Cancer Survivors Care
Follow-up guidelines

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Goals of cancer care

Adding years to life

&

Adding life to years

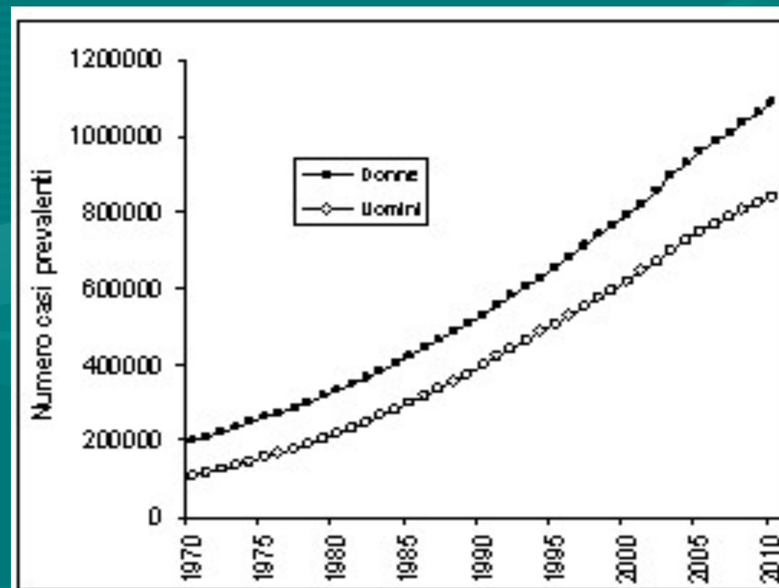
General Principles

- Surveillance for recurrence of primary cancer
- Screening for development of a second primary malignancy
- Long-term physical effects of treatment
- Psychosocial consequences of treatment and fear of recurrence
- Maintain wellness

Cancer prevalence estimates in Italy

De Angelis et al. Tumori

- About 1.700.000 persons are estimated to live with a past diagnosis of cancer
- The rate of increase is impressive: 4% in women and 3% in men, about twice the values attained in 1990 (1850 e 1455 / 100.000 respectively in 1990)



Cancer prevalence estimates in Italy

De Angelis et al. Tumori

- The highest dynamics was observed for prostate cancer and breast cancer
- this growth is mainly attributable to

incidence dynamics	**(+21%)**
survival improvements	**(+14%)**
population aging	**(13%)**

Cancer prevalence estimates in Italy

De Angelis et al. Tumori

- The 2-year prevalent cases were estimated to be **20% of all cancer survivors**
- 21% between **2 and 5 years** from the diagnosis,
- 23% between **5 and 10 years**
- 36% surviving for **more than 10 years**
- Prevalence proportion was **very high in the elderly** (12.6% for 75-84 years and 8% for 60-74 years).

Follow-up – I problemi

– Attività crescente

– Poco considerato negli studi clinici
(poche evidenze – alta eterogeneità)

– Sbilanciato sulla diagnosi precoce della recidiva rispetto agli effetti tardivi dei trattamenti e riabibilitazione

– Insostenibile (giusta allocazione delle risorse)

Follow-up – Caratteristiche

- Basso impatto sulla sopravvivenza
- Alto numero di prestazioni con basso numero di eventi
- Necessità della multidisciplinarietà (specialistica e primaria)

Risorse

- American Society of Clinical Oncology (ASCO)
- National Comprehensive Cancer Network (NCCN)
- European Society of Medical Oncology (ESMO)
- Associazione Italiana Oncologia Medica (AIOM)

Perché le Linee Guida AIOM

www.aiom.it

- Fonte autorevole di evidenza
- Impatto sui comportamenti con miglioramento della appropriatezza
- Strumento di confronto con altre società
- Possibile impatto medico-legale

International and National Cancer Survivor Initiative

- To understand the needs of those living with & beyond cancer
- To develop models of care to meet their needs
- To design evidence-based sustainable services to accommodate the increasing numbers of cancer survivors in the future

Principles

- ***Risk Stratified pathways of care*** rather than one size fits all
- Dynamic ***personal care plan*** which arises from an assessment of the disease, the treatment, and the individuals personal circumstances
- ***Information provision*** should meet individual needs and should be timely, accessible and promote confidence, choice, and control
- Individuals should be ***encouraged to self manage with support and rapid access to appropriate professional when problems arise***

Prototype Testing Hypothesis

By introducing risk stratified levels of care for those living with and beyond cancer there will be a measurable difference in:

The patient experience of care
Have all the information and advice required to manage their condition
Who know who to contact
Who have been offered a care plan

At least a 50% reduction in out patient attendances, and a 10% reduction in unplanned admissions

Model of Care: Living With and Beyond Cancer

ASSESSMENT
CARE PLANNNG
AT DIAGNOSIS

END
OF INITIAL
TREATMENT

Transition from treatment to living beyond cancer:
Clinical management of acute effects, building
capability and confidence to self manage

Post treatment care plan
review and risk stratification

Transition from treatment to living with cancer
or living beyond cancer but with the
consequences of their treatment

Living beyond cancer and remain well:
May involve surveillance and needs
rapid access if symptoms occur

Stocktake, risk stratification
and care plan review

Self-care with support
and open access

Professional care

Shared Care

Complex case
management
through
MDT

Needs stratification

Intervention

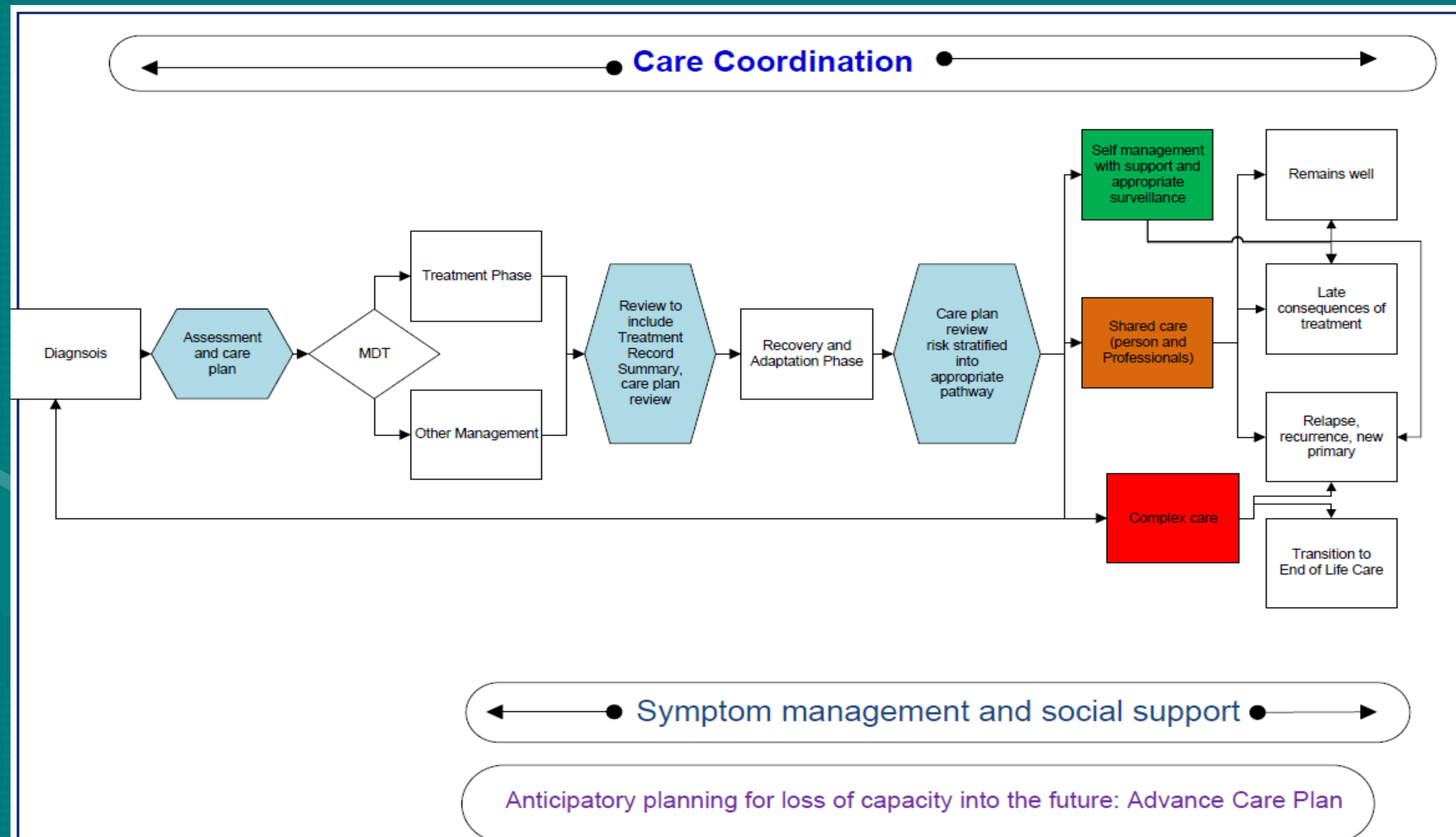
Living beyond cancer with
the consequences of treatment

Dying and transition to end of life care

Assessment and care planning - trigger points

- At diagnosis
- Following treatment
- When positive or negative significant event occurs either patient or professional triggered
- On the transition to end of life care

Transformed Pathways of Care: Overview



Which management?

