ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE
European Society for Medical Oncology

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Indian cancer congress 2011

Bhubaneshwar

11th February 2011

Biennial joint conference of ISMPO (Indian Society of Medical & Paediatric Oncology) and ISO (Indian Society of Oncology)

Theme: Targeting Cancer with Humility

Sri Ravi Rai, ex-union health minister and ex-speaker of the lok sabha inaugurated the Indian Cancer Congress palliative care workshop. The adressal note: " World's cancer burden is rising rapidly and at present is the topmost leading cause of death. Radical and efficient steps must be taken to get rid of this cause or else mortality rates will escalate in poor and developing countries like India. Ignorance and restlessness are pushing the mortality rates to threshold calling for an efficient administration of palliative care"

"The European Society for Medical Oncology wishes to express its best wishes to the meeting organizers for every success. ESMO looks forward to support India's efforts to improve cancer control, as part of our commitment to support developing countries."

David J. Kerr,
ESMO President

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Workshop: Palliative care

Chair persons

Palliative care workshop marks the changing scenario of palliative care management in India, in spite of being 2 decades old. Government of India mandates requirement of palliative care facilities for the recognition. Further, the introduction of master degree in palliative care by Medical Council of India ensures utmost palliative therapy for cancer patients.

Moderator Dr. G.S. Bhattacharya

A high standard of integration of medical oncology and palliative care is on comprehensive services. It is earlier rather than later to realise the intensity of the situation. Majorly basic infrastructure is the most essential need to combact cancer. Operating principles are to be acted straight from the heart with morality and ethics. Old concept – patients at their crucial time on a trial basis, were subjected to palliative care. New concept-every individual from the point of diagnosis is treated through palliative care.

TIME FOR ACTION NOW

Cancer causes more deaths globally than AIDS, malaria and TB combined. In 2005, > 50% of the 11 million estimated patients with cancer and 72% of cancer deaths were in developing countries, which have perhaps 5–10% of global resources.

The Goals are:

- To prevent as many preventable cancers as possible
- To cure as many curable cancers as possible
- To improve the quality of life of patients with cancer at all stages of their disease

"You cannot gain knowledge without practice. Wisdom comes from experience. Knowledge without action is of no value"

Introduction & Palliative care

Dr. Dirk Schrijvers

BELGIUM

Dr. Dirk started his talk by high lighting that India essentially needs palliative care as one million cancer patients have been reported in 2008 and about two third have been dying amongst it because of cancer. Lung cancer have been present in high rate in men and cervix cancer is present in increased number in women. Men affected with cancer are usually of 50's in age and women from 35-39 are affected with cancer. In India, in 2000, about 3-7.9% of aged group people were present. It is estimated that by 2030 about 13% people aged more than 65, this indicates that cancer incidences will be more in the coming days as cancer affects the aged in high percentage. Dr. dirk gives the terminology for palliative care as the medical act to improve a health by interventions aimed at the disease itself where the interventions are surgery, radiotherapy, and medication. The curative treatment aims at curing at care and the palliative treatment aims at improvement of quality of life. Dr. Dirk gives the terminology care as an assistance needed to alleviate complaints and he gives 3 types of care: supportive care, palliative care and endoff the life care. Doctor also speaks about the Incurable disease where the cure is impossible at the moment and he gave wide variety of examples such as HIV, cancer, heart diseases, kidney diseases, psychosis and bipolar disorders. Dr. Dirk speaks that curable disease has to be aimed for complete cure uncurable disease with palliative care. Dr. Dirk defines palliative care as an approach that improves the quality of life of patients and their families facing the problem associated with a life threatening illness. He also adds on by telling palliative care prevents and relieves suffering by early education, impeccable assessment and treatment of physical, psychological and spiritual problems. Palliative care mainly aims at affirming life and regards dying as a normal process and intends neither to hasten or postpone death. To the patient, it provides relief from pain and distressing symptoms, enhances quality of life, positively influences the course of illness. To the family palliative care gives support Dr. Dirk gives 4 main aspects about the palliative care, the physical aspects include pain and other symptoms, Psychological aspects include anxiety, depression, sociocultural aspects include best environment, financial support and communicative support. Finally existential aspect includes religion, hope and meaning of life. The policy statement goals at increasing involvement of professionals in the provision of palliative care and formalizing the special relationship between cancer and palliative care. Dr Dirk specifies the integration in palliative care for different health care providers, governmental, private insurances and charities can help on it. Finally, he also speaks about the integration of palliative care in cancer management. He says that there should be co-operation among international and national organizations to bring on palliative care to full fledge and finally conclude that professionals should be dedicated to promote palliative care, integrate palliative care into clinical practice and to their curricula.

