國外整合醫療發展與國內早期緩和療護推動的探討

張正雄

彰濱秀傳紀念醫院

Integrative Cancer Care
整合癌症照護

Integrative Cancer Care combines leading edge conventional and evidence-based treatment methods with complementary therapies to improve the chance for recovery of body, mind, and spirit.

整合癌症照護 是結合先進的傳統治療和循證的輔助療法，以提升身心靈的康復機會。

主要目標

- – Reducing side effects of toxic treatments
- – 減少有毒治療的副作用
- – Improving the quality of life of our patients
- – 改善病患的生活品質
- – Prolonging disease-free survival
- – 延長無疾病存活期

全人醫療

The Case for Whole-Person Integrative Care

Jonas,W.B.; Rosenbaum, E.
Medicina **2021**, *57*(7), 677;

https://doi.org/10.3390/medicina57070677

Defining Integrative Oncology

Witt et al *NCI Monograph Nov 2017*

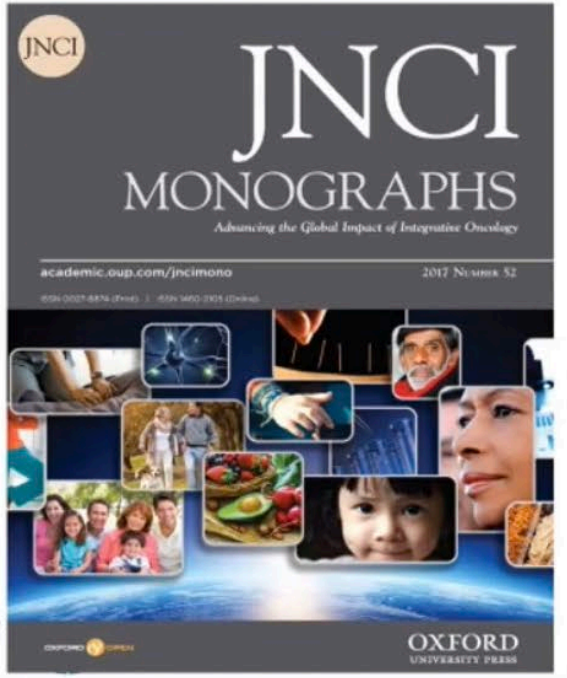
"Integrative oncology is a **patient-centered**, **evidence-informed** field of cancer care that utilizes **mind and body practices, natural products, and/or lifestyle modifications** from different traditions ***alongside*** conventional cancer treatments.

Integrative oncology aims to **optimize health, quality of life, and clinical outcomes**

across the cancer care continuum and to

empower people to **prevent** cancer and **become active participants**

before, during, and beyond cancer treatment."



Dr.Judith Lacey Chris

Approach to implementation of IM in Supportive oncology

Tumour

- Knowledge of the cancer , treatment and expected side effects from therapies enables development of standardised approach

Cancer Treatment

Therapy related side effects eg : immunotherapy, Specific chemotherapeutic agents, radiation, surgery etc

Symptoms

- multimodal and individual IO therapies used to treat specific symptoms

CIM Modality /intervention

eg: exercise, yoga, MBSR, acupuncture, touch therapies, etc

We need to know how to use our toolbox :
The role of the Supportive Care & Integrative Oncology Medical/Holistic Consult

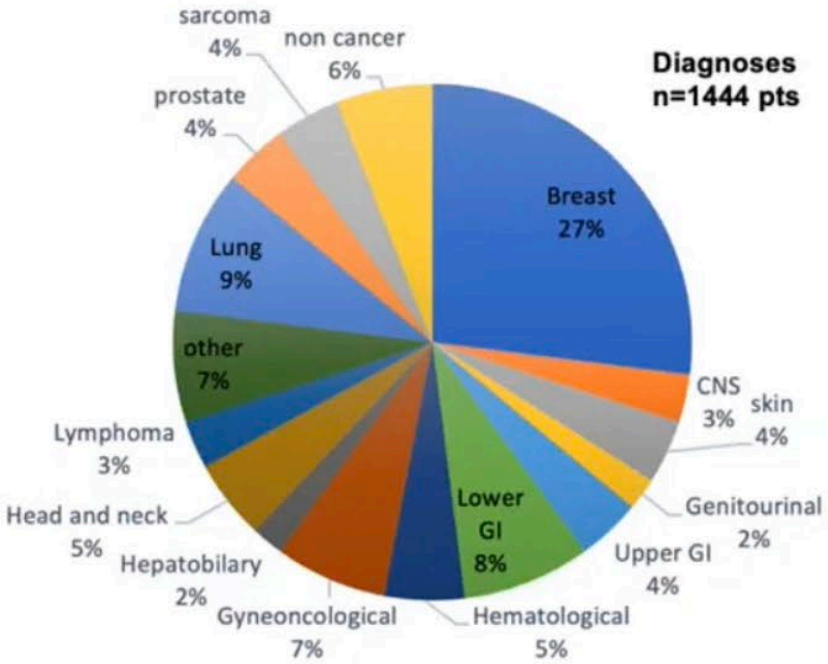
- Comprehensive assessment of current health condition: full symptom review
- Assess potential treatment toxicities& cancer related symptoms.
- Identify and manage reversible symptoms, underlying causes and evaluate and address risk factors
- Unmet needs clinically assessed (guided by PROMS)
- Provides a whole person care approach
- Discusses lifestyle changes, nutrition, exercise, and other therapies that may improve coping and wellbeing.

Work together with a Multidisciplinary team & expanded toolbox

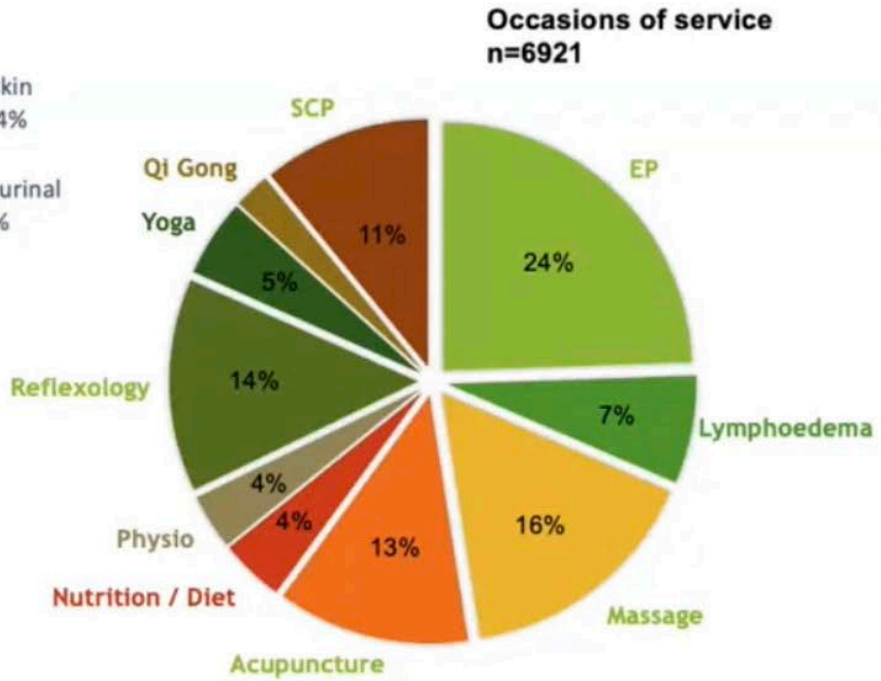
Yoga and yoga therapy	Exercise oncology	Oncology massage
Acupuncture	Reflexology	Qi Gong
Mindfulness, meditation	medicinal cannabis	diet changes, lifestyle changes
Herbs and supplements	Music and Art therapies	health coaching

Reflecting on our own service :Integrative Oncology for treatment induced/related side effects : Lessons learned

Demographic and use of service July 2018-June 2019



Mean age 57 years (SD: 14.9, range 18-103), 68% females



Naehrig, Dhillon …Lacey. Supportive Care Cancer 1-10, 2021

Chris O'Brien Lifehouse

PROMs: Identifying the symptoms: pathways of best evidence informed care

Chris O'Brien Lifehouse

Table 9: Summary of symptoms at all occasions of visit n=404

	All Patients Mean (95% CI)	Symptomatic Patients: Any symptoms N (%)	Symptomatic Patients: Symptom Score Mean (95% CI)	Symptomatic Patients: Moderate or severe symptoms N (%)
Feeling of wellbeing	4.28 (4.07, 4.48)	93% (91, 95)	4.54 (4.37, 4.72)	61% (57, 65)
Sleep	4.39 (4.17, 4.61)	92% (90, 94)	4.72 (4.52, 4.92)	60% (56, 64)
Fatigue	4.54 (4.31, 4.77)	91% (88, 93)	4.98 (4.77, 5.20)	61% (57, 65)
Memory	3.61 (3.38, 3.84)	83% (79, 86)	4.30 (4.09, 4.51)	49% (44, 53)
Appetite	3.46 (3.23, 3.68)	80% (76, 84)	4.23 (4.04, 4.43)	48% (44, 52)
Pain	3.27 (3.04, 3.50)	79% (75, 82)	4.06 (3.84, 4.27)	40% (36, 45)
Sadness	3.28 (2.96, 3.60)	77% (72, 82)	4.23 (3.92, 4.54)	44% (39, 50)
Drowsiness	3.10 (2.87, 3.32)	74% (70, 78)	4.08 (3.87, 4.30)	41% (37, 45)
Distress	3.01 (2.68, 3.35)	72% (67, 78)	4.06 (3.76, 4.36)	40% (34, 46)
Numbness/tingling	3.13 (2.86, 3.40)	70% (66, 74)	4.35 (4.09, 4.61)	41% (37, 45)
Anxiety	2.68 (2.46, 2.90)	69% (65, 73)	3.77 (3.54, 3.99)	34% (30, 38)
Dry mouth	2.76 (2.51, 3.01)	61% (57, 66)	4.32 (4.05, 4.59)	35% (31, 39)
Financial distress	2.54 (2.29, 2.78)	61% (57, 65)	3.98 (3.72, 4.25)	33% (29, 37)
Depression	2.05 (1.86, 2.24)	60% (56, 64)	3.29 (3.08, 3.50)	24% (21, 27)
Shortness of breath	2.11 (1.91, 2.32)	58% (54, 62)	3.47 (3.26, 3.69)	25% (22, 29)

Naehrig, Dhillon ...Lacey. Supportive Care Cancer 1-10, 2

SYMPTOM CLUSTERS

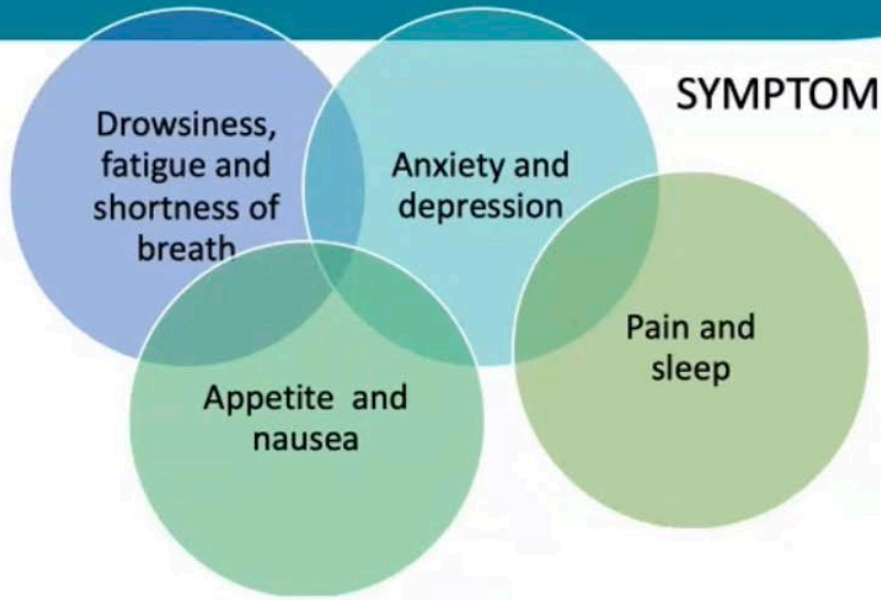
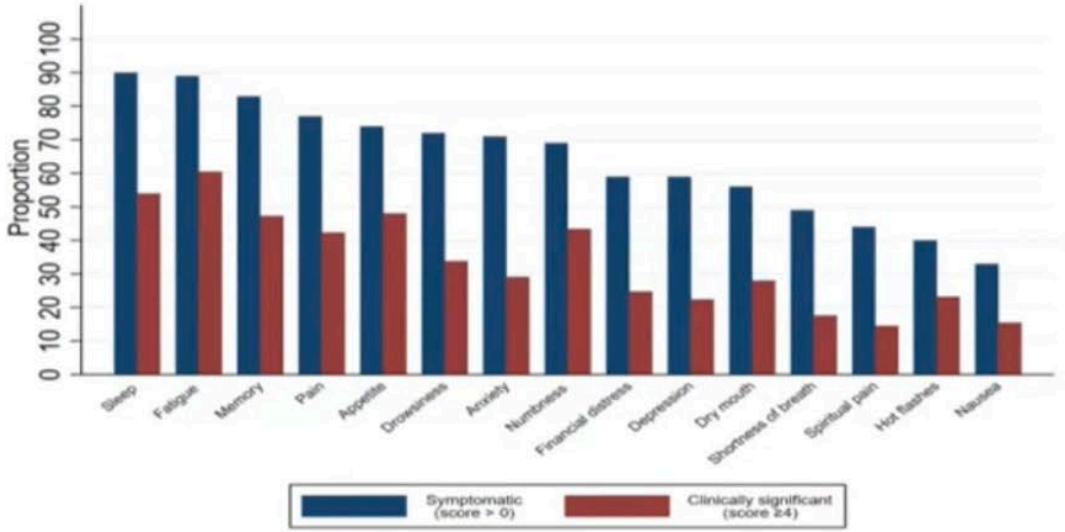


