ewimed report 26

Data collection 2025

Foreword

This year marks the fifth edition of the international ewimed report. The focus is on the management of patients suffering from malignant and non-malignant pleural effusion or ascites. The report summarizes current scientific evidence, incorporates insights from experienced physicians, and demonstrates through selected case examples how the use of Indwelling pleural or peritoneal catheters (IPC) has proven effective in clinical practice.
With this comprehensive overview, the publication aims to further strengthen this therapeutic option in Europe and to highlight its role in medical care.

For improved readability, the term indwelling pleural or peritoneal catheter (IPC) will be used throughout the report.

The ewimed report 2026 is based on the analysis of data from the ewimed patient questionnaire conducted in 2025. For the first time, feedback from Austria has been included alongside data from Germany.
A further chapter focuses on interdisciplinary collaboration. Primarius Priv.-Doz. Dr. Stefan Watzka (thoracic surgery) and Primarius Priv.-Doz. Dr. Arschang Valipour, FERS (pulmonology), share insights from their joint clinical work at Klinikum Floridsdorf, demonstrating how closely their specialties work together. The chapter also includes a physician interview with Hauke Weilert, who provides perspectives on outpatient specialized medical care (ASV) and his role as a clinical oncologist using IPC therapy.
The report also includes insights from Switzerland, highlighting the role of IPC therapy in palliative care, as illustrated by a specific patient case. The edition concludes with a country comparison of ewimed's sales and service units and their palliative care services.

ewimed GmbH

ewimed GmbH is a growing medical technology company based in the Medical Valley in Hechingen and has specialized in the drainage of pleural effusion and ascites for more than 30 years. As a developer, manufacturer, and provider of catheter systems and drainage accessories, ewimed offers a comprehensive product portfolio for the symptom-oriented treatment of both malignant and non-malignant effusions, for use in both hospital and home care settings.
In addition to its products, ewimed supports patients through a comprehensive care concept, from catheter implantation and home drainage to ongoing patient support.
With subsidiaries as well as sales and service units in Germany, Sweden, Switzerland, Austria, Hungary, Denmark, Norway, Belgium, the Netherlands, Luxembourg, and Romania, the company is among the leading providers of drainage systems in Europe. At the same time, ewimed continuously works on developing new solutions to further improve therapy.
Since its foundation in 1991, one principle has remained central: to sustainably support and maintain patients' quality of life.

For reasons of readability, the simultaneous use of gender-specific language forms (m/f/d) has largely been omitted. All personal designations apply equally to all genders.

Lotta and Egon Wiest, Managing Directors and Founders of ewimed GmbH

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1. Results of the patient questionnaire – Germany

For more than 15 years, ewimed has been collecting valuable feedback directly from patients as part of patient training in the home care setting. These surveys are conducted in person by specially trained staff, providing an important foundation for further tailoring the management of pleural effusion and ascites to patients' needs.

The ewimed report 2026 presents the results of the 2025 patient survey by country. For the first time, it also includes a separate analysis of data from Austria, where the survey began at the start of 2025.

The following section presents the results of the 2025 patient survey in Germany.

1.1 Average patient age

In 2025, a slight increase was observed in the average age of patients with pleural effusion, rising to 72.49 years (2024: 72.21 years). A similar trend was seen in patients with ascites, with the average age increasing to 67.36 years (2024: 66.25 years).

1.2 Gender distribution

Overall, the gender distribution remains balanced. Among patients with pleural effusion, 52% are male (2024: 54%), while in ascites patients, the proportion of males is 51% (2024: 53%). Accordingly, 48% of pleural effusion patients are female (2024: 46%), and 49% of ascites patients are female (2024: 47%).

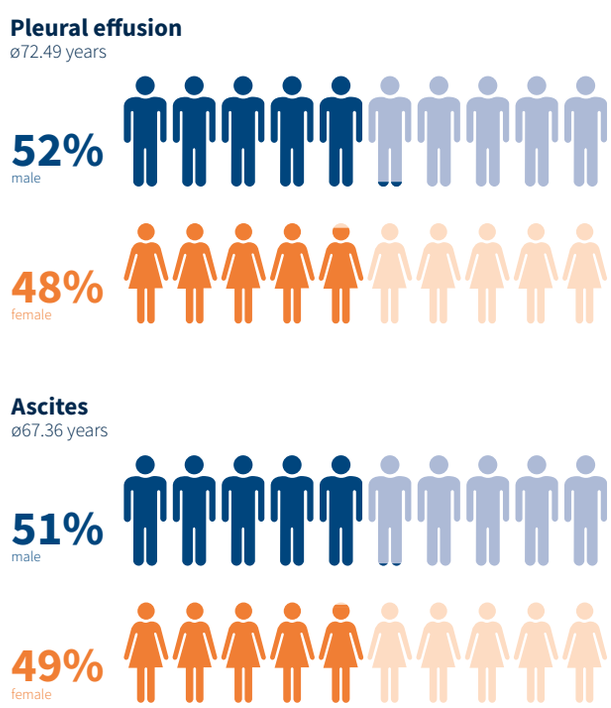

Fig. 1: Average patient age and gender distribution

1.3 Causes of disease and underlying conditions

In the following section of the questionnaire, the causes of disease are differentiated into malignant and non-malignant categories. In addition, the underlying conditions leading to the development of pleural effusion or ascites are examined.

Causes of disease – malignant and non-malignant

In pleural effusion, the proportion of malignant causes remained unchanged compared to the previous year at 76%, while non-malignant conditions account for 24%. A similar pattern is observed in ascites: 78% of cases are attributable to malignant causes, and 22% to non-malignant causes.

Underlying conditions

The figure illustrates the underlying conditions that led to the development of pleural effusion or ascites.
In pleural effusion, bronchial carcinoma remains the most common cause at 39% (2024: 38%). Cardiovascular diseases rank second at 14%, unchanged compared to the previous year. Breast cancer is also a relevant underlying condition, accounting for 13% (2024: 13%).
In ascites, liver cirrhosis remains the most common cause at 18% (2024: 18%), followed by pancreatic carcinoma at 17% (2024: 17%). Cardiovascular diseases account for 13% in 2025, remaining at the same level as in the previous year.

