Cancers gynécologiques et sénologiques

Journée Laurence Leroyer

La « dernière cure » de chimiothérapie

Peut-on la faire?

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Que faire devant un question complexe?

- **Renoncer?**

  incompatible avec le métier d'oncologue qui vise à traiter l'intraitable, essayer de faire accepter l'inacceptable

- **Ne pas traiter le sujet? Et répondre à la question qu'on a envie que l'on nous pose?**

- **Faire fonctionner un réflexe sous-cortical**

  www.pubmed.com

  Last-chemotherapy-end of life-feasibility

- **Appeler un ami?**

- **Ressortir ses vieux cours de philosophie**

  Faire un plan en trois parties….

La notion de pouvoir

Sens 1
Le **pouvoir** est la faculté, la capacité, la possibilité matérielle ou la permission de faire quelque chose.

Sens 2
Le pouvoir désigne la **capacité légale** de faire une chose, d'agir pour un autre dont on a reçu un mandat

Sens 3
Le pouvoir est l'**ascendant**, l'**emprise**, la **domination** qui sont exercés sur une personne ou un groupe d'individus. Il peut être physique, moral ou psychologique. Il permet à un individu ou à un groupe d'appliquer, de faire exécuter ou d'imposer, éventuellement par la force, des décisions dans des domaines très variés

« Dernière cure de chimiothérapie »

Sens 1: Dans un ensemble trié, l'élément qui **arrive après tous les autres**.
Il a fait une toxicité grade IV à la dernière cure

Sens 2: **Ultime,** qui est après tous les autres, ou après lequel il n'y en a pas d'autre.
C'est sa dernière heure, c'est la dernière cure de chimiothérapie que l'on puisse faire

Sens 3: Le plus récent
As-tu vu le dernier livre de Valerie T?

Sens 4: le plus vil, le plus **méprisable**
C'est le dernier des escrocs

Sens 5*:* **Le moins souhaitable**, ce qu'il faut **le plus éviter**
Cette cure de chimiothérapie vue son état, c'était la dernière chose à proposer..

Le dernière cure de chimiothérapie en pratique…

C’est parfois celle que l’imminence du décès nous empêche de continuer.

Le dernière cure

celle que le décès nous empêche de continuer?

Chimiothérapie dans les derniers mois de vie
(en % des patients ayant déjà reçu une chimiothérapie)

	Etude	Localisation	Echantillon de l'étude	Année	3 derniers mois de vie	Dernier mois de vie	15 derniers jours de vie	Remarques
1	Keam B, Oh DY, Lee SH et al. Aggressiveness of cancer-care near the end-of-life in Korea. Jpn J Clin Oncol 2008; 38: 381–386	Lung, gastric, colorectal, biliary pancreatic and other malignancies,	298	2008	49%	18%	5,7%	
2	U. Näppa et al, Palliative chemotherapy during the last month of life; Ann Oncol. 2011 Nov;22(11):2375-80	Gastric, Lung, colorectal, ovarian, breast, other	374	2011	-	23%	-	(>75 years =13%)
3	Martoni AA, Tanneberger S, Mutri V. Cancer chemotherapy near the end of life: the time has come to set guidelines for its appropriate use. Tumori. 2007; 93(5):417–422	Lung, colorectal, breast	793	2007	-	23%	-	12.7% of all patients
4	Andreis F, Chemotherapy use at the end of life. A retrospective single centre experience analysis., Tumori. 2011 Jan-Feb;97(1):30-4.	Breast, Lung, colorectal, gastric, pancreatic	102	2011	50%	16%	6%	Un seul centre
5	Emanuel EJ, Young-Xu Y, Levinsky NG et al. Chemotherapy use among Medicare beneficiaries at the end of life. Ann Intern Med 2003; 138: 639–643.	All locations	?	2003	-	9% of >65 ans	-	
6	M. Frigeri et al , Chemotherapy in patients with advanced pancreatic cancer: too close to death?, Support Care Cancer. 2013 Jan;21(1):157-63	Pancreatic adenocarninoma	231	2013	47%	24%	7%	
7	Braga S et al, The aggressiveness of cancer care in the last three months of life: a retrospective single centre analysis., Psychooncology. 2007 Sep;16(9):863-8.	Breast, Lung, ovarian, pancreatic, colorectal, other	319	2007	66%	37%	21%	Un seul centre

