Follow-up in breast cancer patients: intensive vs minimal, centralized vs distributed

BREAST CANCER:
TOWARD A PATIENT-CENTERED PERSPECTIVE

Brescia – September 30th, 2011

Alessandra Huscher

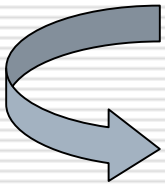
Follow-up in breast cancer patients: facts and myths

What is exactly “follow-up”?

…an action or thing that serves to increase the effectiveness of a previous one…

Follow-up in breast cancer patients: facts and myths

- Breast cancer follow-up should be strongly related to primary treatment end-points



Overall Survival & Quality of Life

- Follow-up should evolve in parallel to primary treatment

Follow-up in breast cancer patients: facts and myths

From surveillance of cancer recurrence to…….

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REVIEW ARTICLE

Implementing a Survivorship Care Plan for Patients With Breast Cancer

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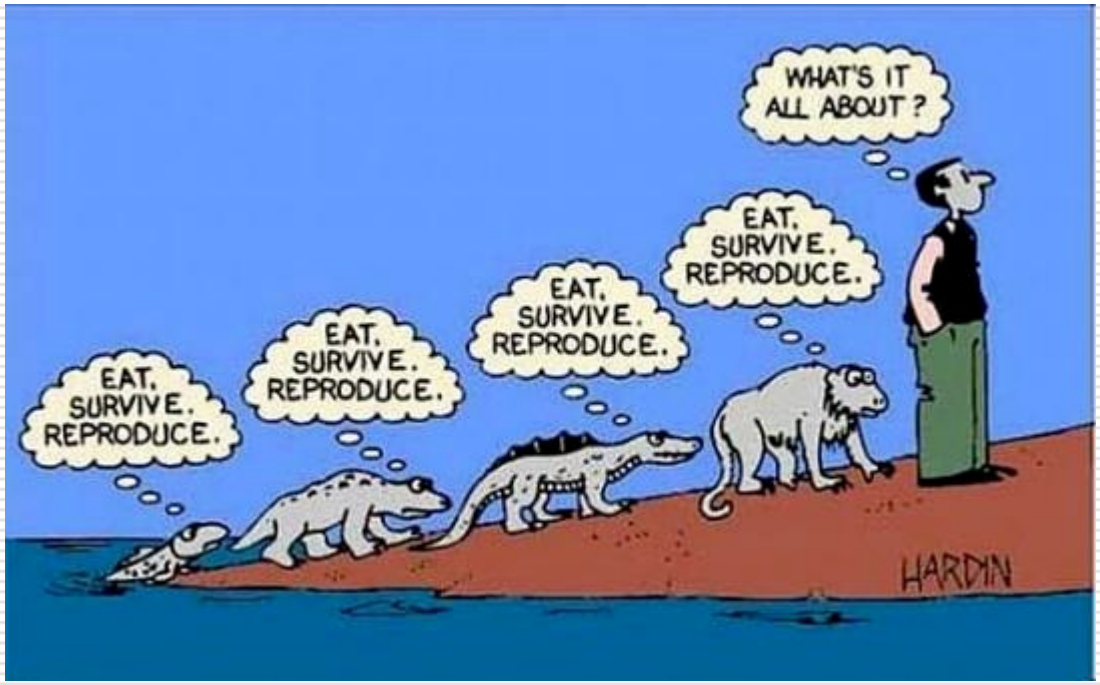
Authors' disclosures of potential conflicts of interest and author contributions are found at the end of this article.

A B S T R A C T

Breast cancer survivors account for 23% of the more than 10 million cancer survivors in the United States today. The treatments for breast cancer are complex and extend over a long period of time. The post-treatment period is characterized by gradual recovery from many adverse effects from treatment; however, many symptoms and problems persist as late effects (eg, infertility, menopausal symptoms, fatigue), and there may be less frequent long-term effects (eg, second cancers, lymphedema, osteoporosis). There is increasing recognition of the need to summarize the patient's course of treatment into a formal document, called the cancer treatment summary, that also includes recommendations for subsequent cancer surveillance, management of late effects, and strategies for health promotion. This article provides guidance on how oncologists can implement a cancer treatment summary and survivorship care plan for breast cancer survivors, with examples and linkage to useful resources. Providing the breast cancer treatment summary and survivorship care plan is being recognized as a key component of coordination of care that will foster the delivery of high-quality cancer care.

What are we really called to do???



What are we really called to do???

