



Survivorship in Cancer Care

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+ Disclaimers

- Participated in Advisory Boards for Amgen, Astellas, Bayer, Janssen, Novartis, Pfizer, Sanofi
- Have clinical trials with BMS, Amgen, AstraZeneca



+ Disclaimers



- >60% of the patients I treat have advanced disease
 - Our patients are living much longer with advanced disease

- Treatments are changing, becoming more complex and personalized – makes giving general suggestions difficult

+ Objectives



- Review Survivorship in Cancer Care
- Discuss challenges in follow-up care of patients treated for a variety of cancers.
- Discuss common side effects/issues post cancer treatment



**CANCER SURVIVOR
AWARENESS MONTH**



Why is Survivorship Important?

- Estimated ~14 million cancer survivors in US
- Increasing number of cancer survivors
- Cancer centres are losing ability to keep up with demand
- Primary Care Physicians also treating older and more complex patients

- Survivorship is a HOT topic



Post-treatment Survivorship

Case

+ Case



- 57-year-old male diagnosed with stage III colon cancer
- Surgery and adjuvant chemotherapy just completed
- Returns to the Medical Oncology office for his first post-treatment follow-up

+ Case



- How should this man be followed and why?

- Specifically:
 - Where?
 - What tests?

Choosing Wisely Canada



Don't deliver care (e.g., follow-up) in a high-cost setting (e.g., inpatient, cancer center) that could be delivered just as effectively in a lower-cost setting (e.g., primary care).



Why do these patients need follow-up?



- detect recurrence
- detect new primary cancers
- monitor for late toxicities
- provide psychosocial support

- General practitioners can do this
 - no detriment in time to diagnosis of recurrence or in health related quality of life



Case: What does this patient need?



- 1) Detect recurrence
 - Each cancer site specific
 - Need to know for that cancer – patterns of recurrence, and whether finding early makes a difference

 - For this patient?
 - Hx, Physical, and CEA q3-6 months x 3 yrs, then q6months x 5
 - CT q6months x 3 yrs, then not at all?
 - Colonoscopy – frequency?



Case: What does this patient need?



- 2) Detect new primary cancer
 - Screening based on other guidelines, unless they have a genetic predisposition
 - ? *Prevention – smoking cessation, diet/exercise*



Case: What does this patient need?



- 3) Monitor for late toxicities
 - Need to know what treatments they had
 - Surgery – which type, when, complications?
 - Chemotherapy – which drugs, and what side effects do they cause
 - Radiation – yes or no, if yes – where?

- 4) Provide psychosocial support



Not
Easy



Survivorship Care Plans

+ Survivorship Care Plans



- Commission on Cancer (CoC) developed SCP in 2014
- Controversial
- ASCO (American Society of Clinical Oncology) came up with its own recommendations

+ Survivorship Care Plans

- Key Components for Patients Treated with Curative Intent
- **Treatment summary:**
- Contact information of the treating institutions and providers.
- Specific diagnosis (e.g. breast cancer), including histologic subtype (e.g. non-small cell lung cancer) when relevant.
- Surgery (yes/no). If yes:
 - Surgical procedure with location on the body
 - Date(s) of surgery (year required, month optional, day not required)
- Chemotherapy (yes/no). If yes:
 - Names of systemic therapy agents administered (listing individual names rather than regimens)
 - End date(s) of chemotherapy treatment (year required, month optional, day not required)

+ Survivorship Care Plans



- Radiation (yes/no). If yes:
 - Anatomical area treated by radiation
 - End date(s) of radiation treatment (year required, month optional, day not required)
- Ongoing toxicity or side-effects of all treatments received (including those from surgery, systemic therapy and/or radiation) at the completion of treatment, and any information concerning the likely course of recovery from these toxicities.
- For selected cancers, genetic/hereditary risk factor(s) or predisposing conditions and genetic testing results if performed.





