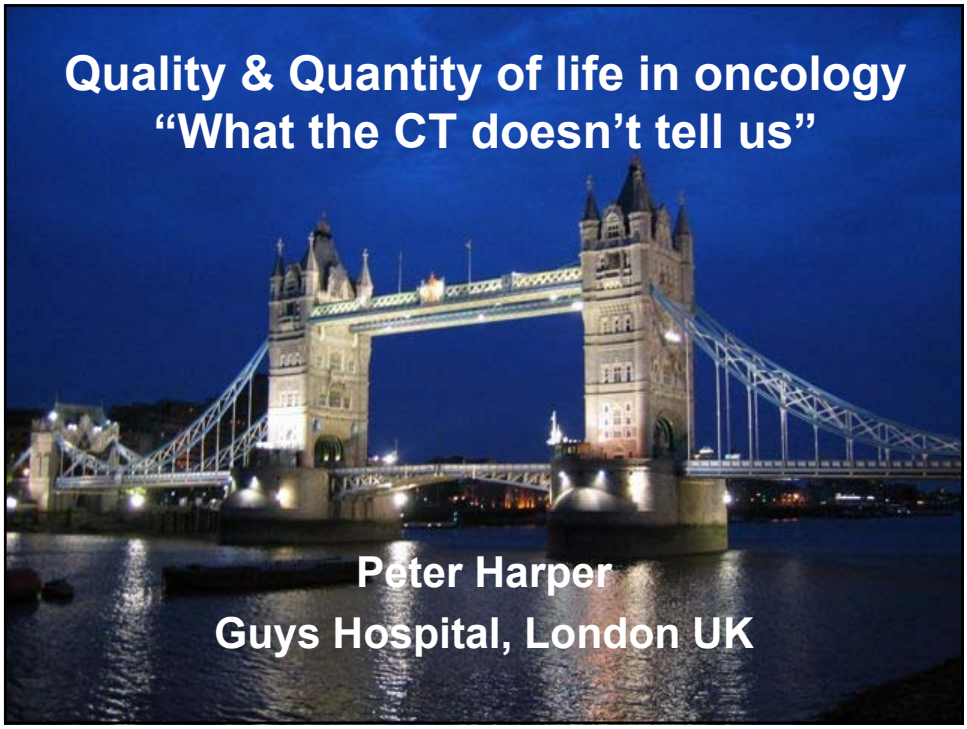
Quality & Quantity of life in oncology
"What the CT doesn't tell us"



Peter Harper
Guys Hospital, London UK

Baby boomers have gone grey !

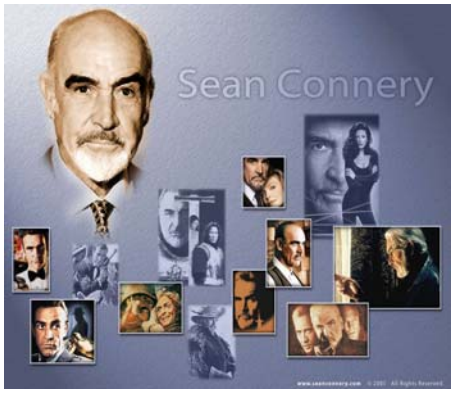
- 57 % of patients with cancer are over 65
- Number of people over 65 yrs old will double in the next 25 years
- 20% of the US population is expected to be more than 65 yrs old in 2030

20% of 260 million = a very large number

Who is OLD?

80 YRS OLD
WORKS FULL TIME…

76 YRS OLD
STILL THE LEADING MAN



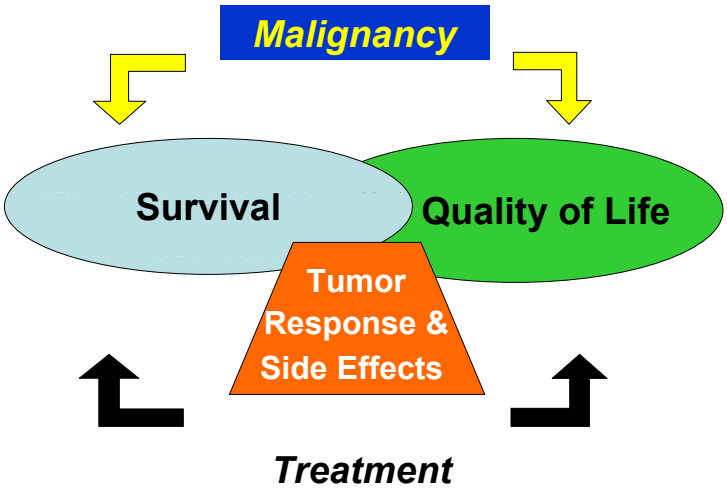
Current expected survivals

Age	Projected life expectancy
70	14.2 yrs
80	7.7 yrs
85	5.4 yrs

Care of the "elderly" will become routine practice.

