



**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**

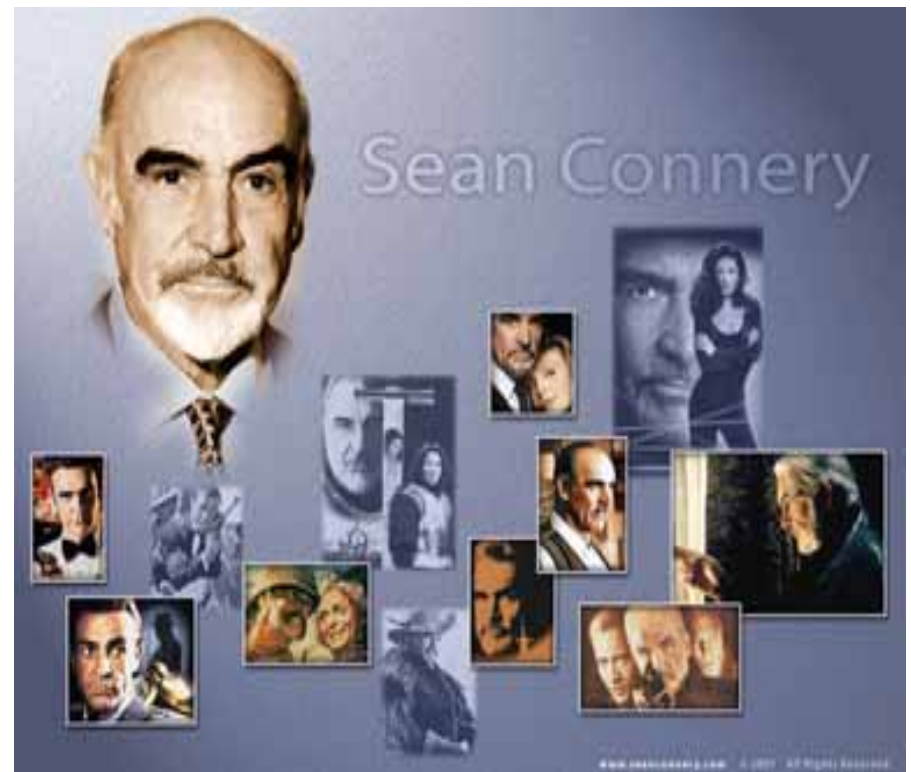
**20% of 260 million = a very large number**

# Who is OLD?

**80 YRS OLD  
WORKS FULL TIME. .**



**76 YRS OLD  
STILL THE LEADING MAN**



# Current expected survivals

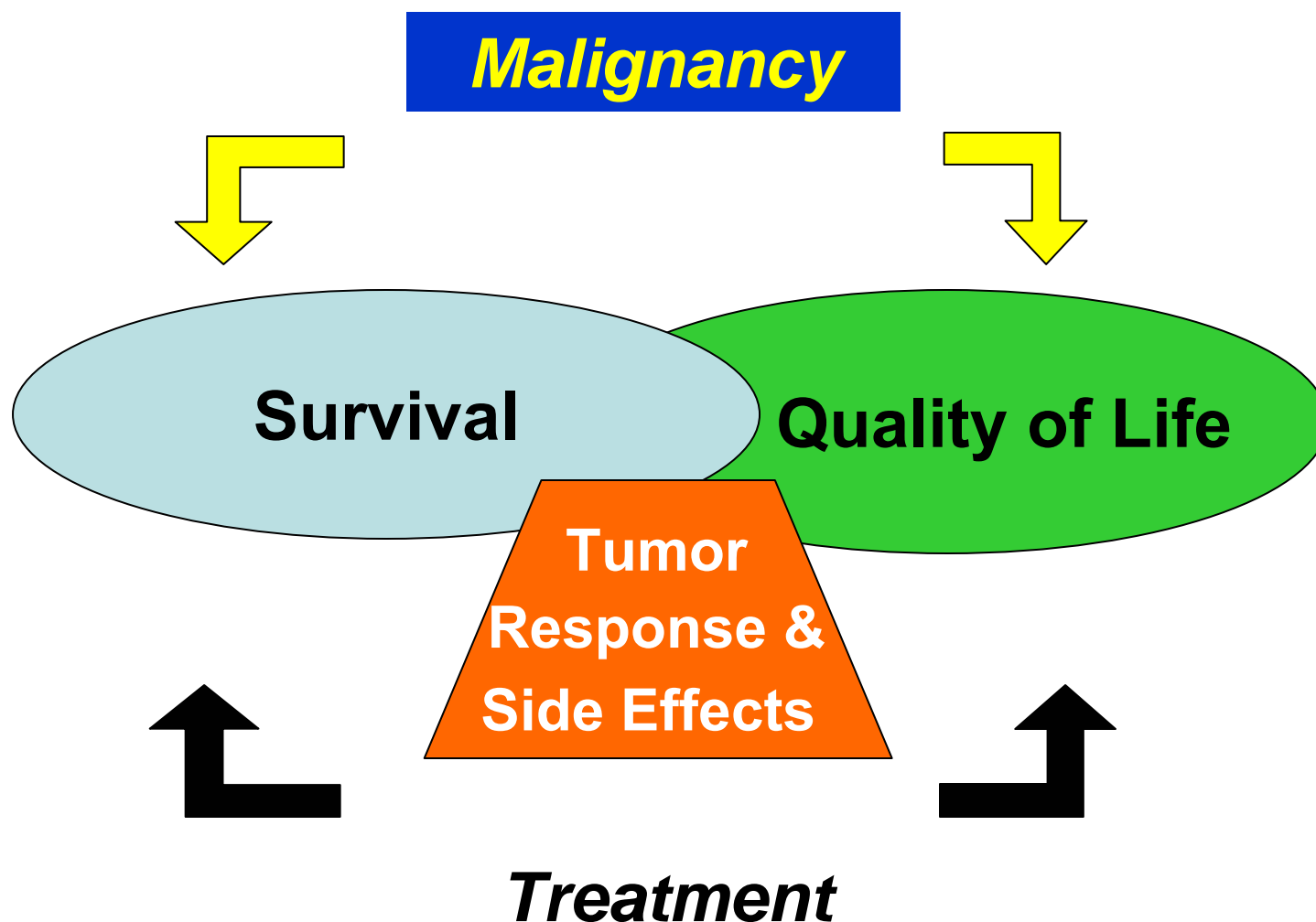
| <b>Age</b> | <b>Projected life expectancy</b> |
|------------|----------------------------------|
| <b>70</b>  | <b>14.2 yrs</b>                  |
| <b>80</b>  | <b>7.7 yrs</b>                   |
| <b>85</b>  | <b>5.4 yrs</b>                   |

