Abstract

The Integrated Approach in Oncology Patients: Care of the Person and Quality of Life

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Introduction. Palliative care aims to improve the quality of life of patients and their families facing problems associated with incurable diseases through the prevention and relief of suffering. It is not limited to the terminal phase of disease and may complement active treatment from the early stages of cancer to manage symptoms throughout the different phases of illness. Early identification of palliative care needs is essential to provide appropriate, continuous, and patient-centred care. In January 2025, the Interdisciplinary Group for Oncology Care (G.I.C.O.) for simultaneous palliative care was established within the Oncology Department of ASL Teramo, promoting the joint provision of oncology and palliative care from the early stages of advanced disease. The organizational pathway includes initial assessment by the oncology team, multidisciplinary discussion, palliative care evaluation, and identification of the most appropriate setting of care, including outpatient, home-based, and hospice services. The aim of this project was to implement a dynamic organizational model, coordinated by the palliative care nurse case manager and supported by a multidisciplinary team, to enable the early integration of oncology and palliative care through appropriate assessment and monitoring tools.

Methods. The project began in January 2025 with the establishment of a multidisciplinary team including referring oncologists, a radiation oncologist, a palliative care specialist, a social worker, a psychologist, nursing coordinators for oncology and the palliative care network, and a nurse case manager responsible for coordinating the group and ensuring continuity of care for patients and families throughout the integrated pathway. Weekly meetings were established to discuss new referrals, patients already receiving simultaneous care, and patients transitioning to exclusive end-of-life care. Three shared operational tools were implemented according to regional guidance: an early palliative care needs reporting form, an early palliative care admission evaluation form, and a simultaneous care monitoring form. These tools included assessment of performance status, pain, symptoms, prognosis, awareness of disease, family and caregiver context, social needs, ongoing treatments, and eligibility for different care settings. Once enrolled in simultaneous care, each patient received an Individualized Care Plan. When appropriate, patients were also included in a telemedicine programme providing televisits, teleassistance, and teleconsultations.

Results. Between January and December 2025, 34 interdisciplinary group meetings were held, including 14 in person at the Oncology Unit and 20 online through the institutional platform. A total

of 61 patients with metastatic cancer were identified as eligible for simultaneous care, while 385 cases were discussed overall. The most prevalent symptoms were pain in 60% of cases, fatigue in 55%, and nausea/vomiting in 37%. Treatment-related complications were generally managed at home; however, 22% of patients reporting grade 3 or 4 symptoms required a short hospital stay.

Discussion. Shared management between oncology and interdisciplinary palliative care teams may positively affect quality of life, symptom management, resource allocation, and continuity of care. Simultaneous care also has the potential to reduce the psychological burden experienced by caregivers and the sense of abandonment associated with advanced disease. Key elements of early and simultaneous palliative care include integration among healthcare professionals, identification of a clearly defined case manager, progressive informed consent, and advance care planning. Within this model, the nurse case manager plays a central role in coordinating professionals, patients, and families throughout a dynamic and progressively adapted care pathway.

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