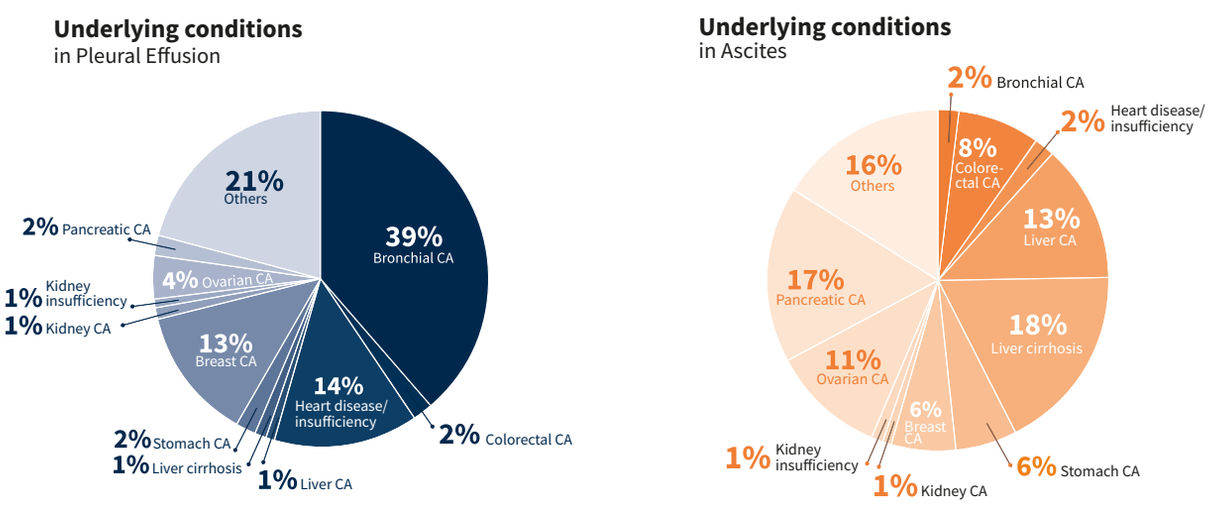

Fig. 2: Underlying conditions

1.4 Proposing versus implanting medical specialties

The questionnaire also captures which medical specialties both determine the indication for IPC therapy and perform the implantation.

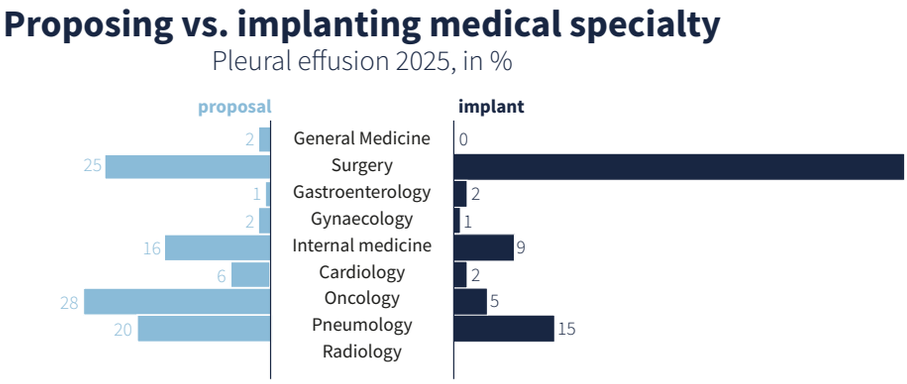

Fig. 3: Proposing vs. implanting medical specialties – pleural effusion

In the management of pleural effusion, various medical specialties were involved in recommending the use of an IPC over the past year. The indication was most frequently established by oncology at 28% (2024: 26%), followed by surgery at 25% (2024: 26%). Pulmonology accounted for 20% (2024: 21%).
Actual implantation of the IPC in pleural effusion was predominantly performed by surgical specialties, which carried out 67% of procedures (2024: 69%). Pulmonology accounted for 15% of implantations (2024: 15%), while internal medicine contributed 9% (2024: 7%) and oncology 5% (2024: 5%).

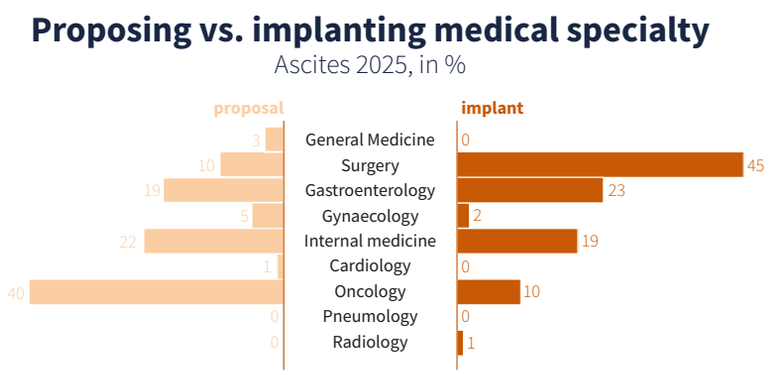

Fig. 4: Proposing vs. implanting medical specialties – ascites

In patients with ascites, the indication for IPC implantation in 2025 was primarily established by oncology, accounting for 40% (2024: 39%). Other key specialties included internal medicine at 22% (2024: 22%) and gastroenterology at 19% (2024: 17%).
Implantation in ascites was performed in 45% of cases by surgical specialties (2024: 45%). Gastroenterology carried out 23% of procedures (2024: 19%), followed by internal medicine at 19% (2024: 20%). Oncology was involved in 10% of implantations (2024: 11%).

1.5 Puncture before to IPC implantation

This section presents the number of punctures performed prior to IPC implantation in patients with pleural effusion and ascites.

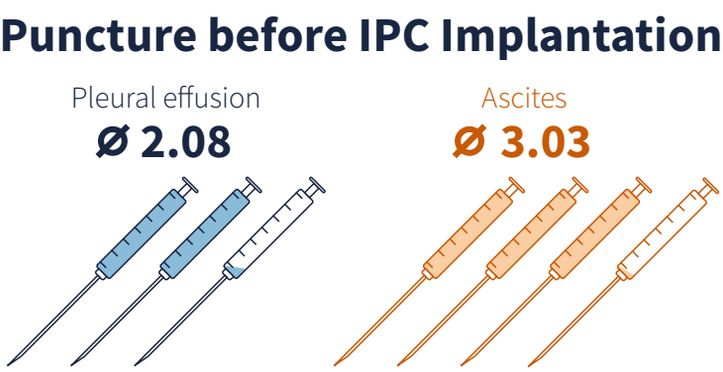

Fig. 5: Puncture before IPC Implantation

In pleural effusion, the average number of punctures decreased slightly compared to the previous year, to 2.08 (2024: 2.16). A similar trend was observed in ascites, where the average number of punctures declined to 3.03 (2024: 3.29). This may indicate that IPCs are being used earlier in the course of treatment. As a result, patients' quality of life may improve, as symptoms can often be managed more consistently and reliably.