- Cancer surveillance
- Side effects reporting and management
- Counselling about risks
- Psychosocial care

What are we really called to do???

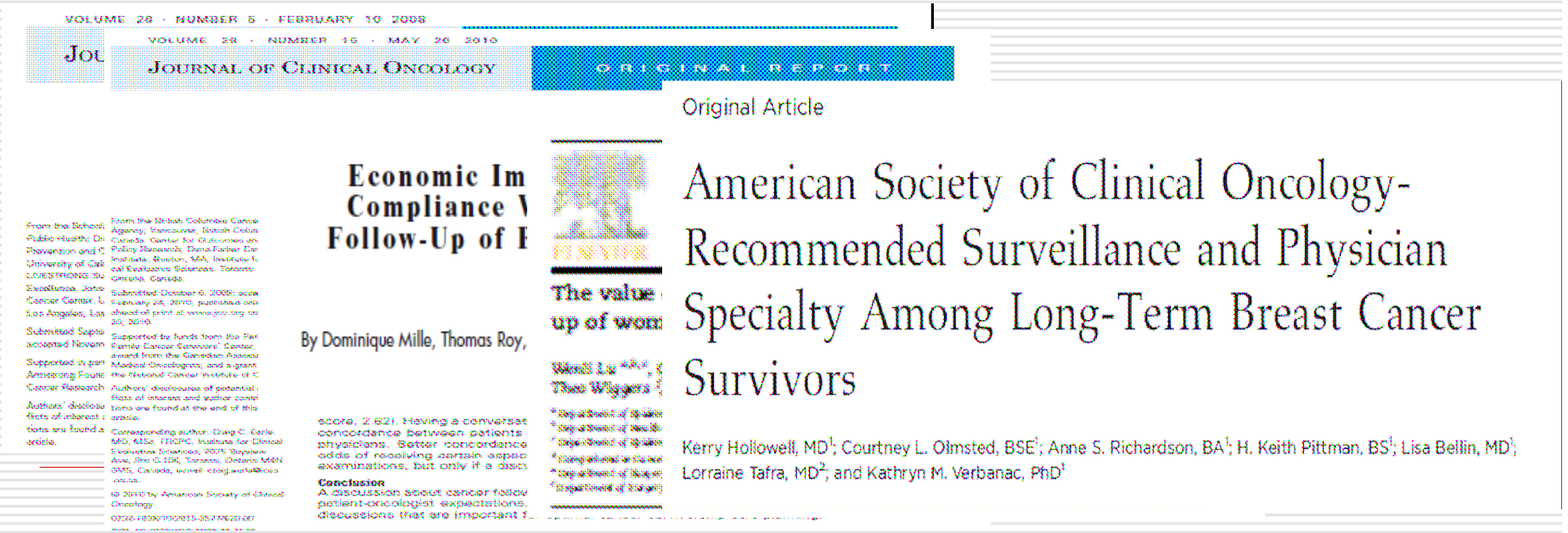
- Evidence based
- Efficient

Why discussion on follow-up in breast cancer patients?

- Heavy burden on out-patients clinics
  - IGL: first two years:2-4 times/yr
  - Increasing number of patients and survivors
- Adequate quality of care
  - Good provision of information
  - Good psychosocial care

Why discussion on follow-up in breast cancer patients?

- Increasing number of reports on efficiency of follow-up



General Aims of Follow-up

- For the *individual* patient: improving OS and QoL by:
  - Detection of new tumor localizations
  - Detection and management of early and late toxicity of treatments
    - Somatic
    - Psychosocial

General Aims of Follow-up

- For the *group* of patients: evaluation of therapeutic results
  - Evaluation of quality
  - Training/Education
  - Research

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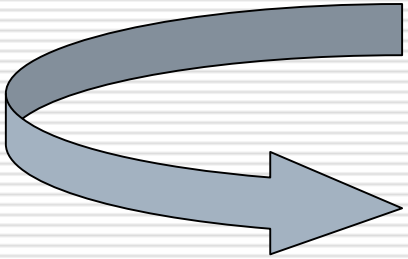
Value of follow-up with respect to recurrences and survival