Medical Oncology Perspective

+ Medical Oncology Perspective



- Comes down to Communication
- Summary of what type of cancer, the intent of treatment, and what treatment/surgery they had for cancer
 - Supportive
 - Symptoms cancer related, treatment related, or something else?
- ?Easier for Oncologists

+ Intent of Treatment



- Adjuvant

- Palliative

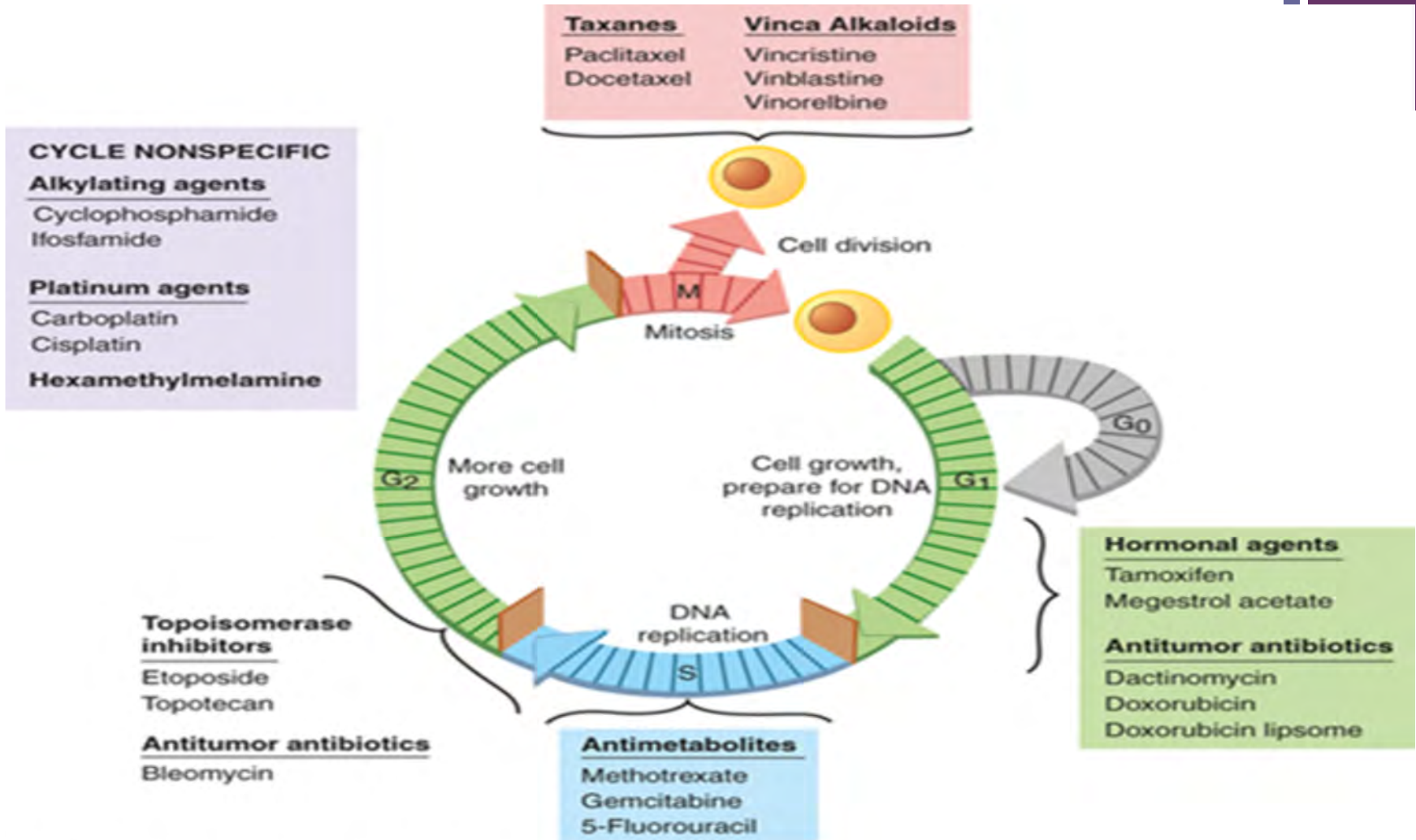


Categories of drug treatment for cancer



- 1) **Chemotherapy**
- 2) **Endocrine therapy**
- 3) **Targeted therapy**
 - often associated with predictive biomarker
- 4) **Immunotherapy**

