Short Communication

BIOMEDICAL Journal of Scientific & Technical Research

ISSN: 2574 -1241

DOI: 10.26717/BJSTR.2024.58.009103

Integrated Care Model: An Effective Model of Palliative Care Delivery in Cancer Patient

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ARTICLE INFO

Received: July 20, 2024

Published: August 08, 2024

Citation: Aref Zribi. Integrated Care Model: An Effective Model of Palliative Care Delivery in Cancer Patient. Biomed J Sci & Tech Res 58(1)-2024. BJSTR. MS.ID.009103.

ABSTRACT

Integrated care in cancer patients has emerged as a topic of debate last years. Two ways of approach were described in the literature: the tumor-directed approach, focusing on treating the disease; and the host-directed approach which focuses on the patient's quality of life (QOL) and symptoms control. Integrated care model (ICM) involves the integration of specialist palliative care (PC) early in the course of cancer trajectory, assimilating tumour-centred and patient-centered approaches with active patient and family involvement in the decisions about cancer care. in this short communication we describe the ICM as a new model of palliative care delivery. Integrated care in cancer patients has appeared as a topic of debate last years. There is two ways of approach in cancer treatment: the tumor-directed approach, focusing on treating the disease; and the host-directed approach which focuses on the patient's quality of life (QOL) and symptoms control. Integrated care model (ICM) involves the integration of specialist palliative care (PC) early in the course of cancer trajectory. Evidence-based medicine is the norm in oncology practice, but evidence as to when to stop aggressive treatment is not clear. In the recent years, ICM has evolved as a new model of palliative care delivery [1], and there is a gradual agglomeration of evidence to reinforce its role [2]. Several patients are now living many years with metastatic disease-like breast, lung, colorectal, and prostate cancer, with 5-year survival rates exceeding the 50 %. we cannot focus on the tumor, without given attention to the patient with the tumor. combination of tumour-centred and the patient-centred approaches is the best approach with active patient and family involvement in the decisions about cancer care. WHO's most recent definition of palliative care [3], points to the integration of oncology and palliative care by phrasing, "Palliative care is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications." In 2010, WHO had recognized cancer as one of four major chronic diseases like cardiology and pulmonology diseases [4]. The ASCO [5] similarly recommends integrating PC early in the course of illness for patients with cancer. The early delivery of host-directed care by PC doctors alongside tumor-directed treatments improve patient-centered care [6]. the increase use of chemotherapy in the final weeks of life was described by many studies, [7,8]

Many factors were described to explain the prescription of chemotherapy in the last weeks before death.

Abbreviations: QOL: Quality of Life; ICM: Integrated Care Model; PC: Palliative Care; PS: Performance Status; EOL: End of Life

Level Of Chemosensitivity of The Tumor

Kao et all [9] treated 398 patients with advanced cancers, 18% and 8% received chemotherapy within 4 and 2 weeks of death, respectively, chemosensitivity of the tumor was a predictor for commencing chemotherapy. Goncalves et all [10] showed that breast and lung cancers, were positively associated with chemotherapy prescription in the last weeks.

Patients with better performance status (PS)

It is clear that poor PS indicates poorer response, shorter survival, and increased toxicity due to chemotherapy [11,12] QOL near death of patients with advanced stage cancer was not improved by palliative chemotherapy, even in patients with good PS. But what about patient with good PS. Prigerson et all described that patients receiving palliative chemotherapy with an ECOG PS of 0 or 1 had significantly worse QOL than those who avoided chemotherapy [13]. But this score has

some weakness, it is predominantly physician assessed and therefore subjective and prone to bias Overestimation of PS is not uncommon.

Patients with no PC Team Involvement had a Higher Risk of Receiving more Aggressive end of Life (EOL) Care

A study [14] of 115 patients under palliative chemotherapy who have no involvement of PC team in their management tend to receive chemotherapy near the EOL, have more aggressive EOL care, and have higher risk of dying from treatment related complications.

Comprehensive Cancer Centers, Often Capable to offer Therapeutic Options like Target Therapies and Immunotherapy that are Inaccessible in Other Types of Facility [15]

In the last few decades, identification of oncogenic driver mutations and derived targeted agents has remodelled the model of cancer treatment. Some studies discussed the EOL care in the era of the immunotherapy and target therapy. A systematic review [16] of the literature evaluated the use of cancer treatment at the EOL. None of the studies provided criteria for discontinuing oral anticancer therapy. Those receiving oral targeted agents continue treatment until closer to death than those receiving intravenous anticancer therapies. distinction between active and palliative interventions in the era of targeted therapies is clouded. Another study [17] Analysed hundred ninety-four cancer patients, 27% patients received immune checkpoint inhibitors (ICIs) in the last month of life. Patients who received ICIs in the last 30 days of life received lesser mean doses and more often ≤3 cycles. They also had higher mean PS scores and higher rates of dying in the hospital. A Chinese study [18] suggested that receiving oral agents had lower risk for hospital death and fewer ICU admissions. Oral agents tend to have lower toxicity and better QOL. ICM means understanding the patient's needs and enhancing the communication with the patient and family, plan for home care, delivering the care in the same department by organizing the oncology care and palliative care as one service, not in a separate way. A comprehensive, integrated approach with a multidisciplinary team can include palliative care specialists at any stage of the disease trajectory, irrespective of whether treatment objective is curative, life-prolonging, or palliative, with a same shared decision making by all the healthcare staff about the main focus of care.

