maccaferri,[1] Giovanna Leonardi,[1] Roberto Marasca,[1] Monica Morselli,[1] Fabio Forghieri,[1] Francesca Bettelli,[1] Angela Cuoghi,[1] Paola Bresciani,[1] Andrea Messerotti,[1] Andrea Gilioli,[1] Anna Candoni,[1] Luca Cassanelli,[1] Elena Sbadili,[1] Ilaria Bassoli,[3] Giuseppe Longo,[4] Fabio Gilioli,[5] Eleonora Borelli ,[1] Sarah Bigi,[6] Roberto D'Amico,[2] Carlo Adolfo Porro,[7,8] Oreofe Odejide,[9] Camilla Zimmermann ,[10,11] Fabio Efficace ,[12] Eduardo Bruera ,[13] Mario Luppi ,[1] Elena Bandieri,[14] Leonardo Potenza [1]

Table 1 Quality indicators for palliative care in patients with multiple myeloma receiving EPC or UHC

Indicators	EPC N=55 (%)	UHC N=231 (%)	Measure	Adjusted (95%CI)	P value
Psychological Support	64.4	28.6	OR	4.64 (2.41 to 8.43)	<0.0001
Assessing and managing pain	100	68.4	OR	nc	nc
Discussion of GOC	74.6	4.3	HR	21.44 (9.75 to 47.16)	<0.0001
Promotion of ACP	13.6	0.0	HR	nc	nc
Home care service utilisation	30.5	22.5	HR	1.1 (0.84 to 2.71)	0.1638

The analysis was adjusted for the following variables in the regression models: age (years), sex (male, female), stage (I, II, III), MMFS = Multiple Myeloma Frailty Score (fit, unfit, frail), intensity of first-line therapy (transplant, no transplant).

ACP, advanced care planning; EPC, early palliative care patients; GOC, goals of care; n, number; nc, no calculable; UHC, usual haematological care.

Giusti D, *et al*. *BMJ Supportive & Palliative Care* 2023;**0**:1–5. doi:10.1136/spcare-2023-004524

WHAT THIS STUDY ADDS

⇒ Patients with multiple myeloma (MM) receiving EPC, when compared with those undergoing usual haematological care, have better pain control, with longer use of strong opioids; higher rates of symptom management; more frequent goals of care discussions; earlier access to home care services and a trend towards higher quality of end-of-life care.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study supports the value of integrating EPC into MM routine practice and may also lay the groundwork for future prospective comparative studies either in this setting or in patients with other HM.

Benefici clinici in studi randomizzati e nella pratica clinica in oncologia ed in ematologia

Differenze tra pazienti con neoplasie solide ed ematologiche

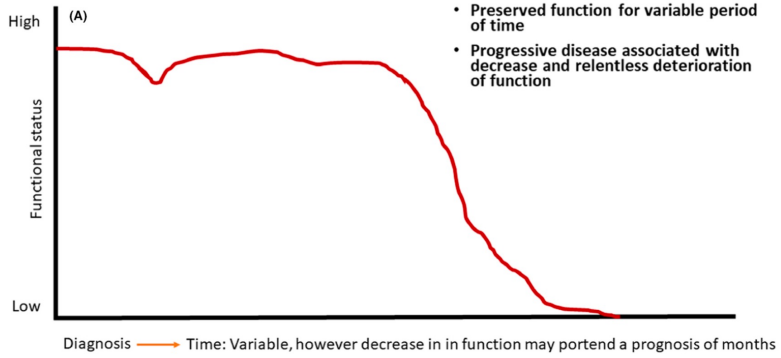
Criticità nella implementazione del modello EPC

Obiettivi futuri di ricerca; Monitoraggio dei *PROs, Comunicazione medico-infermiere-paziente, Formazione*

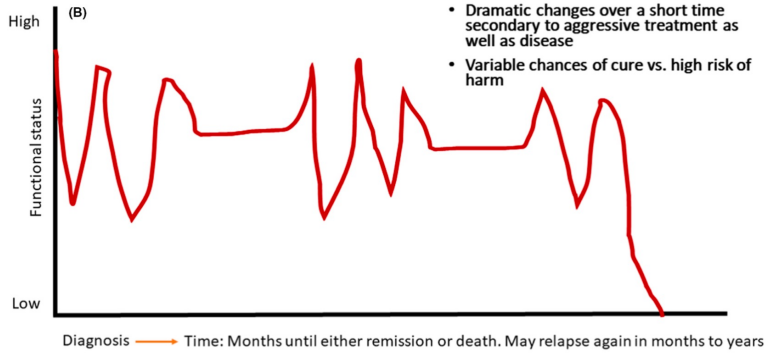
I pazienti ematologicI presentano imprevedibili e peculiari traiettorie di malattia con la possibilità di cura e guarigione anche in caso di recidiva e di refrattarietà.

