











# Getting the 'best' out of supportive care in cancer: contribution of the EORTC QL measures

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# Changing objectives of oncology

## Original aims

Diagnosis

Cure

Palliation

## Modern aims

Prevention

Early and accurate  
diagnosis

Cure

Prolonging life

Palliation

Rehabilitation

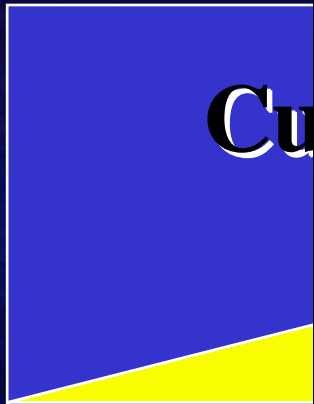
End of life care

# 20<sup>th</sup> century view of cancer care – WHO 1980s resource allocation model



# 20<sup>th</sup> century view of cancer care – what actually happened

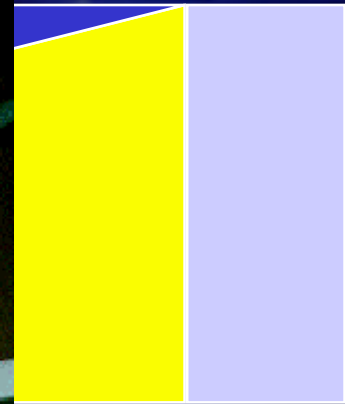
Diagnosis



Cancer



Death



Comfort

# What is Palliative Care?

‘Palliative care is the active holistic care of patients with advanced, progressive illness.

Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount.

The goal of palliative care is achievement of the best quality of life for patients and their families.

NICE, 2004

# What is modern supportive care in chronic disease?

- Symptom control
- Psychological support
- Attention to co-morbidity
- Information about disease and treatments
- Support for family
- Social and financial assistance
- Spiritual support and guidance

*Depends on needs – NOT the stage of disease*

# Supportive care

‘helps the patient and their family to cope with cancer and treatment of it –

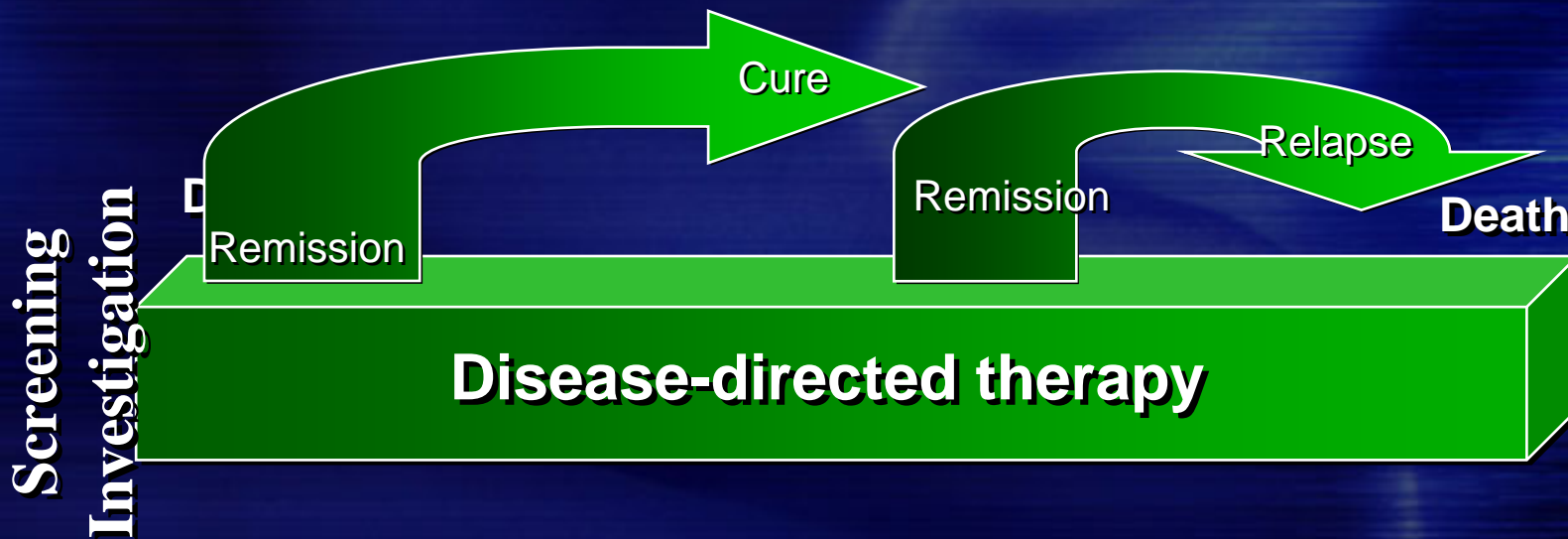
from pre-diagnosis, through the process of diagnosis and treatment, to cure, continuing illness or death and into bereavement.

It helps the patient to maximise the benefits of treatment and to live as well as possible with the effects of the disease.

