

## **Update On Cancer Survivorship Principles In Primary Care**

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## **Learning Objectives**

- Discuss a broad overview of cancer survivors and what their needs are
- How to optimize the care of cancer survivors in the primary care setting
- What are some strategies to improve PCP and Oncologist communication
- What are some common concerns encountered in the primary care setting with cancer survivors

## **Cancer Survivors and their needs**

# The Definition of a Cancer Survivor

National Coalition for Cancer Survivorship

**“A Cancer Survivor is defined by the National Coalition for Cancer Survivorship as anyone with a history of cancer, from the time of diagnosis and for the remainder of life, whether that is days or decades.”**



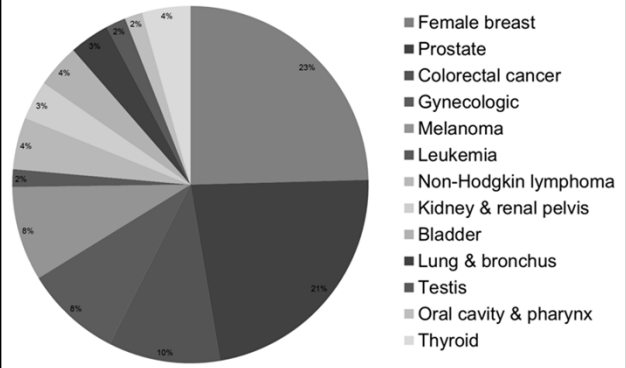
\*National Coalition for Cancer Survivorship (NCCS)/NO Office of Survivorship, Centers for Disease Control and Prevention and Lance Armstrong Foundation

Rowland JH et al. *J Clin Oncol*. 2006;24:5101-5104.

Clark EJ. You have the right to be hopeful. 2004.

<http://www.canceradvocacy.org/resources/publications/hopeful.pdf>.

## US Cancer Survivors: 15 Million+



American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2016-2017*. Atlanta: American Cancer Society; 2016

\* Percentages do not add up to 100 due to survivors diagnosed with more than one type of cancer

## Categorization of Patients with Cancer and Survivors of Cancer

Category	Description
Acute	At first diagnosis or relapse who require acute intervention
Chronic	With cancer that slowly progresses or alternates between phases of remission and relapse
Long term	In clinical remission for long periods of time or for entire life. Remain at risk of distant relapse or secondary tumors.
Cured	Disease free whose life expectancy after years of diagnosis equals sex and age matched members of the general population

***A very heterogeneous group!!!!!!***

**Surbone and Tralongo, JCO. October, 2016**

## Survivor Needs

- Routine primary care, including preventive services
- Management of comorbidities
- Monitoring for and management of physical and psychological sequelae of cancer/treatment
- Recurrence surveillance
- Screening for secondary cancers

## Needs of Survivors are unique

- Individual characteristics
- Other medical comorbidities in addition to cancer history
- Family /social/economic factors
- Stage of disease
- Type of treatments they are receiving or having received

## As an example...

A metastatic breast cancer patient on active chemotherapy:

Intervention /Recommendation	Appropriate?
Optimize blood pressure	Yes
Better diet	Yes
Lose a lot of weight to get to normal BMI	Probably not
Screening colonoscopy /mammogram/papsmear	No

## What about a metastatic patient with no evidence of active disease for > 10 years

- How would these recommendations change?

Intervention /Recommendation	Appropriate?
Optimize blood pressure	Yes
Better diet	Yes
Lose a lot of weight to get to normal BMI	Yes
Screening colonoscopy /mammogram/papsmear	Yes?

## Summary points: Needs of Cancer Survivors

- Cancer survivors are a diverse group with heterogeneous set of needs in the primary care setting
- Where a survivor is in their disease trajectory is a significant determinant of their primary care needs:
  - \* Curative disease vs metastatic/incurable
  - \* Active treatment vs surveillance/remission
  - \* Types of therapies receiving or having received:
    - cardiotoxic treatments
    - neurotoxic treatments
    - hormone manipulation (early menopause, androgen deprivation, anti estrogen therapies)

## **Optimizing the care of cancer survivors in the primary care setting**

### **Why should we focus on survivor needs in the primary care setting?**

- Rapidly growing population of survivors
- Complex needs with significant need for health promotion and health maintenance
- Different phases of cancer continuum have different needs and need different skill sets from health care providers- a PCP is uniquely poised to address these needs while collaborating with oncology team
- Increased emphasis on better quality of life in addition to better cancer outcomes
- Greater emphasis on patient centered issues

### **Needs/preferences**

- Many survivors in the US prefer oncology based follow up within the first 5 years of diagnosis
- Would like PCP to be partnered with oncology team
- Fears of recurrence/anxiety about cancer returning were the primary issue survivors wanted to discuss with oncologist

Tucholka et al, Supportive Care in Cancer, 2018

### **Improving access to primary care**

- Many cancer survivors are not seeing a PCP regularly
- Not getting routine health maintenance regularly
- Health promotion can be improved through partnership with a PCP