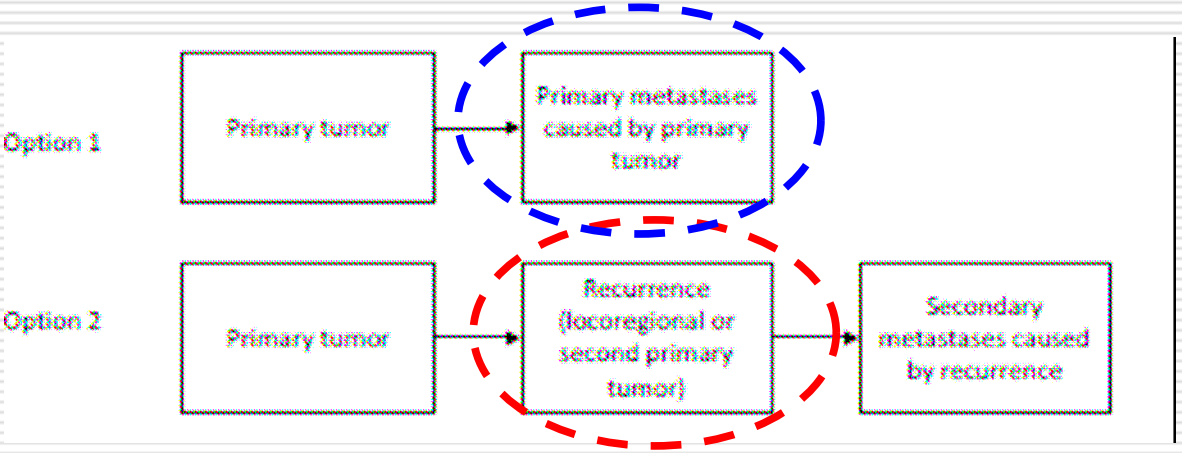
- Intensive follow-up for detection on DM is NOT nowadays evidence-based
  - 2 RCT 2500 pts: no better OS, no better QoL, no significant earlier detection of recurrence (1 month)



IGL: Mammography & Physical examination

Second level exams only if sympthoms

Early detection of relapses and OS



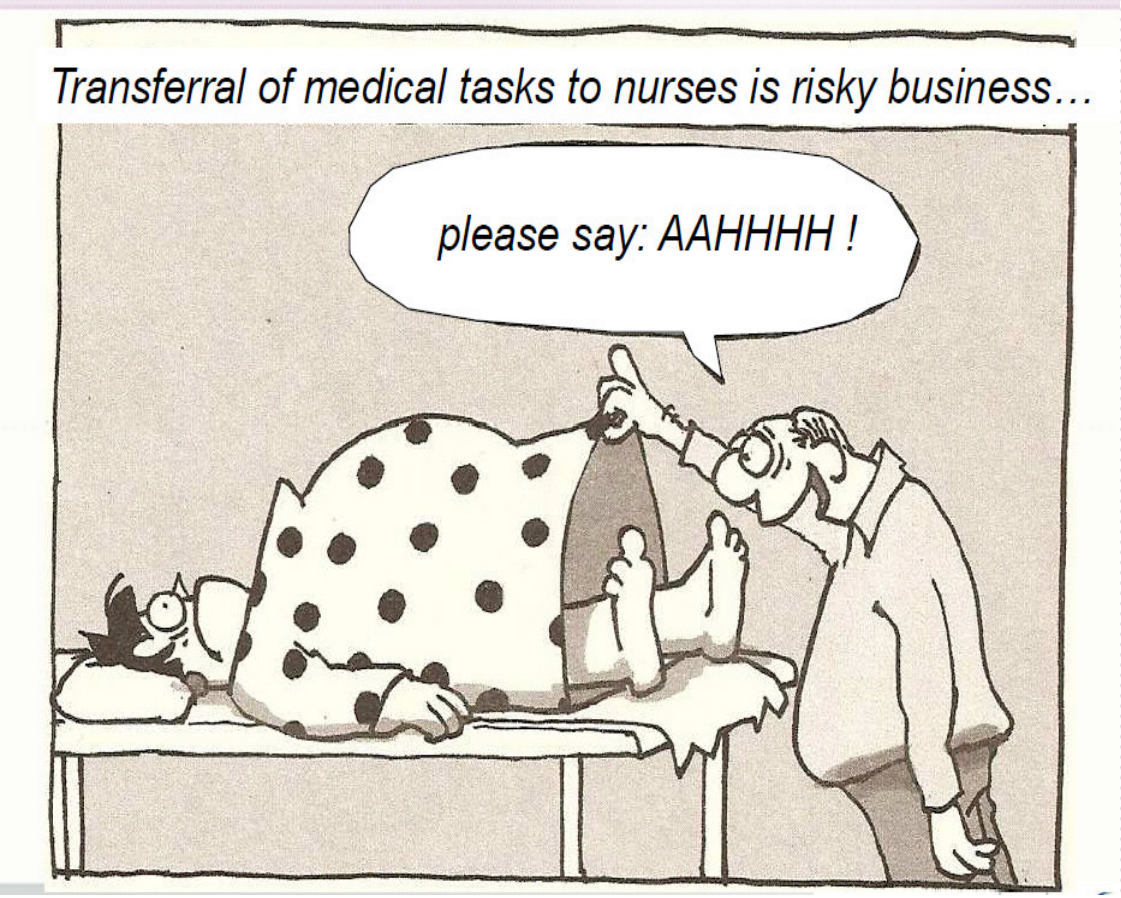
Value of follow-up with respect to recurrences