End of Life Education

End of life education is the palliative care when death is imminent and the care provided to a person to the final stages of their life and this helps out all those with advanced progressive, incurable illness to live as well possible until they die enables identification of palliative and supportive care needs of both patient and family. Dr. Dirk says that the aspects of end of life care is to focus on the physical ,psychological, socio-cultural and existential aspects. Dr. Dirk speaks about Proffesional health caregiver the support study makes us to understand prognosis and preferences for outcomes and risks of treatments and gives the statistics that 46% of DNR orders were written within 2 days of death and 47% of physicians knew that patients wanted to avoid CPR. Doctor also predicts about the evaluation tools at the end of life the physical aspects include the Edmonton symptom assessment scale, pain skills the psychological aspects includes the hospital anxiety and depression scale (HADS), Existential/religious aspects gives way for hope and finally integration into clinical pathway include the liverpool care pathway.

Dr. Dirk gives predicts about the advantages and disadvantages of end of the life care pathway

Advantages

- Time efficient
- Multidimensional aspects
- Measurable,explicit and visible
- Educational tool
- Disadvantages
- Communication difficulties
- Family tensions
- Implementation
- Updating

Dr. Dirk concludes by informing that death is a natural consequence of life and the professional caregivers should enable the patient to die their "own death", bestow sufficient control, enable the family to ask good bye and mourn.

Breaking Bad News

Dr. Gayathri Pala

HYDERABAD

Dr. Gayathri starts with the statement "I have seen your reports. Looks like you have cancer." This is the statement where most of the oncologists would have been using. Defining the bad news as "a information which drastically and negatively alters a persons view of the future." The main bad news in oncology is discussing the diagnosis, hospice referral, news about recurrence, failure of treatment and absence of treatment options which is very difficult to deal with. The main question is how to tell the bad news whether to tell or not to tell? The bad news whatever way it is conveyed, it is a bad news but the main agenda is to deal with side affects when something goes wrong.

Dr. Gayathri's Highlights

1. Who should tell it?

Physician responsible, treating oncologist, sometimes a nurse who is skilled. Different modules of breaking the bad news firstly the nondisclosure method where the physician decides what is best for the patient and the advantages is its easier and takes less time and suits a few who don't want to know and the main disadvantages is lost opportunity to help, adjust and provide interventions undetermining of the patients trust.

The second module is full disclosure model that is telling everything to the patient this is helpful in building trust and helpful for some patients but it may be overwhelming and frightening and finally the third module described by Dr. Gayathri in tailoring the amount of information and rate of disclosure this is best adaptation as doctor says.

2. Strategy of breaking the bad news ?

a. Establish the situation framework that is the facts, proper environment and personnel that is deciding who is best in doing that.

b. Establish consultation framework how to negotiate the agenda.

3. During the breaking of bad news?

Give enough time to analyse the information and handle the emotions, pause and allow to sink in, listen to the patient carefully.

Finally, she concludes by stating that "give full support to the patient and tell them to feel free to come back and leave the door open to patient". She also adds on by giving communication training in breaking the bad news increases self-efficacy and reduces stress.

Pain Management

Dr. Suresh K. Reddy

USA

Pain is the commonest feature of all surveyed symptoms in advanced cancer patients (82%). Pain is an emotional and sensory experience or described in those terms indicating multifactorial natures of pain. Approximately 50% of all cancer patients, 70-80% of all advanced cancer patients, 50% and 30% will have moderate to severe pain and severe pain respectively. In 60-65% pain in cancer is related to direct tumour, 20-25% related to cancer treatment and 10-15% unrelated to cancer.

