



Early Palliative Care Should be a Must

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Short Communication

Advanced cancer patients have complex and multidimensional physical and psychological problems. Palliative care has been recognized as the science fitting these problems along the trajectory of chronic progressive diseases. In the real world, most palliative care is currently provided at the end of life. Palliative care is principally offered only after life-prolonging treatments have failed. Specialized palliative care limited to patients enrolled in hospice-home care ignores the majority of patients facing a serious and more often long-lasting disease. Referral to palliative care tends to occur late in the course of disease. Most patients are referred within 30-60 days of death or in the last days of life [1-4]. Problems and issues of accessing specialist palliative care have been identified and include a lack of knowledge about palliative care among health professionals, a lack of standardized criteria for referring patients, and difficulties in accessing specialized services [5]. The role of oncologists has also been taken into consideration in different geographic areas. In a survey performed in Canada that focused on oncologist attitudes, patients were frequently referred to specialized palliative care, but generally late in the disease course for patients with uncontrolled symptoms [6]. In a survey performed in Europe, only 35% of medical oncologists collaborated with palliative care physicians. Although most of them felt that end-of-life care issues should be coordinated by them, 42% stated that they were inadequately trained to do that [7]. Finally, less than half of Australian oncologists referred more than 60% of their patients to palliative care services [8]. It has been reported that the presence of uncontrolled symptoms, particularly pain, is the principal trigger to patients' referral to palliative care consultation, even in patients with a long prognosis [8-12]. Conversely, symptom-free patients with a short prognosis are unlikely to be referred to palliative care specialists [6]. If referral to palliative care specialists is based on this assumption, it is obvious that a poor symptom assessment with adequate screening tools may limit timely palliative care consultation. Several studies have addressed the lack of capacity of oncologists in assessing physical and psychological symptoms due to a limited training [7]. Simultaneous care has been recommended as the standard of care, according to the suggestions of who [13] palliative care should be applied early in the course of disease in conjunction with other potentially curative therapies. Early referral to palliative care allows palliative care teams to provide early assessment and control of physical and psychological distress, also discussing advanced care planning. The benefits of providing early palliative care integrated with standard oncology care have been shown in several clinical trials [14-16]. This approach may lead to significant improvements in quality life and eventually survival. Despite this promising information, one should be aware that. Reporting of best supportive care in trials remains inconsistent, resulting in uncertain internal and external validity. In most studies it is unclear what the best supportive care was and above all what is the traditional care. More recently, it has been reported that these studies were over-estimating the net clinical effect of the comparator arm [17]. It is quite obvious that patients should be intercepted early in the course of their oncologic treatment in acute hospital to provide timely consultation and offering a planning of care. This pathway along the disease trajectory could be also useful in determining the discontinuation of active treatment in patients who otherwise risk overtreatment with further disproportionate and aggressive oncologic treatments, frequently given in the last months of life [18,19]. Single high level experiences, reported in the literature [20,21], have shown the effectiveness and the economical sustainability of an inpatient acute palliative care unit in a comprehensive cancer center. The development of a range of palliative care programs integrating primary territorial care and specialized palliative services, including those in cancer departments can constitute the ideal synthesis to respond to patients' needs. Palliative care is appropriate and recommended at any stage of disease and should be provided simultaneously with curative treatment [22]. Palliative care should be initiated alongside standard medical care in hospital to ensure that patients receive the best care throughout their disease trajectory [23]. Patients should have access to palliative care services in the inpatient and outpatient settings where they receive the active concomitant treatment. Each oncological department should provide simultaneous treatment to assure the best care. Given the

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abundant literature and the obvious socio-economic implications. Health care systems and hospital leaders should urgently this unmet need.

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