**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 than 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 'Misperception'

(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)

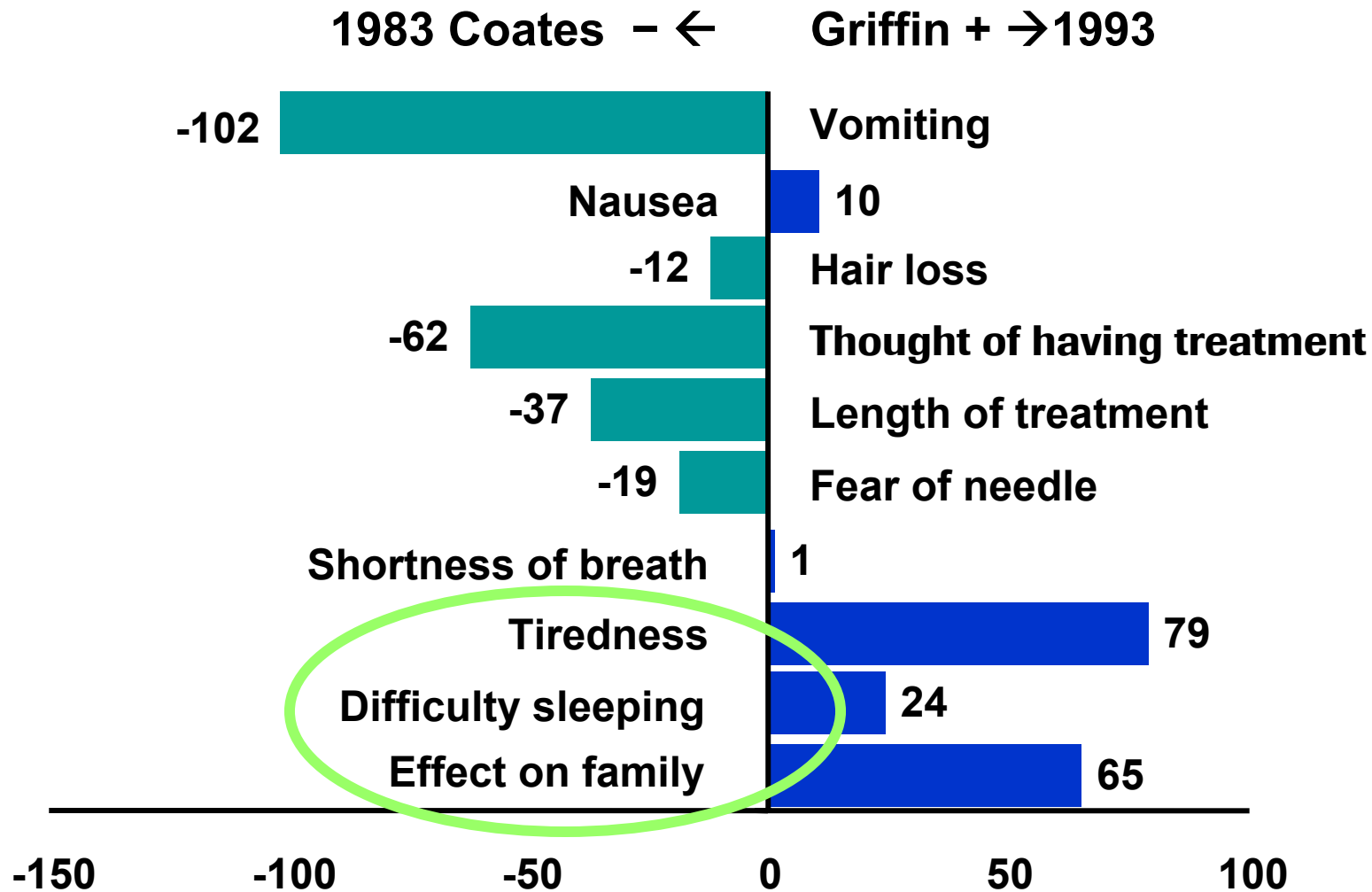
- **99 patients**
- **Out patients**
- **40 % males / 60 % females**
- **Median age : 52 [18 - 78]**
- **All had advanced cancer**
- **All had received chemotherapy within the last 4 weeks**