1.6 Pleurodesis attempt (only pleural effusion)

The final section of the ewimed patient questionnaire examines whether a medical or surgical pleurodesis (VATS/talc) was performed in patients with pleural effusion prior to IPC implantation.
The proportion is 8%, representing a slight decrease compared to the previous year (2024: 9%).

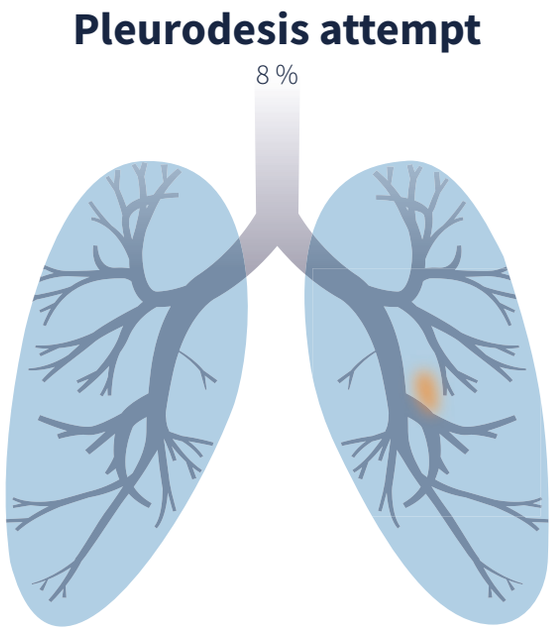

Fig. 6: Pleurodesis attempt

2. Results of the patient questionnaire – Austria

For the first time, the ewimed report also includes patient data from Austria. The following analysis presents the results of the 2025 survey and complements the German data with an additional international perspective.
This allows for the comparison of differences and similarities in care, treatment, and perceived quality of life across countries.

2.1 Average patient age

In 2025, the average age of patients with pleural effusion is 70 years, while the average age of patients with ascites is 65 years.

2.2 Gender distribution

The gender distribution shows that 51% of patients with pleural effusion are male, while the proportion of males in ascites is 59%. Accordingly, 49% of pleural effusion cases and 41% of ascites cases are female.

2.3 Causes of disease and underlying conditions

In the following section of the questionnaire, the causes of disease are categorized into malignant and non-malignant groups. In addition, an analysis is provided of the underlying conditions that led to the development of pleural effusion or ascites.

Causes of disease – malignant and non-malignant

In pleural effusion, 87% of cases are attributable to malignant causes, while 13% are due to non-malignant conditions. In ascites, 90% of cases are attributable to malignant causes and 10% to non-malignant causes.

Underlying conditions

In pleural effusion, bronchial carcinoma is the most common cause, accounting for 45%, followed by breast cancer at 8%. In ascites, pancreatic cancer is the most common underlying condition at 24%. Other relevant causes include colorectal cancer at 13% and liver cancer at 12%.

2.4 Proposing versus implanting medical specialties

In addition the questionaire captures which medical specialties both recommend IPC therapy and perform the implantation.

In pleural effusion, several medical specialties were involved in recommending the use of an IPC over the past year. The indication was primarily established by oncology at 42%, followed by pulmonology at 29%. Internal medicine also contributed with a share of 14%. IPC implantation in pleural effusion was performed in 50% of cases by surgical specialties. Additional procedures were carried out by pulmonology at 24% and internal medicine at 13%.

In patients with ascites, the indication for IPC implantation over the past year was predominantly established by oncology, accounting for 57%. Internal medicine contributed 16%, followed by surgical specialties at 15%.

Implantation in ascites was mainly performed by surgical specialties, which carried out 60% of procedures. Both internal medicine and oncology each accounted for 12% of implantations.

2.5 Puncture before IPC implantation

This section presents the average number of punctures performed prior to IPC implantation in patients with pleural effusion and ascites.

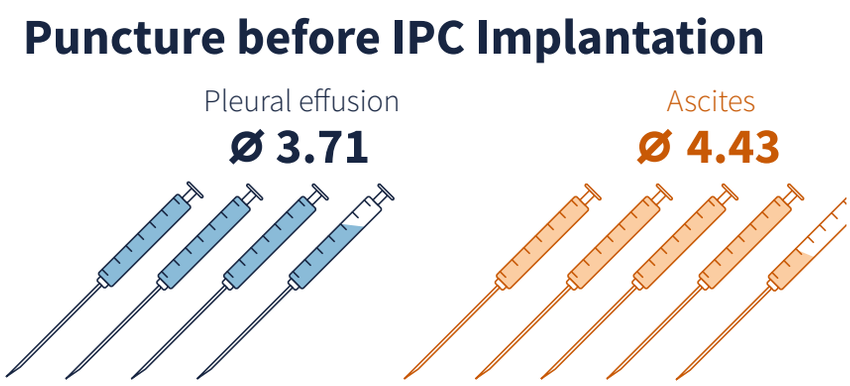

Fig. 7: Puncture before IPC implantation

In pleural effusion, the average number of punctures is 3.71.

In ascites, the average number of punctures is 4.43.

2.6 Pleurodesis attempt (only pleural effusion)

The final section of the ewimed patient questionnaire examines whether a medical or surgical pleurodesis (VATS/talc) was performed as a treatment option in patients with pleural effusion prior to IPC implantation.

The corresponding proportion is 1%.

3. Interdisciplinary collaboration in IPC therapy

3.1 Interdisciplinary approach to treatment success in pleural effusion: Dr. Valipour and Dr. Watzka in discussion

In this report, we present an interdisciplinary discussion between Prim. Priv.-Doz. Dr. Arschang Valipour, FERS (pulmonology), and Prim. Priv.-Doz. Dr. Stefan B. Watzka, BA, MA, FACS (thoracic surgery), both practicing at Klinik Floridsdorf in Vienna.
These experts, both based in Austria, discuss key challenges and current developments in patient care. The discussion shows how closely pulmonology and thoracic surgery work together, from diagnostics and treatment decisions to innovative care concepts.

What role does close collaboration between thoracic surgery, pulmonology, and other specialties and institutions play in the management of patients with pleural effusion? And how do the involved disciplines benefit from each other?

