Border Medical Oncology

• 4 medical oncologists
• 11 staff
• Advanced trainee

• BMO Research Unit
• 12 employees
• Recognised for innovation in clinical trials – high rate of new patients on trials

Disease types in my last 102 new patients: 10/2013 to 5/2014 (%).

- HAEM: 29%
- GI: 18%
- LUNG: 12%
- GYNAE: 7%
- GENITOURINARY: 17%
- SKIN: 6%
- HEAD AND NECK: 3%
- GBM: 1%
- CUP: 3%
- BREAST: 1%
- OTHER: 4%
Geriatric oncology is all about supportive care.

Discuss....

Christopher Steer
Border Medical Oncology
Wodonga
So what is MASCC?

Multinational Association for Supportive Care in Cancer  www.mascc.org  
- Founded in 1990
- Joined with ISOO in 1998 to make MASCC/ISOO
- 750 members from 60 countries
- Truly multidisciplinary - physicians, nurses, pharmacists, scientists, dentists, psychologists and social workers.
- Journal

So Who is MASCC?

Åge Schultz, DVM Ph D
- Executive Director MASCC, aschultz@mascc.org
- Office: Herredsvejen 2, DK-3400 Hillerød, Denmark, CVR 33341385
- Phone +45 4820 7022, mobile +45 2054 8620, fax +45 4821 7022
- Journal “Supportive Care in Cancer”: http://link.springer.com/journal/520

MASCC - 17 Study groups

- Antiemetics
- Bone complications
- Dyspnoea
- Education
- Fatigue
- Geriatrics
- Hemostasis
- Mucositis
- Neurological complications
- Neutropenia, infection & myelosuppression
- Nutrition & Cachexia
- Oral Care
- Paediatrics
- Palliative Care
- Psychosocial
- Rehabilitation, Survivorship & Quality of Life
- Skin Toxicity
What are the supportive care domains we can do something about?

1. Tumour-related
   - Pain
   - Fatigue
   - Nutrition
   - Dyspnoea
   - Bone complications
2. Treatment related
   - Haematological toxicity, infections.
   - Mucositis
   - Neuropathy
   - Antiemetics
   - Cardiac
   - Skin
3. Psychosocial issues, QOL, palliative care

What are the supportive care domains that particularly relate to older adults?

An easier question may be….

Which domains don’t relate to older adults?

- Paediatric issues
- Effect on growth and development
- Fertility?

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines)

Senior Adult Oncology

Version 2.2014

NCCN.org

MD Anderson Cancer Center

Making Cancer History®
It involves:

• Assessment of supportive care needs and subsequent guided intervention (regardless of treatment)
• Strategies to prevent and manage treatment toxicity
  • eg routine use of growth factors in older adults undergoing myelosuppressive chemotherapy
• Identification and management of “geriatric syndromes” as a supportive care strategy.

Practical management of the older patient with cancer is all about supportive care.

Examples

• Neuropathy
• Falls

• Social support
• Cognitive impairment

• Bone marrow toxicity

• Pharmacy issues –
  – polypharmacy, drug interactions, adherence
### Sensory Neuropathy by Treatment Arm

<table>
<thead>
<tr>
<th>Treatment Arm</th>
<th>Cycle 1</th>
<th>Cycle 2</th>
<th>Cycle 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaMg/Placebo</td>
<td>114</td>
<td>103</td>
<td>97</td>
</tr>
<tr>
<td>Placebo/Placebo</td>
<td>113</td>
<td>104</td>
<td>94</td>
</tr>
<tr>
<td>CaMg/Placebo</td>
<td>104</td>
<td>95</td>
<td>88</td>
</tr>
</tbody>
</table>

### Sensitivity to Touching Cold Items

<table>
<thead>
<tr>
<th>Treatment Arm</th>
<th>Days 1</th>
<th>Days 2</th>
<th>Days 3</th>
<th>Days 4</th>
<th>Days 5</th>
<th>Days 6</th>
<th>Days 7</th>
<th>Days 8</th>
<th>Days 9</th>
<th>Days 10</th>
<th>Days 11</th>
<th>Days 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaMg/Placebo</td>
<td>100</td>
<td>98</td>
<td>95</td>
<td>95</td>
<td>92</td>
<td>97</td>
<td>89</td>
<td>82</td>
<td>73</td>
<td>66</td>
<td>59</td>
<td>46</td>
</tr>
<tr>
<td>Placebo/Placebo</td>
<td>100</td>
<td>98</td>
<td>95</td>
<td>95</td>
<td>92</td>
<td>97</td>
<td>89</td>
<td>82</td>
<td>73</td>
<td>66</td>
<td>59</td>
<td>46</td>
</tr>
</tbody>
</table>