Proprio queste peculiarità influiscono sulla difficoltà di prognosi e del *timing* di Interventi di Cure Palliative Precoci

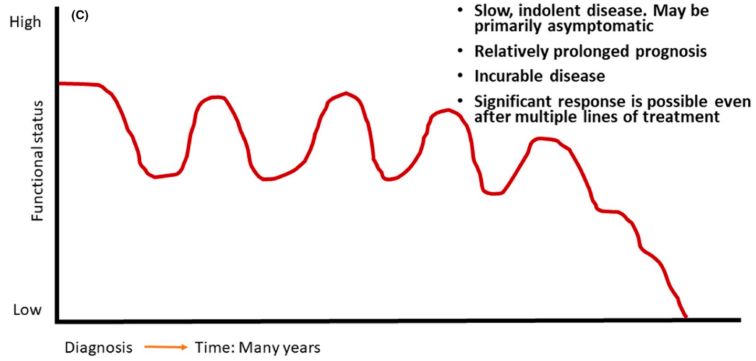
Cancri Solidi Metastatici



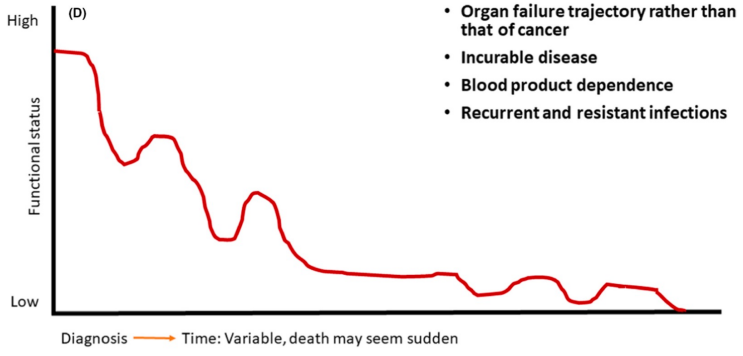
LMA, LLA, Linfomi non-H, B Alto Grado



MM, LLC



SMD, MFI, AA, fine vita



Benefici clinici in studi randomizzati e nella pratica clinica in oncologia ed in ematologia