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	Etude	Localisation	Echantillon de l'étude	Année	3 derniers mois de vie	Dernier mois de vie	15 derniers jours de vie	Remarques
8	Hashimoto K et al, Factors that affect the duration of the interval between the completion of palliative chemotherapy and death., Oncologist. 2009 Jul;14(7):752-9	Breast, ovarian	255	2009	47%	12,6%	3,1%	
9	Kristin M. Sheffield et al, End-of-life care in Medicare beneficiaries dying with pancreatic cancer., Cancer. 2011 Nov 1;117(21):5003-12.	Pancreatic malignancy	22 818	2011	-	16.4% (2004 2006)	–	8.1% (1992-1994)
10	O'Brien ME, Mortality within 30 days of chemotherapy: a clinical governance benchmarking issue for oncology patients. Br J Cancer. 2006 Dec 18;95(12):1632-6.	Breast, gastric, lung, other	161	2006	-	8%	-	
11	Earle CC, Neville BA, Landrum MB, Ayanian JZ, Block SD, Weeks JC. Trends in the aggressiveness of cancer care near the end of life. J Clin Oncol. 2004; 22(2):315–321.	Lung, breast, colorectal, gastric	28 777, aged ≥65	2004	-	-	18,5% des patients avec un cancer métastatique	5.7% ont commencé une nouvelle ligne au cours du dernier mois
12	Asola R, Huhtala H, Holli K. Intensity of diagnostic and treatment activities during the end of life of patients with advanced breast cancer. Breast Cancer Res Treat 2006; 100: 77–82	Breast	?	2006	-	19.7%	-	
13	Kao S, Shafiq J, Vardy J, Adams D., Use of chemotherapy at end of life in oncology patients. Ann Oncol. 2009 Sep;20(9):1555-9	Lung, colorectal, breast, pancreatic, prostate, other	747	2009	-	18%	4,2%	
14	Barbera L, Paszat L, Chartier C. Indicators of poor quality end-of-life cancer care in Ontario. *J Palliat Care* 2006; 22: 12–17	All locations	?	2006	-	16%	4,2%	
15	Earle CC, Landrum MB, Souza JM et al. Aggressiveness of cancer care near the end of life: is it a quality-of-care issue? J Clin Oncol 2008; 26: 2860–2866.	Colorectal, Lung, Breast, Prostate, Hematologic	215 484	2008	-	-	11.6%	

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	Etude	Localisation	Echantillon de l'étude	Année	3 derniers mois de vie	Dernier mois de vie	15 derniers jours de vie	Remarques
16	Gonçalves J-F, Goyanes C, Use of chemotherapy at the end of life in a Portugues oncology center, *Support Care Cancer*, 2008, 16:321-327	All locations	1 064	2008	31%	13%	3%	Un seul centre
17	Hu W, Yasui Y, White J, Winget M., Aggressiveness of End-of-Life Care for Patients With Colorectal Cancer in Alberta, Canada: 2006-2009., *J Pain Symptom Manage*. 2013 Jul 16 [Epub]	Colorectal	2074		30,3% (6 derniers mois)	7.4%	3.7%	
18	Harrington SE et al, The Role of Chemotherapy at the End of Life, JAMA. 2008 June 11; 299(22): 2667–2678	-	-	2008	-	-	-	16%

3 à 20% des patients on reçu une cure de chimiothérapie dans les 15 derniers jours

6 à 37% dans le dernier mois de vie

Le dernière cure

celle que le payeur veut bien rembourser?

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Economic burden of cancer across the European Union: a population-based cost analysis

Ramon Luengo-Fernandez, Jose Leal, Alastair Gray, Richard Sullivan

Summary

Background In 2008, 2·45 million people were diagnosed with cancer and 1·23 million died because of cancer in the 27 countries of the European Union (EU). We aimed to estimate the economic burden of cancer in the EU.

Methods In a population-based cost analysis, we evaluated the cost of all cancers and also those associated with breast, colorectal, lung, and prostate cancers. We obtained country-specific aggregate data for morbidity, mortality, and health-care resource use from international and national sources. We estimated health-care costs from expenditure on care in the primary, outpatient, emergency, and inpatient settings, and also drugs. Additionally, we estimated the costs of unpaid care provided by relatives or friends of patients (ie, informal care), lost earnings after premature death, and costs associated with individuals who temporarily or permanently left employment because of illness.