# 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**

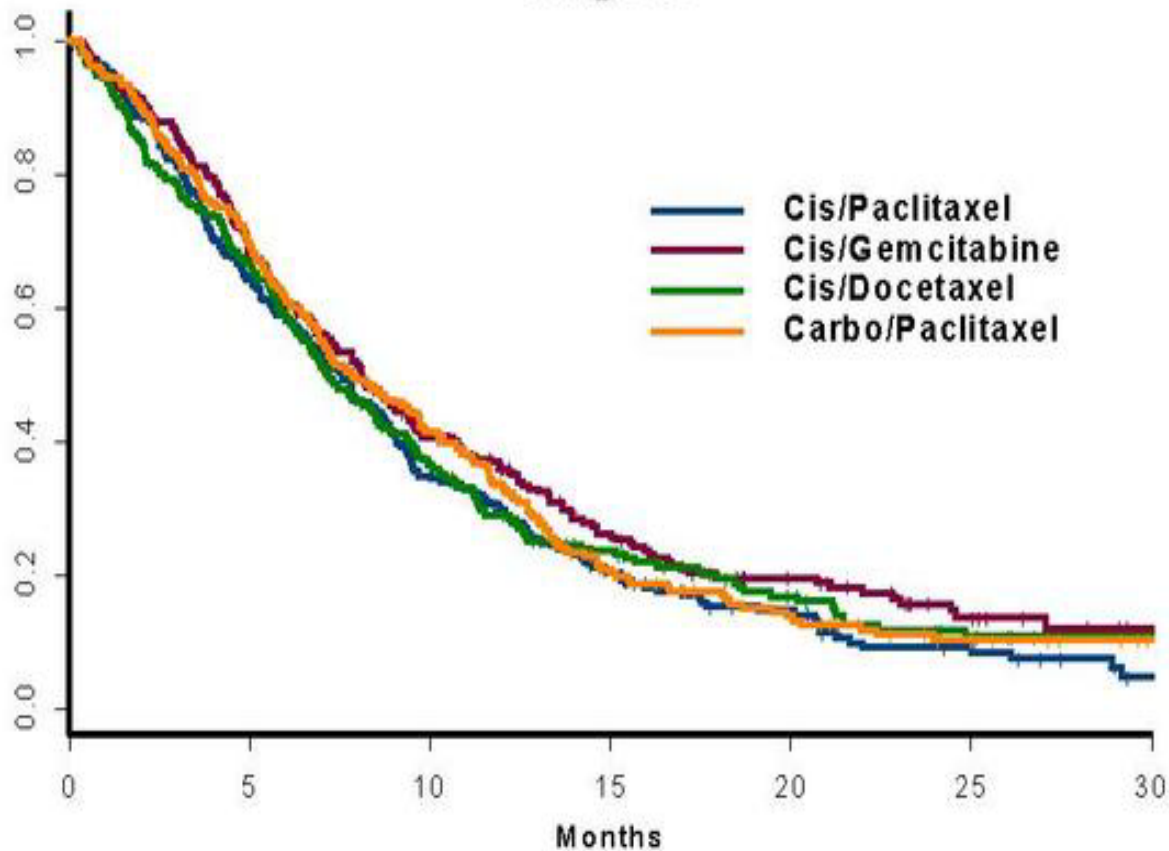
**Treatment has limited impact on survival but....**