- Self management education/training programmes
- Skills development for professionals
- Institutional support for service redesign

Breast Cancer Survivors

- Increase incidence and prevalence
- Increased risk second primary cancer
- Most recurrences within 5 years following treatment – but threat persists 20+ years

Cancer Surveillance Guidelines

- Interval history and physical exam every 6 months for 5 years, then every 12 months
- Annual mammography of preserved tissue
- More intensive surveillance (labs, bone scans, CXR, tumor markers) does not improve survival or quality of life

Cancer Surveillance Guidelines

- Women on Tamoxifen: annual gynecologic assessment every 12 months if uterus present
- Women on an aromatase inhibitor or who experience ovarian failure secondary to treatment should have monitoring of bone health with a bone mineral density determination at baseline and periodically thereafter

Lifestyle change more important for cancer survivors than others

Obesity

Dietary fat intake

Exercise

Smoking

History and Physical Examination

- Weight loss, persistent cough, bone pain
- Breast or chest wall changes, adenopathy
- Yearly pelvic examination
- Depression
- Lymphedema

Complications of treatment

- Premature menopause
- Neurocognitive changes – “chemo brain”
- Osteopenia/Osteoporosis
- Psychological distress
- Altered body image
- Changes in sexuality
- Lymphedema

Treating the Family

- 5-10% caused by mutations in cancer-susceptibility genes
- BRCA 1 and 2 most common
- Genetic counseling

Colon Cancer Survivors

- Recurrence highest first 5 years after resection
- Careful H&P + CEA q 3 mos for first 2 years, then every 6 mos for next 3 years
- Elevated CEA precedes symptoms by 3-8 mos
- Colonoscopy 12 mos post-op, then 3 years, then q 5 years
- No routine CXR's

Complications of Treatment

- Fecal incontinence
- Abdominal adhesions
- XRT → diarrhea, radiation proctitis
- Ostomies – altered body image , sexuality. Consider ostomy therapist for guidance