Our expectations must change with theirs…..

Endpoints and treatment: Relationships and role of patient reported outcomes



Quality trials & QoL in NSCLC

Harper, Plunkett, Khayat, Editorial:JCO 21. 3007- 8: 2003

In evaluating a 'new treatment' two types of 'effect' should be considered

CANCER OUTCOME

Response and Response Duration

PATIENT OUTCOME

Survival and Quality of Life

However medical staff don't always agree with what our patients want.

Attitudes of staff & pts to chemo 'Misperception'

(Relapsed Ovarian Cancer)

'Staff were less tolerant then the patient to the concept of nausea, anorexia, diarrhoea & rash.'

'Staff rated life prolongation by 3 months to 1 year as very much less acceptable than patients.'

Staff said 'not worth it'. Patients said 'Yes we would accept the toxicity for that benefit' and were happy with the decision at later interview. p =.001'

Penson et al .Gyn Oncol

Attitudes of staff & pts to chemo 'Miscommunication'

(Relapsed Ovarian Cancer)

But be careful what the patient hears….

- **Patients believed that they would achieve with second line treatment…**

  Remission in 50%, Cure in 15%

- **Staff had said:**

  Remission in 15%, Cure in 0%

Penson et al .Gyn Oncol

Treatment side effects
Coates' study (1983)

- 99 patients
- Out patients
- 40 % males / 60 % females
- Median age : 52 [18 - 78]
- All had advanced cancer
- All had received chemotherapy within the last 4 weeks

Patients' perception (1983)
Coates' study

1 Vomiting

2 Nausea

3 Loss of hair

4 Thought of coming for treatment

5 Length of time treatment taken at the clinic

6 Having to have a needle

7 Shortness of breath

8 Constantly tired

9 Difficulty sleeping

10 Affects family or partner

11 Affects work / home duties

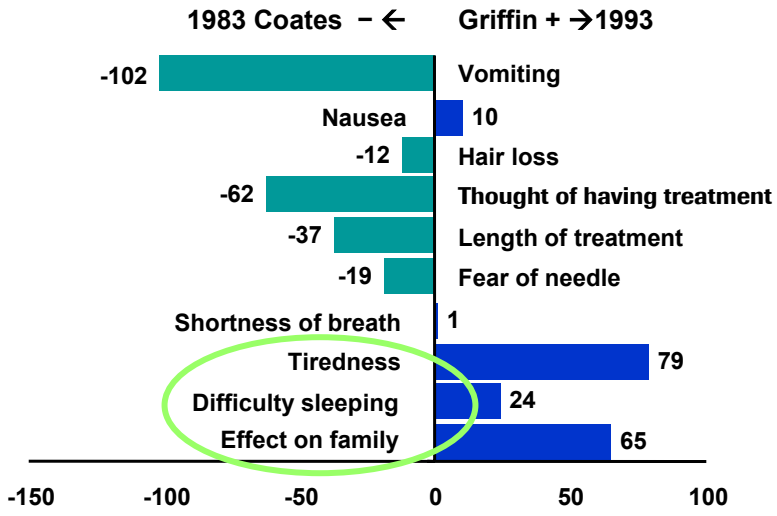
12 Trouble finding somewhere to park

13 Feeling anxious or tense

14 Feeling low, miserable (depression)

15 Loss of weight

Patients' perception
Coates (1983) vs. Griffin (1993)