Findings Cancer cost the EU €126 billion in 2009, with health care accounting for €51·0 billion (40%). Across the EU, the health-care costs of cancer were equivalent to €102 per citizen, but varied substantially from €16 per person in Bulgaria to €184 per person in Luxembourg. Productivity losses because of early death cost €42·6 billion and lost working days €9·43 billion. Informal care cost €23·2 billion. Lung cancer had the highest economic cost (€18·8 billion, 15% of overall cancer costs), followed by breast cancer (€15·0 billion, 12%), colorectal cancer (€13·1 billion, 10%), and prostate cancer (€8·43 billion, 7%).

Interpretation Our results show wide differences between countries, the reasons for which need further investigation. These data contribute to public health and policy intelligence, which is required to deliver affordable cancer care systems and inform effective public research funds allocation.

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Health Economics Research Centre, Nuffield Department of Population Health, University of Oxford, Oxford, UK (R Luengo-Fernandez DPhil, J Leal DPhil, Prof A Gray PhD); **and King's Health Partners Cancer Centre and Institute for Cancer Policy, King's College London, London, UK** (Prof R Sullivan MD)

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For more on **cancer in the European Union in 2008** see http://globocan.iarc.fr

Introduction

Cancer is a major public health issue. In 2008 alone, 2·45 million people were diagnosed with cancer in the 27 countries of the European Union (EU). Cancer incidence and mortality has been reduced in developed countries due to several factors including advances in early detection, diagnostic approaches, and cancer treatment, and lifestyle changes and the development of prevention vaccines for some cancers.[1,2] Nonetheless, more than 1·23 million people still died because of cancer in the EU in 2008. About half of all new cancer diagnoses and deaths in this region in 2008 were attributable to just breast, colorectal, lung, and prostate cancers.

Cancer imposes a substantial economic burden on society. Substantial health-care costs are associated with its prevention and management.[3] Moreover, some patients are unable to continue working, and many rely on friends and family for support during treatment or in the last phases of the disease. Therefore, quantification of the economic burden of cancer in the EU needs not only an estimation of the costs of cancer to health-care systems, but also an estimation of the lost earnings associated with the inability to work (due to illness or premature death) and the costs of unpaid care provided by patients' friends and relatives.

The costs of cancer have been assessed in individual countries—eg, Germany,[4] the Netherlands,[5] and England[6]—and across different European countries.[7] However, the whole economic burden of cancer—including direct health care, informal costs, and economic losses to countries because of premature mortality and morbidity—has not been analysed across the EU in a comparative study. The delivery of affordable cancer care systems requires public health and policy intelligence to incorporate a comprehensive estimation of the costs of cancer care.[8] A systematic cost-of-illness study can provide valuable data for the relative socioeconomic burden of different diseases, which can inform an objective public policy framework for the allocation of governmental research funds.[9,10] We aimed to estimate the economic burden of cancer across the 27 countries that made up the EU in 2009, as well as the specific proportions of total cost attributable to breast, colorectal, lung, and prostate cancers.

Methods

Analysis framework and data sources

We evaluated the costs of all cancers in a population-based cost analysis. Cancer is defined here by the WHO International Classification of Diseases, 10th revision, codes C00–97. We estimated costs associated with breast (C50), colorectal (C18–21), lung (C33–34), and prostate (C61) cancers separately.

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The costs of cancer have been assessed in individual countries—eg, Germany,[4] the Netherlands,[5] and England[6]—and across differe However, the whole econor including direct health care, inf losses to countries because of morbidity—has not been ana comparative study. The deliver systems requires public health incorporate a comprehensive cancer care.[8] A systematic cost- valuable data for the relative different diseases, which can i policy framework for the al research funds.[9,10] We aimed burden of cancer across the 27 EU in 2009, as well as the speci attributable to breast, colorectal,