Treating the Family

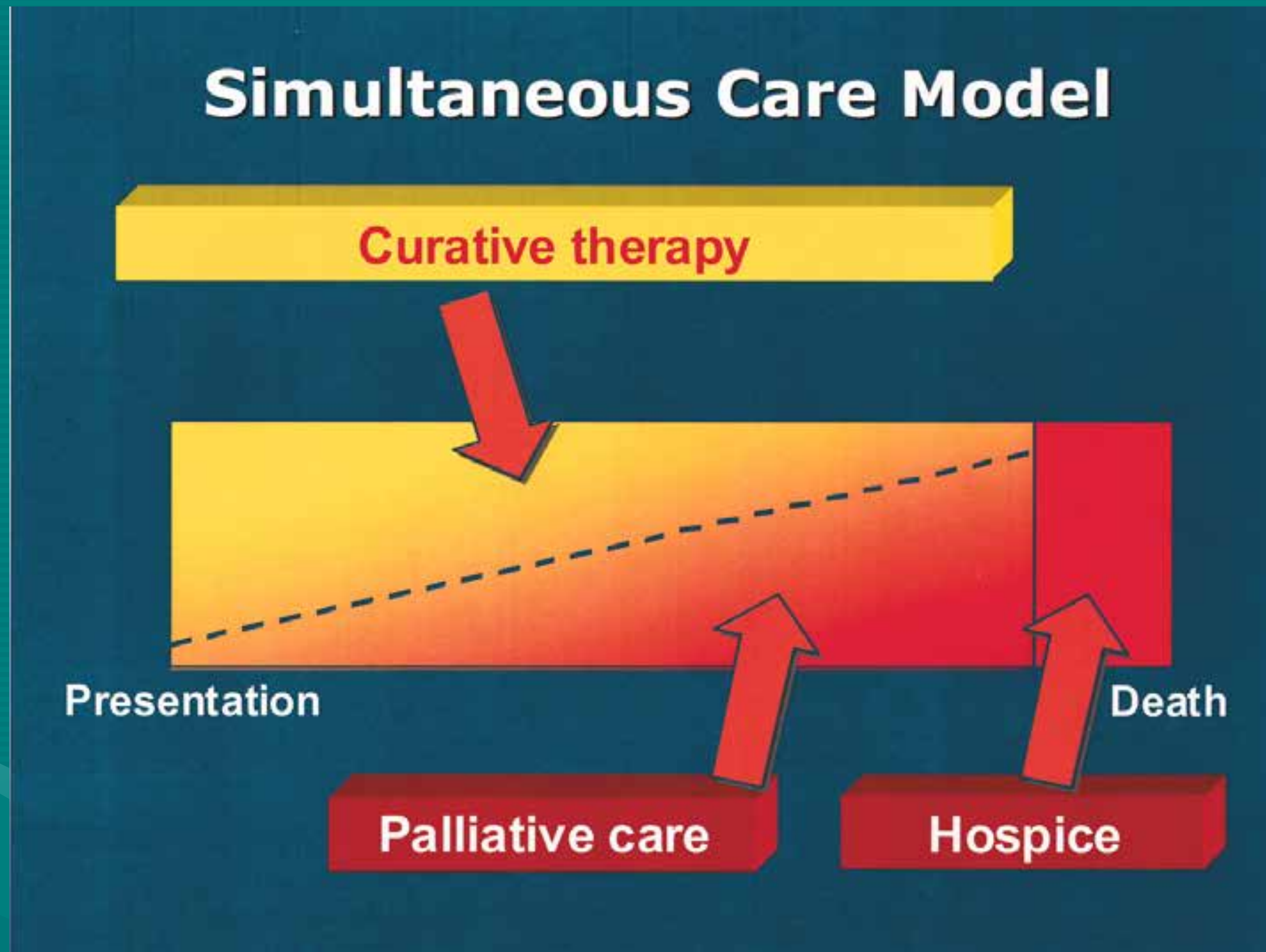
- Sporadic 60%
- Familial 30%
- Hereditary 10%

FAP 100% risk of colorectal cancer
HNPCC – also endometrial (30-60%), small bowel, ureter and renal

Genetic counseling

Fear of Recurrence / Secondary Cancer

- Remember to ask about it
- Don't forget to ask the family too
- Empower the patient
- Refer early – psychoncologist



Meyers F J , Linder J JCO 2003;21:1412-1415

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Highest correlations with suffering

Wilson KG et al. J Clin Oncol 2007

- **Physical problems**
  - Fatigue
  - Pain
  - General malaise
  - Drowsiness
  - Nausea
- **Social-relational concerns**
  - Social isolation
- **Psychological difficulties**
  - Anxiety
  - Depression
  - Loss of interest/pleasure
  - Hopelessness
  - Desire of death
- **Existential issues**
  - Loss of resilience
  - Loss of dignity
  - Loss of control

