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Integration between oncology and palliative care: does one size fit all?

For the very first time, the article of Hui et al. sets up indicators of integration of oncology and palliative care programmes: they consider as ‘major’ indicators of integration the presence of a ‘palliative care inpatient consultation team’ and a ‘palliative care outpatient clinic’ [1].

The authors of the article report data from a previous survey showing how in the United States, among centres which are not designated by the National Cancer Institute—and as such, not specifically working in oncology—only 56% have a ‘palliative care inpatient consultation’ and 22% an ‘outpatient clinic’ [2].

If this is an image of how things work in a country—the United States—with an advanced health care system, may we be entitled to scale the same criteria to most other countries in the world—even if not having the same logistical standards and favourable economical frame?

The real world is not made of big hospitals, with great resources, in rich countries. On the contrary, most cancer patients are followed in small centres, many of which are located in developing countries.

Among the above-mentioned indicators, we miss the presence of ‘community-based palliative care services’, which are important, most of all, in small and/or remote communities, yet the authors say that few panellists work within such settings.

This supports our belief, that these indicators are designed for a ‘rich’ setting, faraway from the real world. Indeed, the same authors state that to meet these integration indicators we need ‘proper funding’, and we know this is not available in most oncology programmes in the world.

That said, we are fully convinced of the value of Hui et al. work, yet we believe that it can be introduced only in advanced health systems with great economical resources.

Besides, we hope for an expert panel determining ‘basic’ criteria for integration of oncology and palliative care; criteria that could help developing sustainable integration programmes, taking into account centres with limited resources and foreseeing a key role for ‘community-based palliative care services’.

For this, it would be necessary to propose goals (e.g. evaluation and treatment of symptoms, continuity of care, non-abandonment at end-of-life, etc.) rather than pre-set models, so that each single centre is able to develop ‘tailored’ programmes to their own resources.

According to our experience, it is possible to build custom-tailored programmes for each single economical, cultural, and geographical situation, bearing in mind that, when we talk about health services, ‘one size does not fit all’ [3, 4].

L. Verna^{1,2}, R. Giusti^{3*}, P. Marchetti³, C. Ficorella¹ & G. Porzio^{1,2}

¹Medical Oncology Unit, University of L’Aquila, L’Aquila;

²Associazione Tumori Toscana, Firenze;

³Medical Oncology Unit, Sant’Andrea Hospital, Rome, Italy

(*E-mail: raffaelegiusti@yahoo.it)

disclosure

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Reply to the letter to the editor ‘Integration between oncology and palliative care: does one size fit all?’ by Verna et al.

We would like to thank Verna et al. [1] for their thoughtful comments regarding our recent *Annals of Oncology* article on the 13 major and 30 minor indicators of integration of oncology and palliative care programs in hospitals with ≥ 100 beds [2]. They commented on the need to have indicators specific for resource-limited settings, and the importance of community-based palliative care programs.

When we first designed this study, we recognized that indicators are highly specific to the health care setting and local resources. Thus, we explicitly asked our panelists to identify indicators of integration for advanced cancer patients in hospitals with ≥ 100 beds [2]. Remarkably, a vast majority of the indicators were supported by our international panelists despite their diverse background representing six continents. The major indicators were endorsed by over 90% of panelists, suggesting that there may be some universal themes of integration beyond nationalities, disciplines and cultures.

The need for integration is independent of resource availability and further studies are needed to examine indicators of integration specific for low-resource settings. In a recent systematic review, we identified several other aspects of integration [3]. For example, the availability of opioid may be an appropriate indicator in low-resource countries, while a comprehensive home palliative

care program may not be possible. On the one hand, integration may be accomplished without a significant investment of resources, such as mandating clinical palliative care rotations for oncology fellows. On the other hand, if the resources are so limited that the basic palliative care infrastructure is lacking, it may be difficult to consider the programs integrated. Ultimately, experts from resource-limited countries need to refine the appropriate indicators for their own settings.