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	Cancer-related health-care costs							Productivity losses		Informal care costs	Total costs	
	Primary care	Outpatient care	Accident and emergency	Inpatient care	Drugs	Total	Percentage of total health-care expenditure	Mortality	Morbidity		Total	Percentage of gross domestic product
Austria	33	53	22	750	343	1202	4%	750	136	550	2638	0·95%
Belgium	34	70	9	550	346	1010	3%	1047	604	553	3214	0·94%
Bulgaria	10	12	2	56	44	124	5%	119	26	31	300	0·86%
Cyprus	<1	1	1	12	22	36	4%	53	5	15	109	0·65%
Czech Republic	29	77	14	284	194	598	5%	446	166	122	1331	0·94%
Denmark	4	55	11	299	205	574	2%	1010	380	277	2241	1·00%
Estonia	8	10	7	27	10	61	6%	61	34	17	172	1·25%
Finland	21	145	20	468	139	804	3%	464	77	166	1511	0·88%
France	114	176	19	3716	3025	7051	3%	4990	2299	2543	16883	0·90%
Germany	710	1689	29	9760	2705	14893	5%	11607	2213	6414	35126	1·48%
Greece	57	126	25	584	453	1244	5%	917	86	348	2596	1·12%
Hungary	26	19	5	121	221	393	5%	416	48	122	980	1·07%
Ireland	32	30	13	417	127	619	4%	603	63	162	1447	0·89%
Italy	487	452	115	4136	1664	6854	5%	3966	143	5491	16454	1·08%
Latvia	5	7	2	34	11	60	5%	88	20	23	191	1·03%
Lithuania	8	8	4	30	9	59	3%	100	40	29	228	0·85%
Luxembourg	4	7	1	53	26	91	3%	57	18	26	191	0·53%
Malta	1	1	<1	6	7	16	4%	12	1	9	38	0·63%
Netherlands	172	250	13	1351	356	2143	3%	2519	706	983	6350	1·11%
Poland	129	368	15	619	267	1399	6%	1306	386	550	3641	1·17%
Portugal	43	65	28	182	247	564	3%	1118	98	268	2048	1·22%
Romania	19	62	2	133	205	421	6%	643	81	112	1257	1·06%
Slovakia	28	71	3	92	112	306	5%	180	88	53	627	1·00%
Slovenia	3	7	5	82	47	145	4%	147	72	42	406	1·14%
Spain	776	340	208	1275	1515	4114	4%	2838	482	1581	9016	0·86%
Sweden	47	244	40	408	233	971	3%	923	478	397	2769	0·95%
UK	153	1072	44	2916	1054	5241	3%	6186	682	2334	14442	0·91%
Total for European Union	2954	5419	659	28357	13604	50994	4%	42565	9431	23216	126205	1·07%

Data are millions of euros, unless otherwise stated. No adjustment for price differentials. Totals do not match sum of costs because of rounding.

Table 1: **Costs of cancer in the European Union in 2009, by country**

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celle que le payeur veut bien rembourser?

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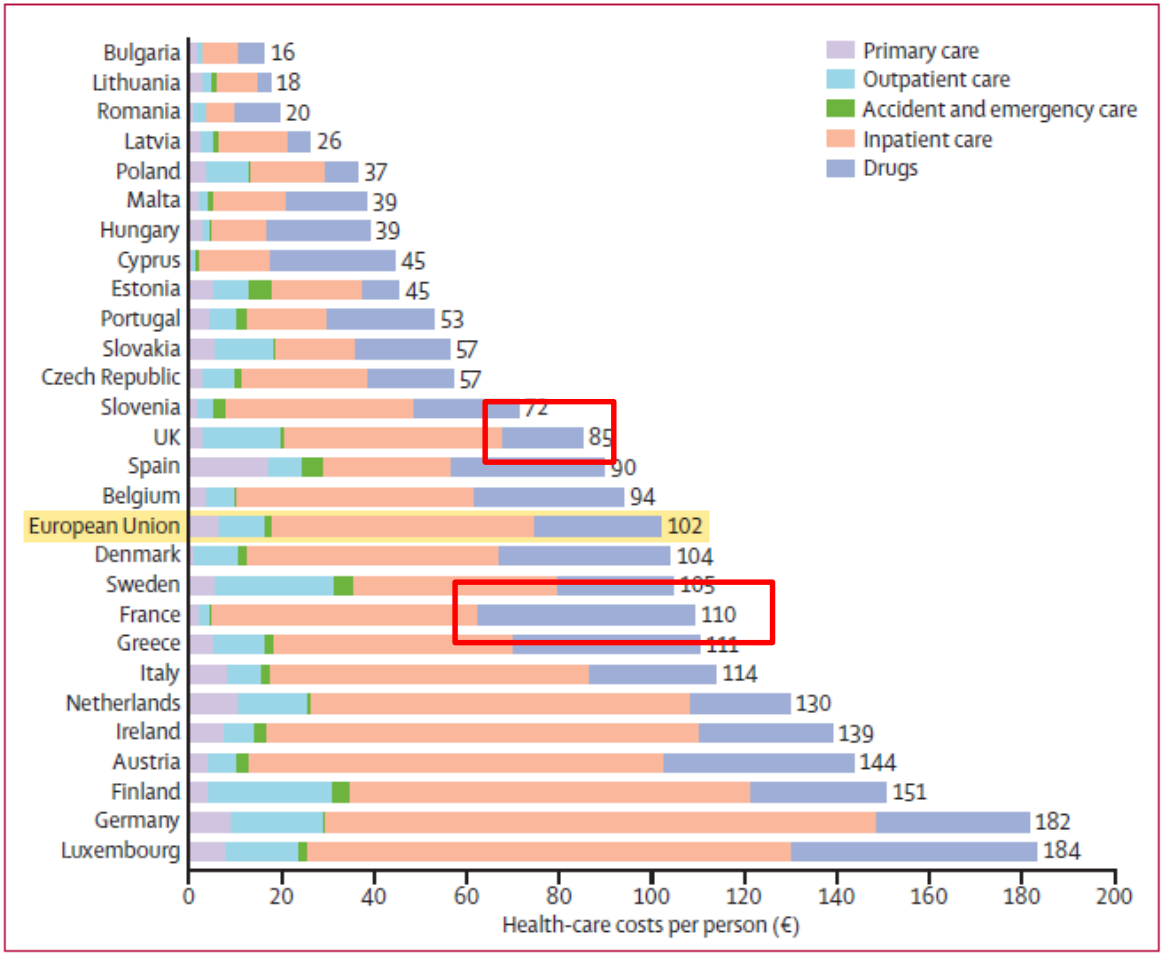