+ Chemotherapy



+ Chemotherapy



■ ACUTE

■ CHRONIC

- Risk of MDS/leukemia
- Cardiotoxicity
- Ovarian Failure/Fertility
- Osteoporosis
- Peripheral Neuropathy
- Hearing
- Cognitive Dysfunction

+ Chemotherapy



- Risk of MDS/Leukemia
 - Not something we screen for
 - Usually check CBC after chemotherapy complete to ensure count recovery
- Cardiotoxicity
 - Risk higher in older adults
 - If symptomatic and/or decreased EF – should be treated and followed
- Osteoporosis
 - Baseline screen if ≥ 65
 - Screen 60-64 if any risk factors or premature menopause

+ Endocrine Therapy



- Breast Cancer

- Tamoxifen
- Aromatase Inhibitors (AIs)

- Prostate Cancer

- Antiandrogen
- LHRH antagonist/agonists

+ Endocrine Therapy

■ Tamoxifen

- Hot flashes
- Increased risk Endometrial Ca
- Bone protective
- Increased risk of VTE

■ Antiandrogens

- Hot flashes
- Sexual Dysfunction

■ AIs

- Arthralgias
- Sexual Dysfunction
- Osteopenia/Osteoporosis

■ LHRH analogues

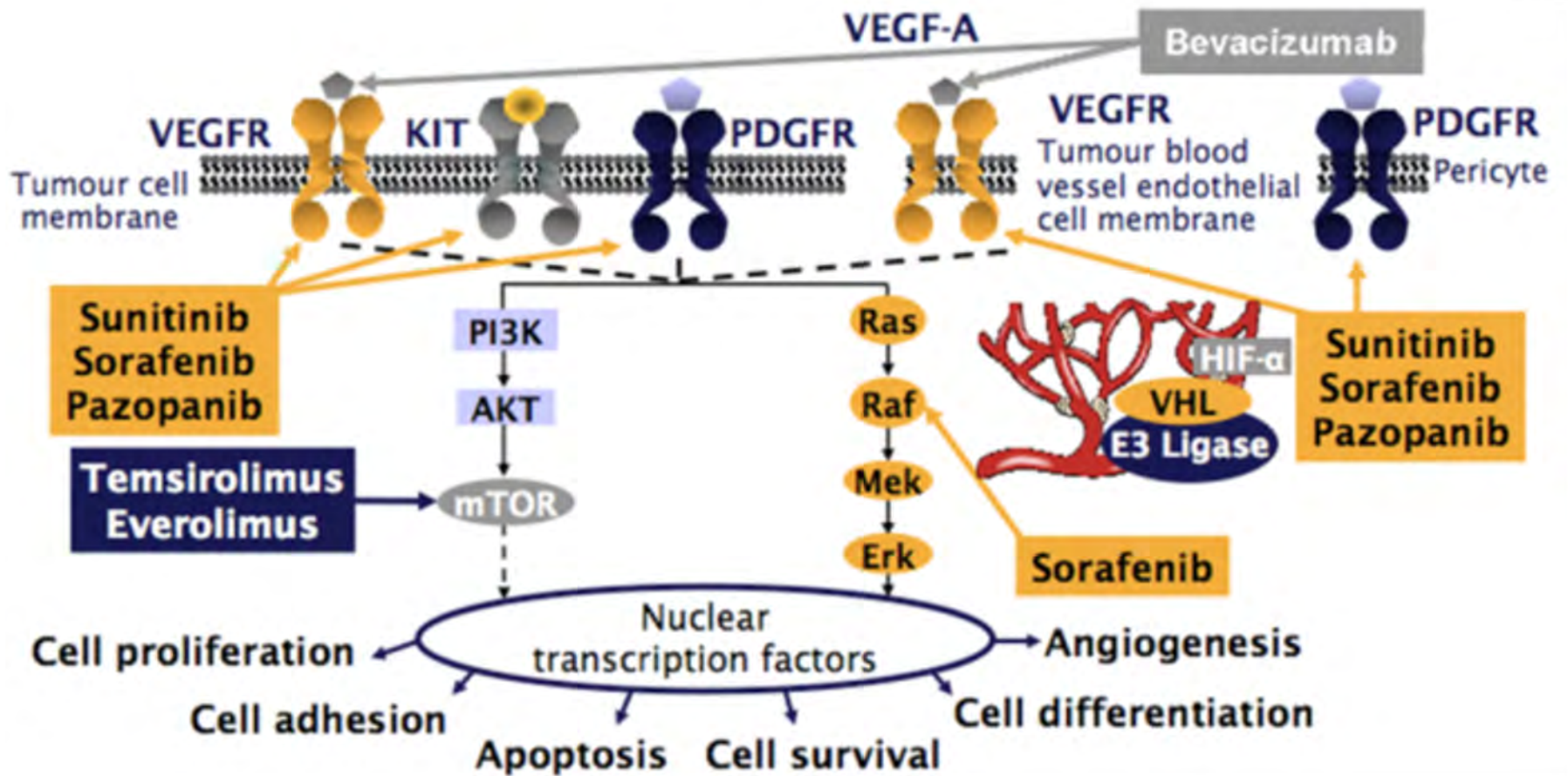
- Hot flashes
- Sexual Dysfunction
- Osteoporosis
- Body Composition and Metabolism/CV risk