There is also a fine distinction between indicators for integration and indicators for program development. While others have examined indicators for palliative care development [4, 5], our study is the first to focus on assessing the level of integration [2]. Clearly, home-based palliative care programs offer tremendous benefits for patients in the community, and is particularly indispensable in the last few months and weeks of life [6]; however, only approximately half of our experts endorsed that such programs as an indicator of integration [2]. This may be because ‘early’ integration occurs predominantly in the ambulatory setting. Instead of operating such community programs, integration means that hospitals closely coordinate with them.

To rephrase the words of the newly elected Canadian Prime Minister Justin Trudeau, ‘A positive, optimistic, hopeful vision of (integration) isn’t a naïve dream—it can be a powerful force for change’. Our indicators set some important goals towards delivery of integrated cancer care. Although a majority of the major indicators are likely universal across many health care settings (e.g. outpatient clinics, interdisciplinary teams and early referral), some minor indicators need to be tailored to local realities and the unique cultural needs (e.g. prognostic discussions). Moving forward, more research is needed to ‘personalize’ the indicators of integration in different health care settings, to fine tune the thresholds, and to validate them against meaningful patient- and caregiver-related outcomes.

D. Hui^{1*}, S. Bansal¹, F. Strasser², T. Morita³, A. Caraceni⁴, M. Davis⁵, N. Cherny⁶, S. Kaasa⁷, D. Currow⁸, A. Abernethy⁹, C. Nekolaichuk¹⁰ & E. Bruera¹

¹Department of Palliative Care and Rehabilitation Medicine, The University of Texas MD Anderson Cancer Center, Houston, USA;

²Oncological Palliative Medicine, Hematology-Oncology, Cantonal Hospital, St Gallen, Switzerland;

³Department of Palliative and Supportive Care and Seirei Hospice, Seirei Mikatahara General Hospital, Hamamatsu, Japan;

⁴Palliative Care, Pain Therapy and Rehabilitation, Fondazione IRCCS Istituto Nazionale dei Tumori di Milano, Milan, Italy;

⁵Department of Solid Tumor Oncology, Taussig Cancer Institute, Cleveland, USA;

⁶Cancer Pain and Palliative Medicine Service, Department of Medical Oncology, Shaare Zedek Medical Center, Jerusalem, Israel;

⁷European Palliative Care Research Centre, Department of Cancer Research and Molecular Medicine, Norwegian University of Science and Technology and The Cancer Clinic, St Olavs Hospital—Trondheim University Hospital, Trondheim, Norway;

⁸Palliative and Supportive Services, Flinders University, Adelaide, Australia;

⁹Duke Clinical Research Institute, Duke University School of Medicine, Durham, USA;

¹⁰Division of Palliative Care Medicine, Department of Oncology, University of Alberta, Edmonton, Canada

(*E-mail: dhui@mdanderson.org)

disclosure

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Reply to the letter to the editor ‘How much evidence isn’t in evidence-based guidelines?’ by Johnson et al.

We appreciate the detailed and nuanced feedback from acknowledged experts and researchers in the field of the palliation of dyspnea [1].

Regarding the methodological critique: in contrast to clinical guidelines for disease-modifying approaches to cancer, the evidence base for the relief of symptoms is characterized by a multiplicity of observational, phase II data and expert opinion and a relative paucity of phase III data. This does not diminish from the imperative of providing pragmatic guidance based on a synthesis of best evidence, but it does make the process far more challenging and open to conjecture. This point has been emphasized previously by Johnson and Currow when they addressed the issue of ‘Gaps in the knowledgebase regarding the use of opioids in the management of dyspnea’ [2].

Regarding the role of sustained release opioids in the management of dyspnea, we have written ‘Normal-release preparations of oral/rectal opioids may be used for titration, switching to sustained preparation afterwards’ [3] this is entirely consistent with the approach in a recent review authored by Currow et al. [4]. The effectiveness of sustained release morphine preparations has been demonstrated in only one randomized controlled trial in cancer patients [5] and it is not appropriate to over extrapolate data derived from patients with chronic obstructive pulmonary disease (COPD) and chronic dyspnea. Indeed, Mercadante et al. showed that episodic severe breathlessness frequently occurs in patients with advanced cancer (70.9%), and