Valipour: From the perspective of the pulmonology department, the management of patients with pleural effusion is a typical example of why interdisciplinary collaboration is essential. Pleural effusion is not an isolated disease, but rather a symptom with a wide range of underlying causes, such as infection, heart failure, malignancy, or autoimmune disease. Depending on the underlying cause, different treatment approaches may be considered, including conservative therapies, punctures, medical thoracoscopy, thoracic surgery, pleurodesis, and IPCs. Close coordination with thoracic surgery, and where appropriate with radiology and pathology for diagnostic clarification and treatment planning, is therefore indispensable.

Watzka: Close collaboration between thoracic surgery, pulmonology, and other specialties enables rapid, competent, and locally accessible care for patients with pleural effusion. It improves both the indication and performance of IPC implantation, as well as subsequent patient management, making the overall treatment pathway more accessible and efficient.

Valipour: In particularly complex clinical situations, multidisciplinary case discussions are also valuable for enabling timely decisions and standardized pathways. This helps ensure a joint decision on whether diagnostic and/or therapeutic puncture, medical thoracoscopy, video-assisted thoracic surgery (VATS), or IPC placement is the most appropriate approach.

What criteria are used to decide whether a catheter should be implanted? Who is involved in this decision, and who else contributes to the process?

Watzka: The decision on whether an IPC should be implanted is based on several considerations. Foremost is the patient's clinical presentation, including the degree of dyspnea, the frequency and necessity of pleural punctures, and the patient's willingness to adapt to the lifestyle changes associated with IPC therapy.

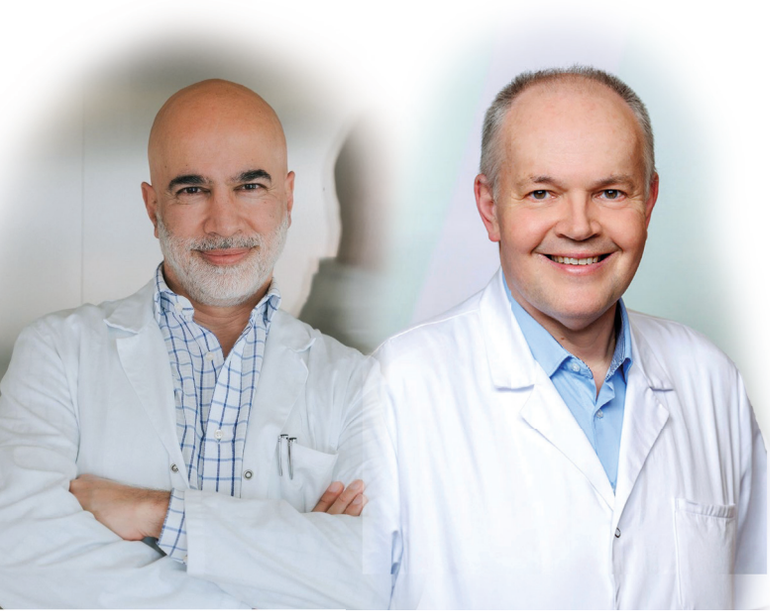

Fig. 8: Prim. Priv.-Doz. Dr. Arschang Valipour and Prim. Priv.-Doz. Dr. Stefan B. Watzka

For instance, regular drainage in the home setting can enable improved symptom control and greater confidence in daily life. Patients often also become more aware of positional changes, such as lying on the affected side, which can be taken into account. From a medical perspective, an IPC is particularly considered when alternative treatment options such as pleurodesis, for example using talc, are not feasible, are contraindicated, or are not appropriate due to ongoing systemic therapy such as chemotherapy or immunotherapy. Situations in which talc pleurodesis is unlikely to achieve a sufficient or lasting effect may also support the indication for IPC implantation.

Valipour: In addition to Dr. Watzka's points, it should be noted that factors such as the presence of a trapped lung, expected survival, and potential contraindications (e.g., active infection, uncontrolled coagulopathy, or highly loculated effusions) must also be taken into account when establishing the indication. Furthermore, the availability of adequate home care support and psychosocial factors also play an important role.

The primary goal should be to ensure patient comfort and, through continuous drainage, to reduce the need for recurrent hospital visits.

Watzka: This approach enhances the practicality of treatment in everyday life, as well as its predictability and the patient's sense of autonomy. Overall, IPC therapy represents a patient-centered and flexible option, which in many cases may contribute to improved quality of life in patients with recurrent or treatment-refractory pleural effusion.

What experience have you gained with the use of IPCs in daily clinical practice?

Watzka: The use of IPCs has been an established part of daily clinical practice in both departments for many years, ensuring a high level of safety, routine, and professionalism. Through this long-standing experience, the entire medical and nursing staff has developed solid expertise in handling these catheters, both with regard to implantation and subsequent care and monitoring.

Valipour: Our clinical experience confirms that rapid and sustained symptom relief, particularly with respect to dyspnea, can be achieved through continuous or intermittent drainage. In many cases, this has made it possible to reduce hospital stays and avoid repeated inpatient punctures. While the primary area of use is naturally malignant pleural effusion, we have also gained experience in selected cases of chronic, recurrent effusions of non-malignant origin. In some patients, spontaneous pleurodesis may occur with IPC use, allowing for subsequent catheter removal.

Watzka: Equally important is the patient's willingness to adapt to the changes associated with IPC therapy. This includes regular drainage of pleural fluid, which provides noticeable relief for many patients and can improve breathing in everyday life. In many cases, drainage can be well integrated into daily routines, depending on the situation, either with the support of relatives or with assistance from trained nursing staff.
Especially at the beginning, patients may experience new physical sensations, such as a temporary feeling of pressure or a foreign body sensation, or changes when lying on the affected side. Discussing these aspects in advance in a calm and structured manner helps to build confidence, reduce uncertainty, and can contribute to improved quality of life. We are currently working on establishing a systematic collection of real-world data from patients treated with IPCs at our institution. The aim is to further improve patient care, better evaluate the use of IPCs, and generate scientifically robust data on treatment outcomes, tolerability, complication rates, and clinical benefits in routine practice. This data collection is intended to serve as an important foundation for future quality improvement initiatives and potential research projects.

Valipour: We are very much looking forward to the first results of our real-world analysis of IPC use in our two departments. It should also be noted that ewimed provides additional training for patients and their relatives in the home setting. This not only helps to reduce the burden on hospital staff, but also enables care in the patient's home, an aspect that is highly valued by many patients.

What developments would you like to see in the future for both specialties in order to further improve patient care? And how might the management of pleural effusion / IPC therapy evolve?

Watzka: To further improve and accelerate the care of patients with pleural effusion, we would primarily like to see a simplification of administrative processes with health insurance providers.* Standardized recognition of these indications would significantly facilitate patient care and expand treatment options.