- **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**

# E1594

Survival by Treatment Group  
Stage IV



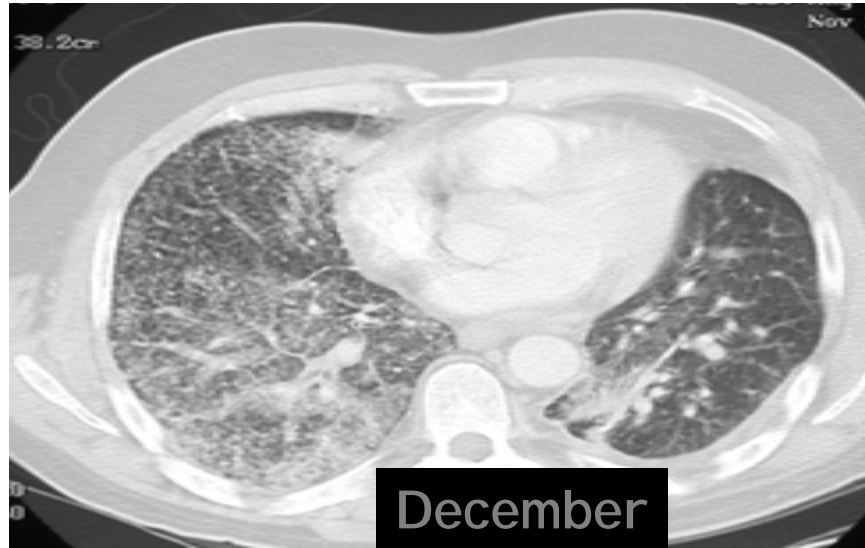
**Have we  
reached the  
ceiling for  
improved  
benefit of  
cytotoxic  
chemotherapy  
in advanced  
NSCLC?**