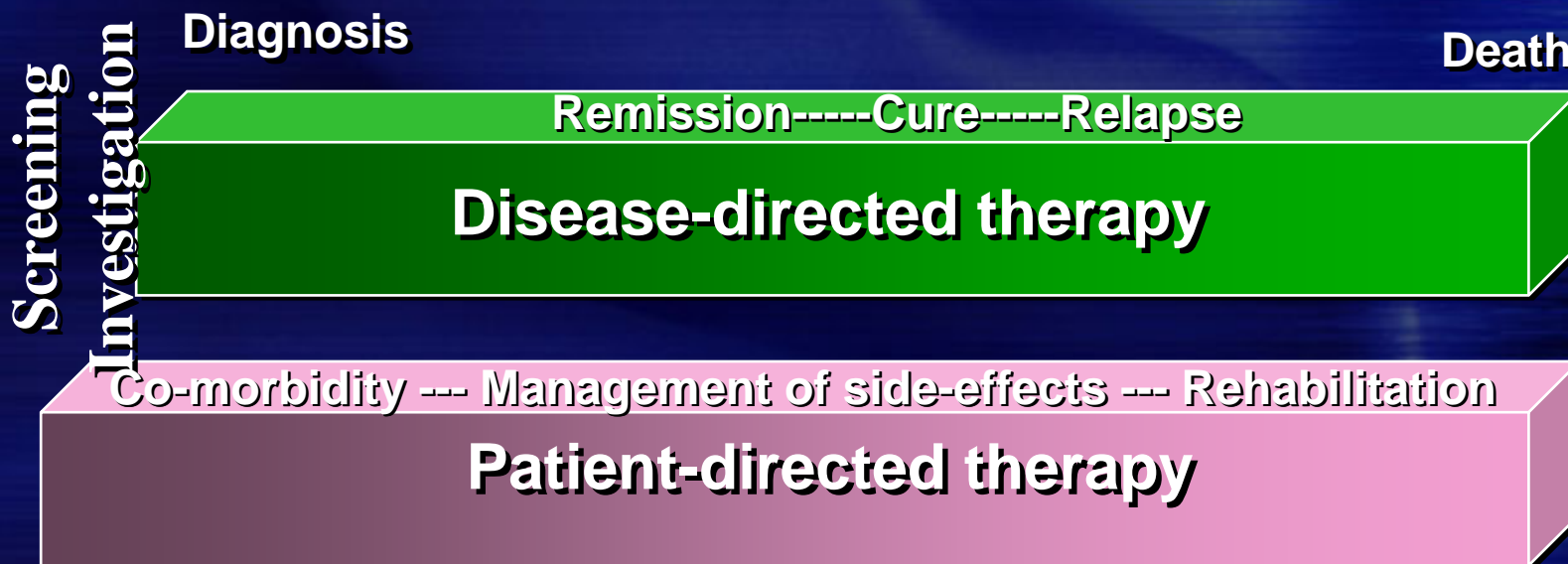
...equal priority alongside diagnosis and treatment.’