Valipour: Recurrent cardiogenic effusions, as well as certain pleural effusions of unclear etiology, may also benefit from IPC therapy after all conservative treatment options have been exhausted. Looking ahead, one potential development could be the use of IPC catheters for therapeutic purposes, for example for the administration of cytotoxic, chemical, or immunological agents.

How has interdisciplinary collaboration proven effective so far, and do you see potential to further involve additional specialties or departments in the future?

Watzka: Interdisciplinary collaboration has proven highly effective in several respects. The continuous professional exchange is particularly valuable, as it has noticeably improved both the quality of care and the level of confidence in managing complex cases, such as treatment-refractory or unclear pleural effusions. There are also clear organizational benefits: patients are seen more quickly, diagnostic pathways are streamlined, and decisions are made collaboratively. This contributes to higher quality of care and greater satisfaction among both patients and the treating teams.

Valipour: In addition to pulmonology and thoracic surgery, other specialties can also be involved in IPC therapy to ensure accurate diagnosis, safe implantation, effective complication management, symptom control, and continuity of care in the outpatient setting. These may include palliative care specialists (for symptom control, quality-of-life goals, and home care), infectious disease specialists (in cases of suspected infection or empyema management), nephrologists (for renal causes or patients on dialysis), rheumatologists (for autoimmune pleural diseases), and hematologists (for hematological conditions or coagulation disorders). General practitioners and social workers also play an important role in long-term care, coordination, and social support for patients.

Watzka: Palliative care services could also be integrated earlier in the treatment process, depending on the individual disease course, to provide more comprehensive and patient-centered care. Overall, current collaboration is functioning very well, and further expansion of the interdisciplinary network could enhance patient care even further.

Valipour: The goal of multidisciplinary collaboration is to improve diagnosis and treatment of the underlying condition, minimize risks, optimize symptom control, and ensure coordinated, patient-centered follow-up care.

We would like to thank Prim. Priv.-Doz. Dr. Arschang Valipour, FERS, and Prim. Priv.-Doz. Dr. Stefan B. Watzka, BA, MA, FACS, for the open and practice-oriented discussion and for their valuable insights into interdisciplinary patient care.

*Reimbursement by health insurance providers is country-specific and depends on the respective national regulations.

3.2 Interdisciplinary oncological care

Hauke Weilert on collaboration within an ASV team (outpatient specialized medical care)

Hauke Weilert has been Head of the Department of Hematology, Oncology, and Palliative Care at Asklepios Klinik Barmbek, as well as Director of the Oncology Center, since January 1, 2025. The specialist in internal medicine, hematology, and oncology, with additional certification in palliative care, previously worked for eight years as Senior Consultant in the same department. He is also the lead of an ASV team, referring to outpatient specialized medical care.
As part of this report, we spoke with Weilert about current challenges and developments in oncological care, including cross-sector collaboration within the ASV framework and the use of IPCs to improve patients' quality of life.

Outpatient specialized medical care (ASV) is a healthcare model funded by statutory health insurance for patients with rare or particularly complex conditions. Within interdisciplinary teams, specially qualified physicians collaborate across sectors to ensure coordinated and high-quality care.

You work within a closely connected network of outpatient oncologists through your ASV team. To what extent does this network contribute to ensuring reliable and local care for your patients after discharge?

As Head of the oncology department, I see our primary role as serving as a central hub for complex diagnostics and treatment recommendations. However, it is important to me that the actual ongoing care of patients is provided locally by outpatient oncologists. Close collaboration with these colleagues is essential. We receive patients for diagnostic clarification or specialized therapies and then intentionally refer them back to outpatient care. This approach is not only practical but also in the best interest of patients, who often have long-standing relationships with their treating physicians.
Through the ASV teams, we are also able to achieve strong integration between outpatient and inpatient care, including the possibility of providing advanced diagnostics in the outpatient setting.
Our overarching goal remains: to deliver high-quality care while ensuring treatment close to the patient's home.

Asklepios Klinik Barmbek has long been considered a pioneer of the ASV model for oncological care in Hamburg. How has collaboration between your oncology department and outpatient colleagues developed over time?

As an inpatient oncology department, we clearly see ourselves as collaborative partners to our outpatient colleagues. Our goal is to provide support where the limits of outpatient care are reached, whether in diagnostics, acute complications, or more complex therapies.
I place great importance on personal accessibility. Many outpatient colleagues contact me or my senior physicians directly, which I strongly encourage. For me, this direct communication is key to effective collaboration, especially in a large center like ours, which could otherwise appear impersonal. In reality, however, we are closely connected, not only within Hamburg but also in the surrounding regions. This structure has developed over many years. Our strength lies in the combination of responsibility, accessibility, and presence. This has been a key factor in successfully establishing oncology services in Barmbek, closely integrated with a strong focus on palliative care. We also operate a large medical care center (MVZ) on site, which enables very short pathways for outpatient integration. For example, if a patient develops fever or dyspnea after chemotherapy, we can respond immediately and admit the patient for inpatient care if needed.
Ultimately, the key question for me is: what does the patient need? They need rapid diagnostics, reliable points of contact, and effective coordination between outpatient

Fig. 9: Mr. Hauke Weilert is Head of the Department

and inpatient care. Our guiding principle is clear: inpatient care when necessary, but outpatient care whenever possible.

Weilert, at what point do you discuss IPC therapy as a treatment option with your patients? How do you approach this conversation, and what has been your experience regarding patients' reactions and understanding of this treatment?

Whether and when I recommend an IPC depends very much on the individual situation. In cases of large pleural effusions or significant ascites, particularly in advanced disease, we often consider a long term solution as early as the first puncture. I do not make this decision in a standardized way. In cases of conditions that are treatable or where the course is still unclear, we often begin with punctures, monitor the volume of fluid, and discuss the IPC option at an early stage. It is important to me not to overwhelm patients, but to communicate transparently that there is a clear plan. Many patients are also specifically referred to us by outpatient oncologists or specialized palliative care teams with the request to place a drainage. In such cases, we carefully review the patient's history, and the option of drainage has often already been discussed in advance. I greatly value this close collaboration with the outpatient sector. I am aware that the idea of a visible catheter can initially be unsettling for many patients, and this should not be underestimated. Many patients are hesitant at first. However, when they experience how quickly fluid reaccumulates and how burdensome frequent punctures can be, their perspective often changes quickly. For me, independence and quality of life are the key factors.

With an IPC, patients can drain small amounts of fluid at home, even on a daily basis. Many report that they have little to no symptoms as a result. And when the catheter is no longer needed, it can be removed without difficulty.