- Follow-up in Hospital compared to GP
  - 1 RCT: No differences in OS end time to recurrence detection

    OS was not primary end point, recurrences were defined as serious clinical events

- Nurse-led Follow-up
  - No difference in time to detect LR

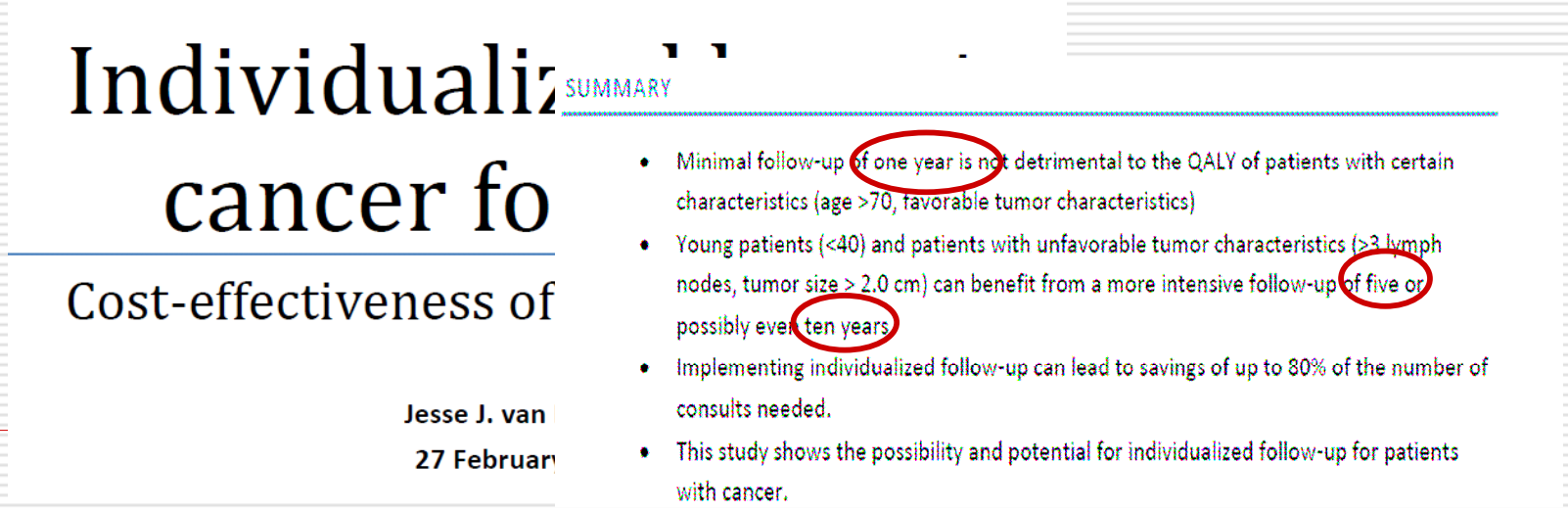
……but…..


Transferral of medical tasks to nurses is risky business…
please say: AAHHHH !

Value of follow-up with respect to recurrences – for how many years??

- Simulation study Enschede – Netherlands:

"Breast cancer patients, instead of standard frequent follow-up, need personalized procedures according to age and stage"



Individuali

cancer fo

Cost-effectiveness of

Jesse J. van

27 Februar

SUMMARY

- Minimal follow-up of one year is not detrimental to the QALY of patients with certain characteristics (age >70, favorable tumor characteristics)
- Young patients (<40) and patients with unfavorable tumor characteristics (>3 lymph nodes, tumor size > 2.0 cm) can benefit from a more intensive follow-up of five or possibly even ten years.
- Implementing individualized follow-up can lead to savings of up to 80% of the number of consults needed.
- This study shows the possibility and potential for individualized follow-up for patients with cancer.