Figure One Comparison of prevalence of ESAS symptoms and severity



CIM/IO therapies commonly offered for Chemo induced /related Symptoms

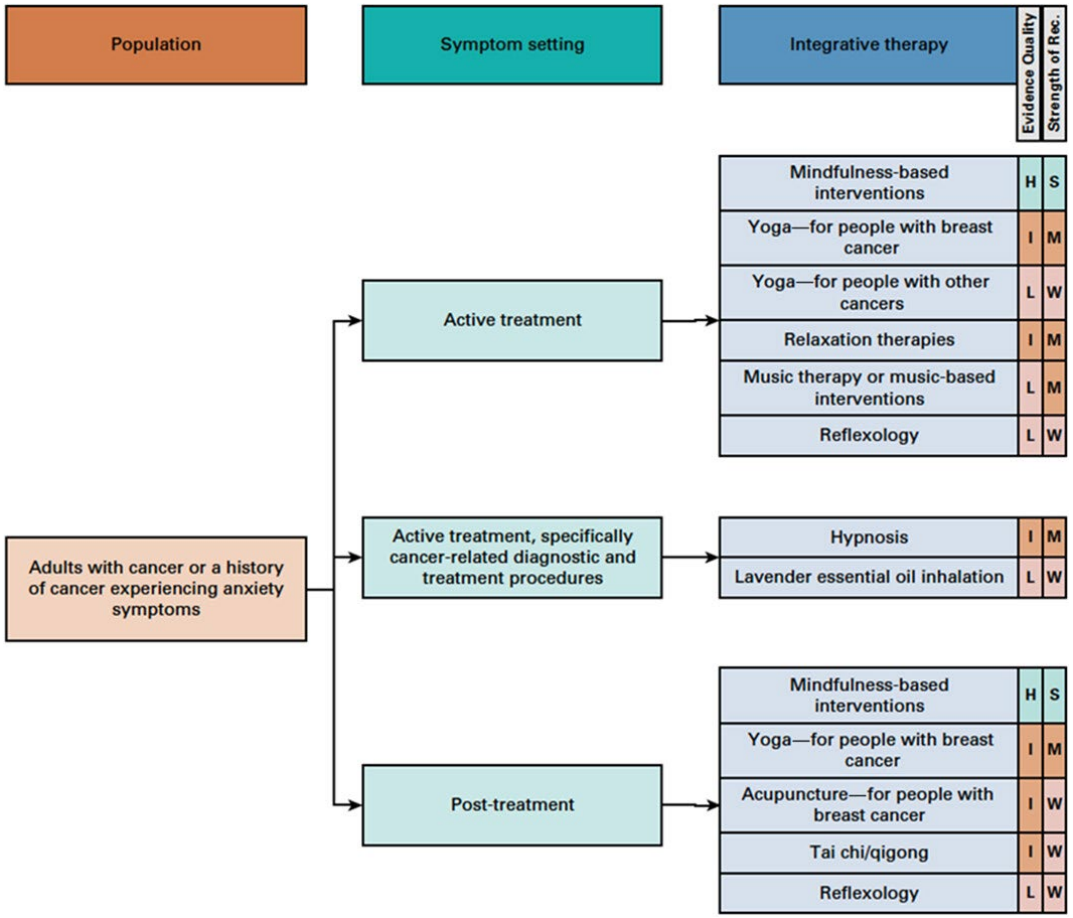
Symptoms commonly experienced	Therapeutic CIM modalities offered after personal assessment and developed care plan
Fatigue	Acupuncture, exercise program onc massage, medical RV, yoga ,qigong
Nausea	Acupuncture, medicinal cannabis, medical RV
Pain	Acupuncture, massage ,Medical, cannabis
Sleep disturbance	Acupuncture, reflexology, onc massage, medical, cannabis , yoga, mindfulness
CIPN	Acupuncture, exercise ,reflexology, medical RV
Dry mouth	Acupuncture, mouthcare
Anxiety	Yoga, massage, reflexology, mindfulness, psychonc, exercise,
Hot Flushes	Acupuncture, Selected herbs, supplements, medical rv
Shortness of Breath	Yoga therapy , mindfulness, exercise ,medical , acupuncture
Arthralgia	Acupuncture, medical, cannabis, exercise, reflexology ,

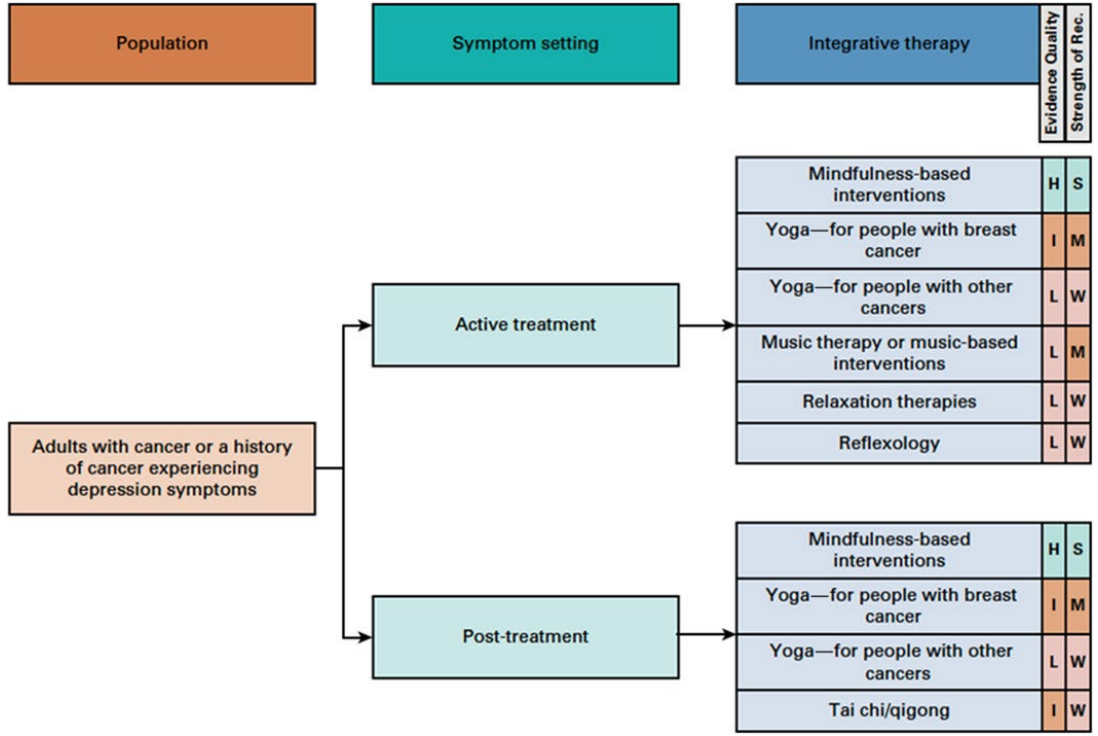
Training and credentialing varies and is important

- Implementing integrative therapies in a clinical setting requires **a coordinated team approach** with **well-trained providers.**
- Best practices suggest that providers be trained to the highest standards

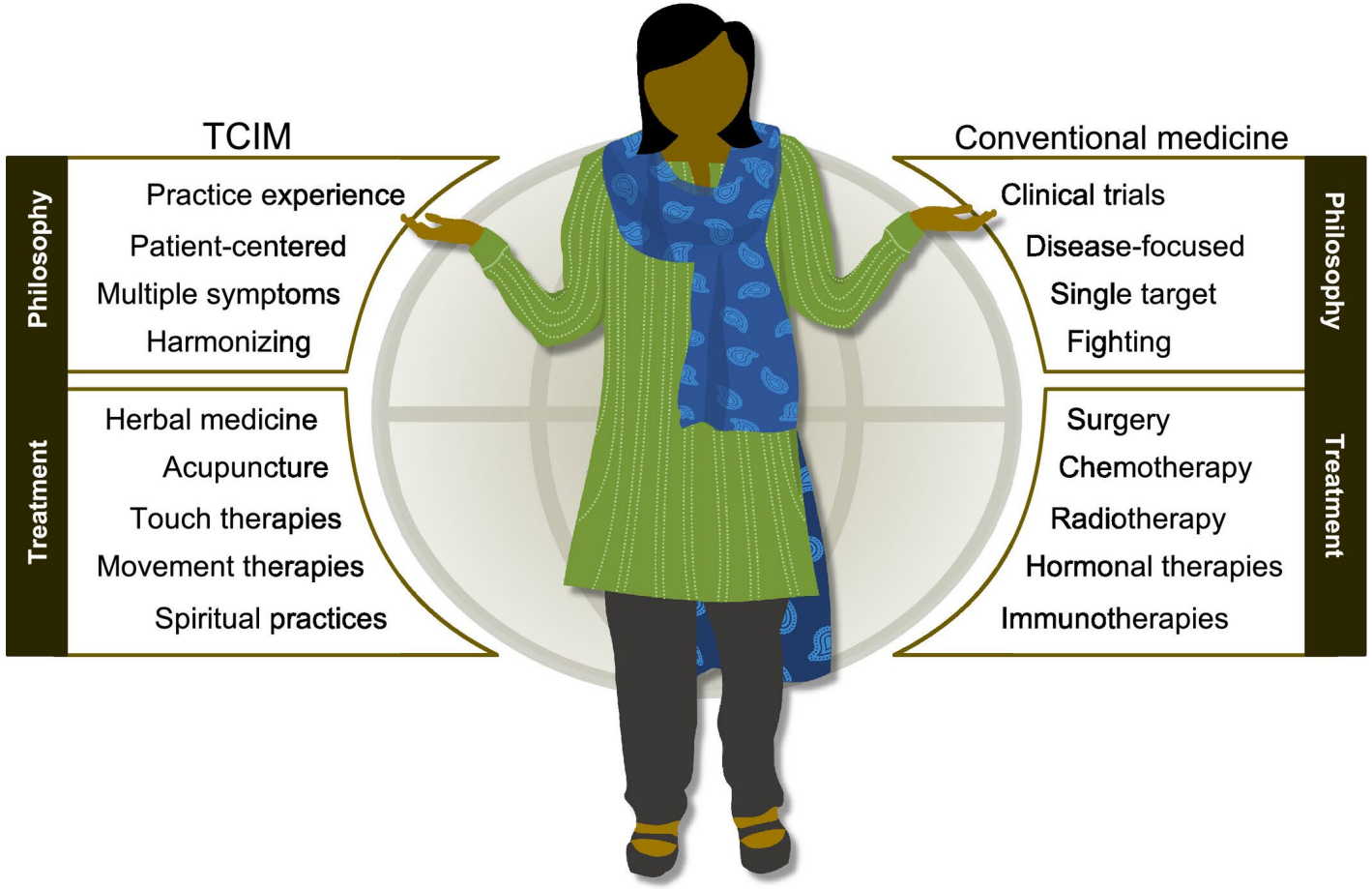
Greenlee et al for SIO , CA CANCER J CLIN 2017;67:194–232

Integrative therapies algorithm for anxiety and depression symptoms
焦慮和憂鬱症狀的整合性治療演繹





Tensions Between Traditional, Complementary, and Integrative Medicine (TCIM) and Conventional Medicine in Low- and Middle-Income Countries
國際上揭示的中西醫療整合需求與障礙



- **CA A Cancer J Clinicians, Volume: 72, Issue: 2, Pages: 144-164, First published: 09 November 2021, DOI: (10.3322/caac.21706)**

- 我們不應該有障礙!
- 但實際上呢?