NSCLC

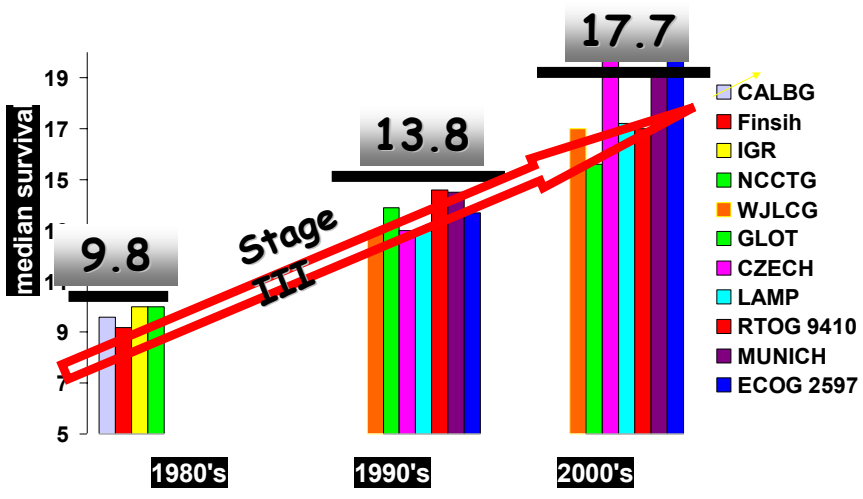
Advanced and metastatic NSCLC

Treatment has limited impact on survival but....

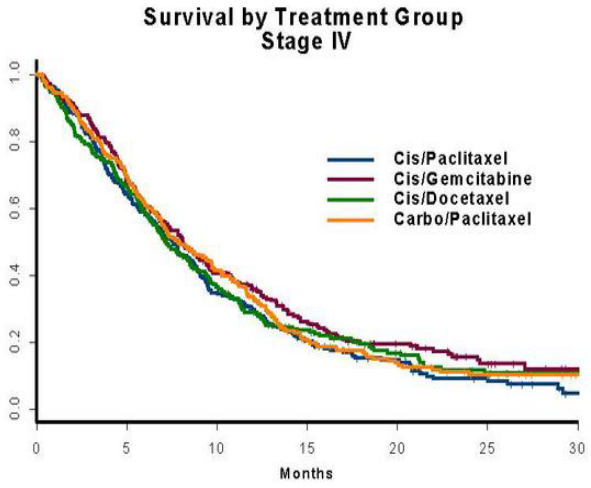
- Is active in any stage of the disease
- Improves symptom control
- Improves QOL
- Active second line and probably third line
- Is cost effective

ALL BASED ON A LARGE BODY OF EVIDENCE

Survival improvement in stage III NSCLC since 1980's



E1594



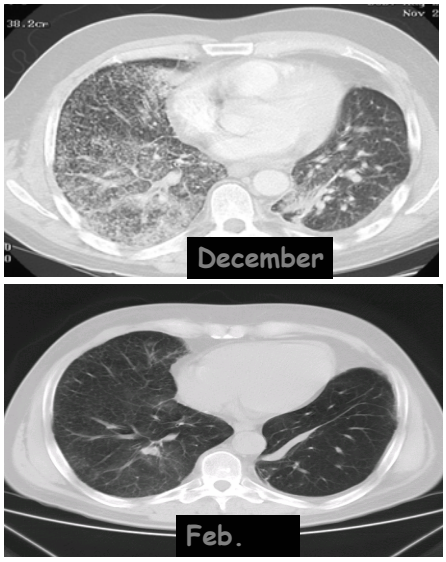
Have we reached the ceiling for improved benefit of cytotoxic chemotherapy in advanced NSCLC?