The common types of pain in cancer are nociceptive, visceral, neuropathic, peripheral and central pain. Pain assessment is an impossible part of pain management where history plays a important role (site, intensity, influencing factor, breakthrough medication and psychosocial history) in the management of cancer pain. Pharmacotherapy and nonpharmacotherapy are the mainstay of treatment. WHO analgesic ladder is the main protocol followed in the management of pain.

The 5 essential concepts in the WHO approach to drug therapy of cancer pain are by the mouth, by the clock, by the ladder, for the individual, with intention to detail. The WHO ladder has given 3 steps. In step one, the pain syndrome is ant or specific type of pain, the pain intensity in mild that is 0-4/10, the medications used are somatic/neuropathic pain syndromes respond mildly. In step 2, pain syndrome is any or specific type the pain intensity is moderate, 4-7/10 and the medications are mild opioids. In step 3, the pain syndrome in any or specific and the pain intensity is moderate-to-severe 7-10/10 and the medications include strong opioids, TCA, AEDs and the response is good. The strong opioid morphine which is taken intravenously and the strong opioids are codeine, hydrocodone (not available), Propoxyphene (not available), and tramadol. The morphine is the gold standard for opioids. It is metabolized to M6G and M3G, where M3G metabolites accumulate in renal dysfunction. Hence adjust the dose of morphine. The starting dose of morphine is 10-15mg q 4 hours and titrate the dose. Subsequently introduce sustained release form when the pain is stabilized. Transdermal fentanly is also used for stable pain however it is difficult to titrate in acute situation. The common limitations with chronic opioids are tolerance, physiological and psychological dependence. Effective pain management would elevate the suffering and improve the quality of life.

Palliative Care: Indian Challenge

Dr. Purvish M Parikh

INDIAN CHALLENGE

About 90% of patients want to die at home – keeping the patient busy at home is very important. National cancer control program sets panel on palliative care (PC). 50% or more PC is present in one state-Kerala. Distortion is infecting India. Usually family members says lie regarding patient to avoid the home care. 37000 new patients are coming to TATA hospital. Lisa Ray – suffered from bone marrow cancer is supporting other patients by joining NGO's and patient support group. Only in major cities, the patient's support groups are existing. Challenges: Planning to bring up health care where ever it is unavailable. Policies for individual – Innovative healthcare solutions

Panel Discussion

Will you use Fentanyl Patches in your treatment?

Dr. Gayathri – Some times I use.
Dr. Chitra Venkateshan – I don't use
Dr. Dirk – Will use in exceptional cases
Dr. Suresh – Not as a first option, may use as a later option
Dr. Prince John – If stable chronic pain presents then I prefer
Dr. Arundhati - If patient is staying at home then I used to prescribe
Dr. Purvish M Parikh – Yes I am using

AND (Allowing natural death) is this sustainable argument in India?

Offering what cannot be done allow natural to take over, but we expect patient's thorough understanding regarding it.

DNR (do not resuscitate) is it legal in India?

Information concerns data sheet, no it is illegal in India.

< 1% chance of survival
< 10-6% survival rate
Conditions cannot be levelled

Euthanesia?

Kindless killing, patient's decision. No treatment orders.

When would you use Morphine?

Dr. Suresh – At all times both intravenously and by oral method.

Dr. Dirk – At all times both intravenously and by oral method.

Dr. Purvish – All routes of administration at all times.

Dr. Gayathri – Only when patient suffers from chronic pain.

Does Morphine induce pain?

All opioid drugs induce pain in renal faliure cases as secondary metabolites are released, fentanyl cannot be used as it is neurotoxic.

"Nurses should be in the forefront in palliative care. Nurses should be self aware first and they should do better job with respect to comfort and care"

Dr. Dinesh Chandra Goswami

Oncology Nurses Training

"Effective communication practices, for a Placebo Effect" in the care Giver (Nursing)

Mr. Kultaran Singh

NEW DELHI

Care givers understand placebo effect for both theraupeutic concepts. Patients have expections from both doctors and family members. Once diagnosis is done, patient comes inside hospital and its nurses responsibility. Challenges in communication: Patients family must be made to believe in disease management. Communication preference: The mode of instruction and understanding is different for different families. Inferences are processed. Behavioral preferences' of patients, caregivers and family members must be assessed. Need for soft skills: Patient and significant others hopes are assessed with level of trust in relation to their caregivers. Psychological responses of patients: JAMA/ CANCET- placebo cell of commerce conditions that it is important to subjective and objective measures of these in upto minimum of 40% of patients in a wide range of clinical conditions. Psychological response of patient receiving diagnosis is evaluated. Placebo means I will please; it has no effect and no response on body. Patient's mind is conditioned for placebo effect Therapeutic lanes are applied to help the patient to lead a comfortable life.