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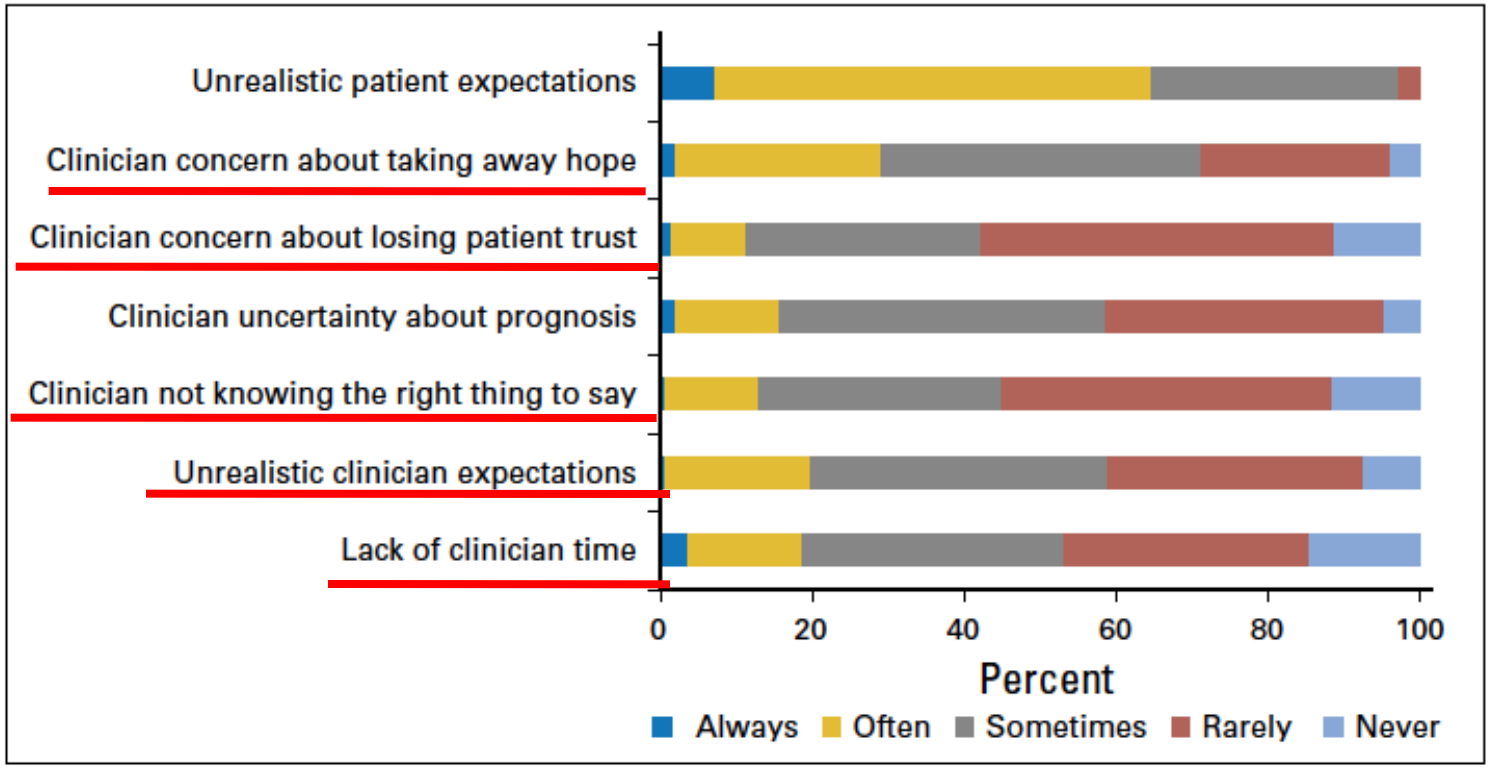
JOURNAL OF CLINICAL ONCOLOGY | ORIGINAL REPORT

2016

Barriers to Quality End-of-Life Care for Patients With Blood Cancers

Oreofe O. Odejide, Angel M. Cronin, Nolan B. Condron, Sean A. Fletcher, Craig C. Earle, James A. Tulsky, and Gregory A. Abel

E gli ematologi riportano di NON ATTIVARE UN percorso di palliazione perchè non vogliono togliere la Speranza ai pazienti, perdere la loro Fiducia, perchè non sanno come COMUNICARLO.



Survey in USA da 334 Emato-Oncologi Nordamericani

Benefici clinici in studi randomizzati e nella pratica clinica in oncologia ed in ematologia

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MISURARE I BISOGNI DEI PAZIENTI: ESAS COME PROs

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

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]

BMJ

Morselli M, *et al*. *BMJ Supportive & Palliative Care* 2022;**0**:1–3. doi:10.1136/spcare-2022-003838

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

> 60ys

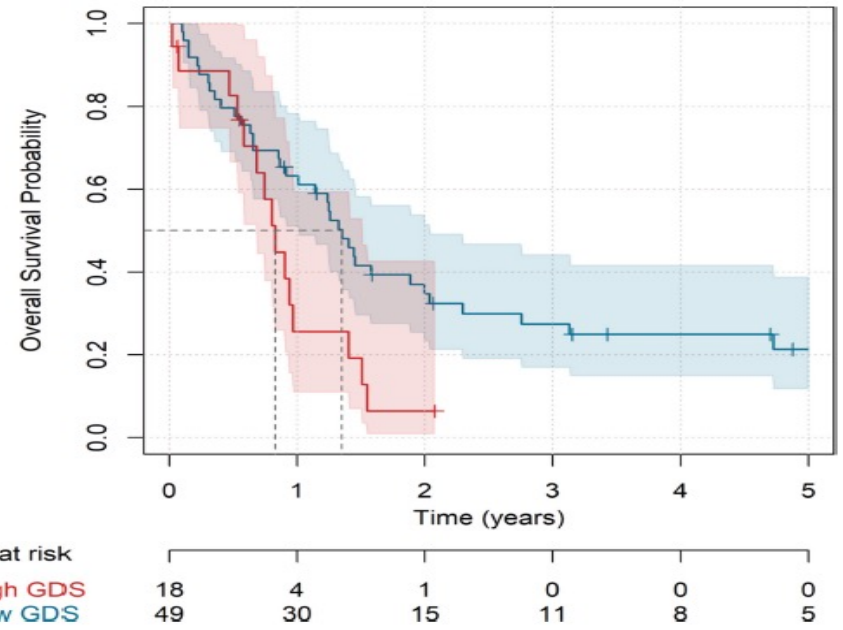

Figure 1 Overall survival curves by Global Distress Score (GDS) score (high vs low).

