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Improving Metastatic Breast Cancer Care Through Integrated Palliative Support

You're listening to *On the Frontlines of Metastatic Breast Cancer* on ReachMD, and this is an *AudioAbstract*. I'm Ryan Quigley, and today we're diving into new data on the impacts of an embedded palliative care model in metastatic breast cancer care.

While metastatic breast cancer remains incurable, advances in treatment have modestly improved survival outcomes. But with longer survival comes greater complexity in care, particularly in managing long-term symptoms, coordinating goals of care, and navigating treatment-related toxicities.

In 2016, the American Society of Clinical Oncology formally recommended early integration of palliative care alongside oncologic treatment as a component of patient-centered care. But in practice, referrals are often reactive and late in the disease course. And so integrating palliative care into routine cancer management through structured, replicable models remains a critical gap in clinical delivery.

A 2025 study by de Matos et al. evaluated the impacts of an embedded palliative care model in this patient population at the Champalimaud Clinical Center's Breast Unit in Lisbon, Portugal. The model placed a full-time palliative care specialist within the oncology team in order to participate in multidisciplinary discussions, shared appointments, and coordinated care planning for patients with metastatic breast cancer.

The research team conducted a retrospective cohort analysis over two consecutive 12-month periods—before and after model implementation. The study included 145 female patients with a median age of 63.5 years who had histologically-confirmed metastatic breast cancer. To evaluate the impact of palliative care intervention, patients who had experienced at least three palliative care encounters were included in the analysis. 66.2 percent of patients had HR-positive, HER2-negative disease, 20.7 percent had HR-negative, HER2-negative disease, and 13.1 percent had HER2-positive disease. 88.3 percent of patients had bone metastasis, 55.8 percent had liver metastasis, 46.8 percent had lung metastasis, and 17.2 percent had central nervous system metastasis.

The primary endpoints were early referral, which was defined as palliative care initiated before third-line treatment, or within three months for triple-negative disease; one-year survival; and overall survival duration. Cancer care delivery was categorized into three patterns based on the majority of appointments for each patient: oncology-predominant, palliative-predominant, or a concurrent pattern in which patients alternated or jointly consulted with oncology and palliative care providers.

After implementation of the integration model, the researchers found that the proportion of patients with metastatic breast cancer who engaged with palliative care increased from 21.4 percent to 67.3 percent. Early referrals rose from 35.3 percent to 61.3 percent, with a p value of 0.008. Additionally, concurrent care models became the most common care delivery pattern, increasing from 30 percent to 61 percent. And though it wasn't statistically significant, after implementing the embedded integration model, a lower proportion of patients died in the emergency department or general hospital ward versus at home or in a palliative care unit.

One-year survival rate and median survival time weren't significantly different between the pre- and post-implementation populations. However, patients in the concurrent care group experienced a statistically significant four-month median survival advantage of 11.3 months compared to 7.6 months in patients in oncology- or palliative-led models at a hazard ratio of 0.78.

These findings suggest several key implications for clinical practice. Proactive palliative integration appears to improve timing of referrals, care coordination, and patient engagement—especially when embedded within an existing oncology infrastructure. And a concurrent care delivery model, rather than single specialty-led care, may offer a survival benefit. It's important to note that the success

of the model hinged on daily availability of triage nurses, integrated scheduling, and shared documentation systems.

As a single-center retrospective study, these findings should be interpreted within context. The authors note several limitations, including the absence of data on performance status, comorbidities, or supportive medications; a relatively small sample size, which may reduce power to detect smaller effects; and potential referral bias due to the center's role as a tertiary referral unit.

Nevertheless, the structural and outcome data provide a useful framework for replication. Additional insights could be gained by integrating patient-reported outcomes to assess quality-of-life and expanding the model to include more than one palliative care provider to ensure continuity.

Overall, this study underscores the value of embedding palliative care within oncology—moving beyond late-stage referrals to a model of concurrent, collaborative care that may improve not just how long patients live, but how well. As metastatic breast cancer care continues to evolve, models such as this one offer a pragmatic and impactful way to improve delivery of patient-centered care.

This has been an *AudioAbstract* for *On the Frontlines of Metastatic Breast Cancer,* and I'm Ryan Quigley. To access this and other episodes in this series, visit ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!