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The Importance of Being Early

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Editorial

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Editorial

Early integration of oncological treatment, which is directed against the cancer itself, with palliative care, which is oriented to the cancer patient [1] is the antithesis of the common idea that palliative care only concerns the end of life. In a practical way this wrong concept prevents effective communication between oncologist and patients who both cannot feel comfortable with the term 'palliative'. The very evidence of different terminologies between specifically oncological and palliative care journals is clear proof of this, [2] so it is appropriate that knowledge of the benefits of EPC and its interprofessional teamwork be brought to the center of medical doctors [3] and oncologists [4,5] training. The international oncology scientific societies have drawn up guidelines as well as position papers on supportive therapies, management of toxicities due to oncological therapies and on palliative care [6-9]. It turns out that palliative care and above all early intervention of its interprofessional team (Early Palliative Care - EPC) improves tolerance to oncological therapies and provides more adequate supports for symptoms induced by tumor and treatments. Interprofessional palliative care team is also able to participate in prognosis and end-of-life discussions thanks to psychiatrist or psychologist, so the oncologist is not left alone [10] in addressing topics that are the pivotal correct communication doctor - oncological patient.

Palliative care should not be provided only in the end-of-life phase, because early access to would permit a better quality of life from the moment of cancer diagnosis. Several trials have been conducted in order to understand the optimal intervention time for palliative care specialist, however, unequivocal results have not always been achieved [7-10]. Generally, EPC timing is suggested by symptoms reported, however, it would be desirable to identify signs and blood chemistry [11-29] to direct to the EPC schedule. Literature data unquestionably support the need for early intervention [27] rather than on demand [26].

During patient's care pathway, intervention of a multidisciplinary palliative care team lightens the symptomatology due to cancer from the early onset of symptoms [12], especially if palliative care is required without waiting for appearance of severe symptoms [14]. Early multimodal intervention for cancer anorexia/cachexia syndrome is one of the clearest paradigms of the EPC [30]. Interprofessional palliative care embodies that the actors involved can be medical doctors and all the professional roles such as the pharmacist, the dietitian, the chaplain, to achieve positive impact on patients and caregivers well-being, because they represent the holistic approach to patients, even if affected by benign neoplasms [25]. Assessment of quality of life reflects the goal of the EPC: patient not neoplastic disease centrality and pain is not the only target [23] managed by interprofessional palliative care team [21], even if it is the main symptom in advanced cancer.

The EPC takes place thanks to the early identification of the patient's needs thanks to an integrated approach and interprofessional observation. The EPC is implemented through all the professional figures in a palliative care team: there is not only the oncologist, who focuses on the treatment of the cancer itself, but also the anesthesiologist, the surgeon, the nurse up to welfare worker.

Policy makers who direct health expenditure are promoting the EPC since reduction in costs per individual patient is obtained [16,17] in the context of health systems with Universal Health Coverage too. Hui D, et al. [27] have underlined the importance of the three branches of palliative care: outpatient palliative care clinics, inpatient palliative care and community-based palliative care. These three care settings should be simultaneously present and

offered, based on patient clinical conditions and oncological treatment setting. There is no doubt that considerable economic resources are required and only most advanced and wealthy health systems may offer home palliative care. Home care requires an important initial investment, but it lowers health care costs [18] thanks to progressive reduction of doctor visits, hospital admissions and an easier placement in hospices. The EPC often suffers delays, not only due to inadequate training of healthcare personnel, but also following a lack of funds, since economic resources are not always appropriately placed.

When patients notice that their cry for help is heard, they know that healthcare team takes care, they understand that above all they can count on assistance whatever the symptoms. All of this reflects on the family and caregivers too, who do not feel alone in dealing with their loved one's oncological disease and create an alliance with the healthcare personnel. The EPC produces positive effects on patient and caregivers mood and mental health, especially if integrated into home care [1], reducing stress and the level of anxiety in order to better face the oncological therapeutic pathway up to in the end - life. Undertaken from the diagnosis of oncological disease, EPC obtains the greatest improvement in psychophysical well-being and satisfaction with treatments, because patients and the families perceive that they are the objective and the center of the oncological path, consequently demonstrating gratitude [2].

Palliative care does not aim to prolong life, but its goal is prevention, treatment and relief of symptoms due to cancer and anti-cancer treatments, in parallel oncological therapies aim to tumor reduction. One again we have an holistic approach where the center is the patient, not the disease. Anti-cancer immunotherapy and target therapies have shifted the objective towards cancer disease chronicization and melanoma is the most evident paradigm [31-36]. This trend imposes EPC, because cancer is a multidimensional disease and oncological treatments, especially if prolonged, induce short and long-term side effects. Health management policy makers can incentivize EPC thanks to the awareness that palliative care specialists can contribute to overcoming clinical barriers to accessing cancer treatments since earlier disease stage, improving therapy tolerance and managing adverse effects.

EPC goal is achieved through education programs, health resources redistribution to form interprofessional teams for outpatient, inpatient and community-based palliative care.

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