Global Distress Score-GDS- ESAS 9 *items*
Tempo di compilazione= 1 minuto

Benefici clinici in studi randomizzati e nella pratica clinica in oncologia ed in ematologia

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Obiettivi futuri di ricerca; Monitoraggio dei *PROs, Comunicazione medico-infermiere-paziente, Formazione*

Centralità della Comunicazione in EPC: Dolore, Sofferenza, Speranza

The Oncologist

Symptom Management and Supportive Care

Changes in cancer patients' and caregivers' disease perceptions while receiving early palliative care: a qualitative and quantitative analysis

Eleonora Borelli, Sarah Bigi, Leonardo Potenza, Sonia Eliardo, Fabrizio Artioli, Claudia Mucciarini, Luca Cottafavi, Katia Cagossi, Giorgia Razzini, Massimiliano Cruciani, Alessandra Pietramaggiori, Valeria Fantuzzi, Laura Lombardo, Umberto Ferrari, Vittorio Ganfi, Fausta Lui, Oreofe Odejide, Cristina Cacciari, Carlo Adolfo Porro, Camilla Zimmermann, Fabio Efficace, Eduardo Bruera, Mario Luppi, Elena Bandieri

The Oncologist 2021;9999:•• www.TheOncologist

RESEARCH ARTICLE

Different semantic and affective meaning of the words associated to physical and social pain in cancer patients on early palliative/ supportive care and in healthy, pain-free individuals

Eleonora Borelli[1,2]*, Sarah Bigi[3], Leonardo Potenza[4,5], Fabrizio Artioli[6], Sonia Eliardo[6], Claudia Mucciarini[6], Katia Cagossi[6], Giorgia Razzini[6], Antonella Pasqualini[6], Fausta Lui[1,2], Fabio Ferlazzo[7], Massimiliano Cruciani[6], Eduardo Bruera[8], Fabio Efficace[9], Mario Luppi[4,5€], Cristina Cacciari[1,2€], Carlo Adolfo Porro[1,2€], Elena Bi

PLOS ONE | https://doi.org/10.1371/journal.pone.0248755 March 31, 2021

Gratitude among advanced cancer patients and their caregivers: The role of early palliative care

Eleonora Borelli[1*], Sarah Bigi[2], Leonardo Potenza[1,3], ampiero Porzio[6†], ace[9†], Eduardo Bruera[10†], ri[5†]

TYPE Original Research
PUBLISHED 27 September 2023
DOI 10.3389/fnins.2023.1234286

Ricerca multidisciplinare al confine tra le scienze mediche, neuro-cognitive e linguistiche per studiare e migliorare l' evoluzione della comunicazione e relazione con i pazienti ed i loro *caregivers*.

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

Sarah Bigi[1,*], 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,†], Eduardo Bruera[11,†], Mario Luppi[2,3,*,†], Elena Bandieri[4,†]

Words hurt: common and distinct neural substrates underlying nociceptive and semanti

Eleonora Borelli[1], Francesca Benuzzi[2]*, Daniela Elena Bandieri[3], Mario Luppi[1,4], Cristina Cacciar Carlo Adolfo Porro[2†] and Fausta Lui[2†]

TYPE Community Case S
PUBLISHED 06 March 202
DOI 10.3389/fpubh.2023

ist, 2022, **27**, e168–e175
g/10.1093/oncolo/oyab027
ess publication 4 February 2022

TYPE Original Research
PUBLISHED 14 September 202
DOI 10.3389/fonc.2023.1213

Current Oncology MDPI

Review

Investigating Positive Psychological Well-Being in Early Palliative Care: Values of Hope, Gratitude, and Death Acceptance.