This is an integral part of our approach. I am convinced that IPC therapy can provide meaningful support. We make every effort to guide patients in the best possible way, individually, transparently, and with the aim of supporting their autonomy.

How do you perceive the impact of IPCs on your patients' quality of life, particularly in advanced malignant disease? For example, do patients have concerns about traveling with an IPC? How do you address this?

Especially at the beginning, we observe a considerable degree of uncertainty and anxiety, which is entirely understandable, as we are often treating patients with advanced disease, frequently in a palliative context. For us, the central question is always what is the goal of therapy. The answer is clear, quality of life and freedom. In this context, the use of an IPC represents a significant advancement, as it reduces the need for repeated punctures every few days. Many patients initially find the presence of a catheter unsettling or feel unsure about its handling. However, this is often overcome once they experience the practical benefits. With an IPC, patients gain greater independence, and even travel can become feasible again. Feedback from patients is consistent: quality of life can improve noticeably.

If you had one wish: what specific technical, organizational, or structural developments would you like to see in clinical oncology?

What makes daily practice most challenging for me are the sector boundaries between outpatient and inpatient care, a system that has developed historically but is increasingly becoming an obstacle. This separation leads to significant organizational burden: different structures, incompatible IT systems, and a lack of interfaces. For example, I am unable to access outpatient findings. The ASV model is a step in the right direction, as it allows hospital-based oncologists to also provide outpatient services. However, the barriers remain high, and the resources required to overcome them are disproportionate. At the same time, our patients clearly benefit from transitions between outpatient and inpatient care. In principle, the shift toward more outpatient care is meaningful. However, it often complicates communication and continuity of care. There is a clear need for reform in this area. These structural barriers need to be reduced in order to enable more effective and patient-centered care.

We would like to thank Hauke Weilert for clearly illustrating how well-connected structures between hospital and outpatient care can help close gaps in care and provide tangible relief for patients in their daily lives.

4. IPC in palliative care

Malignant ascites and pleural effusion are associated with a high symptom burden and a significant reduction in quality of life in many patients receiving palliative care. The goal of palliative treatment is to effectively relieve these symptoms while minimizing burdensome interventions.

In this context, tunneled Indwelling peritoneal or pleural catheters (IPC) represent a practical treatment option, enabling continuous symptom control and frequently being used in the outpatient setting. Their use requires close interdisciplinary collaboration between medical, nursing, and palliative care teams.

Against this background, the study by Wong et al., Indwelling Peritoneal Catheters for Managing Malignancy-Associated Ascites[1] (2015), analyzes the use of IPCs in patients with malignant ascites and provides important insights into safety, symptom relief, and quality-of-life outcomes in the palliative care setting.

The study evaluated the use of IPCs for the treatment of malignant ascites in palliative patients. A total of 395 catheters were implanted in 386 patients.

The technical success rate was 100%, and the mean catheter dwell time was 66 days. Complications occurred in 5.57% of cases, with non-fatal infections being the most common (3.8%). In 4.05% of cases, no recurrence of ascites was observed, allowing for catheter removal.

Following catheter implantation, a significant improvement in dyspnea was observed, as measured by a significantly increased Transitional Dyspnea Index compared to baseline. In a smaller subgroup of patients who completed repeated quality-of-life questionnaires (EORTC), overall quality of life also improved significantly. Functional domains improved, and symptoms such as fatigue, pain, dyspnea, and loss of appetite were notably reduced.

Overall, the authors conclude that IPCs represent a safe and practical palliative treatment option with a low complication rate, which may provide meaningful symptom relief and improvement in quality of life in selected patients

[1] Wong, B. C. T., et al. Indwelling Peritoneal Catheters for Managing Malignancy-Associated Ascites. SAGE Journals, 2015

4.1 Palliative care in practice – cross-sector collaboration

Palliative care extends far beyond the purely medical treatment of patients with incurable disease. It is based on the concept of total pain, which understands suffering as a multidimensional phenomenon, encompassing physical, psychological, social, and spiritual aspects. Accordingly, palliative care focuses not only on symptom control, but also on identifying and alleviating all dimensions of this holistic burden. The goal is to support patients without curative treatment options, as well as their relatives, in maintaining or regaining quality of life.

Achieving this goal requires close coordination between various disciplines and professional groups. Physicians, nursing staff, therapists, psychologists, social services, and volunteers each contribute distinct yet equally essential components to patient care.

Palliative care thus represents a model of care that combines medical expertise with human compassion, where interdisciplinary collaboration becomes a key quality factor.

Fig. 10: Dr. med. Sivan Schipper and Nurse Specialist Tamara Schellenbaum

An exemplary model of palliative care in practice is provided by the palliative care unit at Spital Uster in Switzerland. Under the leadership of Dr. med. Sivan Schipper, the team delivers care to patients in palliative situations with a high level of professional expertise and strong commitment. In daily clinical practice, the department clearly demonstrates that high-quality palliative care is only possible through consistent interdisciplinary and interprofessional collaboration, and that this collaboration extends well beyond the core team.

In recognition of this work, the palliative care unit at Spital Uster received the qualitépalliative certification in December 2024.

Interdisciplinarity – beyond boundaries
A patient case from Spital Uster

Mr. M. was 72 years old when he was diagnosed with alcohol-induced liver cirrhosis in February 2025. He was born in Serbia and had been living in Switzerland with his family since the 1970s. He was widowed and had several children and grandchildren. Prior to hospitalization, he lived with his daughter, son-in-law, and grandchild.

1 Medical course
The patient was admitted with decompensated liver cirrhosis, presenting with hepatic encephalopathy (confusion, somnolence, flapping tremor) and four-quadrant ascites, on the background of known alcohol-related liver cirrhosis and pre-existing pauci-immune glomerulonephritis. This was his fourth hospitalization within the same year (two prior admissions due to decompensated liver cirrhosis and one due to glomerulonephritis).
Hepatic encephalopathy was successfully managed by increasing the dose of lactulose, and the patient became progressively more oriented. In addition, a paracentesis was performed with drainage of 2.6 liters of clear fluid with

normal cell count, along with intravenous administration of 20 g albumin. An attempt to increase the dose of spironolactone and low-dose torasemide resulted in deterioration of renal function with progressive hyperkalemia. Due to rapidly recurrent ascites, a joint decision was made with the patient and his relatives to proceed with IPC implantation. Placement of a transjugular intrahepatic portosystemic shunt (TIPS) was evaluated in an interdisciplinary setting; however, this option was not pursued due to the increased risk of exacerbating the existing hepatic encephalopathy. Given the patient's unstable condition, poor prognosis, and his explicit wishes, a joint decision was made with his relatives to forgo all life-prolonging measures and to focus on goals centered around quality of life. During several multidisciplinary discussions, it became clear that the patient's primary wish was to spend the final stage of his life in his home country, Serbia. This wish was supported by his family but posed a significant challenge due to his complex and unstable medical condition.