NICE 2004

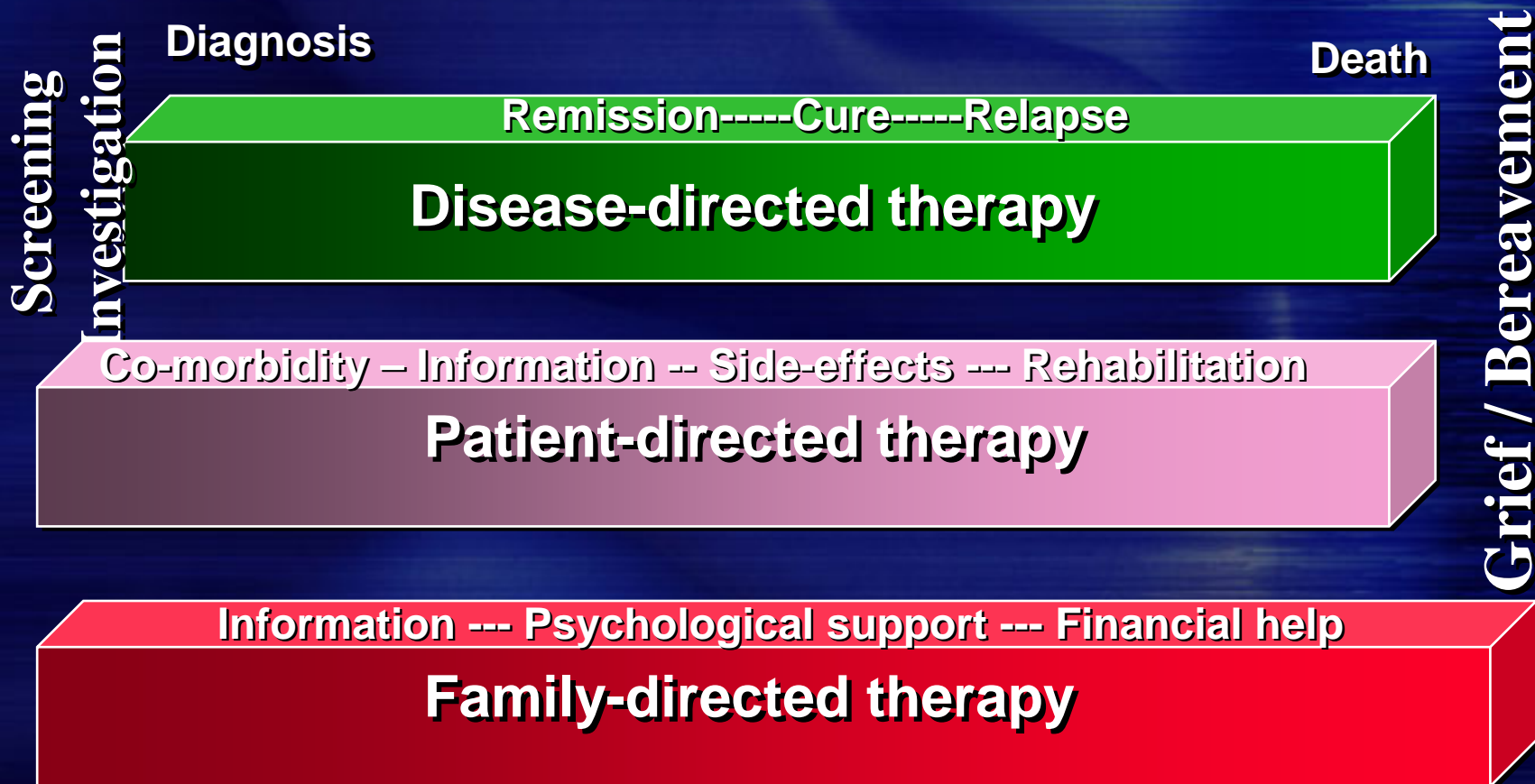
# Sheffield model of supportive care



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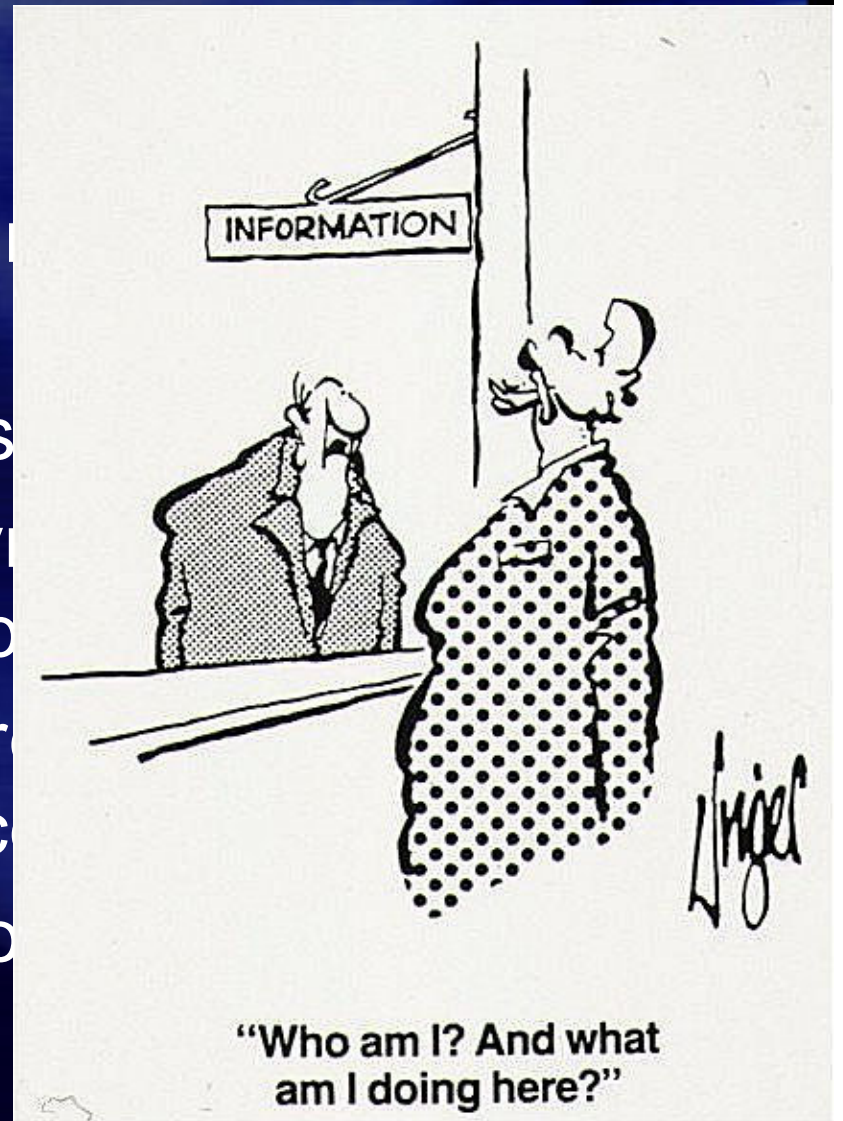


# Sheffield model of supportive care



# Who needs supportive care?

- Patients and families seeking information about illness and treatments
- Patients and carers with psychological distress
- Patients with unrelieved symptoms and side-effects
- Patients and carers who are struggling with the changing aims of anti-cancer therapy
- Patients and families approaching end of life



# Important times for supportive care

- Screening and investigation
- Breaking bad news
- Early curative or life prolonging treatment
- Recurrence
- Progression
- Terminal care
- Bereavement support



"All your tests were negative ... which is positive."