+ Endocrine Therapy

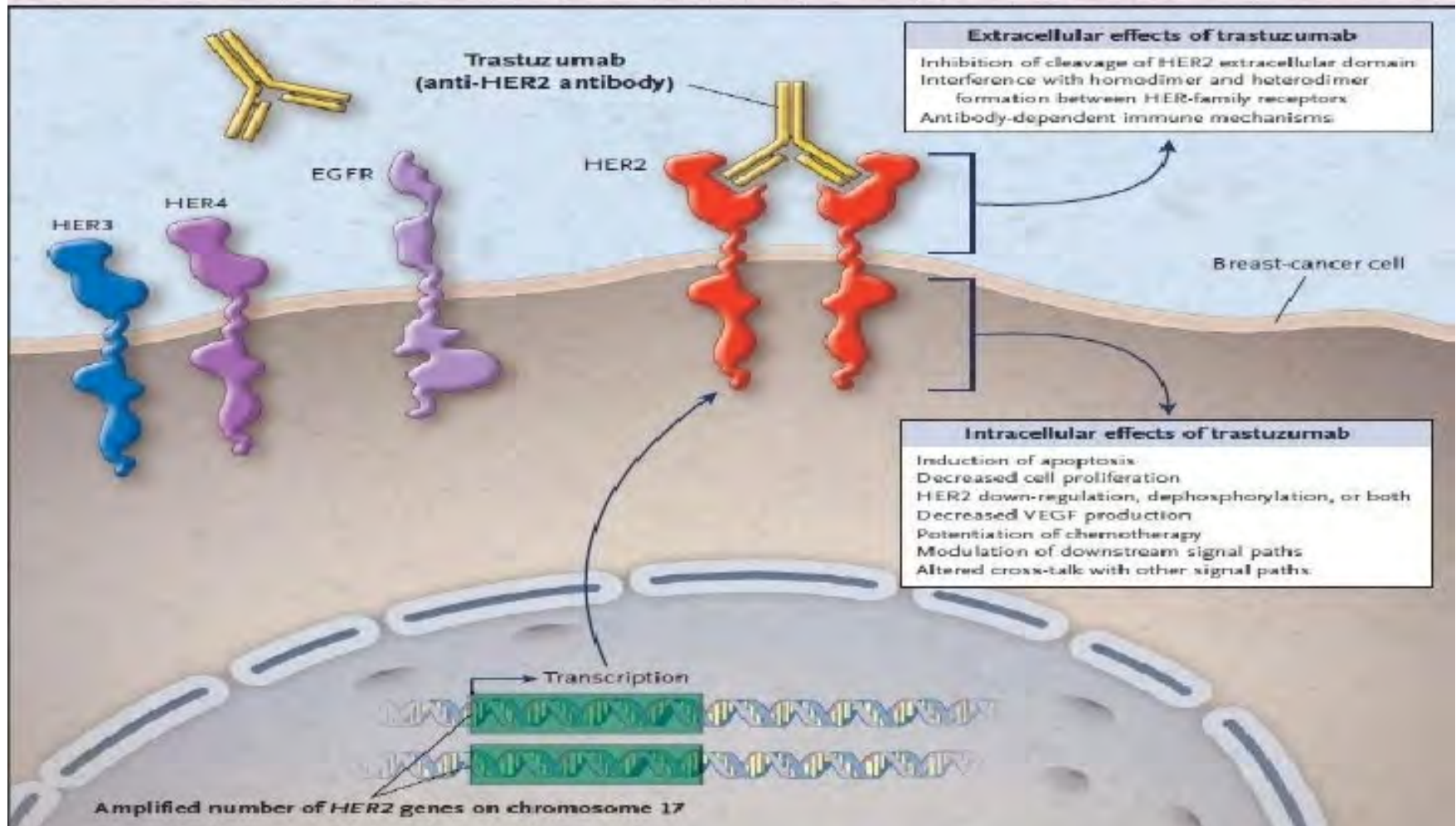


- Risk of Endometrial Cancer
 - No role of screening currently
 - Postmenopausal bleeding should be referred to Gyne for biopsy
- Risk of VTE
 - Risk 2-3 x, duration of therapy, and compounded risk if other risk factors
- Osteoporosis
 - Baseline for men initiating ADT
 - As mentioned previously for women
- Cardiovascular Risk
 - Regular risk factor reduction – smoking cessation, exercise...