2 IPC implantation

To achieve effective symptom control and avoid further hospitalizations and paracenteses, an IPC was implanted on July 22, 2025. The procedure was performed without complications in the medical outpatient department. The following day, Mr. M.'s daughters were instructed by ewimed staff on the handling and care of the catheter directly in the hospital, and just four days later, the family traveled together to Serbia.

In Serbia, the daughters carried out daily drainage. When needed, for example for planned suture removal, they consulted a locally based physician. There were several telephone consultations with ewimed to address questions regarding catheter care. Using modern communication tools such as FaceTime, wound conditions were assessed and guidance on catheter handling was provided by an ewimed staff member. Dr. med. Sivan Schipper and Nurse Specialist Tamara Schellenbaum also remained in regular contact with the family, providing medical and nursing advice.

3 Interdisciplinary and interprofessional collaboration in the case of Mr. M.

The care of Mr. M. represents an example of successful, patient-centered, interprofessional collaboration in palliative care, placing both the patient and their relatives at the center.

Medical team

Palliative care physicians and gastroenterologists worked in close collaboration to evaluate possible treatment options. As the case progressed, particular focus was placed on continuous adjustment of medication in light of the complex hepatorenal condition, as well as on advance care planning, including medication management, emergency planning, and clarification of treatment goals. IPC implantation was planned during the inpatient stay and performed by Dr. med. Sivan Schipper.

Treatment decisions in our setting are made jointly within the interdisciplinary care team together with the patient and their relatives […] However, the fact that, as a palliative care physician, I perform the implantation of peritoneal catheter systems myself provides additional flexibility. This means I am not dependent on the availability of other specialties and can act more quickly. Earlier implantation allows patients to benefit from the system for a longer period […]
— Dr. med. Sivan Schipper

Palliative nursing care

Palliative care nursing ensured daily clinical care, systematically monitored symptoms, and coordinated preparation for home care. A key component was the training of relatives in the safe performance of drainage procedures. A particularly important role was played by APN (Advanced Practice Nurse) and nurse specialist Tamara Schellenbaum, whose proficiency in Serbian created a reliable communication bridge, promoted transcultural understanding, and significantly contributed to building trust.

Specialized outpatient services
Palliative home care services (Spitex) and psychiatric home care services supported the patient in the home setting and contributed to symptom control, particularly with regard to fatigue, dyspnea, and psychological burden. Given the presence of depressive symptoms, they played a key role in stabilizing the patient's emotional condition and relieving the burden on relatives.

Social services / case management
Social services coordinated the logistical, organizational, and financial aspects of the patient's planned return to his home country, Serbia. This included assessing local healthcare structures, ensuring the availability of relevant documentation, and providing support with administrative matters, such as the cross-border transport and availability of necessary medications. This structured approach made it possible to prepare and realize a central wish of the patient.

Therapeutic services
physiotherapy, occupational therapy, and nutritional counseling
Physiotherapy and occupational therapy supported mobility, strength, and activities of daily living in order to maintain functional capacity for as long as possible despite disease progression. Nutritional counseling provided liver-specific recommendations, addressed loss of appetite, and adapted dietary plans to the clinical course, an important component in stabilizing the patient's overall condition.

Voluntary services and complementary therapies
Volunteers provided valuable support alongside professional care, particularly during phases of agitation and aggressive behavior associated with hepatic encephalopathy. They offered emotional relief for the family and contributed to additional presence and orientation. The patient also benefited from complementary therapeutic approaches such as music therapy and therapy dogs, which had a stabilizing effect, reduced agitation, supported non-verbal expression, and enhanced subjective well-being..

Collaboration between disciplines
The complexity of the clinical condition, encompassing medical, nursing, psychosocial, and existential factors, required dynamic collaboration between all involved professionals. This was based on the following principles:

+ Regular exchange within a weekly interprofessional team meeting
+ Joint definition of realistic treatment goals, with close involvement of the patient and their relatives
+ Close collaboration and communication between the care team, relatives, and follow-up care providers, in this case, general practitioners and nursing staff in Serbia, as well as with external service providers (including ewimed)
+ Shared identification and management of distressing symptoms, with a joint focus on psychosocial support and preparation for the final phase of life

The care of Mr. M. demonstrates how coordinated, interprofessional management of complex palliative conditions can lead to a meaningful improvement in quality of life. The implantation of the IPC enabled effective symptom control and allowed the patient to maintain a self-determined life in a familiar environment […]
— Tamara Schellenbaum

IPC as part of the total pain management approach?

The treatment objectives, particularly the improvement of the patient's quality of life, were achieved on multiple levels.

Improvement of distressing physical symptoms

From a medical perspective, the catheter enabled controlled and gradual decompression of the abdomen, leading to immediate relief of abdominal tension and associated symptoms. Mobility and the ability to perform activities of daily living improved. In addition, regular drainage of ascites contributed to stabilization of hepatic encephalopathy, the episodic exacerbations of which had previously been closely associated with fluid accumulation. By reducing pressure fluctuations and relieving the portal system, a more stable cognitive state was achieved, which in turn facilitated communication and social interaction.

Autonomy and psychosocial relief

Further paracenteses were avoided. The patient's sense of autonomy and control increased.
An important factor, particularly in the context of his underlying depressive symptoms.

Fulfillment of the patients wish

Of central importance was that the IPC facilitated the realization of the patients final wish: to spend the last phase of his life in his home country, Serbia. This was of fundamental importance to him on an emotional and spiritual level.
In summary, the IPC did not represent a life-prolonging intervention, but rather a consistently quality-of-life-oriented measure. It contributed to a sustained reduction in both physical symptom burden and psychosocial distress, enabling a greater degree of autonomy and dignity in the final stage of life.

4 Afterword

On August 18, 2025, Mr. M. passed away with good symptom control, in the presence of his family, as he had wished in his home country of Serbia.

We are very grateful to Dr. Schipper, Tamara, the entire team, and ewimed for the excellent collaboration and support in the care of our father […]
— The family of Mr. M.