**More of Avastin Later**

# **A Request For Innovation In Cancer Treatments**

**ERLOTINIB  
(TARCEVA)**

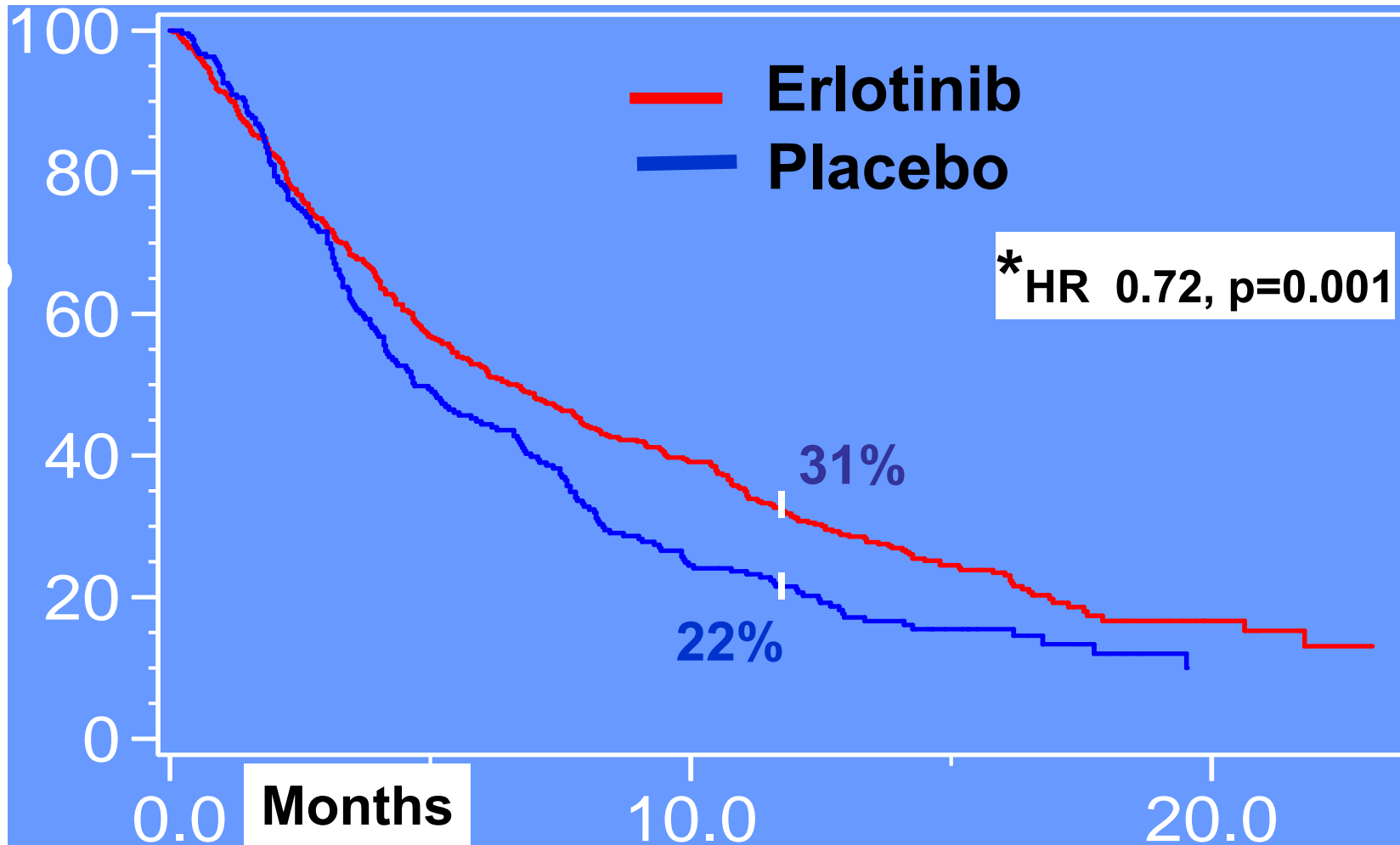
# EGFR response 3<sup>rd</sup> line



**BR 21: Erlotinib vs placebo in 2nd or 3rd line therapy in advanced NSCLC**  
*Shepherd et al, ASCO 2004; abs 7022*

- **731 patients, 50% adenocarcinoma**
- **OR: 9%**
- **Response duration: 7.9 vs 3.7 months**
- **PFS: 2.2 vs 1.8 months (p<0.001)**
- **OS: 6.7 vs 4.7 months (p<0.0001)**
- **Smoking status was the only parameter influencing the effect of treatment**

# BR.21 Overall Survival



\*Adjusted for stratification factors

**BEVACIZUMAB  
(AVASTIN)**

# Phase III Trial of Bevacizumab in 855pts Non-Squamous NSCLC: ECOG 4599

## Eligibility:

- Non-squamous NSCLC
- No Hx of hemoptysis
- No CNS metastases

## Stratification Variables:

- RT vs no RT
- Stage IIIB or IV vs recurrent
- Wt loss <5% vs  $\geq$ 5%
- Measurable vs non-measurable

(PC)  
Paclitaxel 200 mg/m<sup>2</sup>  
Carboplatin AUC = 6  
(q 3 weeks) x 6 cycles