**Mean score (0-10 scale)**
Discomfort Swallowing Cold Liquids

Mean score (0-10 scale)

CaMg/CaMg 112 104 97 97 91 87 84 77 71 68 52 40
Placebo/Placebo 109 99 99 95 90 86 81 68 67 64 44 39
CaMg/Placebo 110 103 100 98 93 95 88 82 77 64 60 49

Days

Cycle 1 Cycle 1 Cycle 1 Cycle 1 Cycle 2 Cycle 2 Cycle 2 Cycle 2 Cycle 3 Cycle 3...

10 9 8 7 6 5 4 3 2 1 0

Mean score (0-10 scale)

P=0.4274

Discomfort Swallowing Cold Liquids

Prevention and Management of Chemotherapy-Induced Peripheral Neuropathy in Survivors of Adult Cancers: American Society of Clinical Oncology Clinical Practice Guideline


Recommendations:
On the basis of the paucity of high-quality, consistent evidence, there are no agents recommended for the prevention of CPN. Compared to the treatment of existing CPN, the best available data support a moderate recommendation for treatment with duloxetine. Although the CPN trials are inconclusive regarding tricyclic antidepressants (such as nortriptyline), gabapentin, and a compound topical gel containing lidocaine, amitriptyline HCL, and ketamine, these agents may be offered on the basis of data supporting their utility in other neuropathic pain conditions given the limited other CPN treatment options. Further research on these agents is warranted.


Supportive Care Makes Excellent Cancer Care Possible

Management options for established chemotherapy-induced peripheral neuropathy

Debra R. Packman, James C. Watson, Maryann B. Lutberg, Nina D. Wagner-Johnston, Alexandra Choo, Party Rosenthal, Xi Jing Zhang, Christopher Au, casual Jacob, Kevin D. Christman, Judith Prete, Pascal Jean-Pierre, Young Oh, Joyk Kim, Marie Fitch, Harvey Verk, Suzanne Kommor, Charles L. Loprinzi

Discussion

There are multiple described therapies for treating CPN, most of which have little data to demonstrate their efficacy. Moreover, the interpretation of the available literature is hindered by the use of a variety of different tools to measure CPN, making comparisons challenging [115]. In addition, neuropathy associated with different chemotherapeutic agents may have different responses to treatment due to potential variations in clinical manifestations and pathophysiology. In patients without any contraindications for treatment with SNRLs, it is reasonable to initiate therapy with a trial of duloxetine, or, alternatively, gabapentin. However, recommendations for the treatment of CPN as second line therapy are limited by the lack of strong evidence.

Supportive Care (2014) 32:2281–2290
DOI: 10.1002/sca.23884

Supportive Care Makes Excellent Cancer Care Possible

Fall-related injuries in elderly cancer patients treated with neurotoxic chemotherapy: A retrospective cohort study

Peter R. Ward*, Mitchell D. Wong, Ravansar Moore, Arash Naeim
UCLA Medical Center, Los Angeles, CA, USA

Methods: We conducted a retrospective cohort analysis using the records of 65,311 patients with breast, colon, lung, or prostate cancer treated with chemotherapy in the SEER-Medicare database from 1994 to 2007. The primary outcome was any fall-related injury defined as a traumatic fracture, dislocation, or head injury within 12 months of the first dose of chemotherapy. The sample population was divided into 3 cohorts based on whether they received the taxane agent, oxaliplatin, or irinotecan.

Results: The rate of fall-related injuries for patients receiving a doublet of neurotoxic chemotherapy (9.15 per 1000 person-months) was significantly higher than for those receiving a single neurotoxic agent (7.76 per 1000 person-months) or a non-neurotoxic agent (5.19 per 1000 person-months). Based on the Cox proportional-hazards model risk of fall-related injuries was highest for the cohort receiving a neurotoxic doublet after the model was adjusted for baseline characteristics.

Conclusions: Among elderly cancer patients, use of neurotoxic chemotherapy is associated with an increased risk of fall-related injuries.

Supportive Care (2014) 32:2268–2279
DOI: 10.1002/sca.23864

Supportive Care Makes Excellent Cancer Care Possible
SEER database analysis

N = 65,311 patients over 65 years with breast, prostate, lung or colorectal cancer treated with chemotherapy.