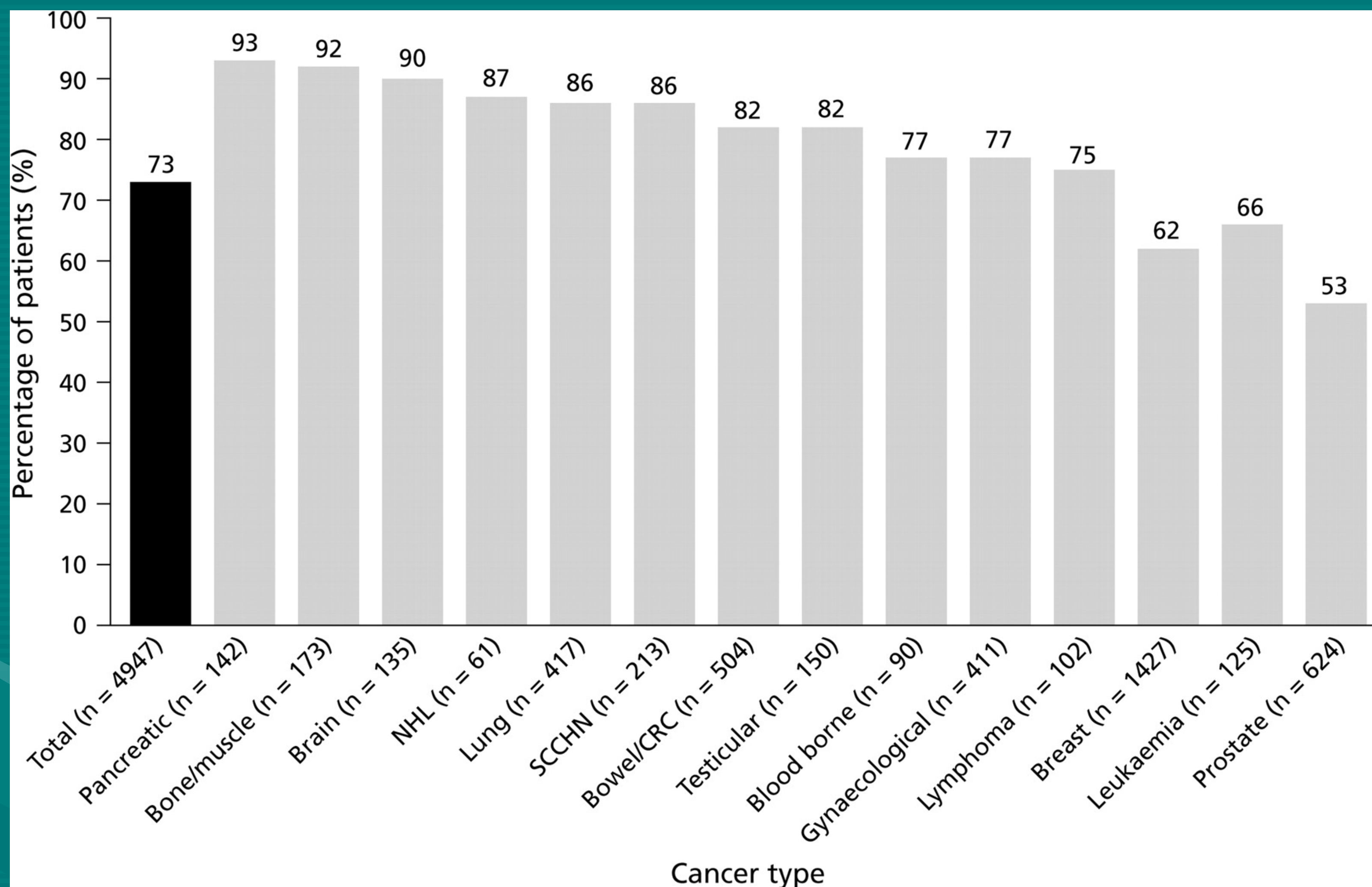
Infermiere Medico (specialista – ass. primaria)
Fisioterapista Psicologo
Assistente sociale Volontario
Assistente spirituale ...

"... Le Cure Palliative richiedono un approccio d'équipe, che riconosca il ruolo dei vari membri coinvolti.
Il personaggio preminente del gruppo può variare a seconda delle necessità del paziente ..."

OMS - Organizzazione Mondiale della Sanità.
Collana Rapporti Tecnici 804 - Ginevra 1990

COMPLEMENTARIETA'
INTERAZIONE
COORDINAMENTO

Incidence of pain due to cancer type.