Evidence

證據在哪裡?

Evidence for Better Health Outcomes

Evidence for Improved Patient Satisfaction

Evidence for Lower Cost

Evidence for Improved Clinician Experience

Jonas,W.B.; Rosenbaum, E. *Medicina* **2021**, *57*(7), 677; https://doi.org/10.3390/medicina57070677

Research Article

Feasibility of Aerobic Exercise and Tai-Chi Interventions in Advanced Lung Cancer Patients: A Randomized Controlled Trial

Integrative Cancer Therapies
Volume 20: 1–12

DOI: 10.1177/15347354211033352
journals.sagepub.com/home/ict
SAGE

Denise Shuk Ting Cheung, PhD[1], Naomi Takemura, BN[1], Tai Chung Lam, MBBS[1,2], James Chung Man Ho, MD[1], Wen Deng, PhD[1], Robert Smith, PhD[1], Yinxia Yan, PhD[1], Anne Wing Mui Lee, MD[1,2], and Chia Chin Lin, PhD, FAAN[1,3,4]

Research Article

Use of Complementary Traditional Chinese Medicines by Adult Cancer Patients in Taiwan: A Nationwide Population-Based Study

Integrative Ca
2018, Vol. 17(
DOI: 10.1177/
journals.sagepu

Yi-Ting Kuo, MD[1,2*], Tung-Ti Chang, MD, PhD[1,3*], Chih-Hsin Muo, MS[4], Mei-Yao Wu, MD, PhD[3], Mao-Feng Sun, MD, PhD[1,3], Chia-Chou Yeh, MD, PhD[2,5], and Hung-Rong Yen, MD, PhD[1,3,6]

Table 1. Demographic Characteristics of Taiwanese Adults Diagnosed With Cancer From 2001 to 2009 Who Used and Did Not Use Traditional Chinese Medicine (TCM).

Variable	No TCM (n = 508 179), n (%)	TCM (n = 74 620), n (%)	*P*	Odds Ratio (95% CI)
Age at baseline, y, mean (SD)[a]	62.5 (15.1)	55.5 (13.5)	<.0001	
18-39	39 075 (7.7)	9183 (12.3)		2.26 (2.19-2.34)
40-59	175 280 (34.5)	37 888 (50.8)		2.07 (2.03-2.12)
≥60	293 824 (57.8)	27 549 (36.9)		Reference
Sex			<.0001	
Female	218 582 (43.0)	39 440 (52.9)		1.59 (1.56-1.62)
Male	289 597 (57.0)	35 180 (47.1)		Reference
Urbanization			<.0001	
1 (highest)	136 340 (26.8)	21 524 (28.8)		1.13 (1.10-1.16)
2	146 522 (28.8)	23 377 (31.3)		1.16 (1.13-1.19)
3	83 102 (16.4)	12 053 (16.2)		1.06 (1.02-1.09)
4 (lowest)	142 206 (28.0)	17 665 (23.7)		Reference
Occupation			<.0001	
White-collar[b]	66 934 (19.2)	15 879 (30.0)		1.37 (1.33-1.40)
Blue-collar[c]	174 617 (50.2)	24 610 (46.4)		1.05 (1.02-1.07)
Others[d]	106 366 (30.6)	12 501 (23.6)		Reference

Table 6. The Distribution of Clinical Conditions of Traditional Chinese Medicine Users.

Disease (ICD-9-CM)	Visited TCM Clinics 9 or Fewer Times per Year (n = 49900), n (%)	Visited TCM Clinics More Than 9 Times per Year (n = 24720), n (%)	χ^2 *P* Value
Pain (338, 338.0-338.4, 716, 716.9, 724.1-724.5, 729.5, 784.0, 784.1, 786.5, 789.0, and 789.6)	34514 (69.2)	18786 (76.0)	<.0001
Nausea, vomiting, dyspepsia, gastritis, and abdominal pain (787.0, 536.2, 536.8, 535, 789.0, and 787.9)	31782 (63.7)	17171 (69.5)	<.0001
Insomnia (780.5 and 307.4)	21675 (43.4)	132426 (54.3)	<.0001
Dizziness and headache (780.4 and 784.0)	22032 (44.2)	12944 (52.4)	<.0001
Myositis and myalgia (729.1 and 729.4)	17401 (34.9)	10590 (42.8)	<.0001
Constipation (564.0, 564.00-564.02, and 564.09)	15449 (31.0)	8237 (33.3)	<.0001
Anxiety and depression (300, 311, and 309)	14001 (28.1)	8025 (32.5)	<.0001
Hot flashes (627.2, 627.3, and 782.62)	5322 (10.7)	3701 (15.0)	<.0001
Malaise and fatigue (780.7)	6337 (12.7)	3454 (14.0)	<.0001
Diarrhea (787.91)	1848 (3.70)	1203 (4.87)	<.0001
Lymphedema (457.0, 457.1, 457.2, 457.8, 624.8, 729.81, and 757.0)	987 (1.98)	826 (3.34)	<.0001
Weight loss (783.21, and 799.4)	1558 (3.12)	685 (2.77)	.008
Xerostomia (527, 527.0, and 527.7)	405 (0.81)	290 (1.17)	<.0001
Dyspnea (786.0)	4892 (9.80)	2482 (10.0)	.31

Table 8. Hazard Ratios (HRs) and 95% Confidence Intervals of the Association Between Traditional Chinese Medicine (TCM) Usage and Mortality in Adult Cancer Patients.

	Deaths	Mortality	Crude HR (95% CI)	Adjusted[a] HR (95% CI)
No TCM	273 887	16.68	1.00	1.00
TCM	32 851	10.20	0.65 (0.64-0.66)[b]	0.69 (0.68-0.70)[b]

[a]Adjusted for age, sex, level of urbanization, occupation, annual medical center visits, and annual non–medical center visits.
[b]$P < .0001$ for crude and adjusted HRs.

REVIEW Open Access

Acupuncture for cancer pain: an evidence-based clinical practice guideline

Long Ge[1,2,3,4†], Qi Wang[1,2†], Yihan He[5,6,7†], Darong Wu[5,6,7†], Qi Zhou[8†], Nenggui Xu[9†], Kehu Yang[2,3,4,10†], Yaolong Chen[3,4,8,10†], Anthony Lin Zhang[11†], Haiqing Hua[12†], Jinchang Huang[13†], Ka-Kit Hui[14†], Fanrong Liang[15†], Linpeng Wang[16†], Bin Xu[17†], Yufei Yang[18†], Weimin Zhang[19†], Baixiao Zhao[20†], Bing Zhu[21†], Xinfeng Guo[5,6,7*], Charlie Changli Xue[5,6,7,11*] and Haibo Zhang[5,6,7*] on behalf of International Trustworthy traditional Chinese Medicine Recommendations (TCM Recs) Working Group

Abstract

Background: This study aims to develop an evidence-based clinical practice guideline of acupuncture in the treatment of patients with moderate and severe cancer pain.

Methods: The development of this guideline was triggered by a systematic review published in *JAMA Oncology in 2020*. We searched databases and websites for evidence on patient preferences and values, and other resources of using acupuncture for treatment of cancer pain. Recommendations were developed through a *Delphi* consensus of an international multidisciplinary panel including 13 western medicine oncologists, Chinese medicine/acupuncture clinical practitioners, and two patient representatives. The certainty of evidence, patient preferences and values, resources, and other factors were fully considered in formulating the recommendations. The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach was employed to rate the certainty of evidence and the strength of recommendations.

Results: The guideline proposed three recommendations: (1) a strong recommendation for the treatment of acupuncture rather than no treatment to relieve pain in patients with moderate to severe cancer pain; (2) a weak recommendation for the combination treatments with acupuncture/acupressure to reduce pain intensity, decrease the opioid dose, and alleviate opioid-related side effects in moderate to severe cancer pain patients who are using analgesics; and (3) a strong recommendation for acupuncture in breast cancer patients to relieve their aromatase inhibitor-induced arthralgia.

ASCO special articles

Integrative Medicine for Pain Management in Oncology: Society for Integrative Oncology–ASCO Guideline

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abstract

PURPOSE The aim of this joint guideline is to provide evidence-based recommendations to practicing physicians and other health care providers on integrative approaches to managing pain in patients with cancer.

METHODS The Society for Integrative Oncology and ASCO convened an expert panel of integrative oncology, medical oncology, radiation oncology, surgical oncology, palliative oncology, social sciences, mind-body medicine, nursing, and patient advocacy representatives. The literature search included systematic reviews, meta-analyses, and randomized controlled trials published from 1990 through 2021. Outcomes of interest included pain intensity, symptom relief, and adverse events. Expert panel members used this evidence and informal consensus to develop evidence-based guideline recommendations.

RESULTS The literature search identified 227 relevant studies to inform the evidence base for this guideline.

RECOMMENDATIONS Among adult patients, acupuncture should be recommended for aromatase inhibitor–related joint pain. Acupuncture or reflexology or acupressure may be recommended for general cancer pain or musculoskeletal pain. Hypnosis may be recommended to patients who experience procedural pain. Massage may be recommended to patients experiencing pain during palliative or hospice care. These recommendations are based on an intermediate level of evidence, benefit outweighing risk, and with moderate strength of recommendation. The quality of evidence for other mind-body interventions or natural products for pain is either low or inconclusive. There is insufficient or inconclusive evidence to make recommendations for pediatric patients. More research is needed to better characterize the role of integrative medicine interventions in the care of patients with cancer.

Additional information is available at https://integrativeonc.org/practice-guidelines/guidelines and www.asco.org/survivorship-guidelines.

J Clin Oncol 00. © 2022 by American Society of Clinical Oncology

ASSOCIATED CONTENT

Appendix

Data Supplement

Author affiliations and support information (if applicable) appear at the end of this article.

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Society for Integrative Oncology Clinical Practice Guidelines Committee approval: May 6, 2022.

ASCO Evidence Based Medicine Committee approval: May 20, 2022.

INTRODUCTION

Pain is one of the most common, disabling, and feared symptoms experienced by patients diagnosed with cancer.[1,2] Among patients with advanced cancer, pain can be a result of tumor burden or invasion of bones, muscles, or nerves. In addition, many conventional cancer treatments such as surgery, chemotherapy, radiotherapy, immunotherapy, or hormonal therapy can result in both acute and chronic pain conditions such as aromatase inhibitor (AI)–induced joint pain or chemotherapy-induced peripheral neuropathy (CIPN) pain.[3,4] With improved oncologic treatment, many patients diagnosed with advanced cancer now live longer with symptomatic illness and ongoing oncologic treatment. Additionally, increasing numbers of patients experience remission and join the 16.9 million cancer survivors in the United States alone.[5] Many survivors, however, continue to experience chronic pain resulting from their cancer treatment that not only negatively affects their quality of life, but also their daily functions.[6] Chronic pain may also lead to nonadherence to oncologic treatment such as hormonal therapies,[7,8] thus, potentially compromising overall survival. Therefore, effective pain management is of critical importance throughout the cancer care trajectory.