Conclusion

Integrated care model offers better quality of life for the patients and less aggressive treatment in the end of life. Patient-centred care should be an integrated part of oncology care independent of patient prognosis and treatment intention. To achieve this goal, it must be based on understanding the patient's needs, delivering oncology care and palliative care in the same time and place as well as the education of healthcare staff about the new models of care.

References

1. Hannon B, Swami N, Pope A, Rodin G, Dougherty E, et al. (2015) The oncology palliative care clinic at the Princess Margaret Cancer Centre: An early intervention model for patients with advanced cancer. Support Care Cancer 23: 1073-1080.
2. Howie L, Peppercorn J (2013) Early palliative care in cancer treatment: Rationale, evidence and clinical implications. Ther Adv Med Oncol 5: 318-323.
3. Sepúlveda C, Marlin A, Yoshida T, Ullrich A (2002) Palliative care: the World Health Organization's global perspective. J Pain Symptom Manage 24: 91-96.
4. Alwan A (2011) Global status report on noncommunicable diseases 2010: World Health Organization.
5. Smith TJ, Temin S, Alesi ER, Amy P Abernethy, Tracy A Balboni, et al. (2012) American Society of Clinical Oncology provisional clinical opinion: the integration of palliative care into standard oncology care. J Clin Oncol 30: 880-887.
6. Kaasa S, Loge JH, Aapro M, Tit Albreht, Rebecca Anderson, et al. (2018) Integration of oncology and palliative care: a Lancet Oncology Commission. Lancet Oncol 19: e588-e653.
7. Lee HS, Chun KH, Moon D, Hahn Kyu Yeon, Sanghoon Lee, et al. (2015) Trends in receiving chemotherapy for advanced cancer patients at the end of life. BMC Palliat Care 14(4): 1-6.
8. Earle CC, Neville B A, Landrum MB, John Z Ayanian, Susan D Block, et al. (2004) Trends in the aggressiveness of cancer care near the end of life. J Clin Oncol 22(2): 315-321.
9. Kao S, Shafiq J, Vardy J, Adams D (2009) Use of chemotherapy at end of life in oncology patients. Ann Oncol 20(9): 1555-1559.
10. Goncalves JF, Goyanes C (2008) Use of chemotherapy at the end of life in a Portuguese oncology center. Support Care Cancer 16(4): 321-327.
11. Stanley KE (1980) Prognostic factors for survival in patients with inoperable lung cancer. J Natl Cancer Inst 65(1): 25-32.
12. Pater JL, Loeb M (1982) Nonanatomic prognostic factors in carcinoma of the lung: A multivariate analysis. Cancer 50(2): 326-331.
13. Prigerson HG, Bao Y, Shah MA, M Elizabeth Paulk, Thomas W LeBlanc, et al. (2015) Chemotherapy use, performance status, and quality of life at the end of life. JAMA Oncol 1(6): 778-784.
14. Karim SM, Zekri J, Abdelghany E, Dada R, Munsoor H, et al. (2015) Time from last chemotherapy to death and its correlation with the end-of-life care in a referral hospital. Indian J Med Paediatr Oncol 36(1): 55-59.
15. Morden NE, Chang CH, Jacobson JO, Ethan M Berke, Julie P W Bynum, et al. (2012) End-of-life care for Medicare beneficiaries with cancer is highly intensive overall and varies widely. Health Aff 31(4): 786-796.
16. Clarke G, Johnston S, Corrie P, Kuhn I, Barclay S (2014) Diffcult decision-making at the end of life: stopping oral palliative anticancer treatment. A systematic literature review and narrative synthesis. BMJ Support Palliat Care 4(Suppl 1): A27-A28.
17. Glisch C, Saeidzadeh S, Snyders T, Gilbertson White S, Hagiwara Y, et al. (2020) Immune Checkpoint Inhibitor Use Near the End of Life: A Single-Center Retrospective Study. J Palliat Med 23(7): 977-979.
18. Sheng J, Zhang YX, He XB, Fang WF, Yang YP, et al. (2017) Chemotherapy near the end of life for Chinese patients with solid malignancies. Oncologist 22(1): 53-60.

ISSN: 2574-1241

DOI: 10.26717/BJSTR.2024.58.009103

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Submission Link: https://biomedres.us/submit-manuscript.php