Breivik H et al. Ann Oncol 2009;20:1420-1433

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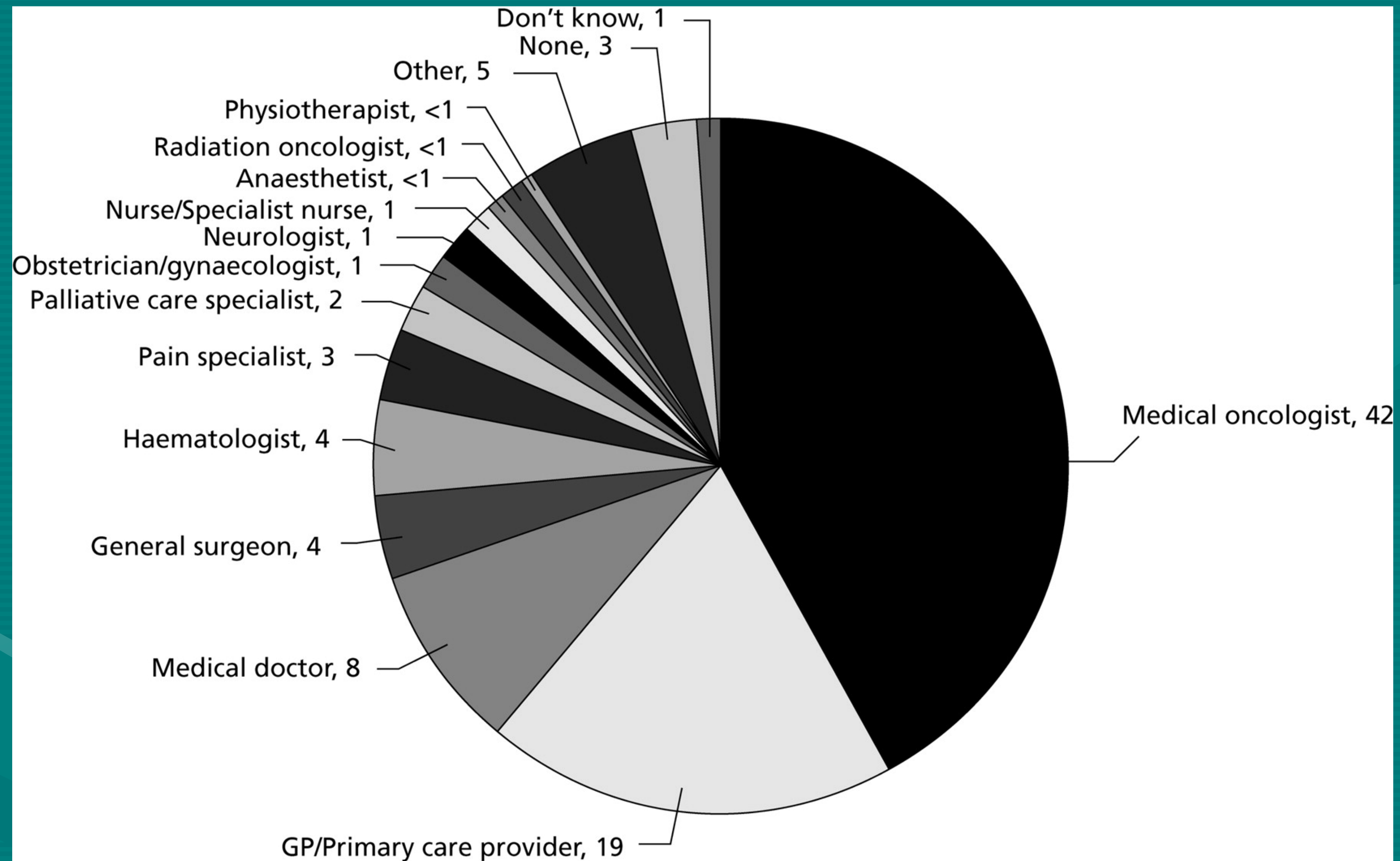
Annals of Oncology

Health care professional responsible for treating or managing patient pain.