As pain in patients and survivors of cancer is complex with different etiologies (eg, tumor burden, treatment-related, and non–cancer-related) and varying presentations (eg, neuropathic and musculoskeletal) and duration (eg, acute and chronic), pain

腫瘤疼痛照護的整合醫學：腫瘤整合學會-ASCO 指南

Integrative Medicine for Pain
Management in Oncology: Society for Integrative Oncology–ASCO Guideline

目的

本聯合指南是關於控制癌症患者疼痛的整合方法，目的是為執業醫師以及其他醫療保健治療者提供實證醫學上的建議。

方法

腫瘤整合學會和 ASCO 召集整合腫瘤專家小組，包含內科腫瘤科、放射腫瘤科、外科腫瘤科、緩和治療科、社會科學、身心醫學、護理和病患權益代表者。文獻檢索包括從 1990 年到 2021 年發表的系統性回顧、統合分析和隨機對照試驗。結果包括疼痛強度、症狀緩解和副作用。專家小組依據這些證據以及共識，制定有實證醫學的指南建議。

結果

文獻檢索認證了 227 項相關研究，為本指南提供證據基礎

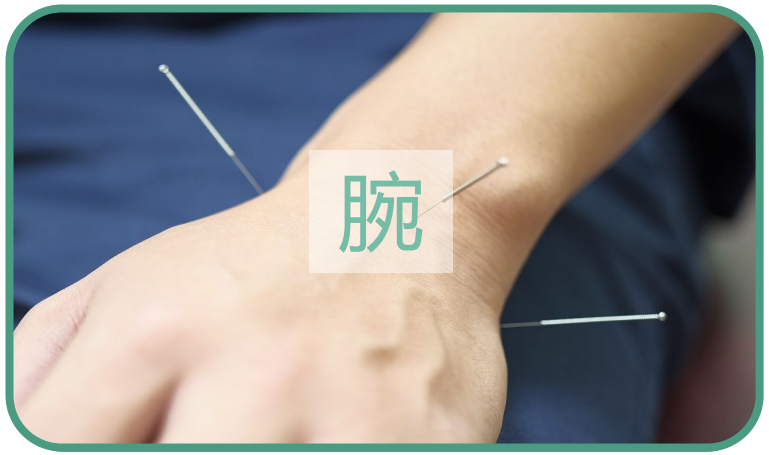
建議

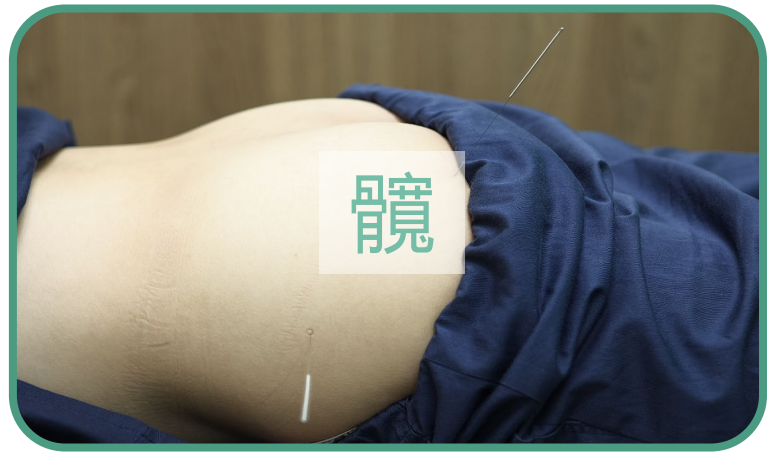
1. 針灸應（should be）被推薦給乳癌患者治療 AI 引起的關節疼痛。
2. 針灸、反射區療法、穴位按摩可（may be）推薦用於一般癌症疼痛和肌肉骨骼疼痛。
3. 催眠可（may be）推薦用於經歷術後疼痛的患者。
4. 按摩可（may be）推薦接受緩和安寧治療的患者。

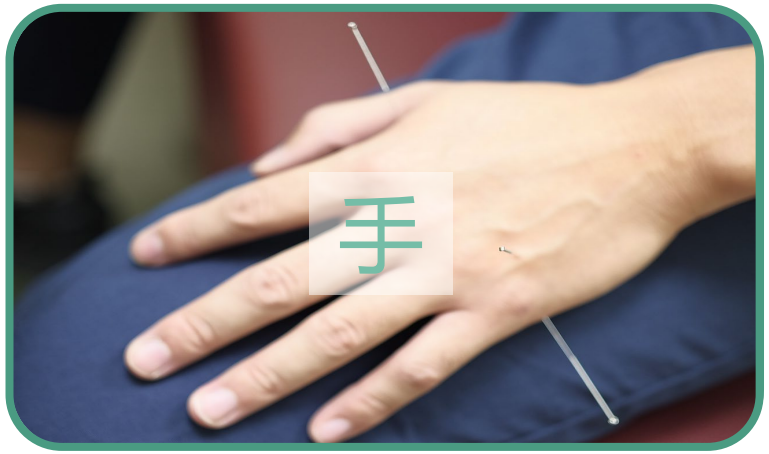
以上建議證據等級為中等，利益大於風險，推薦強度中等。

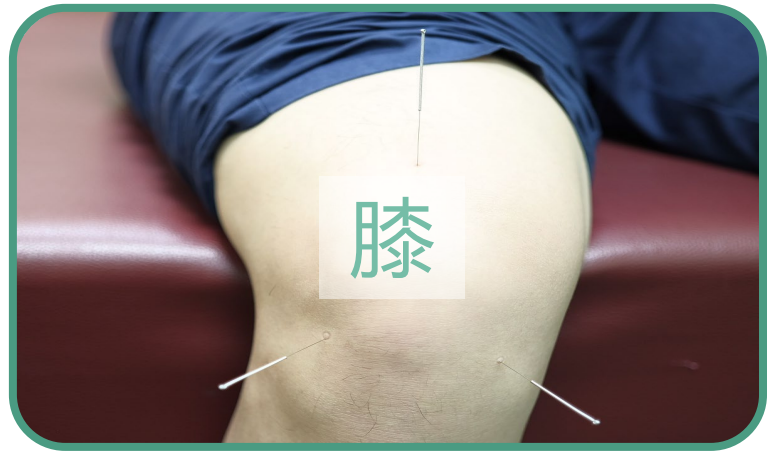
其他身心治療或天然產品治療疼痛的證據質量低或不確定。沒有足夠的證據來為兒科患者提出建議。需要更多的研究來定位整合醫學在腫瘤患者照護中的角色。

薬物引起關節痛









Hindawi
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Review Article

Efficacy and Safety of Acupuncture against Chemotherapy-Induced Peripheral Neuropathy: A Systematic Review and Meta-Analysis

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19個隨機對照試驗進行全面文獻搜索和分析，涵蓋了1174名患者。結果顯示，與藥物和假針灸相比，針灸顯著改善化療誘發導致周邊神經病變。

手足症候群專用紅玉膏

大黃

黃芩

黃連

黃柏

清血熱祛瘀阻，養血生肌斂瘡

紫草

牡丹皮

血竭

當歸

漢方九九重陽足浴包

黃耆

雞血藤

紅花

仙鶴草

小茴香

溫腎壯陽氣，通絡祛瘀阻

延胡索

乾薑

巴戟天

肉桂

OPEN ACCESS

Association between physical activity and the time course of cancer recurrence in stage III colon cancer

Justin C Brown ,[1] Chao Ma,[2] Qian Shi,[3] Donna Niedzwiecki,[4] Tyler Zemla,[3] Felix Couture,[5] Philip Kuebler,[6] Pankaj Kumar,[7] Judith O Hopkins,[8] Benjamin Tan,[9] Smitha Krishnamurthi,[10] Eileen M O'Reilly ,[11] Anthony F Shields,[12] Jeffrey A Meyerhardt[2]

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bjsports-2022-106445).

For numbered affiliations see end of article.

ABSTRACT

Objective We determined if postoperative physical activity prevents or delays cancer recurrence in patients with stage III colon cancer.

Methods This cohort study nested within a randomised trial enrolled 1696 patients with surgically resected stage III colon cancer. Physical activity was calculated based on self-reporting during and after chemotherapy.

WHAT IS ALREADY KNOWN ON THIS TOPIC?

⇒ Physical activity after surgical resection for stage III colon cancer is associated with significantly longer disease-free survival.

⇒ Physical activity may confer a disease-free survival benefit by preventing or merely delaying the time of cancer recurrence.


開會
運動
研討
講座
極美 多功能會議空間

癌症患者中醫門診延長照護計畫

1. 術後或接受化學治療、放射線治療過程中副作用明顯之癌症患者，依據CTCAE評估表，至少兩項症狀程度為grade 2以上者。
2. 正在接受其他抗癌治療且出現嚴重副作用或後遺症，經醫師評估須延長照護之癌症患者，依據CTCAE評估表，至少兩項症狀程度為 grade 2以上者。

第一階段開始：112.07.31-09.22

時間	治療服務項目（依據個人所需而定）
08:00-08:30	報到
08:30-09:00	運動前診察與準備
09:00-11:00	週一太極/週三瑜珈/週五氣功
11:00-12:00	醫師診察/針灸傷科治療
12:00-13:30	午間休息 用膳與午休
13:30-14:00	營養與食療指導/護理照護技巧與護理指導/藥物與藥膳諮詢 情緒舒壓技巧/醫師衛教課程 (營養、護理、個管、心理、醫師指引)
14:00-16:00	醫師診察/針灸傷科治療


週一太極


週三瑜珈


週五氣功

秀傳癌醫中心

癌症運動訓練班

太極、瑜珈、氣功

2023年07月31日~09月22日

對象：中部地區癌友(每班15名)

地點：秀傳癌醫中心7樓

報名：04-7117466#66611

太極拳

7/31~9/18每周一上午9:00-11:00

瑜珈

8/2~9/20每周三上午9:00-11:00

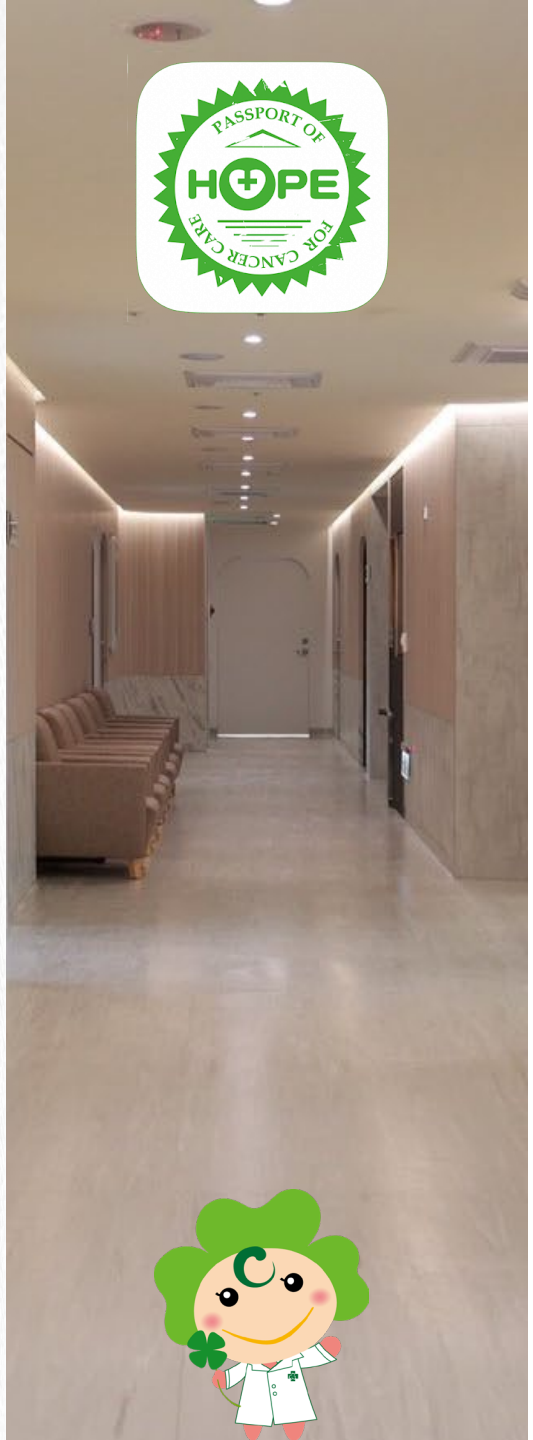
氣功

8/4~9/22每周五上午9:00-11:00

報名注意事項：

1. 為確保服務品質，活動採報名制，前一個月開放報名，名額限15位病人。
2. 癌友需繳交保證金1,000元，請評估身體或治療的狀況報名課程，如需請假或無故缺席達課程三分之一者(3堂)，則保證金將代捐給台灣癌症全人關懷基金會。
3. 每項課程報名達7名以上即開班。
4. 報名錄取依本院受理報名順序為主，報名結果及開班訊息以電話通知。