***Figure 1*: Health-care costs of cancer per person in European Union countries in 2009, by health-care service category**

Data not adjusted for price differentials.

Le dernière cure

Un modèle français permissif?

Chaque oncologue français est un Jérôme Kerviel potentiel?

Forte disponibilité des innovations thérapeutiques en France
Avastin ovaire non disponible au Canada

Pas de limite tant que dans le cadre de l'AMM

Aucune limitation du nombre de lignes

Référentiel NICE britanniques

Le dernière cure

Un modèle français permissif?

Jusqu'à quand?

Oui car çà marche!

Les patients réfractaires aux drogues conventionnelles peuvent tirer bénéfice de l'innovation thérapeutique

The Oncologist
Lung Cancer

Outcomes of Patients with Advanced Non-Small Cell Lung Cancer Treated in a Phase I Clinic

FILIP JANKU,[a] APOSTOLIA M. TSIMBERIDOU,[a] XUEMEI WANG,[b] DAVID S. HONG,[a] AUNG NAING,[a] JING GONG,[a] IGNACIO GARRIDO-LAGUNA,[a] HENRIQUE A. PARSONS,[a] RALPH G. ZINNER,[c] RAZELLE KURZROCK[a]

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Key Words. Phase I • Non-small cell lung cancer • Survival

Disclosures: Filip Janku: None; **Apostolia M. Tsimberidou:** None; **Xuemei Wang:** None; **David S. Hong:** None; **Aung Naing:** None; **Jing Gong:** None; **Ignacio Garrido-Laguna:** None; **Henrique A. Parsons:** None; **Ralph G. Zinner:** None; **Razelle Kurzrock:** None.

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ABSTRACT

Background. **The outcomes of patients with advanced non-small cell lung cancer (NSCLC) treated in phase I clinical trials have not been systematically analyzed.**

Methods. **We reviewed the records of consecutive patients with advanced/metastatic NSCLC who were treated in the Phase I Clinical Trials Program at MD Anderson from August 2004 to May 2009.**

Results. **Eighty-five patients (51 men, 34 women) treated on various phase I protocols were identified. The median age was 62 years (range, 30–85). The median number of previous systemic therapies was two (range, 0–5). A partial response was observed in eight patients (9.5%) and stable disease lasting ≥4 months was observed in 16 patients (19%). The median overall survival time was 10.6 months and median progression-free survival (PFS) time was 2.8 months, which was 0.6 months shorter than the median PFS of 3.4 months following prior second-line therapy. Factors predicting longer survival in the univariate analysis were an Eastern Cooperative Oncology Group performance status (PS) score of 0–1, no prior smoking, two or fewer organ systems involved, a hemoglobin level ≥12 g/dL, liver metastases, a history of thromboembolism, and a platelets count > 440 × 10^9/L. In the multivariate analysis, a PS score of 0–1 and history negative for smoking predicted longer survival. Sixty-two (73%) patients had grade ≤2 toxicity, and there were no treatment-related deaths.**