More of Avastin Later

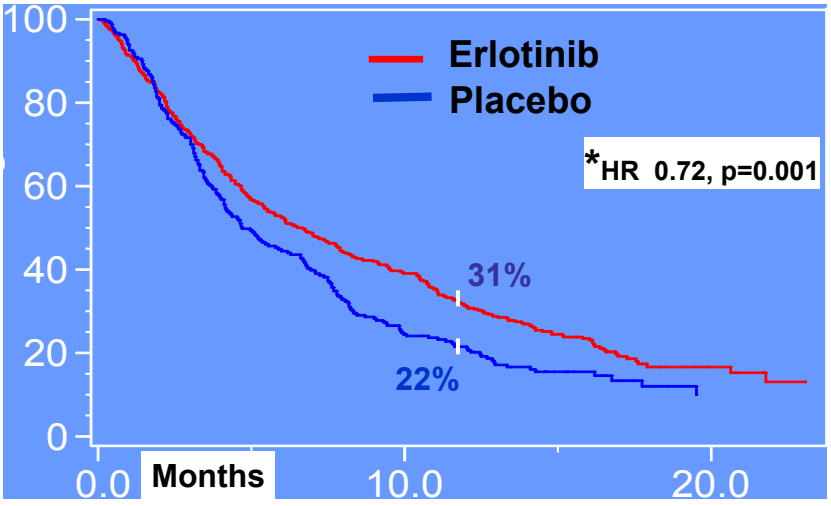
Schiller et. al., NEJM 346:92-8, 2002

A request for innovation in cancer treatments

Erlotinib response 3rd line

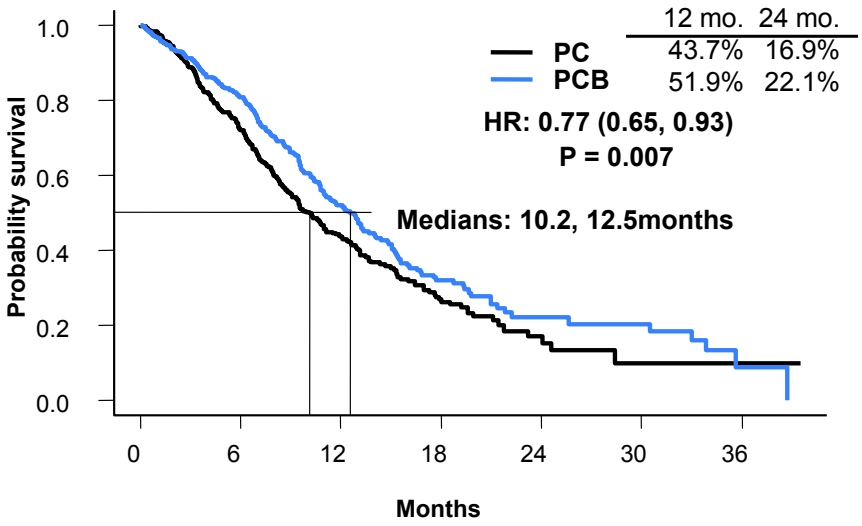


BR.21 Overall survival



*Adjusted for stratification factors

Avastin in NSCLC / E4599: Survival ECOG's ' New Standard of Care'



Current clinical dilemmas

- ECOG says Carbo Paclitaxel with Avastin is the gold standard for NSCLC. Is it?
- Have we reached a plateau with current treatments?
- Is Tarceva the gold standard 2nd line /3rd line?
- Enrich the population. Personalised medicine!!!!!!!

BC

Global Herceptin adjuvant programme

HERA (ex-US)
(n=5090)

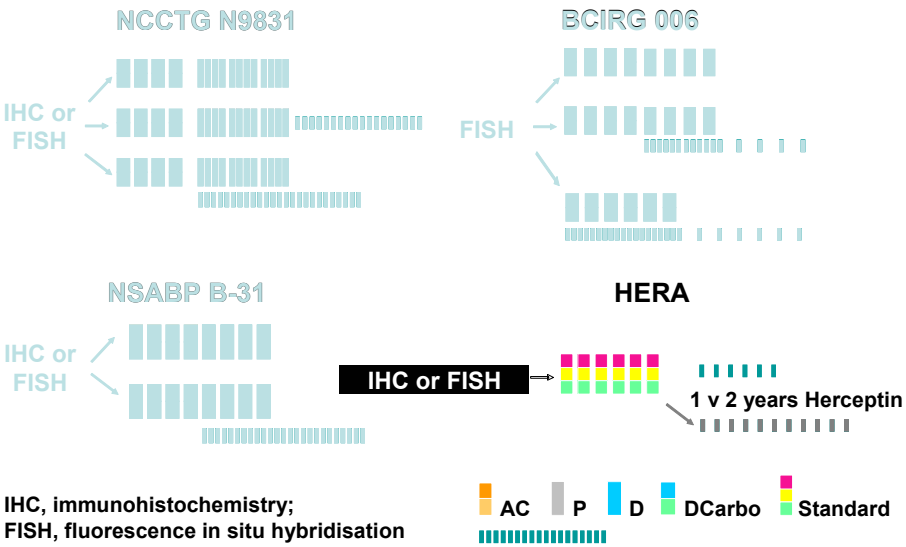
NSABP B-31 (US)
(n=1960)

NCCTG N9831 (US)
(n=3046)

BCIRG 006 (global)
(n=3222)