主辦：彰化秀傳紀念醫院癌症資源中心 暨 台灣癌症全人關懷基金會



秀傳整合醫療中心

Show Chwan Integrative Medicine and Wellness Center

癌醫中心七樓

提供腫瘤患者整合服務

中醫

中藥調理、針灸治療神經病變麻木
無痛雷射針灸、靜脈雷射補充體能
藥膏、足浴、太極、氣功、瑜珈等

營養

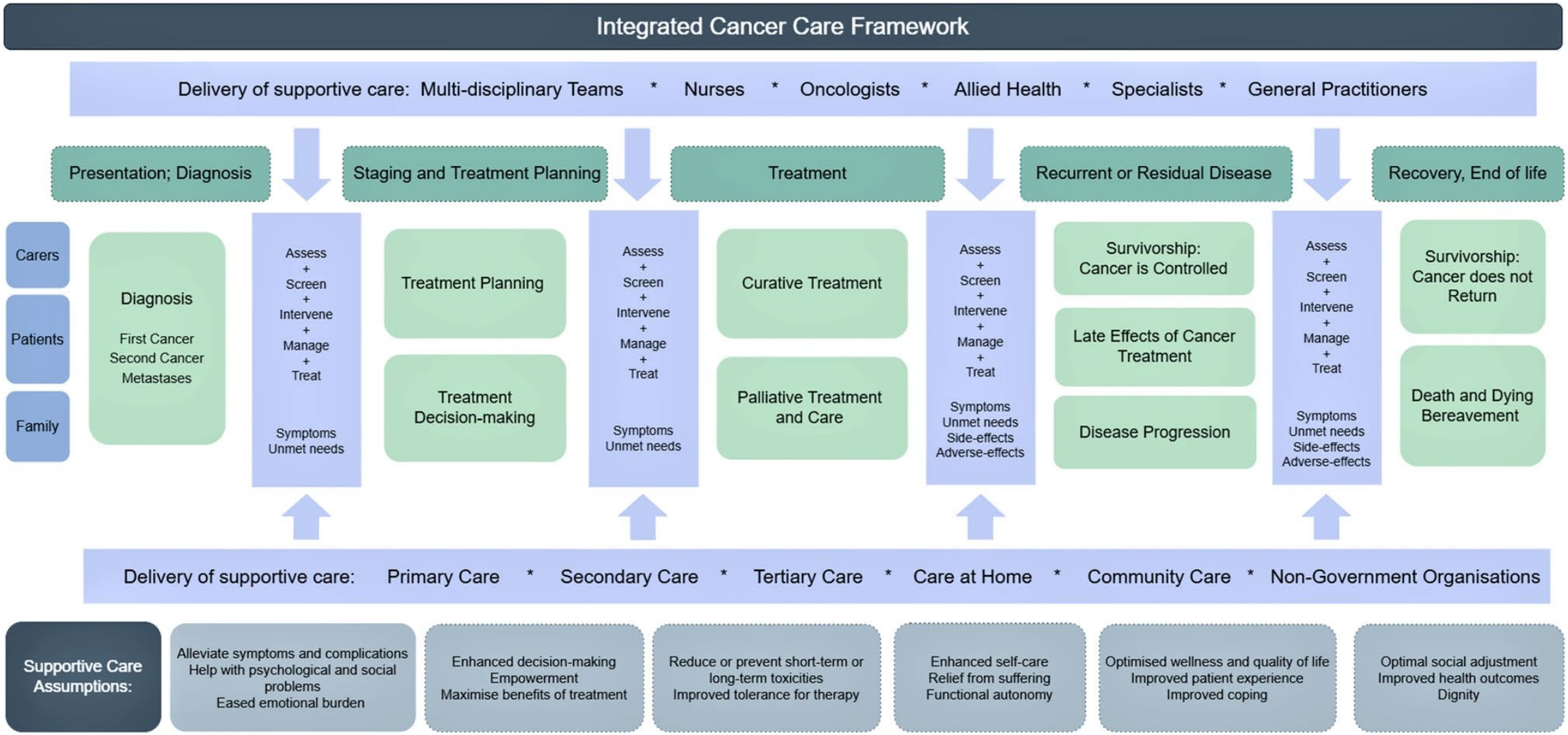
個人化癌症飲食指南、解答各類癌症飲食問題、營養補給建議等

心理

專業心理諮商、心理支持、心理放鬆技巧等
透過專業談話提升生活品質，有助於增加罹癌後心理適應能力

復健

因癌所致肢體淋巴水腫、癌後軟組織沾黏、活動度受限、運動建議等


Integrated Cancer Care Framework
Delivery of supportive care: Multi-disciplinary Teams * Nurses * Oncologists * Allied Health * Specialists * General Practitioners
Presentation; Diagnosis
Staging and Treatment Planning
Treatment
Recurrent or Residual Disease
Recovery, End of life
Carers
Patients
Family
Diagnosis
First Cancer
Second Cancer
Metastases
Assess + Screen + Intervene + Manage + Treat
Symptoms
Unmet needs
Treatment Planning
Treatment Decision-making
Assess + Screen + Intervene + Manage + Treat
Symptoms
Unmet needs
Curative Treatment
Palliative Treatment and Care
Assess + Screen + Intervene + Manage + Treat
Symptoms
Unmet needs
Side-effects
Adverse-effects
Survivorship: Cancer is Controlled
Late Effects of Cancer Treatment
Disease Progression
Assess + Screen + Intervene + Manage + Treat
Symptoms
Unmet needs
Side-effects
Adverse-effects
Survivorship: Cancer does not Return
Death and Dying
Bereavement
Delivery of supportive care: Primary Care * Secondary Care * Tertiary Care * Care at Home * Community Care * Non-Government Organisations
Supportive Care Assumptions:
Alleviate symptoms and complications
Help with psychological and social problems
Eased emotional burden
Enhanced decision-making
Empowerment
Maximise benefits of treatment
Reduce or prevent short-term or long-term toxicities
Improved tolerance for therapy
Enhanced self-care
Relief from suffering
Functional autonomy
Optimised wellness and quality of life
Improved patient experience
Improved coping
Optimal social adjustment
Improved health outcomes
Dignity

整合 － 對談與溝通

君臣佐使


6701診
「生之本，本於陰陽」
秀傳整合醫療中心集結天、地、人為一體，
志業於傳統中醫、現代營養，
融合復健治療、心理諮詢，發揮各家學說之理，
法四時陰陽之道，
謹道如法，長有天命，
打造屬於您治療旅程中的綠洲休憩站。
The amalgamation of the two energies, yin-yang, makes life possible.
Show Chwan Integrative Medicine and Wellness Center unites Heaven, Earth, and Humanity,
incorporating traditional medicine, nutrition, rehabilitation,
We advocate the natural order of the
Show Chwan Integrative
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Show Chwan Integrative Medicine and Wellness Center

報到系統

「生之本，本於陰陽」

秀傳整合醫療中心集結天、地、人為一體，
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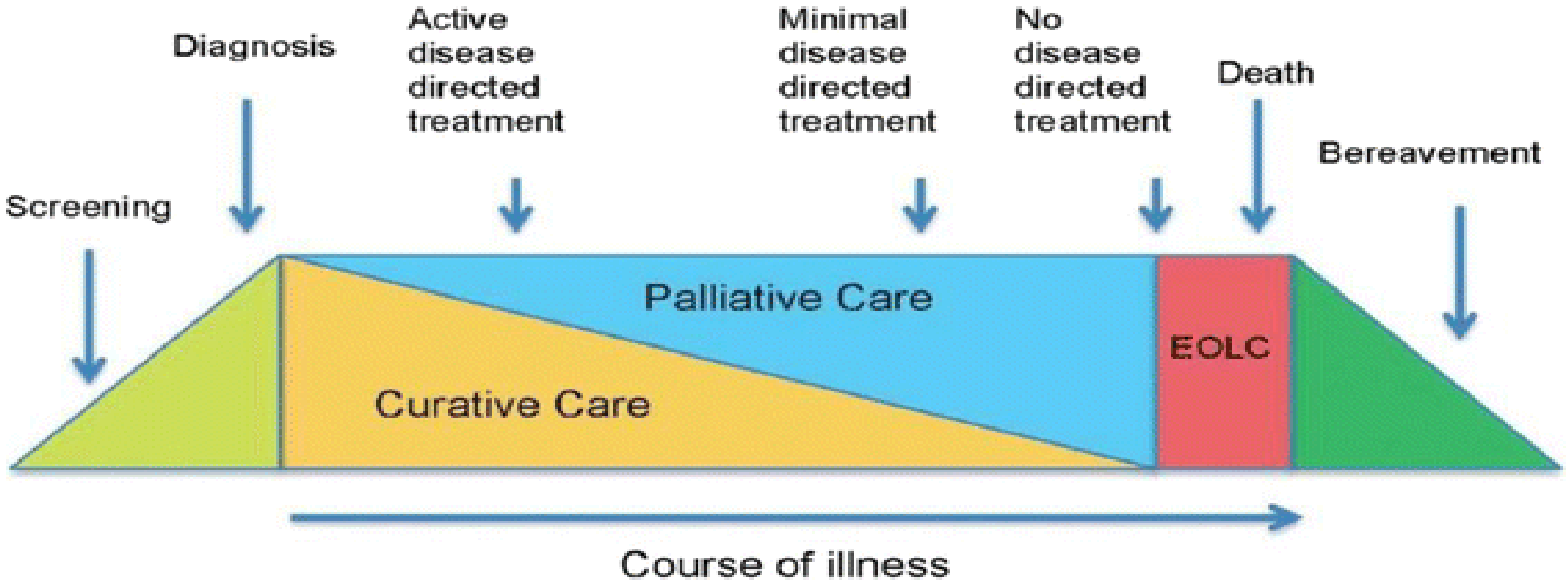
The amalgamation of the two energies, yin-yang, makes life possible.
Show Chwan Integrative Medicine and Wellness Center unites Heaven, Earth, and Humanity,
incorporating traditional medicine, nutrition, rehabilitation, counseling, and diverse professions into our practice.

We advocate the natural order of the universe, behaving based on the doctrines to foster longevity.
Show Chwan Integrative Medicine and Wellness Center is the rest area along your medical journey.

What’s palliative care？
緩和療護是什麼？

Palliative Care vs Hospice Care

"Would I be surprised if this patient died within 12 months?"



https://media.springernature.com/full/springer-static/image/art%3A10.1186%2Fs12904-017-0221-0/MediaObjects/12904_2017_221_Fig2_HTML.gif

Jennings, Marks, & Lum, 2022

Hospice care – 安寧療護

The modern **hospice** movement began in the UK in the 1960s. Cicely Saunders, a 20th century British nurse and social worker, was responsible for the formation of the core tenets applied in hospices around the world through her experiences at St Luke's Home.

The concepts of "total pain", including physical, spiritual, and psychological discomfort; the proper use of opioids for patients with physical pain; attention to the needs of "family members and friends who provide care for the dying",

Palliative care – 緩和療護

The term **palliative care** (in the setting of treatment given with the goal of symptom relief) was probably first coined by the Canadian surgeon Balfour Mount in 1974.

Three main features were developed, namely, multidimensional assessment and management of severe physical and emotional distress; interdisciplinary care by multiple disciplines in addition to physicians and nurses; emphasis on caring not only the patients but also for their families .

Comparing Palliative Care and Hospice Care

Palliative Care	Hospice Care
Physical and psychosocial relief	Physical and psychosocial relief
Focus on quality of life	Focus on quality of life
Multidisciplinary Team Approach	Multidisciplinary Team Approach
Any stage of disease	*Prognosis 6 months or less*
May be concurrent with curative treatment	*Excludes curative treatment*

VS

https://www.nhpco.org/wp-content/uploads/2019/04/PalliativeCare_VS_Hospice.pdf

Supportive care - 支持性照護

Supportive care emerged as a concept and care approach in the late 1980s, somewhat later than palliative care, but with a similar focus on the individual patient with cancer, the host, not the tumour.