Conclusion. **Phase I clinical trials were well tolerated by selected patients with advanced NSCLC treated at M.D. Anderson. Nonsmokers and patients with a good PS survived longer. PFS in our population was shorter in smokers/ex-smokers and patients with a PS score of 2. It is reasonable to refer pretreated patients with a good PS to phase I clinical trials. *The Oncologist* 2011;16:327–335**

Correspondence: Filip Janku, M.D., Ph.D., Department of Investigational Cancer Therapeutics (Phase I Clinical Trials Program), Unit 455, The University of Texas MD Anderson Cancer Center, 1515 Holcombe Boulevard., Houston, Texas 77030, USA. Telephone: 713-563-2632; Fax: 713-745-8056; e-mail: fjanku@mdanderson.org Received September 9, 2010; accepted for publication January 7, 2011; first published online in *The Oncologist Express* on February 21, 2011. ©AlphaMed Press 1083-7159/2011/$30.00/0 doi: 10.1634/theoncologist.2010-0308

85 patients

9.5% de réponse partielle
19% de maladie stable de plus de 4 mois

Comment faire que la dernière cure ne soit pas imposée par le décès?

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Effect of Early Palliative Care on Chemotherapy Use and End-of-Life Care in Patients With Metastatic Non–Small-Cell Lung Cancer

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See accompanying editorial on page 353

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Authors' disclosures of potential conflicts of interest and author contributions are found at the end of this article.

Clinical Trials repository link available on JCO.org

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A B S T R A C T

Purpose
Prior research shows that introducing palliative care soon after diagnosis for patients with metastatic non–small-cell lung cancer (NSCLC) is associated with improvements in quality of life, mood, and survival. We sought to investigate whether early palliative care also affects the frequency and timing of chemotherapy use and hospice care for these patients.

Patients and Methods
This secondary analysis is based on a randomized controlled trial of 151 patients with newly diagnosed metastatic NSCLC presenting to an outpatient clinic at a tertiary cancer center from June 2006 to July 2009. Participants received either early palliative care integrated with standard oncology care or standard oncology care alone. By 18-month follow-up, 133 participants (88.1%) had died. Outcome measures included: first, number and types of chemotherapy regimens, and second, frequency and timing of chemotherapy administration and hospice referral.

Results
The overall number of chemotherapy regimens did not differ significantly by study group. However, compared with those in the standard care group, participants receiving early palliative care had half the odds of receiving chemotherapy within 60 days of death (odds ratio, 0.47; 95% CI, 0.23 to 0.99; $P = .05$), a longer interval between the last dose of intravenous chemotherapy and death (median, 64.00 days [range, 3 to 406 days] *v* 40.50 days [range, 6 to 287 days]; $P = .02$), and higher enrollment in hospice care for longer than 1 week (60.0% [36 of 60 patients] *v* 33.3% [21 of 63 patients]; $P = .004$).

Conclusion
Although patients with metastatic NSCLC received similar numbers of chemotherapy regimens in the sample, early palliative care optimized the timing of final chemotherapy administration and transition to hospice services, key measures of quality end-of-life care.

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INTRODUCTION

The integration of palliative care early in the course of disease for patients with incurable malignancies has recently gained attention as a feasible and efficacious approach for not only improving quality of life and mood but also possibly extending survival.[1-4] One plausible hypothesis for this survival benefit is that early palliative care enhances the management of adverse effects and complications from treatment, allowing patients to receive more regimens of chemotherapy. Alternatively, in targeting symptoms and assisting with treatment decisions,[5] palliative care may improve the quality of care delivered at the end of life and support health care clinicians and patients discern the optimal timing for transitioning to hospice services. In addition, the integrated model of care may facilitate the cessation of anticancer therapy at the end of life for patients who could suffer adverse outcomes from aggressive treatment.