Higher rate of *fall related injuries* seen in patients who have received doublet neurotoxic chemotherapy vs single agent vs non-neurotoxic.

**Falls**

- 30% of older patients fall each year
  - Increases to 50% after age 80
- 10% have injury
- Prevention
  - Exercise (balance, strength, endurance)
  - Environmental
  - Address vision issues
  - Reduce psychoactive meds

Mohile et al. JCO, 2011, p<.001
Falls in older cancer patients – a summary #2

Prevention strategies include:

- Minimising peripheral/motor neuropathy
- Ceasing medications linked with falls eg psychotropic.
- Treating vitamin D deficiency.
- Individually tailored exercise programmes.
- Modify home environment
- Appropriate foot care and footwear.
- Treat vision impairment, postural hypotension etc...
- No evidence that aids prevent falls but possibly this is because no trials have been done with the ability to show an impact.

Reduction of Cancer-Related Fatigue With Dexamethasone: A Double-Blind, Randomized, Placebo-Controlled Trial in Patients With Advanced Cancer

Suren Voyssifard, Susan Freiberger-Strong, J. Lynne Dalman, Marion O. Fulgaco-Gong, Janet Bell, Alexandra T. Pham, Steven M. Tsai, Jennifer Kasper-Green, Hilal-Reddy, Daniel Hill, Charles Chi, Lisa Mawe, Sarah E. Reddy, and Deborah Brown

RESULTS

A total of 84 patients were evaluable (dexamethasone, 43; placebo, 41). Mean ± standard deviation improvement in the FACT-F subscale at 15 was significantly higher in the dexamethasone than in the placebo group (10.3±5.1 vs. 9.6±8.1; P = .006). The improvement in FACT-F total quality-of-life scores was also significantly better for the dexamethasone group at day 16 (P = .003). The mean differences in the ECOG physical distress scores at day 15 were significantly better for the dexamethasone group (P = .013, respectively). No differences were observed for ECOG overall symptom distress (P = .22) or psychological distress score (P = .78). Frequency of adverse effects was not significantly different between groups (41 of 42 vs 44 of 50; P = .14).

CONCLUSION

Dexamethasone is more effective than placebo in improving CRF and quality of life in patients with advanced cancer.

J Clin Oncol 31:3076-3082. © 2013 by American Society of Clinical Oncology

Supportive Care Makes Excellent Cancer Care Possible.
Summary and Conclusions

- Supportive care in older patients with cancer crosses all domains
- MASCC provides another platform for education and research in geriatric oncology with a focus on improving supportive care assessment and intervention.
- Synergies exist between SIOG and MASCC and this collaboration should continue.
- The MASCC model is further evidence of the need for a multidisciplinary approach, eg participation from other team members such as nursing, pharmacy and psychology.

Geriatric oncology – existing service framework

- Border Medical Oncology in Albury-Wodonga.
  - Regional centre with no access to state-funded oncology outpatient services.
  - Most patients access care in oncology private rooms and pay copayments at the oncologists’ discretion.

Wide range of community aged care services exist – mostly funded by federal government.
Limited need for inpatient geriatric services for oncology patients.
Conquering the Silo Mentality

Utilising existing community-based supportive care and aged care resources for older patients with cancer.

Updated results of the Care Coordination in the Older Adult with Cancer (CCOAC) project.

C.B. Steer¹, PL Chia¹ J. O’Connor², C. Underhill¹, J. Donnelly¹, R. Myers³, R. Eek¹, K. Clarke¹, C. Packer²

¹Border Medical Oncology, ²Hume Regional Integrated Cancer Service, Wodonga, Australia

SIOG 2012: J Geriatric Oncology Volume 3, S1, Page S98, October 2012

Conquering the Silo Mentality

Organised a meeting between aged care and oncology services
• Established lines of communication.

Albury Wodonga CCOAC project

• Multidimensional CCOAC screening tool
  – based on tool developed by team at the Royal Adelaide Hospital.
• Steering committee formed comprising oncology and aged care providers, community health organisations and consumers.
• Development of a model tailored to local conditions and available resources.
• Employment of a geriatric oncology care coordinator to perform screening and referrals.
Methods #1: Screening vs Assessment

**Screening** is a brief process for **identifying the risk of** requiring supportive care services.

**Assessment** is a more in-depth process that **confirms the presence of** supportive care needs.

Methods #2a – The CCOAC Tool

The CCOAC tool is a composite of validated screening tools. It is self-administered and printed on **yellow paper**.