+ Targeted Therapy



Trastuzumab: Mechanism of Action



+ Targeted Therapies



- Cetuximab

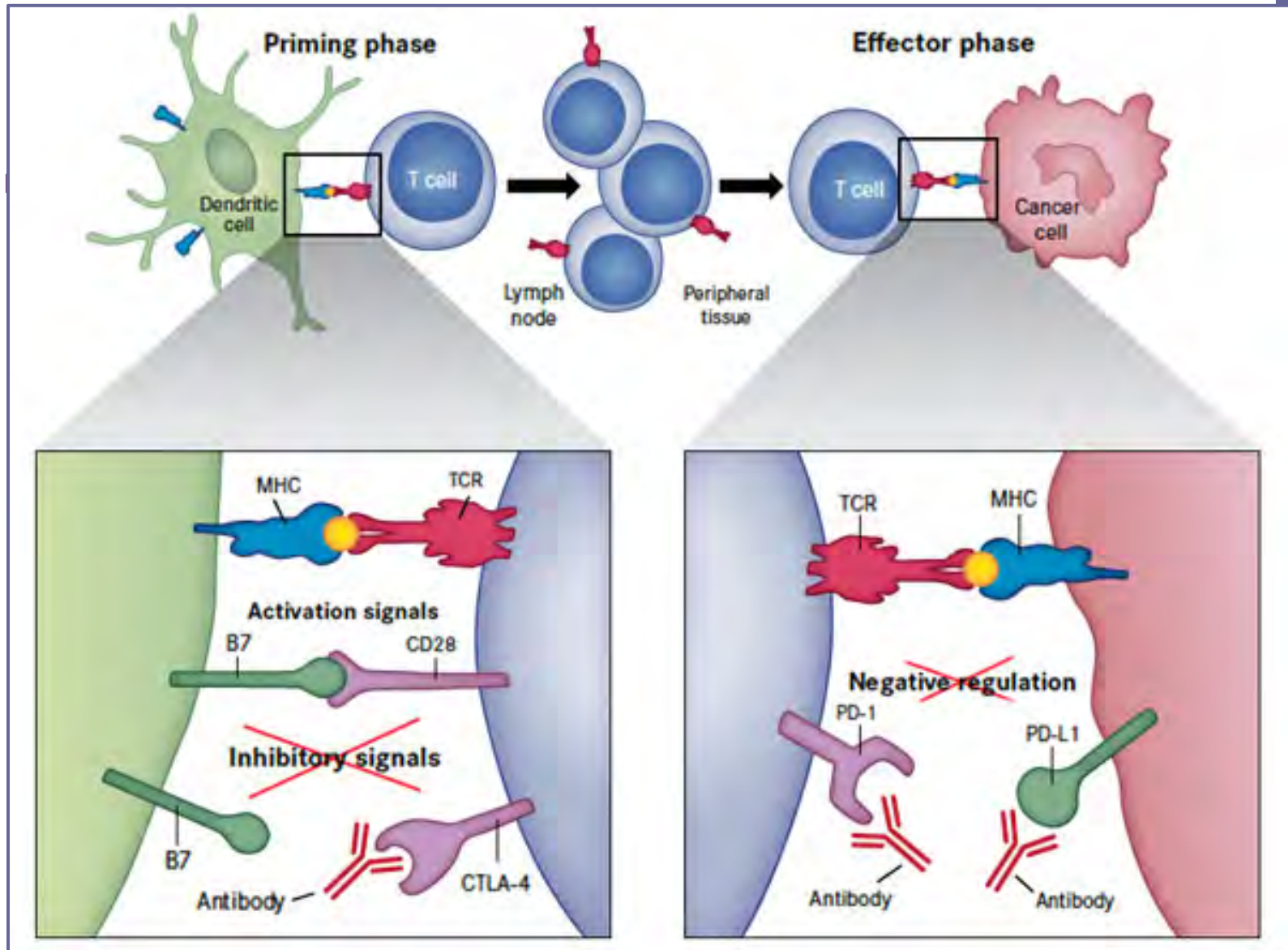
- Rash, fatigue
- Hypomagnesemia

- Trastuzumab & Pertuzumab

- Cardiotoxicity (Trast > Pertuzumab)
 - Usually asymptomatic decrease in LV function, reversible



Immunotherapy





Immune Checkpoint Inhibitors Toxicity



- Well tolerated treatment for most
 - Not like traditional chemotherapy – ie. Fatigue/nausea/vomiting/myelosuppression
- But when it does happen – can be significant
 - Non-Immune Mediated
 - Infusion reaction, fatigue
 - Immune Mediated
 - Think of a general ramping-up of your own immune system to fight cancer – so can develop ***auto-immune*** like side effects



Immune Checkpoint Inhibitors Toxicity



- In general:
 - Least toxic: PD-1/PD-L1 inhibition
 - More Toxic: CTLA-4 inhibition
 - Most toxic – Combination CTLA-4 inh + PD-1 inh
- Can happen months after they had therapy...
 - Especially with CTLA-4 Inhibition