# The multiprofessional supportive care 'virtual team'



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# 'Best' supportive care in oncology

- Why did oncology adopt 'best supportive care' in clinical trials?
- What is actually meant to happen when a patient gets 'best' supportive care?
- Do oncologists know what is necessary for supportive care?
- Is 'BSC' meant to make the patient - or the oncologist – feel better?

# Relevance of EORTC QL measures in supportive care

- EORTC QLQ-C30
  - emphasis on physical symptoms and physical functioning
  - role and social functioning
  - global assessment of quality of life
- EORTC modules
  - designed mainly to focus on trials in earlier stage of disease
  - modules on satisfaction, information, fatigue, spirituality etc

# Non-small cell lung cancer

- NSCLC – a classic disease for ‘supportive care’
  - Mostly incurable
  - Heavy symptom burden from diagnosis
  - Socio-economic disadvantages
  - Many new options in disease modification and palliation

# HR QoL in NSCLC – systematic review of RCTS

Bottomley et al, *JNCI* 2003

- 29 RCTs from 1980-2002
  - 8445 patients
  - 24 chemotherapy; 3 RT; 2 combination
  - 21 studies compared anti-cancer treatments
  - 8 compared anti-cancer treatment versus BSC
- 27/29 had survival endpoint
- 15/29 (56%) no survival difference
  - 9/15 – HRQoL data provided additional subjective information
- 12/29 (44%) showed survival difference
  - 6/12 – HRQoL data gave additional significant differences

# How was QL measured?

Bottomley et al, *JNCI* 2003

- HRQoL was primary endpoint in 6/29 studies
- Only 9/29 proposed HRQoL hypothesis
- Baseline HRQoL mandatory in only 4/29
- HRQoL tool justified in 10/29
  - EORTC QLQ-C30 in 14
  - LC-13 in 9
  - FACT-L in 4

# How good was the HRQoL data?

Bottomley et al, *JNCI* 2003

- 24/29 studies had adequate coverage of HRQoL domains
- 15/29 studies found statistically significant differences in HRQoL
  - Only 6 examined clinical significance
- 17/29 studies presented HRQoL data well
- 11/29 studies reported missing data inadequately

# Gastrointestinal cancer

- Cochrane systematic review of RCTs in gastrointestinal cancer in which anti-cancer treatment is compared to BSC
- Search 1966-2002
  - 1980 citations
  - 14 covered chemotherapy and BSC
  - 7 were RCTs
  - 4 finally analysed

Ahmed et al, *Cochrane Library* 2004

# Cochrane review of GI cancer

Ahmed et al, *Cochrane Library* 2004

- 4 RCTs – 3 colorectal and 2 gastric cancer
- Total 483 patients
- All included metastatic disease
- Chemo regimens
  - Octreotide
  - Irinotecan
  - ELF
  - 5FU/cisplatin

- All had survival as primary outcome
- 2 trials used term 'BSC'; 2 used 'SC'
  - All used different definitions
  - 4 included use of analgesics
  - 2 included antibiotics
  - 1 mentioned psychological support
- HRQoL measured in 3 out of 4
  - 2 used EORTC QLQ-C30
  - 1 used FLIC

# HRQoL results in GI cancer

Ahmed et al, *Cochrane Library* 2004

- Advanced upper/lower GI cancer – octreotide (Cascinu 1995)
  - No HRQoL
- Metastatic colorectal cancer – irinotecan (Cunningham 1998)
  - Irinotecan + SC better QoL than SC alone (apart from diarrhoea)
  - Time to HRQoL deterioration longer in chemotherapy arm
- Advanced gastric cancer – ELF regimen (Glimelius 1997)
  - More patients had a higher QoL for 4 months with ELF+ BSC