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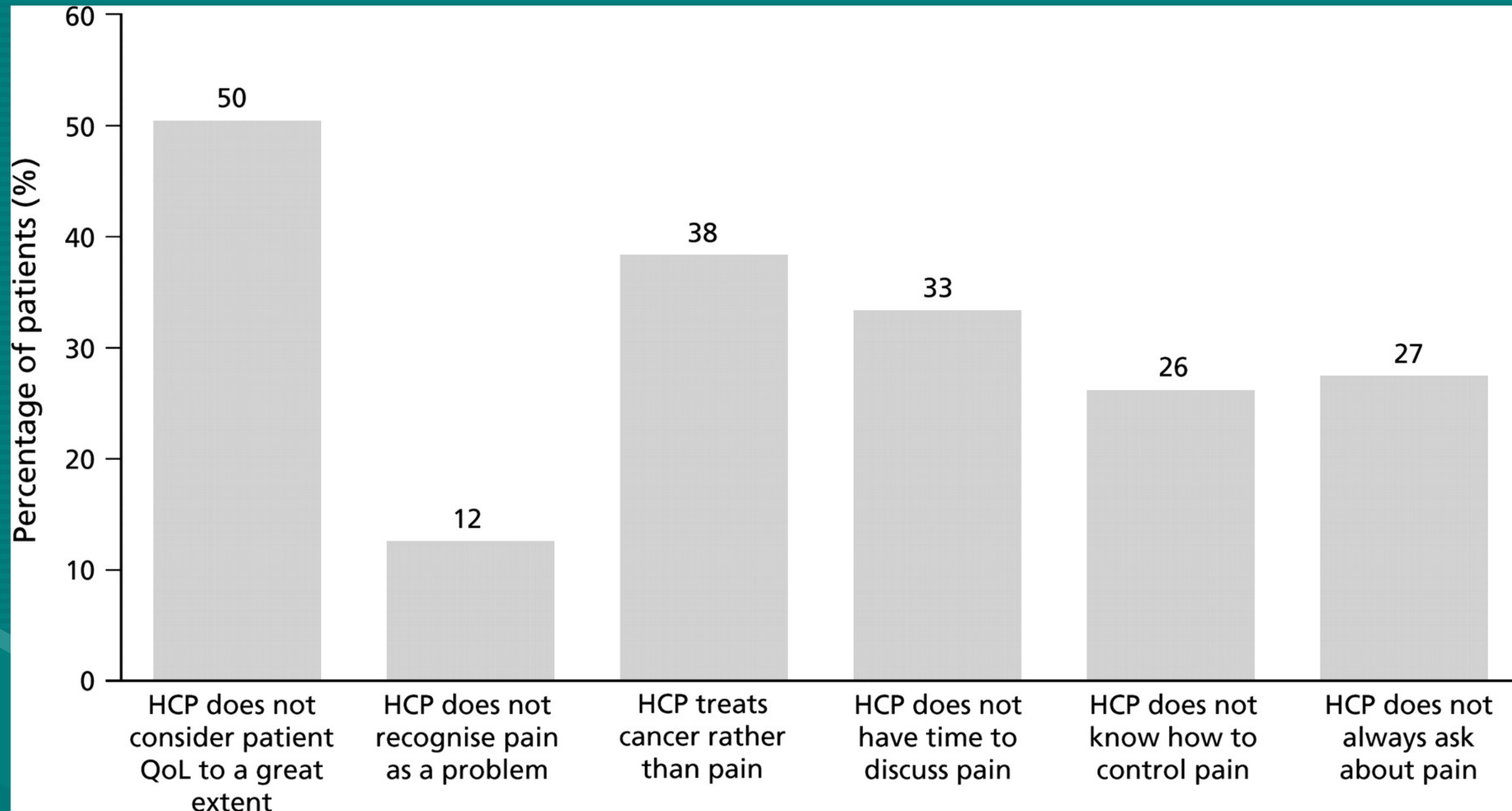
Patient beliefs about their pain treatment from their health care provider (HCP)—global survey results (n = 573).



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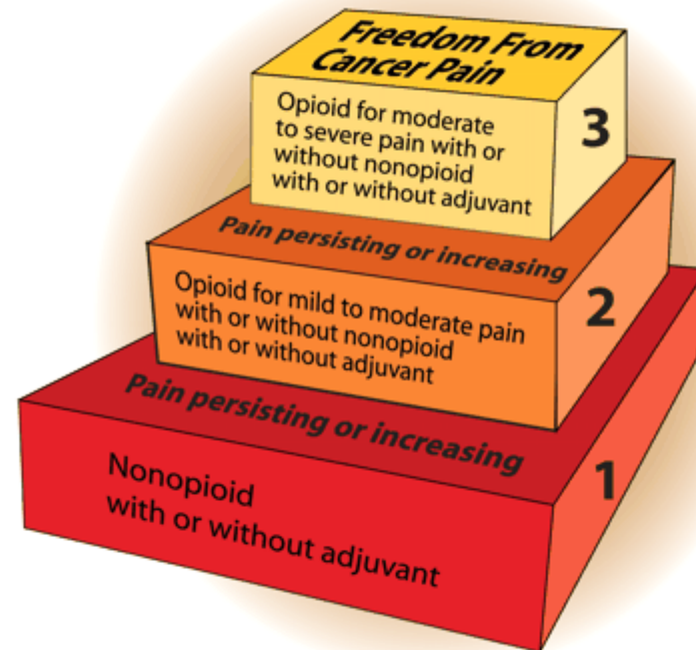
British Journal of Cancer (2009) 100, 1566–1574.

Pattern and quality of care of cancer pain management. Results from the Cancer Pain Outcome Research Study Group

G Apolone et al. (G: Azzarello, co-investigator)
on behalf of the Cancer Pain Outcome Research Study Group (CPOR SG) Investigators

"…results suggest that the recourse to WHO third-level drugs still seems delayed in a substantial percentage of patients. This delay is probably related to several factors affecting practice in participating centres and suggests that the quality of cancer pain management in Italy deserves specific attention and interventions aimed at improving patients' outcomes".