A new medical discipline aiming to provide predominantly cancer patients with support for the management of “treatment-related effects”

Definition of palliative care in 2002 declared by WHO - 定義

- Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual
- 促進生活品質/ 身心靈

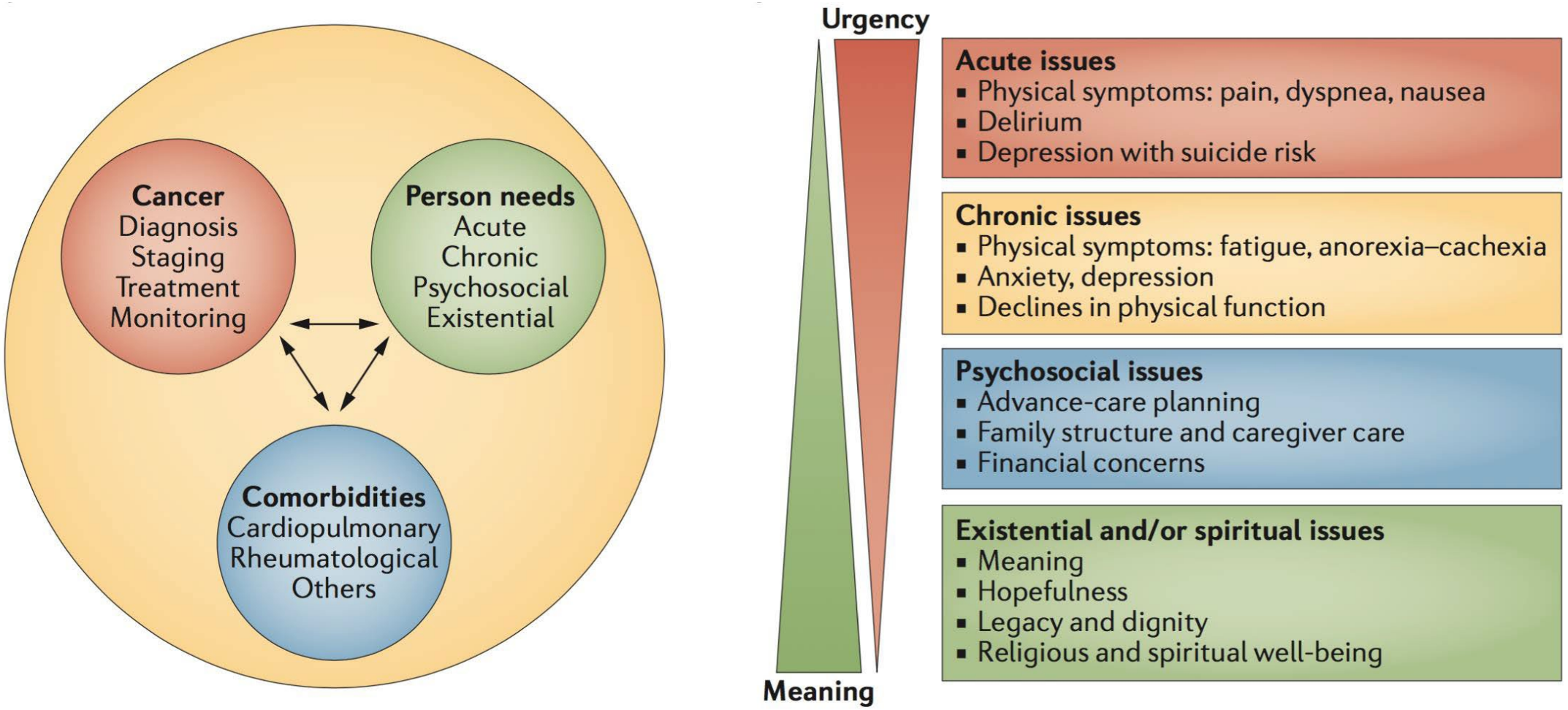
Five Main Ideas
五個主要重點

- (I) QOL focused approach - 生活品質
- (II) Whole-human approach - 全人
- (III) Care that encompasses both the patient and those involved with the patient (particularly caregivers) - 全家
- (IV) Respect patient autonomy and choice- 自主選擇
- (V) Support people through frank and thoughtful discussions on difficult subjects - 全程

Why they need early palliative care?

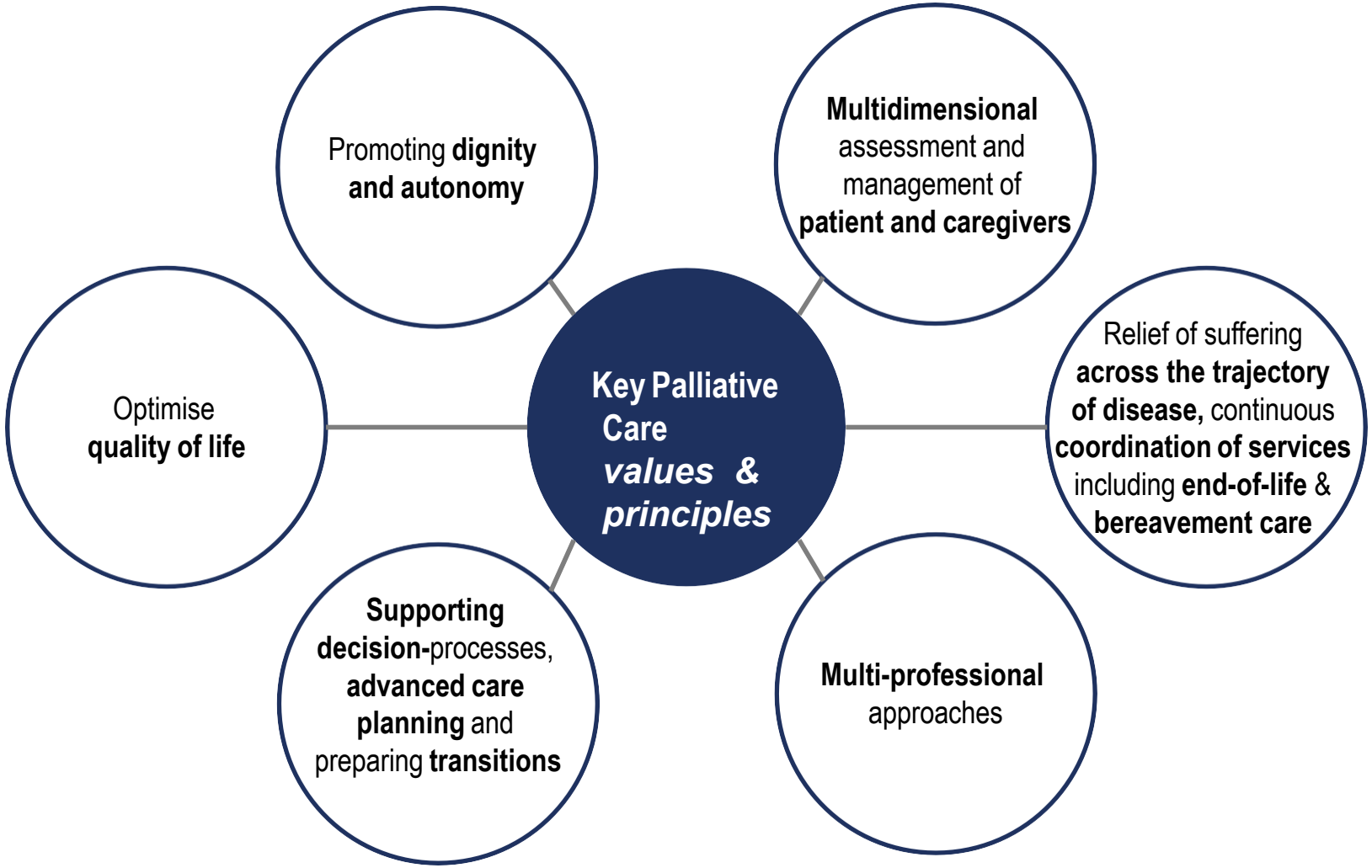
APPROACH TO THE PATIENT WITH INCURABLE CANCER

Palliative care needs in oncology 癌症患者緩和療護的需求



Hui D, and Bruera E, Nat Rev Clin Oncol 2016;13(3):159-171. Reprinted by permission from Mcmillan Publishers Ltd, copyright 2016

緩和療護的內容和時間表



Lorenz KA, *et al.,* Ann Int Med 2008;148:147–59; Tieman J, *et al.,* J Clin Oncol 2008;26:56-79

What is the efficacy?

Advocacy for early palliative care –
2010, Temel *et al.* announced a clinical trial concerning "early palliative care" in the *NEJM*

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

Early, Integrated Palliative Care in Patients with Metastatic Lung Cancer 轉移性肺癌臨床試驗

150 patients with newly diagnosed metastatic NSCLC

- Early palliative care integrated with standard oncology care
- Standard oncology care

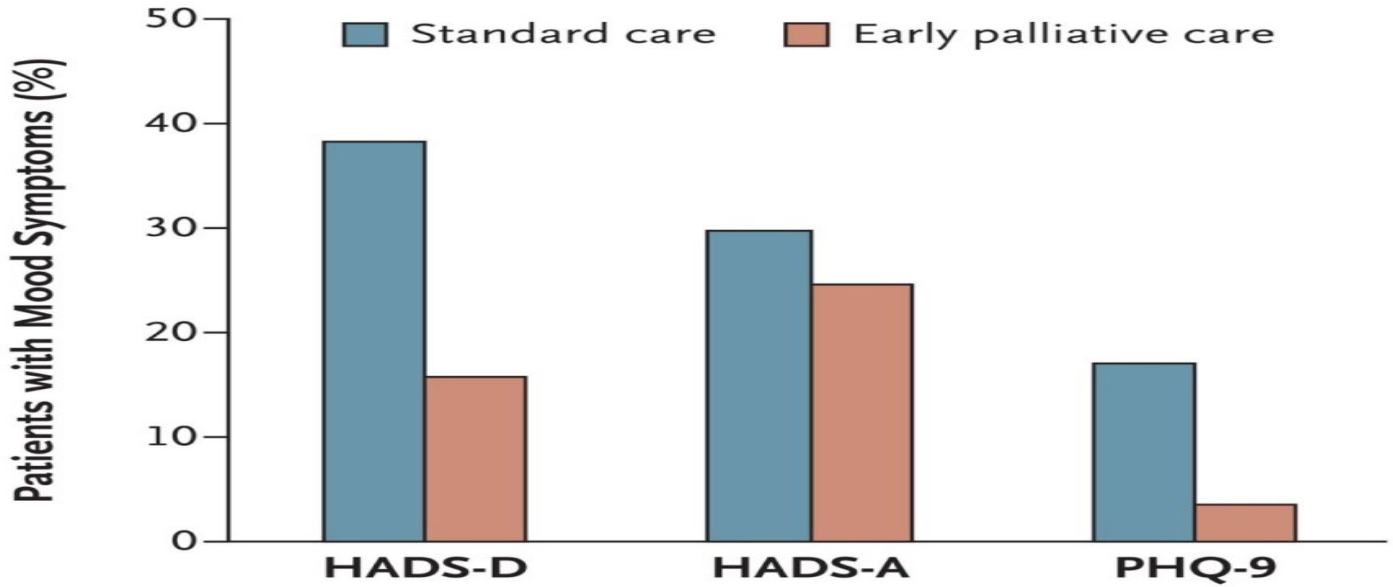
Palliative Care Model

- Palliative care provided by physicians and nurse practitioners
- Visits occurred in the Cancer Center (medical oncology, radiation oncology or chemotherapy visits).
- Oncology and palliative care visits were done in tandem or simultaneously.
- Visits were not scripted or prescribed.
- If patients were admitted to the hospital, they were followed by the palliative care team

Temel NEJM 363 (8) 2010

早期緩和治療對患者報告指標的影響

Variable	Standard Care (N=47)	Early Palliative Care (N=60)	Difference between Early Care and Standard Care (95% CI)	P Value†	Effect Size‡
FACT-L score	91.5±15.8	98.0±15.1	6.5 (0.5–12.4)	0.03	0.42
LCS score	19.3±4.2	21.0±3.9	1.7 (0.1–3.2)	0.04	0.41
TOI score	53.0±11.5	59.0±11.6	6.0 (1.5–10.4)	0.009	0.52



Temel NEJM 363 (8) 2010

最新的！

- *JAMA Network Open.* 2024;7(8):e2426304. doi:10.1001/jamanetworkopen.2024.26304 (