# Symptom burden in GI cancer

Ahmed et al, *Cochrane Library* 2004

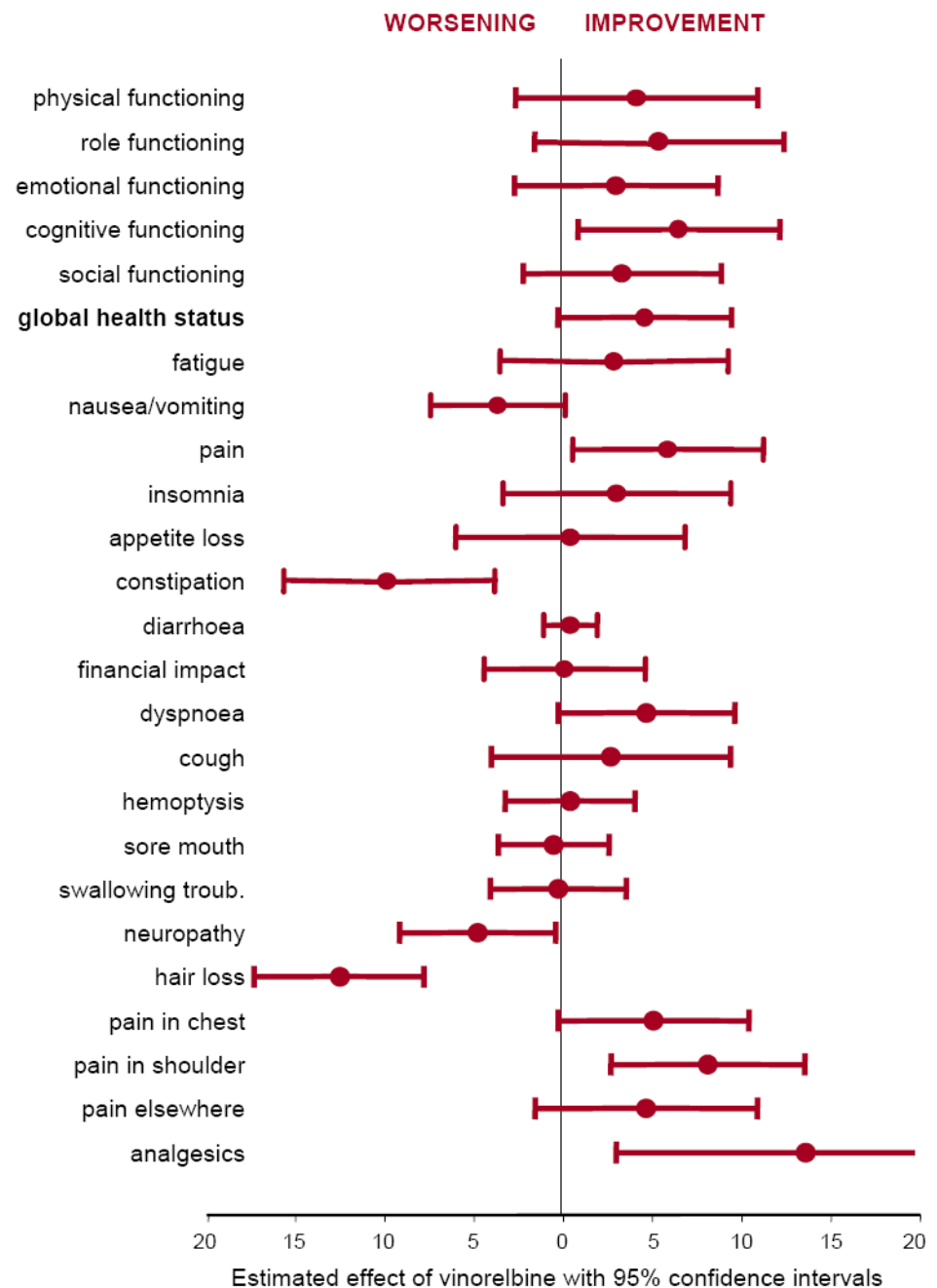
- 1 trial had no subgroup analysis for symptom control
- Only 1 trial described symptom-free period or improved symptoms in absence of toxicity
- Only 3 trials described pain relief
- All trials described toxicity
  - 2 trials reported hospitalisation for toxicity

# Special situations in supportive care

- Older people
- Socio-economically disadvantaged
- Community versus hospital based treatment
- Symptom control

# Older people with

- High level of co-morbidities
- Increased tendency to experience side effects
- Changing tolerance to symptoms
- Changing attitude to death
- Can HRQoL measure these differences?



# Socio-economically disadvantaged groups

- 129 patients with lung cancer in deprived and affluent areas of Scotland
- 78% extensive disease
- 37% received BSC; 30% RT; 28% chemo

Montazeri et al, *Health Qual Life Outcomes* 2003

# Social differences in lung cancer

Montazeri et al, *Health Qual Life Outcomes* 2003

EORTC functioning	Affluent	Deprived	p
Role	72.8	58.5	0.04
Physical	74.3	61.7	0.03
Cognitive	85.2	86.9	ns
Social	86.6	85.8	ns
Emotional	80.0	78.2	ns
Global QL	56.9	51.4	ns

# Social differences in lung cancer

Montazeri et al, *Health Qual Life Outcomes* 2003

EORTC scales	Affluent	Deprived	p
Pain (overall)	23.3	24.8	ns
Dyspnoea	27.8	41.6	0.02
Cough	44.7	53.9	ns
Fatigue	26.0	38.3	0.06
Appetite loss	22.8	36.9	ns
Financial	6.6	8.5	ns
Peripheral neuropathy	3.8	18.4	0.01