Palliative care in rural segment

Prof. Shad Salim Akhtar

SRINAGAR

About 28% enjoy privileges, 72% population in Kashmir leads a low profile life.WHO says that cancer may not be the killer for now at Kashmir but the mortality rate is to go up in coming days. Cancer incidence and mortality: Prevalence of tobacco use in Kashmir nearly 50% among males, which increases incidences in cancer by 50% to 75%. Gastric and esophageal cancers are commonest. Pain is the most recurrent symptom of all. Lack of awareness creates delay in treatments increasing the mortality rates. Muslims believe that pain and suffering deletes sins. Selective listening: Focusing part of the discussion is when we are listening we listen only to what we want to. Education in rural areas needs to be made to improve the living conditions of the people to lead a happier and healthier life.

Alternative Medicine

Dr. Bhabagrahi Pati

CUTTACK

Homeopathy is the new most invention in palliative care which is safe, has no adverse effects, it is cost-effective, easily palatable, painless, increase our immune boosters, helps in prevention of malignancy, provides antidotes and adverse effects of drugs. Cancer overcomes the most dreaded disease that is arriving from the abnormal cell and establishes its site and localizes its place. Cancer is cured by chemotherapy, radiation therapy, and hormone therapy. Advance case treatment with homeopathy: boosts immune system, controls spread of cancer, helps to lead normal life. Holistic approach speaks of the theory of individualism which treat man as a whole: homeopathy treats the patient not the disease. Signs and symptoms are only manifestation of patient which is taken into consideration. Absence of genuine drugs and wrong choices by surgeon worsens the conditions of patients when administered by Morphine if suffering from renal failure. An example of the study made is as follows: number of patients - 60, period of research is one year. Patient with a background of post surgical and post chemotherapy cancer cases having symptoms of hiccups associated with chest pain, heart burn, nausea with burning heat on face, post-operative cancer stomach. To patient with these complications STRONTIUM CARB 30/3 hourly proved to cease down pain

Case Discussed

A 46 year old man with history of SCC left tonsil, had resection, now with recurrence, experiencing moderate pain. He was started on paracetamol 500 mg every 4 hrs as needed for pain. Pain persisted and then medication changed to ibuprufen 400 mg oral three times a day. However, pain was not controlled and the pain score rates was 7/10, and there was also difficulty swallowing. Tramadol 50 mg three times a day was started.

Patient developed mild nausea and constipation. To control vomiting and contipation, Metoclopramide (prokinetic agent) was added along with senna. But pain still persisted. Morphine was added at 5 mg oral every 4 hrs as needed. After 2 days pain was 3/10 and the patient was able to swallow better. After 5 days, patient started complaining of nausea and vomiting with increasing pain.

After ruling out constipation, swallowing got worsed and ryles tube was passed for feeding. Then morphine was changed to liquid form. If fentanyl patch was to be planned, then the conversion table needs to be follwed strictly. The use of anti-epileptic and dexamethasone is as indicated.

Highlight of the day

- Inaugural Function
- Sir Dorabji Tata Oration
- Molecular oncology from bench to bed side
- ISO past president oration
- Gene signature vs. Individual biomarkers in lung cancer
- Novel approaches in the management of head and neck cancer

Awards

Oral award presentations

Breast cancer
- Dr. Ashok Kalwar
- Dr. P Suresh Nair
- Dr. Sajjan Singh

Head and Neck cancer
- Dr. Divyesh Anand
- Dr. Naresh Somani

Lung cancer
- Akash Srivastava

Bladder cancer
- Dr. Sanju Cyriac Pandarakalam

Leukaemia
- Swati Dasgupta

Bone Tumours
- Dr. Mandip C. Shah

Ovarian Cancer
- Dr. Tejal Kishor Gorasia

Contact numbers

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Evolving Therapies in Multiple Myeloma