General Aims of Follow-up

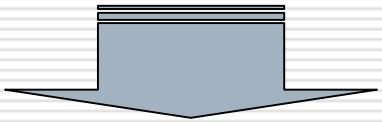
- For the *individual* patient: improving OS and QoL by:
  - Detection of new tumor localizations
  - Detection and treatment of early and late toxicity
    - Somatic
    - Psychosocial

Somatic sequelae

- Reporting is frequently suboptimal
- Detection of toxicity could require long follow-up, probably illimited

Somatic sequelae

- Surgery
- Radiation therapy
- Chemo – Hormonal Therapy



- Revalidation programs are beneficial
- Screening of secondary tumors or heart toxicity is beneficial
- Management of menopausal sympthoms, supply vit D/ Ca are beneficial

Evidence for value of follow-up in QoL

- 3 RCT
  - Hospital vs GP: No difference in anxiety or health related QoL
  - F-up once a year + mammography, hospital vs GP: no difference
  - Nurse led-on demand: no difference

Psychosocial sequelae

- In patient's perception are not the aim of "specialistic" follow-up

..doctors do not listen…

or

..just give me a pill..

Psychosocial sequelae

- Group intervention and providing informations and education are most effective

MaCAre Trial Kimman EJC 2011

General Aims of Follow-up

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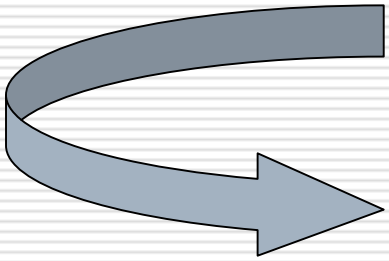

Clinical Results and Toxicity

How to improve current practice?

- Apply evidence based procedures
  - In low risk pts yearly evaluation could be sufficient?
- Stress the need for side effects reporting
- Provide correct information
  - On follow-up role, providers and sequelae
- Plan unlimited follow-up
  - Mainly based on collaboration of GP

ASCO Recommendation 2010

Original Article

American Society of Clinical Oncology-Recommended Surveillance and Physician Specialty Among Long-Term Breast Cancer Survivors

Kerry Hollowell, MD[1]; Courtney L. Olmsted, BSE[1]; Anne S. Richardson, BA[1]; H. Keith Pittman, BS[1]; Lisa Bellin, MD[1]; Lorraine Tafra, MD[2]; and Kathryn M. Verbanac, PhD[1]

ASCO Recommendation 2010

BACKGROUND: It is unclear whether it is appropriate to transfer the follow-up care of breast cancer (BrCa) survivors from cancer specialists to primary care physicians (PCPs). This contemporary study compared physician specialty and documented the long-term surveillance of survivors who underwent surgery at an American academic center. **METHODS:** Women in this institutional review board-approved study underwent breast surgery between 1996 and 2006. Data were collected for 270 patients with stage I to III BrCa (mean follow-up, 6 years). Charts were reviewed based on American Society of Clinical Oncology (ASCO) guidelines for recommended surveillance frequency and care. **RESULTS:** The majority of patients (90%; n = 242) were followed by specialists with 10% (n = 28) followed by PCPs. Patients with advanced disease and a greater risk of disease recurrence more often received specialist care. Patients followed by specialists were more often seen at ASCO-recommended intervals (eg, 89% vs 69% of patients followed by a PCP at follow-up Year 6; $P < .01$); however, many patients were followed inconsistently. Breast disease was often not the focus of PCP visits or mentioned in clinic notes (18% patients). Women seen by specialists were more likely to have documented clinical examinations of the breast (93% vs 44% at Year 6), axilla (94% vs 52%), or annual mammograms (74% vs 48%; $P = .001$-$.02$). **CONCLUSIONS:** Consistent compliance with surveillance guidelines and chart documentation needs improvement among all providers; however, specialists more consistently met ASCO guidelines. If transfer of care to a PCP occurs, it should be formalized and include follow-up recommendations and defined physician responsibilities. Providers and patients should be educated regarding surveillance care and current guidelines incorporated into standard clinical practice. ***Cancer* 2010;116:2090–8.**

DIPOBS Project

- BC pts referred to GP after
  - Low risk: 2 years of specialistic F-up
  - High risk: 5 years of specialistic F-up
- Defined procedures
- Training of GP
- F-up data re-adressed to Hospitals

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TKS for the attention!!!!!!!!!