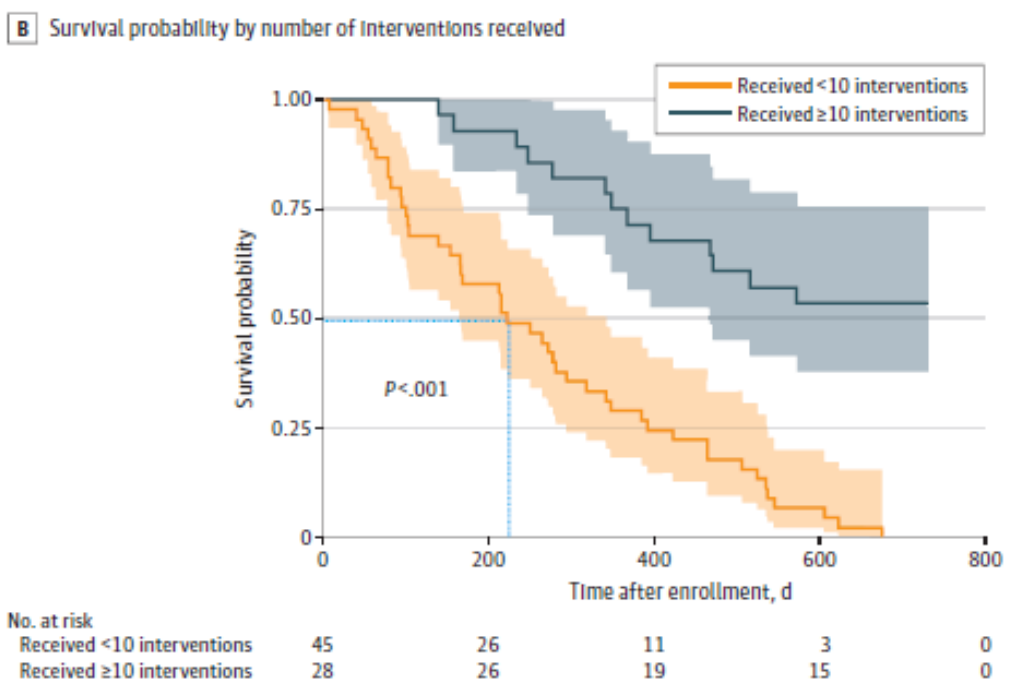
JAMA Network Open

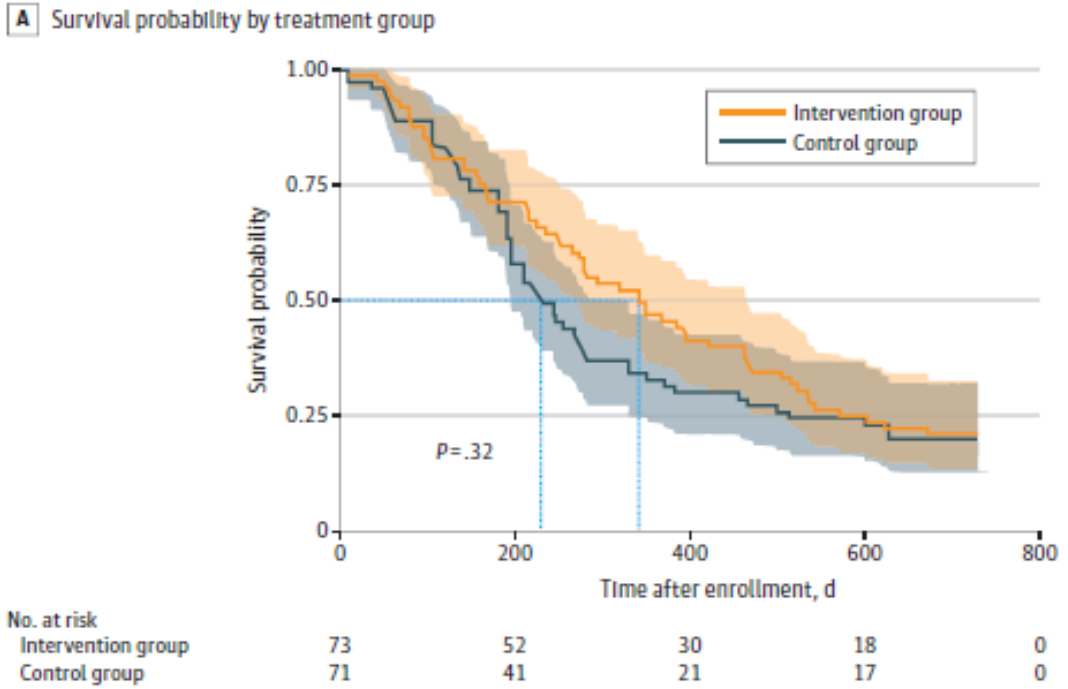
Original Investigation | Oncology

Early Integrated Palliative Care in Patients With Advanced Cancer
A Randomized Clinical Trial

EunKyo Kang, MD; Jung Hun Kang, MD; Su-Jin Koh, MD; Yu Jung Kim, MD; Seyoung Seo, MD; Jung Hoon Kim, MD; Jaekyung Cheon, MD; Eun Joo Kang, MD; Eun-Kee Song, MD; Eun Mi Nam, MD; Ho-Suk Oh, MD; Hye Jin Choi, MD; Jung Hye Kwon, MD; Woo Kyun Bae, MD; Jeong Eun Lee, MD; Kyung Hae Jung, MD; Young Ho Yun, MD

Figure 2. Kaplan-Meier Curve for Cancer Survival





Early palliative care might have more beneficial effects on quality of life and intensity of symptoms among patients with advanced cancer than among those given usual or standard cancer care alone. The effects are of clinical relevance for patients at an advanced disease stage with limited prognosis, when further decline in quality of life is the rule.

Cochrane Library

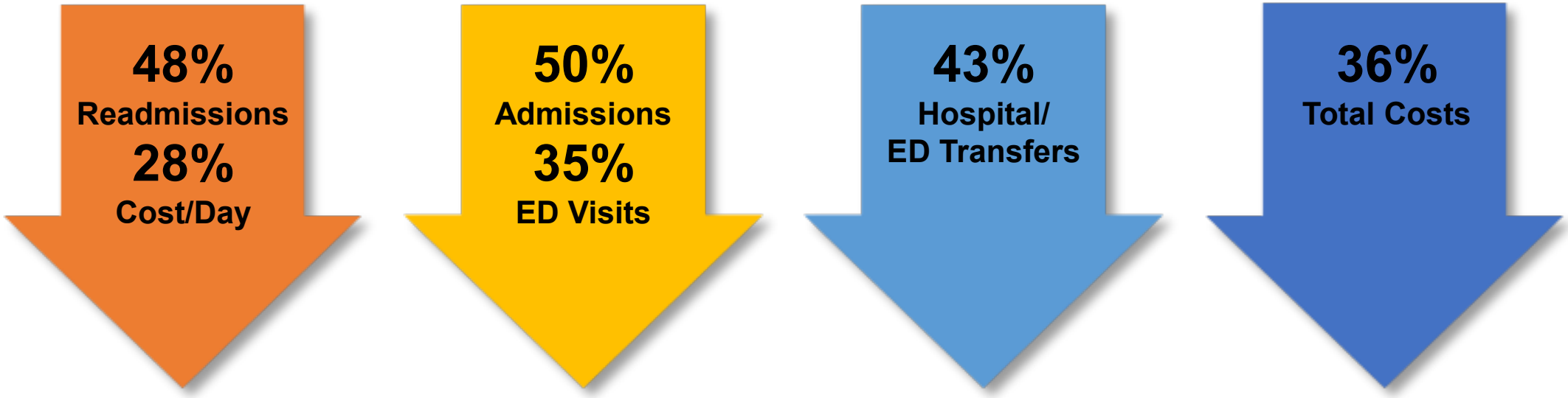
Cochrane Database of Systematic Reviews

Early palliative care for adults with advanced cancer (Review)

Haun MW, Estel S, Rücker G, Friederich HC, Villalobos M, Thomas M, Hartmann M

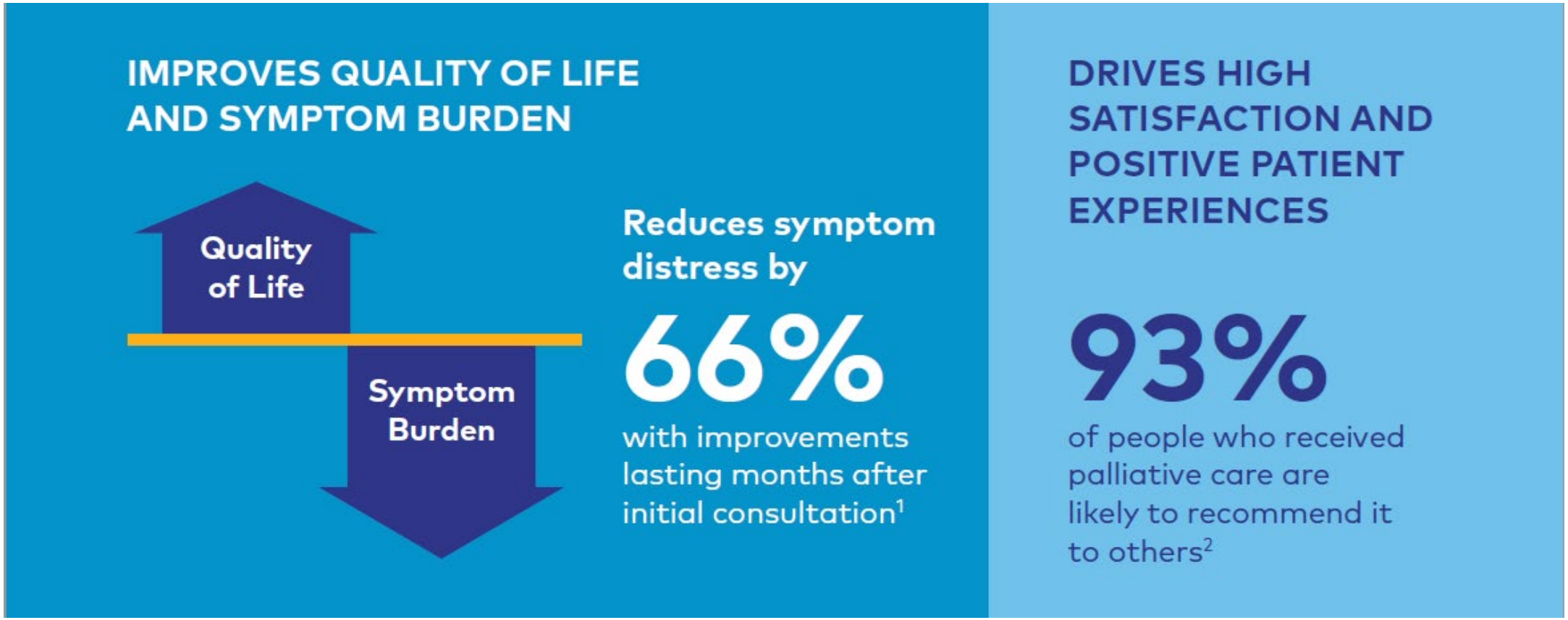
Haun_et_al-2017-Cochrane_Database_of_Systematic_Reviews

Palliative Care Reduces Avoidable Spending and Utilization in All Settings



Source Centers to Advance Palliative Care

Palliative Care Improves Quality of Life



Center to Advance Palliative Care, 2018 Retrieved from https://www.capc.org/tools-for-making-the-case/downloadable-tools/

Integration of palliative care into standard oncology care

ASCO guideline

- The guideline states that, "*Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment*", and
- Strongly recommends "*Integration of palliative care into standard oncology care*".

Components of integration from seven randomised trials

	Jordhøy et al (2000)[47]	Temel et al (2010)[3]	Zimmermann et al (2014)[5]	Bakitas et al (2015)[48]	Maltoni et al (2016)[49]	Temel et al (2017)[50]	Grønvold et al (2017)[51]
Clinical structure							
Palliative care inpatient consultation team	Y	Y	Y	Y	..	Y	Y
Palliative care outpatient clinic	Y	Y	Y	Y	Y	Y	Y
Community-based care or home palliative care	Y	..	Y	..	..	..	..
Clinical processes							
Multidisciplinary specialised palliative care team	Y	Y	Y	Y	Y	Y	Y
Routine symptom screening in the outpatient oncology clinic	..	..	..	..	..	..	..
Administration of systemic cancer therapy (eg, chemotherapy and targeted agents) possible in patients admitted to palliative care service	Y	Y	Y	Y	Y	Y	Y
Follow prespecified palliative care guidelines	Y	Y	..	..	Y	Y	Y
Early referral to palliative care	Y	Y	Y	Y	Y	Y	Y
Availability of clinical care pathways (automatic triggers) for palliative care referral	..	..	..	..	..	..	..
Palliative care team routinely involved in multidisciplinary tumour conference for patient case discussions	..	Y	..	..	..	..	..
Communication, cooperation, and coordination between palliative and oncology service	Y	Y	..	..	Y	..	..
Routine discussion of prognosis, advance care planning with goals of care	Y	Y	Y	Y	Y	Y	Y

Y=presence of component in trial. Table adapted from Hui and colleagues.[44,52]

台灣早期緩和療護的進展

＜紅色字體處為衛生福利部於111年修訂公告之內容＞

【加分項目】基準3.3	
癌症防治醫療機構應針對~~晚期~~癌症病人建立緩和醫療之照護標準與流程。	
評分說明	符合項目： 1. 已建立~~晚期~~癌症病人接受緩和醫療之照護標準　與流程。 2. 在兩種癌別或兩個腫瘤相關病房（安寧病房除　外）開始實行。

【加分項目】基準3.3（續）

重點

1. 照護標準與流程應包含啟動轉介緩和醫療之條件、轉介流程與照護服務內容等，並不限於晚期癌症。
2. 晚期癌症定義：癌症出現遠處轉移或復發，但透過治療仍可延長病人生命（生命預期存活期＞6個月）。
3. 緩和照護團隊除需包含醫師（安寧專科醫師或腫瘤治療專科醫師）、護理師、社工師、心理師外；亦可自行增加其他相關人員（如靈性關懷人員等）。可由現有安寧緩和照護團隊或多專科團隊中成立功能小組負責辦理。
4. 緩和照護團隊成員應接受相關教育訓練，課程內容至少應涵蓋身心症狀處理、共同醫療決策、病人自主權利（AD）及照護者支持等面向。