No crossover  
to  
Bevacizumab  
permitted

(PCB)  
PC x 6 cycles  
+  
Bevacizumab  
(15mg/kg q 3 wks) to PD

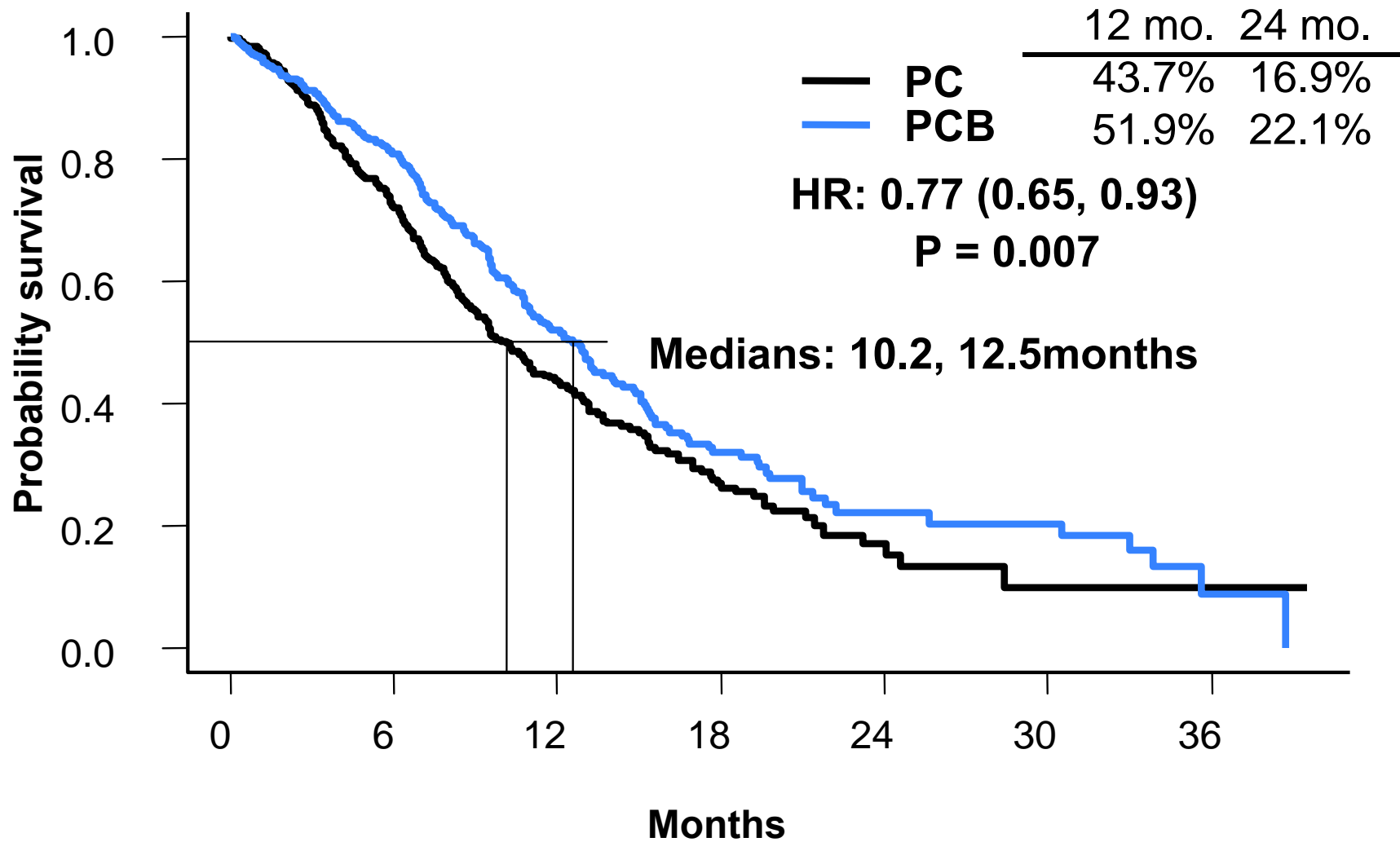
# PC vs PCB in NSCLC

- Bevacizumab improves survival when added to PC chemotherapy
- Bevacizumab also improves response rate and progression-free survival
- PCB is now the ECOG reference standard for the first-line treatment of advanced non-squamous cell NSCLC

# Avastin in NSCLC

## E 4599: Survival

### ECOG's 'New Standard of Care'



BC

# Global Herceptin adjuvant programme

**HERA (ex-US)**  
(n=5090)

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

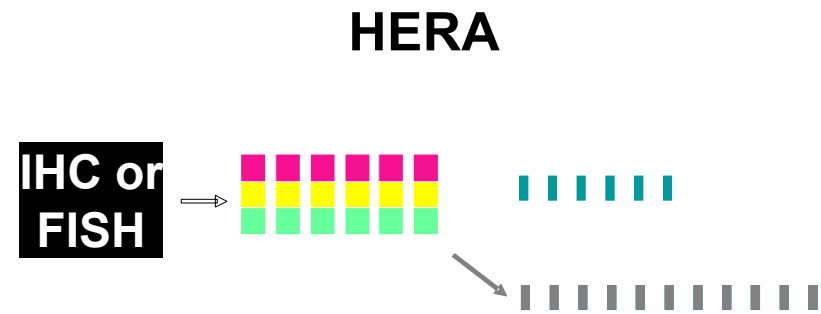
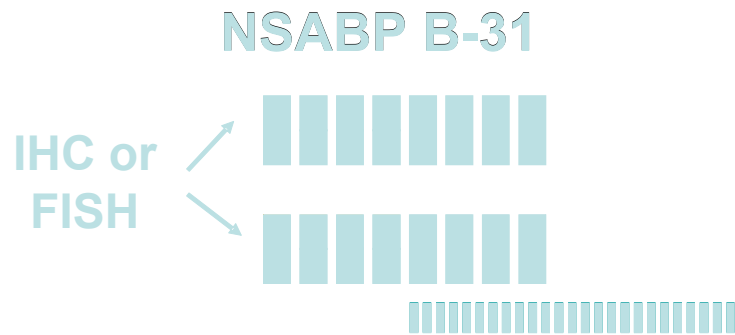
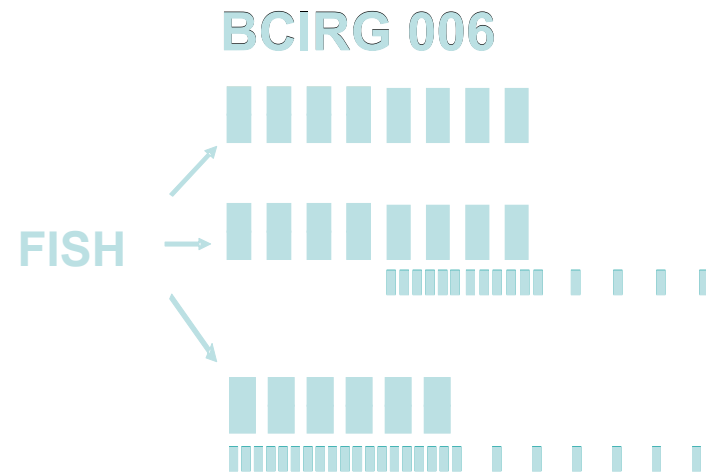
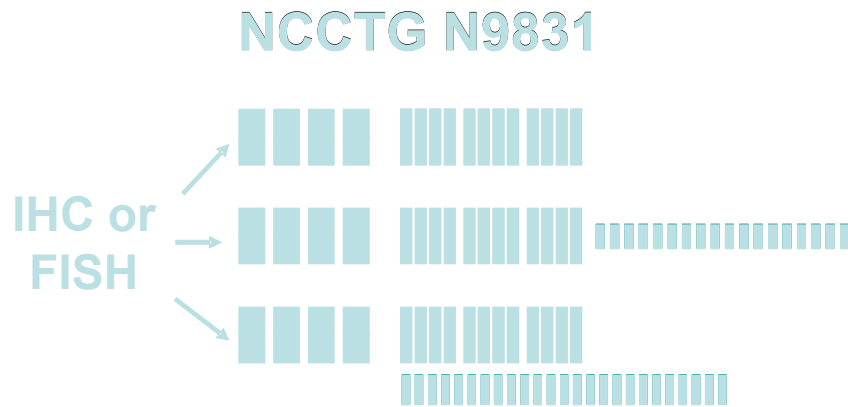
**NCCTG N9831 (US)**  
(n=3046)