# Community versus hospital treatment

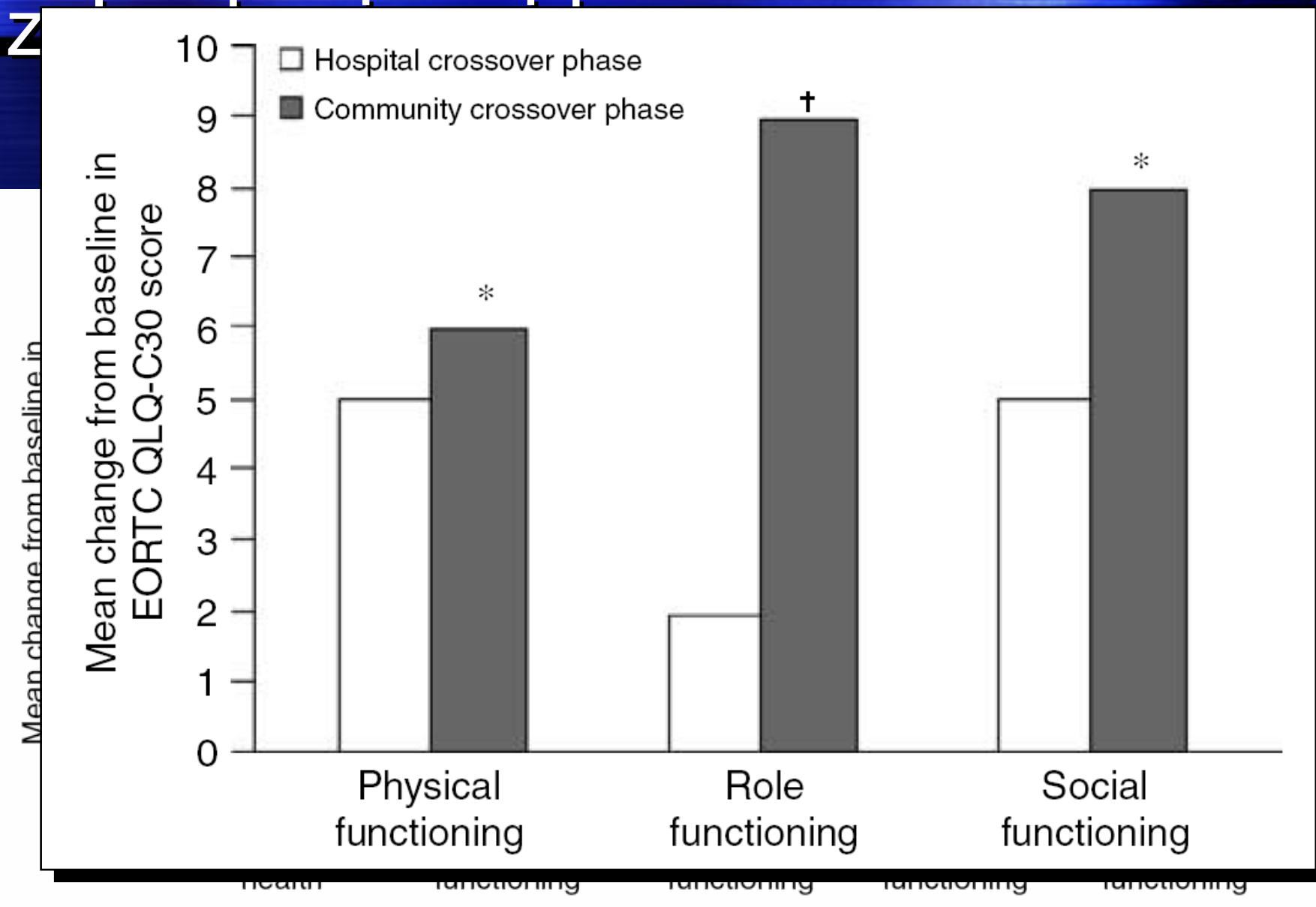
- Bisphosphonates proven to improve pain from bone metastases in cancer
  - Stop activation of osteoclasts
  - Reduce resorption of bone
  - Possibly reduce tumour activity and spread
- Zoledronic acid can be given as 15 minute intravenous infusion
- Would it help to provide infusion therapy nearer to patients' homes?

# Community versus hospital zoledronic acid

- RCT of 3 monthly infusions in hospital versus 3 infusions at community centre and crossover
- Breast cancer, n= 101
- Pain assessed with Brief Pain Inventory
- HRQoL assessed by EORTC QLQ-C30 and BR-23