At ewimed, we extend our heartfelt wishes to Mr. M.'s family for the future and are deeply moved by their unity and dedication to their father. We would also like to express our sincere thanks to Dr. med. Sivan Schipper and Nurse Specialist Tamara Schellenbaum for providing these insights into their daily work in the palliative care unit at Spital Uster, and for their ongoing commitment together with their team. We are proud to be able to contribute in a small way to this care.

In the words of Mr. M., which he shared with an ewimed staff member after receiving training on drainage procedures at Spital Uster:
"Hvala i doviđenja…"
"Thank you, and hopefully goodbye…"

4.2 Palliative care services in an international comparison

Palliative care in Europe is organized differently across countries and continues to evolve. While well-established care structures already exist in many countries, future priorities increasingly focus on expanding outpatient services, integrating palliative approaches at an earlier stage, and strengthening networking, quality assurance, and interdisciplinary collaboration.

In this context, modern care options such as IPCs also play an important role in enabling a treatment approach that is as minimally burdensome, safe, and close to the patient's home as possible. The following country examples provide an overview of current structures, key challenges, and strategic development goals in specialized palliative care.

Germany

Palliative care in Germany is well established and firmly integrated into the healthcare system. It includes general palliative care provided by general practitioners and nursing services, complemented by specialized outpatient palliative care (SAPV). SAPV teams work in an interdisciplinary manner and are typically led or supported by physicians. Additional key components include hospices and palliative care units within hospitals.
Across Germany, a wide range of care services is available: approximately 330 palliative care units in hospitals, around 270 adult hospices, and about 20 children's hospices. The largest share is represented by SAPV teams, with more than 400 services nationwide. In all areas, specially trained physicians provide medical support to patients with serious illness, aiming to relieve symptoms and maintain quality of life as effectively as possible. Due to demographic changes, the importance of palliative care is expected to continue to increase.

Switzerland

In Switzerland, specialized palliative care is well established. It includes numerous certified inpatient facilities, 35 palliative care units with a total of 399 beds in 2023, as well as hospital-based consultation services and mobile palliative care teams. Based on a national strategy, the platform Palliative Care promotes networking, knowledge exchange, and quality development. In the coming years, the focus will be on further developing these services and sustainably improving quality of care through enhanced collaboration and improved data availability.

Austria

In Austria, specialized hospice and palliative care services are now largely established nationwide, for example in Tyrol since 2019. These include centrally coordinated palliative care units, hospices, mobile palliative care teams for home-based care, and outpatient palliative clinics.

Over the next ten years, the focus will be on further expanding outpatient care structures, particularly mobile teams, as well as strengthening basic palliative care through targeted training in nursing homes and home care services. At the same time, the academic foundation of palliative medicine is being strengthened, including the establishment of an endowed professorship in palliative medicine in Innsbruck. In addition, the development of caring communities is being promoted to better integrate end-of-life care into society and to reduce avoidable hospital admissions through improved home care. Another key focus is supporting family caregivers and strengthening collaboration between general practitioners and specialized palliative care teams.

Sweden

In Sweden, palliative care is centered on a holistic, person-centered approach. National healthcare guidelines aim to improve accessibility, equity, and consistency in end-of-life care. In addition, a national palliative care registry supports the systematic collection of care data and contributes to continuous quality improvement. In the coming years, these measures are expected to further enhance the quality of life of patients with incurable diseases and to effectively alleviate suffering.

Denmark

In Denmark, palliative care is gaining increasing importance. Hospitals and municipalities have established specialized palliative care teams, which are now used more frequently as patients live longer with chronic and life-limiting conditions and spend more time in the palliative phase. In the coming years, the focus will be on strengthening cross-sector collaboration and integrating palliative care earlier in the disease trajectory. The aim is to ensure optimal symptom control and to maintain quality of life as effectively as possible in the final stage of life.

Hungary

In Hungary, hospice and palliative care services have expanded significantly in recent years. Nationwide, numerous outpatient hospice services now cover more than 80% of regions, complemented by several inpatient hospices. However, challenges remain: psychosocial support services are still underrepresented, and access to palliative care for non-cancer patients remains limited. Over the next ten years, the focus will be on strengthening funding and workforce resources to ensure sustainable and high-quality end-of-life care. In addition, the multidisciplinary, holistic approach is to be further developed, with earlier integration of palliative care in the disease trajectory to ensure not only physical symptom control but also psychological, social, and spiritual support for patients and their families.

If you are interested in contributing to the ewimed report 2027 or would like to suggest topics, please feel free to contact us.
Our aim is to develop the ewimed report each year in close alignment with the healthcare system, physicians, and medical professionals.

Contacts

Austria
ewimed austria GmbH
Tullnerbachstrasse 92a
3011 Neu-Purkersdorf
Tel.: +43 2231 2250-0
info@ewimed.com

Belgium
ewimed Belgium BV
Kortrijksesteenweg 1126a
9051 Sint-Denijs-Westrem
Tel.: +31 203 695 620
info.be@ewimed.com

Denmark
ewimed Denmark A/S
c/o Beierholm
Knud Højgaards Vej 9
2860 Søborg
Tel.: +45 31 43 50 60
info.dk@ewimed.com

Germany
ewimed GmbH
Im Nasswasen 5
72379 Hechingen
Tel.: +49 7471 73972-0
info@ewimed.com

Hungary
ewiCare Medical Center
Hidász utca 1.
1026 Budapest
Tel. +36 1 998 8295
info@ewicare.com

Luxembourg
ewimed GmbH
Dorfstrasse 24
72379 Hechingen
Tel.: +49 7471 73972-0
info@ewimed.com

Netherlands
ewimed Netherlands B.V.
Johan Cruijff Boulevard 65
1101DL Amsterdam
Tel.: +31 203 695 620
info.nl@ewimed.com

Norway
c/o Value Oslo AS
Erik Børrensen alle 7
3015 Drammen
Tel.: +45 31 43 50 60
info.no@ewimed.com

Romania
ewimed Healthcare Systems SRL
str. Maria Rosetti nr. 6, et 3B, Sector 2
020481 București, Rumänien
Tel.: +40 (31) 229 84 48
contact@ewimed.ro

Sweden
ewimed Sweden AB
Regus Malmö C
Adelgatan 21
211 22 Malmö
Tel.: +46 8 25 11 69
info.se@ewimed.com

Switzerland
ewimed Switzerland AG
Freiburgstrasse 453
3018 Bern
Tel.: +41 31 958 66 66
info.ch@ewimed.com

List of figures

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Germany | ewimed GmbH | Im Nasswasen 5 | 72379 Hechingen | Tel.: +49 7471 73972-0
info@ewimed.com | www.ewimed.com