Although patients, family members, and clinicians have expressed a clear desire for quality end-of-life care that emphasizes pain and symptom management and preparation for dying,[6-10] trends in oncology treatment for those with incurable cancer reveal a markedly different picture of clinical practice. Increasing numbers of patients receive multiple regimens of chemotherapy with ongoing administration near the end of life,[11,12] although the likelihood of response to second-line chemotherapy for malignancies, such as non–small-cell lung cancer (NSCLC), is less than 10%.[13-15] Also, emergency

Essai randomisé
151 patients avec un cancer du poumon

Randomisation
- Soins palliatifs précoce + prise en charge oncologique
- Prises en charge oncologique

Comment faire que la dernière cure ne soit pas imposée par le décès?

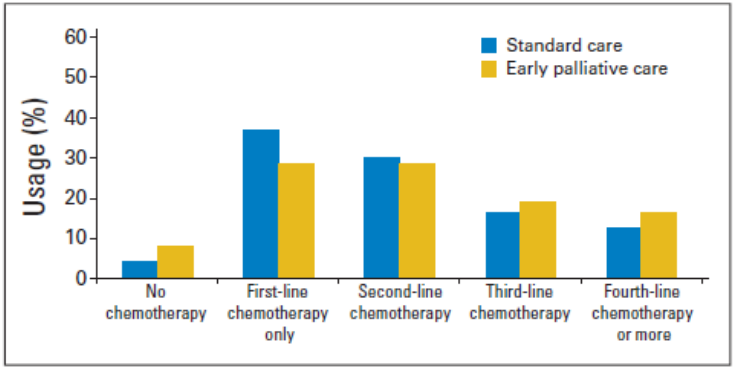

Fig 2. Chemotherapy use between study groups in entire sample (n = 147). Rates of chemotherapy use did not differ significantly between groups for participants who received no chemotherapy (standard care [SC], three of 73 [4.1%] *v* early palliative care [PC], six of 74 [8.1%]; *P* = .49); first line only (SC, 27 of 73 [37.0%] *v* early PC, 21 of 74 [28.4%]; *P* = .30); second line (SC, 22 of 73 [30.1%] *v* early PC, 21 of 74 [28.4%]; *P* = .86); third line (SC, 12 of 73 [16.4%] *v* early PC, 14 of 74 [18.9%]; *P* = .83); and fourth line or more (SC, nine of 73 [12.3%] *v* early PC, 12 of 74 [16.2%]; *P* = .64). Four participants had missing chemotherapy data because they transferred care to other institutions, reducing sample size from 151 to 147.

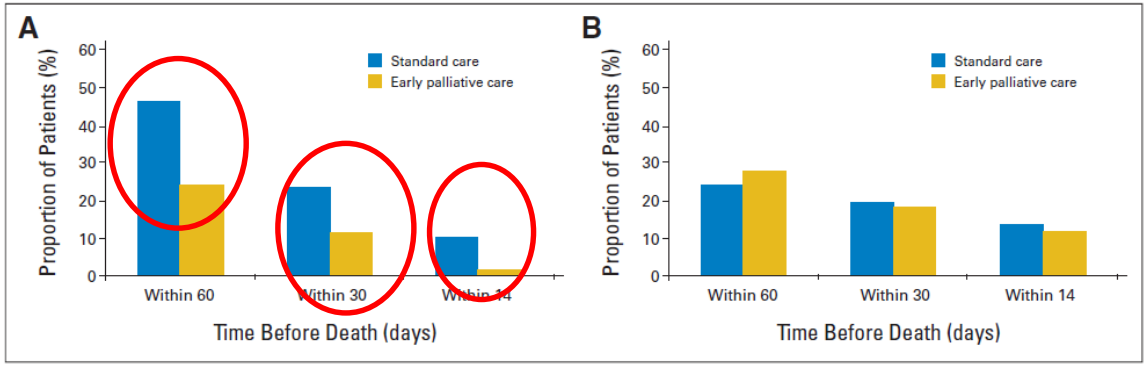

Fig 3. Administration of final regimen of (A) intravenous and (B) oral chemotherapy at end of life (n = 129). Within 60 days of death, a significantly greater percentage of patients were receiving intravenous chemotherapy as final regimen in standard-care (SC) group compared with early palliative care (PC) group (SC, 31 of 67 [46.3%] *v* early PC, 15 of 62 [24.2%]; *P* = .01). Finding remained similar within 30 days (SC, 16 of 67 [23.9%] *v* early PC, seven of 62 [11.3%]; *P* = .07) and 14 days of death (SC, seven of 67 [10.4%] *v* early PC, one of 62 [1.6%]; *P* = .06), although not quite meeting threshold for statistical significance. Percentages of patients receiving oral chemotherapy did not differ significantly between groups within each of three time frames (all *P* values ranging from .67 to > .99).