Dr. Noopur Raje
USA

In the last years 5 drugs combination have been approved where bortezomib for relapsed and refractory multiple myeloma (MM), Lenalidomide and dexamethasone for relapased/refractory MM, Bortezomib with pegylated doxorubicin for relapased/refractory MM, Thalidomide in combination with dexamethasone in newly diagnosed MM and Melphalan with prednisolone with bortezomib for the newly diagnosed MM. The Mayo clinic study to asses the impact of survival in the last 30 years shows an increased survival (shift of curve to the right) was attributed to the newly available drugs. This benefit what reflected for younger patients but no change in the elderly.

The key questions which needs to be answered are as follows:

1. What is the best therapy for newly diagnosed MM?
2. Does choice of initial therapy matter ?
3. Should therapy be tailored according to age, high risk ?
4. How long to treat ?
5. Have novel therapies improved transplantation outcome ?

IFM trial in patients aged more than 70 years where MPT was compared to MP showed an increase in survival in the MPTR indicating the advantage of thalidomide. Further MPT was superior to MP and MEL100. Some of the patients were looked for transplantation. Based on this "all the age groups should be exposed to the new drugs" in front-line treatment of MM in transplantation ineligible patients

The vista trial in elderly patients showed bortezomib with MP showed a 33% increase in the complete remission rate, which is remarkable. In addition a significant increase in the overall survival was observed. The newer drugs overcame the adverse prognostic factors. An independent phase III trial comparing VMP vs. VMPT showed an increase in the complete response in the 4 drug regimen. However, an increase in toxicity was observed. The neuropathy toxicity was reduced in the Once weekly regimen. Thus the selection of the regimen or drug is based on response rate, overall survival and balanced toxicity. Maintenance therapy with VT or VP in VMR vs VTP arm showed no difference in response but increasing toxicity. Palumbo et al trial showed superiority of MPR followed by are compared to MPR and MP. The progression to disease was reduced to 50% and was well tolerated. An increased incidence of secondary cancer was observed there by raising the question how long to be used. Lenalidomide with high dose dexa vs Lenalidomide with low dose dexa in newly diagnosed showed an increased response rate with former but had detrimental effect on overall survival. This was attributed to the toxicity of high dose steroid (DVT, PE, infections) .

Front line treatment of MM in transplantation eligible patients IFM trial on bortezomib with dexa vs VAD showed increased toxicity with VAD with no other clinical advantage giving a equivocal benefit with newer drugs. GIMEMA trial od VTD vs TD showed superior progression free and response rate without any difference on overall survival balancing the neuropathy is the challenge. HOVON-65 trial comparing VAD vs PAD with bortezomib maintenance showed an increase in response rate over time with incremental improvement in remission. For the first time, a progression free and overall survival advantage was observed. In a non randamized phase II study with lenalidomide with bortezomib with dexa was well tolerated currently this ongoing trial is looking at role of transplantability.

In maintenance therapy, thalidamide was not a good choice as it failed to show a real benefit. CALGB 100104 study showed lenalidomide increased TTP, PFS with no difference on overall survival. In this study, 25 new malignancies were observed with bortezomib. To summarise maintenance therapy shows increased survival, with a toxicity concern. Bortezomib is a promising agent.

Newer drugs

Pomalidomide is more potent than thalidomide and linalidomide due to its super imposed structural modification. A remarkable 30% response rate sustained for 8-10 months was observed. Promalidomide is close to obtain FDA approval.

Carfilzomib is a novel proteosome inhibitor. Carfilzoib increased the PFS by 4 months and overall survival by 15.5 months in patients refractory to all agents.

Vorinostat and panobinostat are pan HDAC inhibitor, which blocked ubiquitinated protein catabolism and is promising novel agents.

Elotuzumab is an antibody directed against protein CS1 expressed ubiquotously on myeloma cells. An impressive response has been observed in phase I and II studies . Elotuzumab is found to be as promising as Rituximab for myeloma patients.

To conclude combinations in induction therapy , role of transplant under investigation where we need to pick and choose the right patients. We need more data on maintainence therapy. The current data cannot be generalized and there is a need for risk stratification for future studies.

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