**BCIRG 006 (global)**  
(n=3222)

• **4 Trials**

• **>13,000 patients**

# Adjuvant Herceptin trials

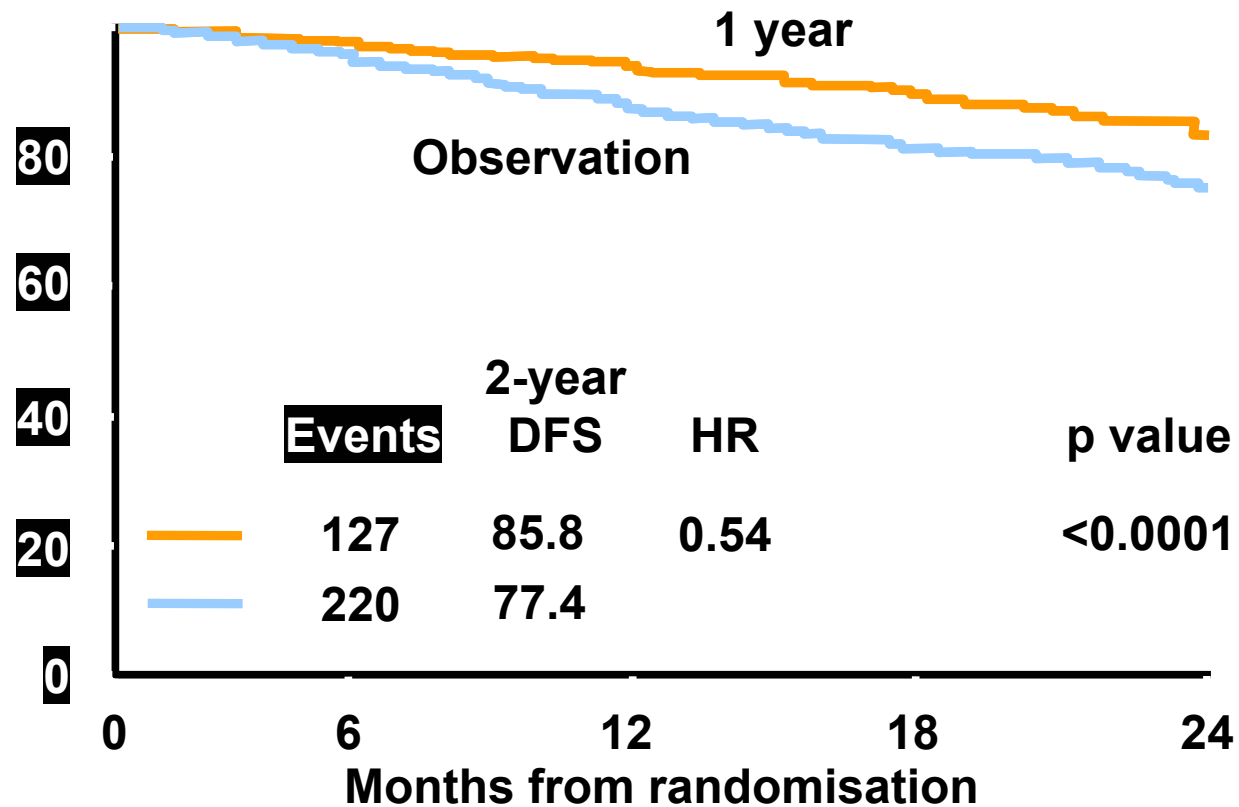


IHC, immunohistochemistry;  
FISH, fluorescence in situ hybridisation



# HERA: DFS

Patients (%)