Mieux estimer le temps à vivre?

Les oncologues sont des gens optimistes

343 médecins 5 établissements médicaux Chicago
468 patients en fin de vie
Médiane survie 24 jours

20% des estimations étaient exactes
63% trop optimistes
17% trop pessimistes

Plus d'expérience = plus de fiabilité
Plus d'investissement affectif = moins de fiabilité

Mieux vaut être désaffectivé… pour prédire le temps jusqu'au décès des ses patients…

Hématologue versus Oncologue…

Perceptions of palliative care among hematologic malignancy specialists: a mixed-methods study.

J Oncol Pract. 2015 Mar;11(2):e230-8.doi10.1200/JOP.2014.001859.

PURPOSE:

Patients with hematologic malignancies are less likely to receive specialist palliative care services than patients with solid tumors. Reasons for this difference are poorly understood.

METHODS:

This was a multisite, mixed-methods study to understand and contrast perceptions of palliative care among hematologic and solid tumor oncologists using surveys assessing referral practices and in-depth semistructured interviews exploring views of palliative care. We compared referral patterns using standard statistical methods. We analyzed qualitative interview data using constant comparative methods to explore reasons for observed differences.

RESULTS:

Among 66 interviewees, 23 oncologists cared exclusively for patients with hematologic malignancies; 43 treated only patients with solid tumors. Seven (30%) of 23 hematologic oncologists reported never referring to palliative care; all solid tumor oncologists had previously referred. In qualitative analyses, most hematologic oncologists viewed palliative care as end-of-life care, whereas most solid tumor oncologists viewed palliative care as a subspecialty that could assist with complex patient cases. Solid tumor oncologists emphasized practical barriers to palliative care referral, such as appointment availability and reimbursement issues. Hematologic oncologists emphasized philosophic concerns about palliative care referrals, including different treatment goals, responsiveness to chemotherapy, and preference for controlling even palliative aspects of patient care.

CONCLUSION:

Most hematologic oncologists view palliative care as end-of-life care, whereas solid tumor oncologists more often view palliative care as a subspecialty for comanaging patients with complex cases. Efforts to integrate palliative care into hematologic malignancy practices will require solutions that address unique barriers to palliative care referral experienced by hematologic malignancy specialists.

Mauvaise qualité des soins selon NCCN

Les mesures connues efficaces sont sous utilisées

Les mesures connues inefficaces sont supra-utilisées

Les décisions dont l'efficacité est équivoque sont mises en œuvre en accord avec le prescripteur plutôt qu'en accord avec les désirs du patients

Le pouvoir médical

"Le pouvoir médical s'apparente à un **pouvoir divin, un pouvoir de vie et de mort.** Celui de sauver le malade, ou pas. Et cela peut être grisant.

On ne fait pas réfléchir le médecin à son rôle et à ses limites ; au contraire, on renforce **son image toute-puissante** par les moyens techniques qu'on lui donne.

Le médecin référent a le pouvoir de décision finale, quelle qu'ait été la force des arguments opposés par les autres, et alors même que son approche peut être biaisée par une charge émotionnelle.

Il faut qu'un circuit de décision collectif s'impose au stade où l'on réfléchit à la poursuite d'un traitement, comme on l'a imposé au stade du diagnostic. Il s'agit non **plus seulement de s'interroger sur les moyens techniques** à mettre en œuvre, mais **de réfléchir à l'éthique et au sens de notre action."**

Pr François Goldwasser

Résumer « l'irrésumable »

Stricto-Sensu réaliser une chimiothérapie jusqu'au bout est faisable, jusqu'à maintenant.

La limitation des ressources va-t-elle nous forcer à aborder cette question sous un angle économique?

Poser la question de la « dernière cure » implique la notion de situation critique, extrême. Intérêt d'en discuter dès le départ de la prise en charge?

Identifier ceux qui vont en bénéficier

- **Pronopal, Palliachim…**

Résumer « l'irrésumable »