Elena Bandieri[1§], Eleonora Borelli[2*§], Sarah Bigi[3], Claudia Mucciarini[1], Fabio Gilioli[1], Umberto Ferrari[1], Sonia Eliardo[1], Mario Luppi[4†], Leonardo Potenza[4†]

Early palliative care for solid an blood cancer patients and caregivers: Quantitative and qualitative results of a long-terr experience as a case of value-based medicine

Sarah Bigi[1*†], Eleonora Borelli[2†], Leonardo Potenza[2,3†], Fabio Gilioli[4], Fabrizio Artioli[5], Giampiero Porzio[6], Mario Luppi[2,3†]

Caregiver's quality of life in advanced cancer: validation of the construct in a real-life setting of early palliative care

Eleonora Borelli[1], Sarah Bigi[2], Leonardo Potenza[1,3], Fabio Gilioli[4], Fabio Efficace[5], Carlo Adolfo Porro[6,7], Mario Luppi[1,3*] and Elena Bandieri[8]

CENTRALITA' della COMUNICAZIONE (e dei CAREGIVERS)

Iniziativa editoriale che raccoglie video interviste di CG di paz onco-ematologici seguiti in EPC, che vuole approfondire i temi della **COMUNICAZIONE**

Benefici clinici in studi randomizzati e nella pratica clinica in oncologia ed in ematologia

Differenze tra pazienti con neoplasie solide ed ematologiche

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Obiettivi futuri di ricerca; Monitoraggio dei *PROs, Comunicazione medico-infermiere-paziente, Formazione*

DIFFUSIONE CULTURALE E FORMAZIONE DI *POLICYMAKERS*, *STAKEHOLDERS*, CITTADINANZA, ACCADEMIA

JAMA Oncology May 2022 Volume 8, Number 5 681

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

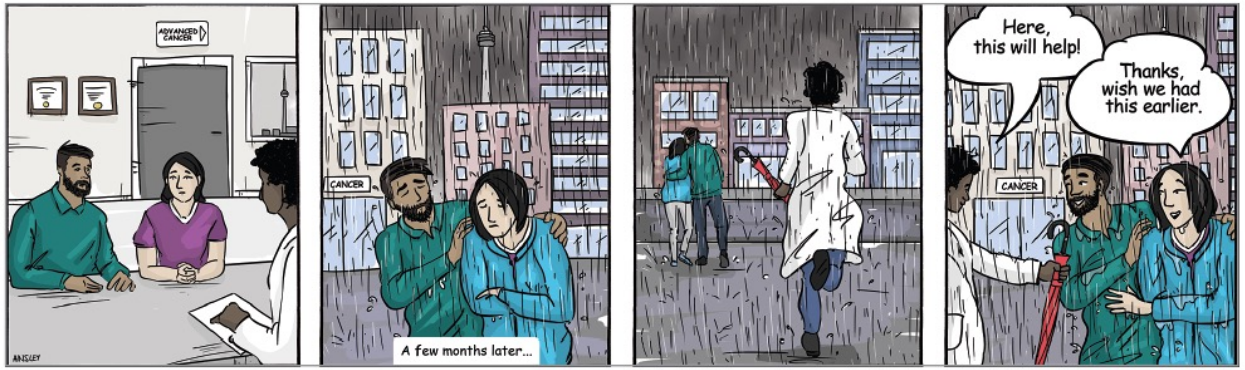
ecancer 2022, 16:1377; www.ecancer.org; DOI: https://doi.org/10.3332/ecancer.2022.1377

Camilla Zimmermann, MD, PhD

Jean Mathews, MD

Figure. Illustrated Metaphor of Late vs Early Palliative Care

A Late palliative care referral



B Early palliative care referral

EVITARE LO STIGMA DELLE CURE PALLIATIVE:

«…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…»

FORMAZIONE DI EMATOLOGI, ONCOLOGI, INFERMIERI IN CURE PALLIATIVE PRECOCI

UNIMORE
UNIVERSITÀ DEGLI STUDI DI MODENA E REGGIO EMILIA

Dipartimento di Scienze Mediche e Chirurgiche
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1° Master Universitario di Secondo Livello

LE CURE PALLIATIVE PRECOCI E SIMULTANEE IN ONCO-EMATOLOGIA E MEDICINA INTERNA: LA CLINICA, LA COMUNICAZIONE E LA QUALITÀ DI VITA

Direttore del Master: prof. Leonardo Potenza (UniMoRe)
Coordinatore Didattico e Organizzativo: dott.ssa Elena Bandieri (Ausl Modena)
Referente: dott.ssa Eleonora Borelli (UniMoRe)
Comitato scientifico: dott.ssa Elena Bandieri, prof. Roberto D'Amico, prof. Massimo Dominici, prof. Fabio Efficace, dott. Fabio Gilioli, prof. Frank Reinhard Heinrich Lohr, dott. Giuseppe Longo, prof. Mario Luppi