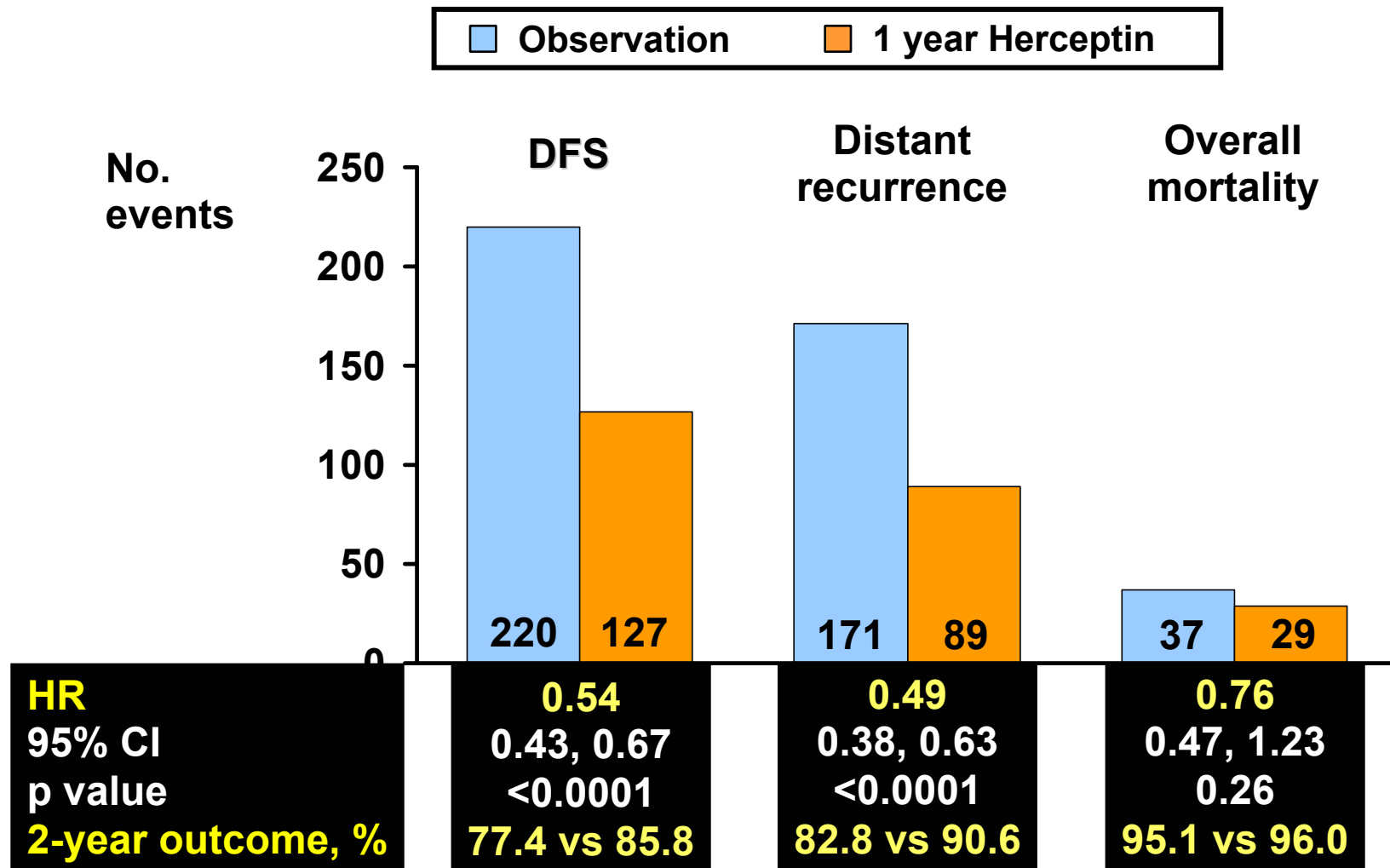


| No. at risk        | 0    | 6    | 12  | 18  | 24  |
|--------------------|------|------|-----|-----|-----|
| 1 year (Orange)    | 1694 | 1172 | 885 | 532 | 268 |
| Observation (Blue) | 1693 | 1108 | 767 | 445 | 224 |

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?**

# 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!