- **Domains include:**
  - IADL’s*
  - medications
  - social supports
  - cognition
  - psychological state,
  - vision and hearing,
  - falls
  - weight loss
  - comorbidities
  - the distress thermometer
  - a pain scale
  - performance status
  - caregiver concerns

*Action research project: We removed basic ADL’s after the initial stage as most patients were ambulatory

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  - performance status
  - caregiver concerns

*Action research project: We removed basic ADL’s after the initial stage as most patients were ambulatory

Methods #2b – The CCOAC Tool

- The CCOAC tool was sent to all new patients over the age of 70 prior to their first appointment with an oncologist.
  - The patient sent the tool in or brought it to the initial consultation.
  - The care coordinator then phoned every patient to clarify supportive care needs and risks. The **caregiver** was also interviewed.
Methods #3 – Model

• Referrals made to community-based services for further assessment and intervention.

• Referral services included
  - community aged care
  - community allied health
  - cancer care coordinators
  - palliative care
  - carer support agencies

• Where possible streamlined “eReferrals” were made using existing referral infrastructure.
• Some simple interventions were provided on the phone by the care coordinator e.g. practical information and reassurance.

Results – Patient Characteristics

• Between 3/2011 and 2/2012
• 155 patients over the age of 70 years underwent screening and guided intervention

<table>
<thead>
<tr>
<th>Patient characteristics</th>
<th>N (n=155)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Age (Range)</td>
<td>78 (70-96)</td>
<td></td>
</tr>
<tr>
<td>Male/Female</td>
<td>93/62</td>
<td>60% / 40%</td>
</tr>
<tr>
<td>Malignancy – Solid tumour</td>
<td>116</td>
<td>75%</td>
</tr>
<tr>
<td>Treatment Intent - Curative</td>
<td>45</td>
<td>29%</td>
</tr>
<tr>
<td>- Palliative/Unclear</td>
<td>96/13</td>
<td>62% / 8%</td>
</tr>
<tr>
<td>Living Alone</td>
<td>43</td>
<td>28%</td>
</tr>
<tr>
<td>Charlson Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 0-2</td>
<td>134</td>
<td>86%</td>
</tr>
<tr>
<td>- &gt;2</td>
<td>21</td>
<td>14%</td>
</tr>
<tr>
<td>Karnofsky PS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;70/&lt;70</td>
<td>117/38</td>
<td>76% / 24%</td>
</tr>
</tbody>
</table>

Results – Screening Test (n = 155)

<table>
<thead>
<tr>
<th>Screening test results</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients reporting problem with at least 1 IADL</td>
<td>45</td>
<td>29%</td>
</tr>
<tr>
<td>Distress thermometer: Any / Score &gt;5</td>
<td>85 / 23</td>
<td>56% / 16%</td>
</tr>
<tr>
<td>Pain score: Any pain / Score&gt;5</td>
<td>73 / 20</td>
<td>47% / 13%</td>
</tr>
<tr>
<td>Patients identifying feeling depressed</td>
<td>39</td>
<td>43%</td>
</tr>
<tr>
<td>Patients where memory was an issue</td>
<td>15</td>
<td>17%</td>
</tr>
<tr>
<td>Patients unable to identify their tumour stream/illness (n = 120)</td>
<td>59</td>
<td>49%</td>
</tr>
<tr>
<td>Self-reported fall in last 6 months?</td>
<td>31</td>
<td>20%</td>
</tr>
</tbody>
</table>
Interventions – streamlined referrals to EXISTING services

Cost analysis

• Formal cost analysis was performed including all aspects of the process...
  • preparation, delivery, collection, analysis and interpretation of the supportive care screening tool by cancer care coordinator (assuming time taken = 20mins per patient)

  • At $42.40 per patient, the process is relatively cheap.

CCOAC Conclusions

• The model was feasible, acceptable, cheap and delivered streamlined referrals for supportive care services for older adults with cancer at our regional centre.

• The “Older Adult” Cancer Care Coordinator is a key to the success of the process

• We found issues with health literacy
  – 49% patients unable to write down their diagnosis – a potential area for further study.

• Aspects of this pilot programme have been adopted into standard of care
  – all patients at our centre undergo supportive care screening and referrals are now made to existing services including aged care.
MASCC in AUSTRALIA 2016

MASCC/ISOO 2016
International Symposium on Supportive Care in Cancer
Save The Date...Adelaide, Australia - June 23-25 2016

2015 Copenhagen, Denmark

MASCC/ISOO International Symposium - Supportive Care in Cancer
Supportive Care Makes Excellent Cancer Care Possible

MASCC 2013 highlights