Freedom From Cancer Pain
Opioid for moderate to severe pain with or without nonopioid with or without adjuvant
3
Pain persisting or increasing
Opioid for mild to moderate pain with or without nonopioid with or without adjuvant
2
Pain persisting or increasing
Nonopioid with or without adjuvant
1

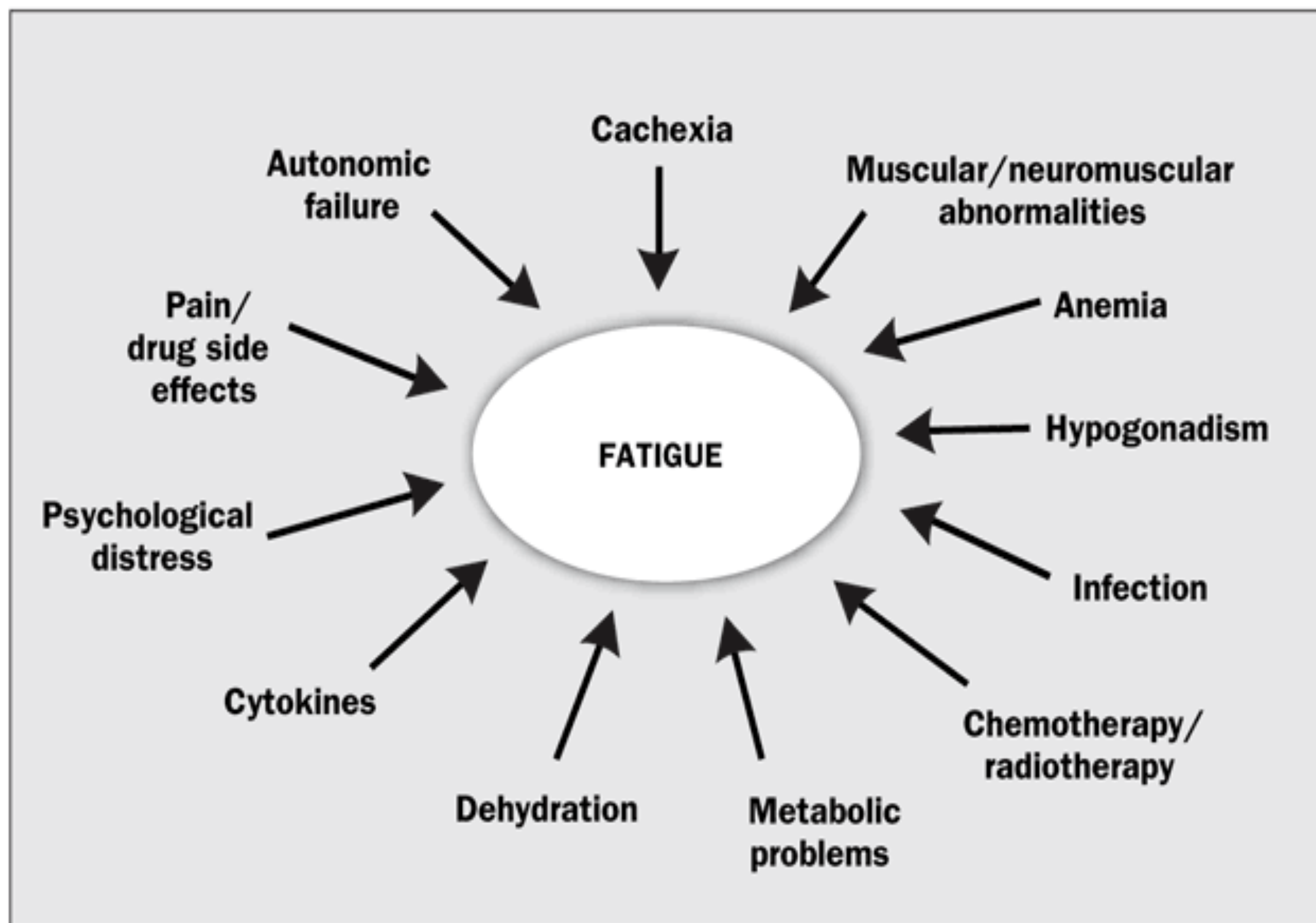


FIGURE 1: Contributors to fatigue in cancer patients

Evidenze a supporto dei differenti approcci terapeutici

Cortisonici/progestinici

Antidepressivi

Psicostimolanti

Altre forme di supporto

Trattamento anemia

Esercizio fisico

Supporto psicologico

Conclusions…we need to move forward…

"- Which road do I take? she asked.

- It depends: Where do you want to go?" **(Alice in woderland)**

WE NEED TO GO TOWARDS HARMONIZATION AS MUCH AS WE CAN