Wardley et al, Brit J Cancer 2005

# Community versus hospital



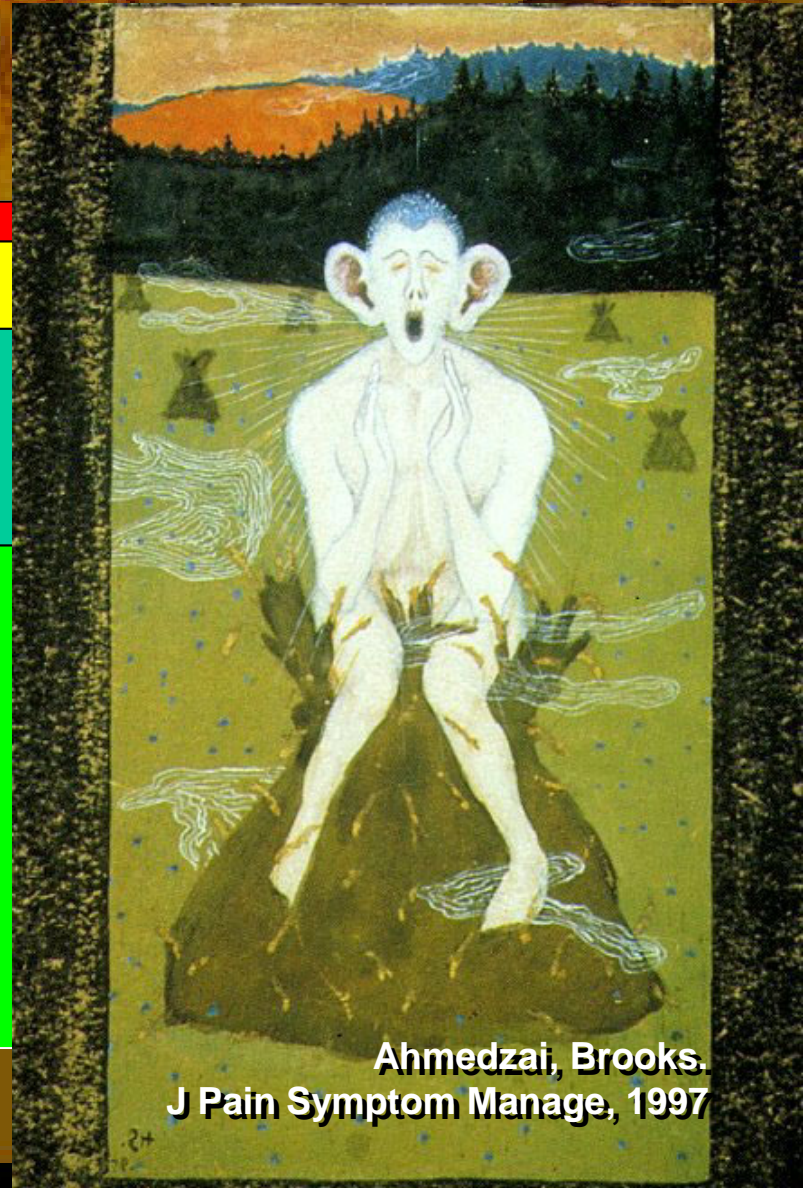
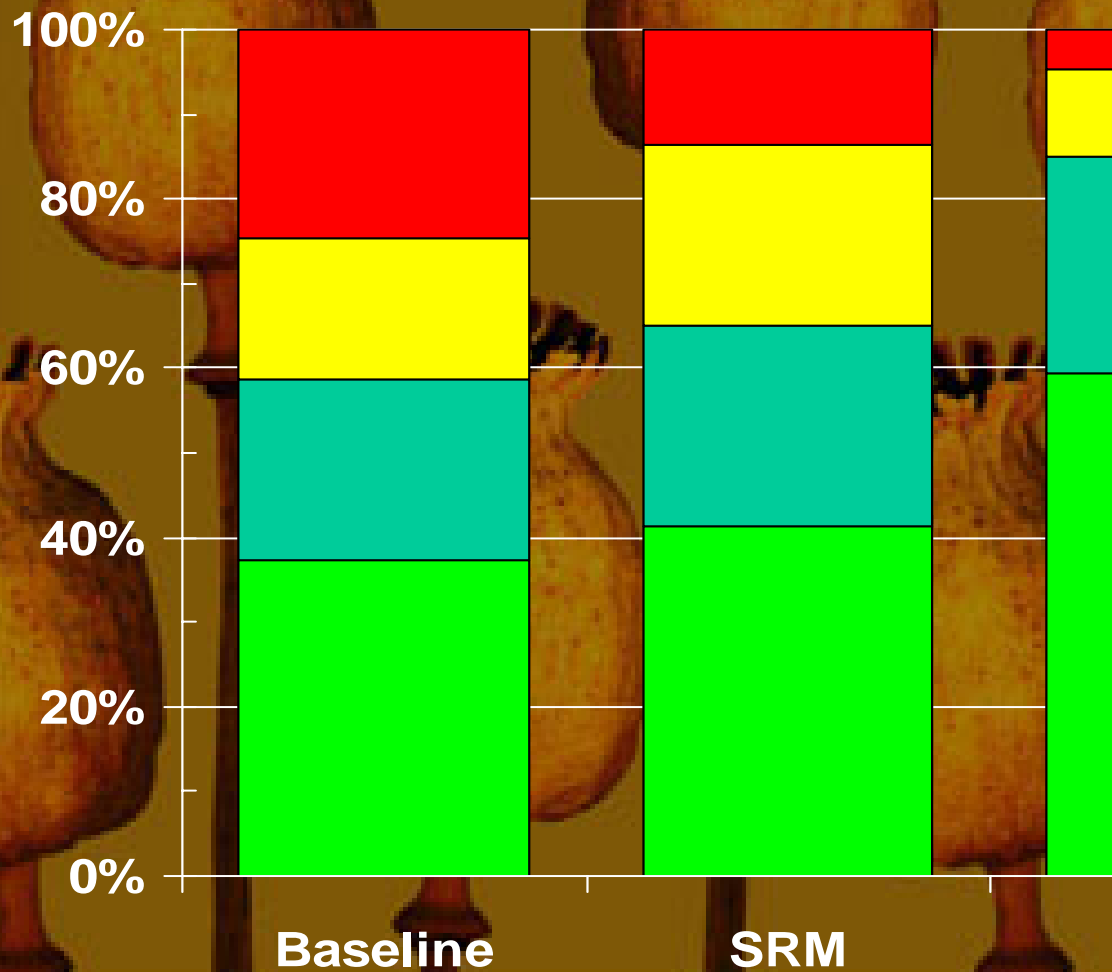
# Cancer symptom palliation

