In Reply

EDUARDO BRUERA, SRIRAM YENNURAJALINGAM

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

Disclosures: The authors indicated no financial relationships.

Porzio and colleagues kindly commented on the location of palliative care delivery based on the statements that were made in our manuscript [1]. In the letter, the authors propose that cancer centers should incorporate their own resources for palliative care delivery at home to allow symptom control and family support as well as to reduce inappropriate admission to hospitals. Although our paper focused on the delivery of care within cancer centers both in the inpatient and outpatient settings, we agree with Porzio and colleagues that community-based palliative care is very important for patients with advanced cancer. Future research should focus on the advantages of early combined palliative outpatient and home care rather than outpatient care only. Patients receive treatments until quite late in the trajectory of their illness since the development of targeted therapies. These patients frequently have severe fatigue, cachexia, a poor performance status, and early stages of delirium. In the U.S., home care is delivered mainly by hospices, and these more frequently become involved very

late in the course of the disease, when cancer treatment has been discontinued [2]. In Canada, programs such as the Edmonton Regional Palliative Care Program [3] have allowed >80% of cancer patients to access palliative care before death. The Edmonton program is based on coordinated care among independent hospitals, including the cancer center, a community-based physician and nurse network, and three inpatient hospices. Both the model proposed by Porzio and colleagues of cancer center extension to the community and the Edmonton model of intensive coordination among independently administered programs are capable of providing seamless care.

AUTHOR CONTRIBUTIONS

Conception/Design: Eduardo Bruera, Sriram Yennurajalingam
Provision of study material or patients: Eduardo Bruera, Sriram Yennurajalingam
Collection and/or assembly of data: Eduardo Bruera, Sriram Yennurajalingam
Data analysis and interpretation: Eduardo Bruera, Sriram Yennurajalingam
Manuscript writing: Eduardo Bruera, Sriram Yennurajalingam
Final approval of manuscript: Eduardo Bruera, Sriram Yennurajalingam

REFERENCES

1. Bruera E, Yennurajalingam S. Palliative care in advanced cancer patients: How and when? *The Oncologist* 2012;17:267–273.
2. Casarett D, Abraham JL. Patients with cancer referred to hospice versus a bridge program: Patient characteristics, needs for care, and survival. *J Clin Oncol* 2001;19:2057–2063.
3. Bruera E, Neumann CM, Gagnon B et al. Edmonton Regional Palliative Care Program: Impact on patterns of terminal cancer care. *CMAJ* 1999;161:290–293.

Correspondence: Eduardo Bruera, M.D., Palliative Care & Rehabilitation Medicine, Unit 1414, The University of Texas MD Anderson Cancer Center, 1515 Holcombe Boulevard, Houston, Texas 77030, USA. Telephone: 713-792-6084; Fax: 713-792-6092; e-mail: ebruera@mdanderson.org Received March 6, 2012; accepted for publication April 24, 2012; first published online in *The Oncologist Express* on May 17, 2012. ©AlphaMed Press 1083-7159/2012/\$20.00/0 <http://dx.doi.org/10.1634/theoncologist.2012-0102>