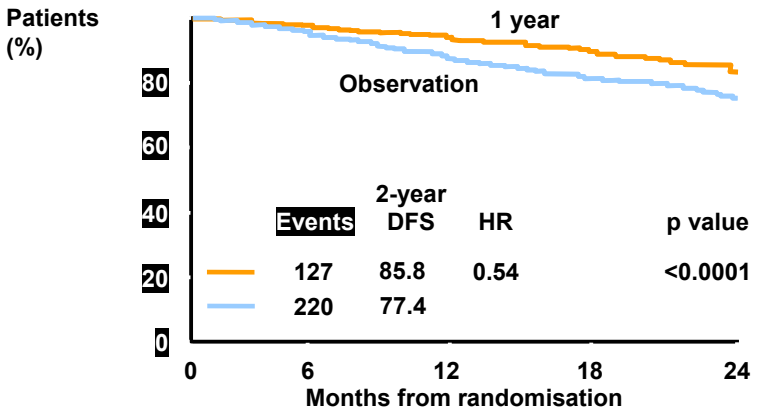
- **4 Trials**
- **>13,000 patients**

Adjuvant Herceptin trials



IHC, immunohistochemistry;
FISH, fluorescence in situ hybridisation

HERA: DFS

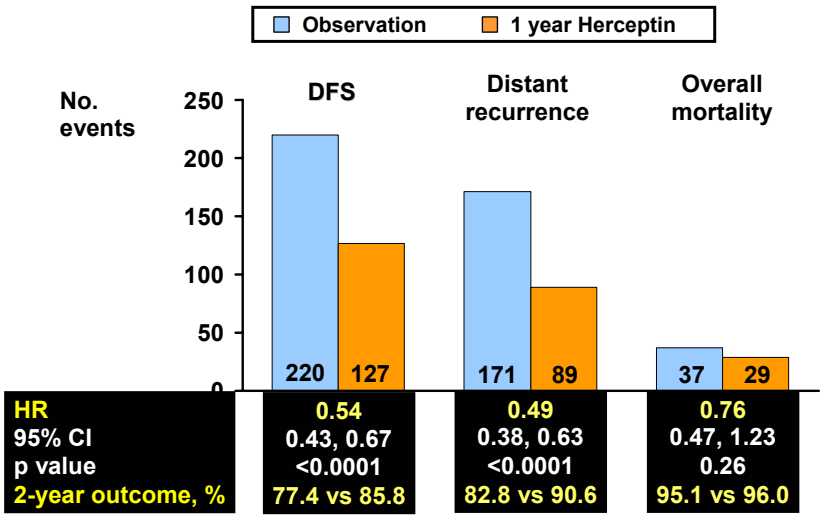


No. at risk	1694	1172	885	532	268
	1693	1108	767	445	224

Median follow-up: 1 year; DFS, disease-free survival;
HR, hazard ratio; CI, confidence interval

Piccart-Gebhart et al 2005

HERA: efficacy endpoints



Piccart-Gebhart et al 2005

Current clinical dilemmas

- What is the gold standard combination with Herceptin?
- When should you use Herceptin?
- When should you stop? If ever?
- Should you continue after progression and switch chemo agents eg Docetaxel to Vinorelbine?
- Can you continue in the setting of a falling LVEF?
- Should Herceptin be given first line with Aromatase Inhibitors?

Should we give Herceptin with chemotherapy or following chemotherapy?

- Herceptin following chemotherapy improves DFS and DDFS (HERA)
- Concurrent chemotherapy plus Herceptin may be superior to sequential therapy (N9831)
- Concurrent therapy is associated with greater cardiotoxicity

Other clinical practice implications

- Benefit of Herceptin is independent of chemotherapy and patient characteristics
- Radiotherapy can be given before or concurrent with Herceptin
- Data are currently not available on benefit of Herceptin
  - as monotherapy or combined with endocrine agents in patients not indicated for chemotherapy
  - in patients with primary tumours <1 cm

Conclusion

Patients are living their experience of cancer treatment. Our support is essential:

- for their quality of life
- for their adherence to treatment
- for their rehabilitation

Conclusion

- Let us listen to their feelings
- Give them appropriate time and concern
- Help them in finding solutions to the cancer effects, treatment effects and take on board their global issues

Conclusion

- **Patients tell us that every month of life is precious if ‘symptoms’ are controlled**
- **We must be careful to listen to their needs and issues and respond to those and not judge by our own preconceptions [Age is not in itself a reason to modify treatment]**
- **Treat the patient *and* the disease, not *just* the disease!**