- Oral morphine therapy is 'standard' for moderate-severe cancer pain (twice daily)
- Transdermal fentanyl patch (every 3 days) potentially offers greater convenience and symptom benefits
- RCT of oral morphine versus TDF in 202 cancer patients – 2 weeks with crossover
- First large cancer pain study to include quality of life measurement
- EORTC QLQ-C30 and sleep, bowel function questionnaires

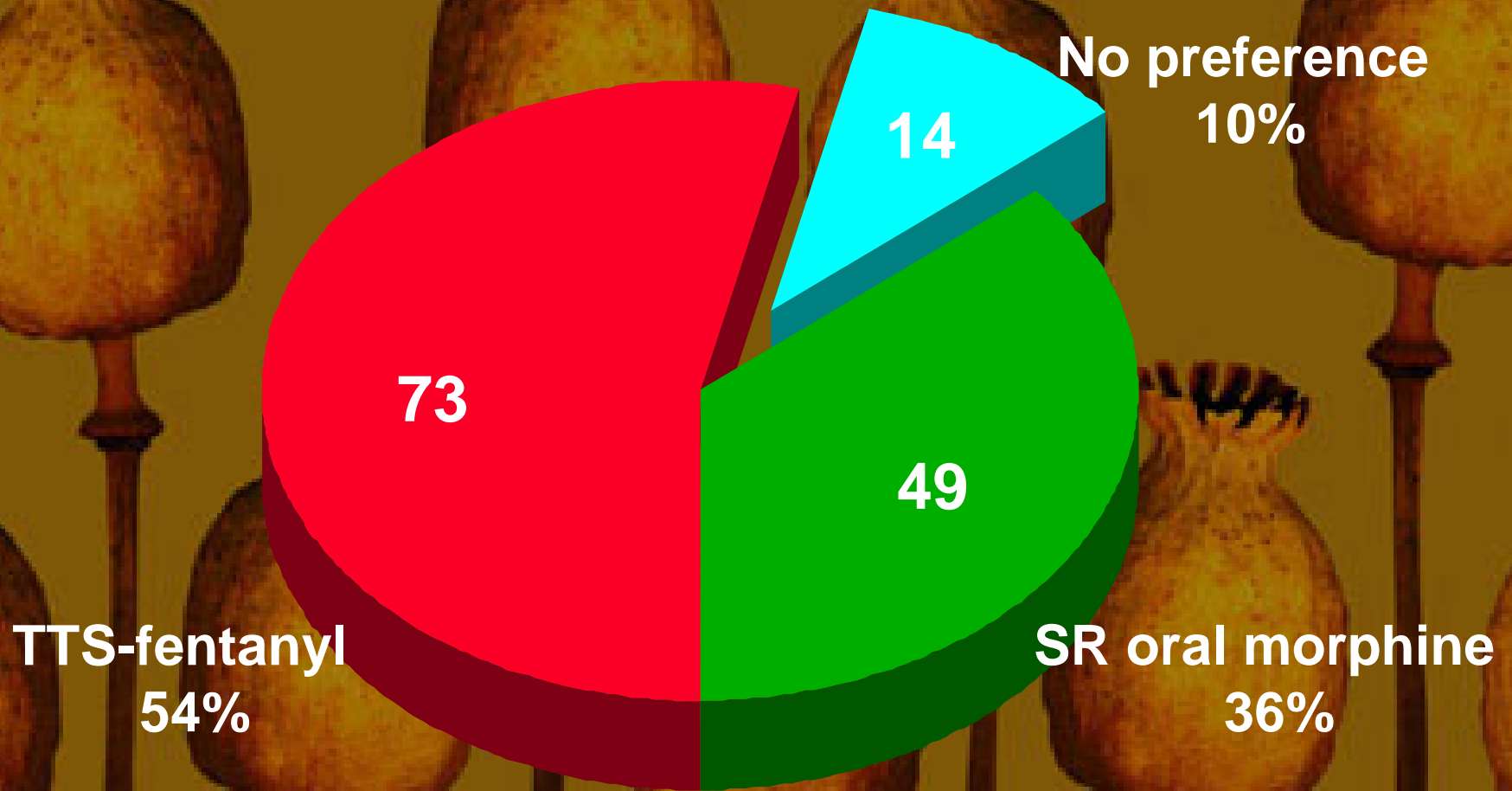
Ahmedzai et al, J Pain Symptom Manage 1997

# Side-effects of strong opioids – Constipation

$p < 0.001$



# Patient preference: TTS-fentanyl vs. SR oral morphine



TTS-fentanyl vs. SR oral morphine;  $p=0.037$

# Analysis of patients' preferences

Which medication?

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TTS-  
fentanyl      SR oral  
morphine

Caused less interruption of  
daily activities

Caused less  
family/caregiver  
burden

Was more convenient  
to take

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No significant differences in  
functioning or global quality of life!

49%

22%

<0.001

58%

22%

<0.001

# Conclusions

- Oncology has adopted 'best supportive care' as a euphemism for 'standard oncology services'
- Cancer care has focussed heavily on end of life palliative care
- Supportive care issues also need to be addressed at all stages
- HRQoL is essential measure of supportive care
- EORTC has another 25 years of work to do!