Da settembre 2023 a giugno 2025
c/o Centro Oncologico Modenese (COM) e Centro Servizi
Policlinico di Modena - Largo del Pozzo 71, Modena

FORMAZIONE DI EMATOLOGI, ONCOLOGI, INFERMIERI IN CURE PALLIATIVE PRECOCI

Haematology and specialist palliative medicine education and training

Table 1 Italian ministerial decrees on education themes and requirements in PC

Italian Ministerial decree 28 March 2013: equivalent specialties to palliative care	Anaesthesia and intensive care, geriatrics, haematology, infectious disease, internal medicine, neurology, oncology, paediatrics, radiotherapy
Italian Ministerial decree 19 May 2020, specialty school of medicine and palliative care. Structural requirements (annex B1): university or affiliated specialist structures that must be present in the training network	Medical oncology, internal medicine, anaesthesia, intensive care and pain therapy, geriatrics, neurology, hospices, domiciliary PC units, ambulatory PC units and hospital consultancy PC services
Italian Ministerial decree 19 May 2020, specialty school of medicine and palliative care. Disciplinary requirements (annex B1): disciplinary scientific sectors considered compulsory and indispensable	Medical oncology, neurology, internal medicine and anaesthesia, intensive care and pain therapy (fundamental teachings)

PC, palliative care.

BMJ

Luppi M, *et al*. *BMJ Supportive & Palliative Care* 2023;**0**:1–2. doi:10.1136/spcare-2023-004505

Nel mondo scientifico Nordamericano, si persegue da alcuni anni un **percorso di formazione cosiddetto di "dual board certificate" di uno specialista oncologo medico o ematologo clinico, in Cure Palliative.**

The Case for Focused Palliative Care Education in Oncology Training

Ramy Sedhom, MD[1]; Arjun Gupta, MD[1]; Jamie Von Roenn, MD[2]; and Thomas J. Smith, MD[1]

Accepted on February 6, 2020 and published at ascopubs.org/journal/jco on April 9, 2020: DOI https://doi.org/10.1200/JCO.20.00236

Annals of Hematology
https://doi.org/10.1007/s00277-021-04512-0

LETTER TO THE EDITOR

Education of early palliative care specialists among hematologists and oncologists to address patients' rather than physicians' rights

Leonardo Potenza[1] · Mario Luppi[1] · Eleonora Borelli[1] · Sarah Bigi[2] · Elena Bandieri[3]

CONCLUSIONI

- Consolidati benefici sono associati all'integrazione di EPC nel Percorso dei Pazienti con Cancro Avanzato. Oltre alle raccomandazioni ASCO, ESMO, AIOM, l'integrazione di EPC in pazienti con LMA, dovrebbe essere ritenuto il nuovo *standard* di cura.

- La soddisfazione dei bisogni di pazienti (IN PRIMIS IL DOLORE) con diverse neoplasia ematologiche, attraverso un modello integrato di EPC, è necessario e urgente.

- Priorità: Formazione e Ricerca

RINGRAZIAMENTI

Prof. Leonardo Potenza
Prof. Mario Luppi
Early Palliative Care Service for Hematologic Patients
Chair and Division of Hematology UNIMORE/AOU Modena, Italy

Dr. Eleonora Borelli
Department of Medical and Surgical Sciences, UNIMORE, Modena, Italy

Prof. Sarah Bigi
Department of Linguistic Sciences and Foreign Literatures, Catholic University of the Sacred Heart, Milan, Italy

Prof. Carlo A. Porro
Department of Biomedical, Metabolic and Neural Sciences. Center for Neuroscience and Neurotechnology,
Rector, University of Modena and Reggio Emilia, Modena, Italy

Prof. Elena Bandieri
Early Palliative Care Service for Oncology Patients
USL Modena, UNIMORE, Modena Italy

Prof. Eduardo Bruera
Palliative Care & Rehabilitation Medicine, UT MD Anderson Cancer Center, Houston, TX, USA.

Prof. Fabio Efficace
Chairman
Working Party QoL. Italian Group for Adult Hematologic Diseases (GIMEMA), Data Center and Health Outcomes Research Unit, Rome, Italy.
Northewesten University, Chicago, IL, USA

Prof. Camilla Zimmermann
Princess Margaret Cancer Centre, University Health Network, University of Toronto, Toronto, Ontario, Canada

Prof. Oreofe Odejide
Department of Medical Oncology, Dana-Farber Cancer Institute, Boston, MA, USA.