秀傳彰濱緩和照護團隊

目的，原則與目標

目的：

減輕痛苦，促進舒適

維護病人自主控制權

原則：

針對痛苦和不適症狀提供解除方案

整合病人與家屬心理和靈性層面的照顧

目標：

協助病人及其家屬獲得罹病後最佳的生活品質

服務項目

提供緩和照護的團隊服務

提供疾病治療流程與預後的充分資訊

面對死亡威脅的心理輔導與價值觀的再澄清

促進病人與家屬，病家與原治療團隊間之互動與了解

瀕臨死亡前後提供家屬支持及生活模式重建，並轉介安寧團隊的延續照護。

緩和照護
收案原則

新診斷癌症病人

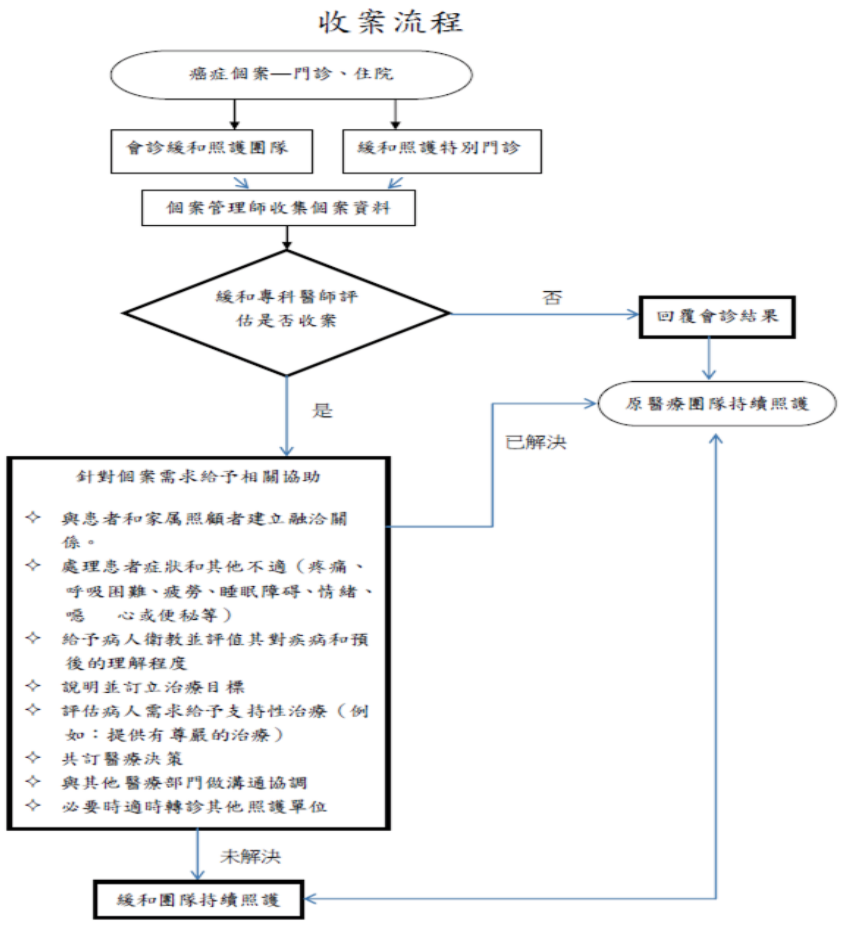
身體上有較嚴重的疾病症狀或心理、社會及靈性方面的照顧需求

病人與家屬對於疾病，治療目標與預後的認知不足

病人對於治療的選擇與疾病惡化後的處理模式，明顯有下決定上的困難

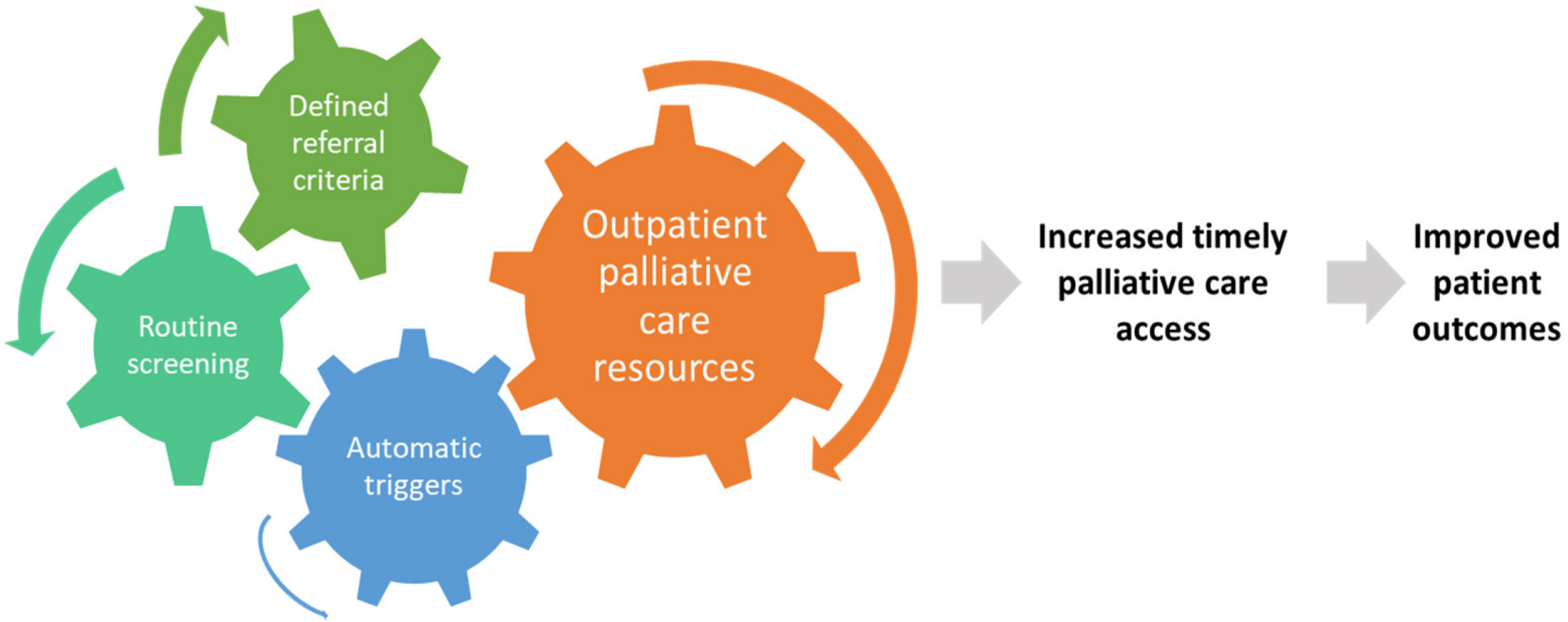
家屬與病人，病家與原治療團隊間對於治療流程與目標有溝通上的問題

收案流程與篩選量表



緩和照護團隊篩選量表	這件事對你的生活所造成的影響程度?	結果
1. 得了癌症之後，我每日的活動量是: ☐ 正常 ☐ 減少了一點 ☐ 減少，但每日在床上的時間不會超過一半 ☐ 大量減少，而且每日有超過一半的時間在床上 ☐ 嚴重減少，而且一天大部分時間在床上	☐ 完全不會 ☐ 中度影響 ☐ 嚴重影響	由心理師進行： 疲憊評估_____分 因疲憊進行收案： ☐ 是 ☐ 否
2 得了癌症之後，我感到沮喪、憂鬱、無望: ☐ 完全不會 ☐ 部分日子 ☐ 很常 ☐ 大部分日子 ☐ 所有日子	☐ 完全不會 ☐ 中度影響 ☐ 嚴重影響	簡式健康量表評估_____分，因心理評估後進行收案 ☐ 是 ☐ 否
3. 得了癌症之後，我可以做: ☐ 所有我想做的事 ☐ 大部分我想做的事 ☐ 很多我想做的事 ☐ 部分我想做的事 ☐ 完全不能做我想做的事	☐ 完全不會 ☐ 中度影響 ☐ 嚴重影響	由營養師評估 進行營養評估_____分 因營養問題進行收案： ☐ 是 ☐ 否
4. 得了癌症之後，我經驗到的疼痛程度是: ☐ 沒有 ☐ 輕微 ☐ 中等 ☐ 嚴重 ☐ 無法忍受的痛/頻繁地疼痛	☐ 完全不會 ☐ 中度影響 ☐ 嚴重影響	由醫師或癌症個案管理師評估： 進行疼痛評估_____分， 因疼痛進行收案： ☐ 是 ☐ 否
5. 得了癌症對我家庭造成很大的負擔: ☐ 完全不會 ☐ 有時 ☐ 大部分的日子是如此 ☐ 每天當中大部分的時間是如此 ☐ 總是（每天且時時刻刻）	☐ 完全不會 ☐ 中度影響 ☐ 嚴重影響	由社工師進行評估 進行經濟評估，因經濟進行收案： ☐ 是 ☐ 否
6. 得了癌症對我和我的家庭之經濟狀況影響程度: ☐ 完全不會 ☐ 輕微 ☐ 中等 ☐ 嚴重 ☐ 非常嚴重	☐ 完全不會 ☐ 中度影響 ☐ 嚴重影響	

Conceptual model for timely palliative care



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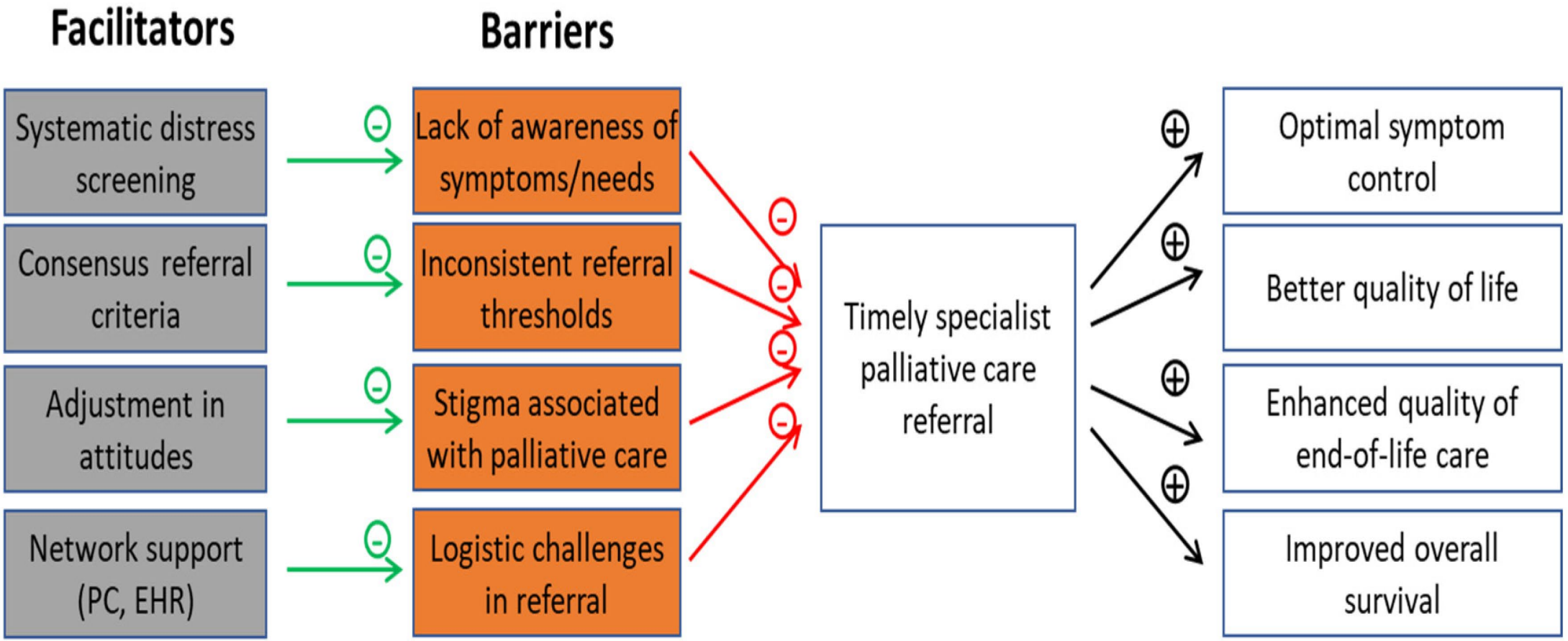
及時轉診緩和療護的障礙和促進因素



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結論

- 患有無法治癒癌症的患者，在整個疾病過程中都需要緩和療護
- 越來越多強有力的 1 級證據，顯示緩和治療對患者和負責照顧家屬的益處
- 已發表關於該主題的隨機試驗，顯示跟主要治療整合可以帶來病人健康上的益處，但整合的內容、時間和方式尚未完全確定
- 緩和療護已成為國家癌症防治計劃的一部分

Q&A