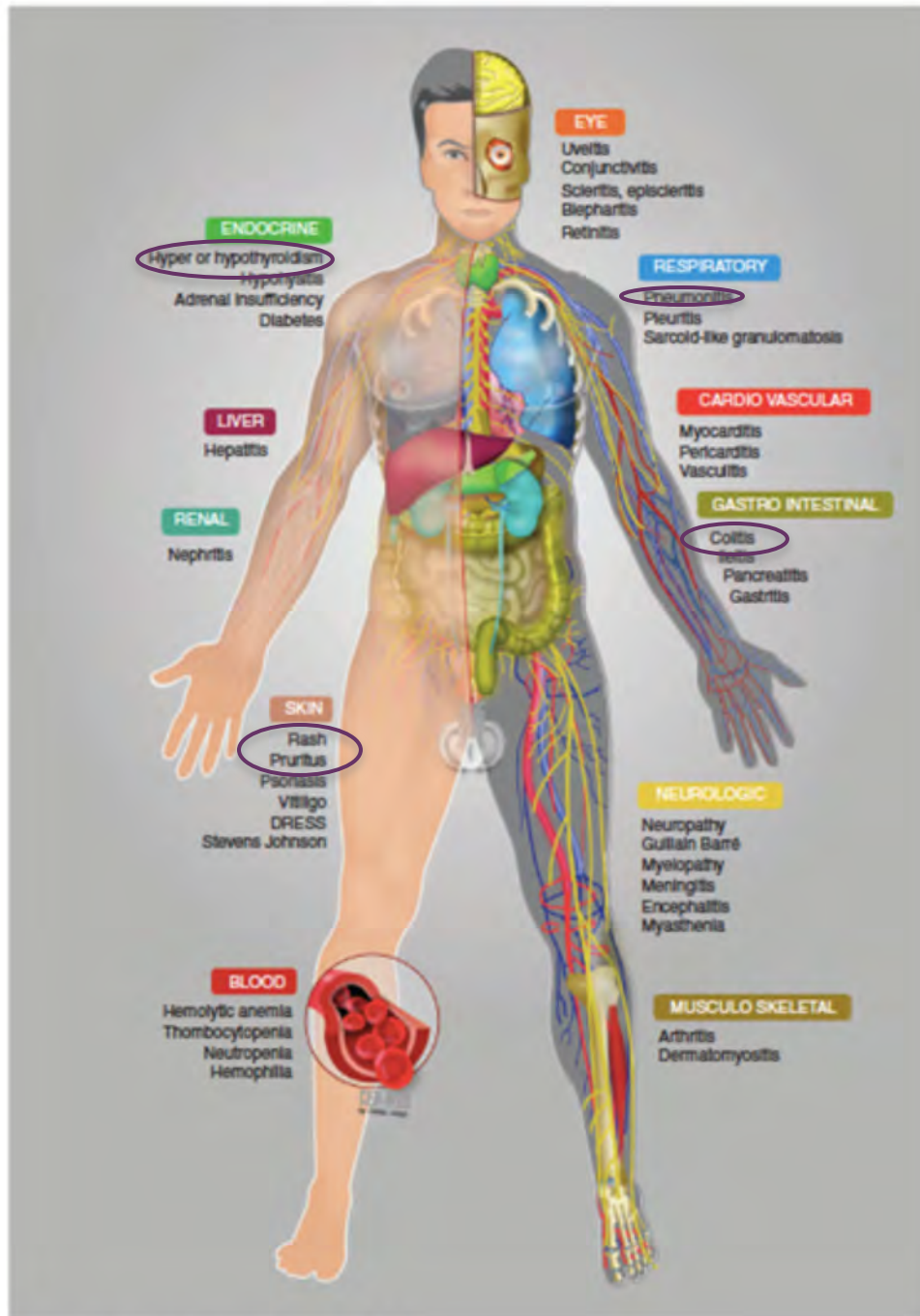


Figure 2. Spectrum of toxicity of immun checkpoint blockade agents.



Immune Checkpoint Inhibitors



- Be aware that the drugs are out there
- Starting to use them in the Adjuvant setting
 - Unsure how we will follow them at this point
- Pharmacists at MCH and SJRH working on education materials for patients and family doctors

+ Survivorship - Practically



- Provide psychosocial support
- Discuss Lifestyle Modification
- Manage Long Term Side Effects
- Ensure follow-up guidelines followed

+ Summary



- Survivorship is a HOT topic
- Follow up guidelines vary depending on intent and type of treatment
 - Changing constantly
- Collaboration and Communication is key to ensure patients are supported



Questions?