## Summary: Optimizing care for cancer survivors- Dual management

- Many survivors prefer close partnership between oncologist and PCP
- Dual care: oncologists manage the surveillance recommendations of the cancer while PCP manage routine health maintenance and other medical comorbidities
- There is some evidence that outcomes are improved with respect to health maintenance and screening

## Improving primary care of survivors

- Lifestyle
- Secondary cancer screening guidelines
- Late effects of cancer treatment

## Examples of late effects chemotherapy and radiotherapy

Organ system	Late effect of chemotherapy (agents)	Late effect of radiotherapy
Bone and soft tissues	Avascular necrosis (corticosteroids)	Short stature Atrophy Fibrosis Osteonecrosis Second cancers
cardiovascular	cardiomyopathy (anthracyclines, trastuzumab)	Pericardial effusion Pericarditis Coronary artery and peripheral vascular disease
Pulmonary	Pulmonary fibrosis Interstitial pneumonitis (bleomycin)	Pulmonary fibrosis Decreased lung volumes
Central nervous system	Leukoencephalopathy (methotrexate)	Neurocognitive impairment Radiation necrosis Second malignancies

Note: All examples are not listed in the table above.

## Resources for the PCP

- National Comprehensive Cancer Network
- American Society of Clinical Oncology
- American Cancer Society
- Children's Oncology Group
- Cancerpcp.org
- Cancer Survivorship E-Learning Series for Primary Care Providers (George Washington University)

## **Strategies to improve PCP and Oncologist communication**

## **Barriers to Dual management between PCP and Oncologists: Fragmentation of Care**

- One major barrier to successful transition is fragmentation of care
- Many cancer survivors choose to receive treatment at hospitals where their PCPs are not affiliated.
- They can see multiple health care providers
- Cancer center may not be coordinated electronically with the PCP's office
- Even in the same medical system, there may not be a collaborative relationship and communication between PCP and oncologist
- They may not have a PCP

## **Communication tools**

- A phone call
- Communication through electronic medical record (if same health system)
- Paper records/faxes
- Cancer treatment summary and care plans

## **Tools: Treatment Summary/ Care Plan**

- Record of treatment received
- Care Plan:
  - Potential long-term effects of cancer or treatment
  - Follow-up care:
    - What tests you need; when you need to be seen
  - Identify providers:
    - Who is going to take responsibility for what

## ASCO Treatment Plan and Summary

<ul style="list-style-type: none"> <li>■ Name, age, contact information</li> <li>■ Breast cancer diagnosis</li> <li>■ Surgery (type/dates)</li> <li>■ Patient history, including comorbid conditions</li> </ul>	<ul style="list-style-type: none"> <li>■ Adjuvant chemotherapy/radiation therapy (planned and received)             <ul style="list-style-type: none"> <li>– Details on agents/doses prescribed (dates initiated/completed)</li> <li>– Toxicities (anticipated, experienced)</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>– Hormonal therapy (agent, duration, date to be initiated)</li> <li>– Trastuzumab (dates, ejection fraction)</li> <li>– Provider contacts (including referrals)</li> <li>– Pre- and posttreatment comments (eg, baseline assessments, patient counseling, follow-up recommendations)</li> </ul>

## Survivorship Care Plan

Follow-Up Care	Providers to Contact		
Medical history and physical examination	<ul style="list-style-type: none"> <li>• First 5 years</li> <li>• Year 6+</li> </ul>		
Posttreatment mammography	<ul style="list-style-type: none"> <li>• First 5 years</li> <li>• Year 6+</li> </ul>	Follow-Up Care	Visit Frequency
Breast self-examination	• N/A	Medical history and physical examination	<ul style="list-style-type: none"> <li>• Years 1 to 3: every 3 or 6 months (including key notes for 1st-year visits)</li> <li>• Years 4 to 5: every 6 or 12 months</li> </ul>
Pelvic examination	Ob/gyn		
Coordination of care	<ul style="list-style-type: none"> <li>• First 5 years</li> <li>• Year 6+</li> </ul>	Mammography	<ul style="list-style-type: none"> <li>• Every 6 or 12 months as indicated</li> </ul>
Genetic counseling	If indicated, based on risk factors	Notes	<ul style="list-style-type: none"> <li>• May include any relevant patient notes and/or recommendations</li> </ul>

Journal of Cancer Survivorship  
<https://doi.org/10.1007/s11764-017-0673-5>

REVIEW



Survivorship care plan outcomes for primary care physicians, cancer survivors, and systems: a scoping review

Weston LaGrandeur<sup>1</sup> | Julie Armin<sup>2</sup> | Carol L. Howe<sup>3</sup> | Leila Ali-Akbarian<sup>4</sup>

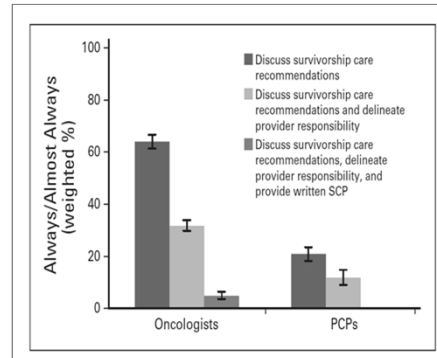
Received: 11 September 2017 / Accepted: 22 December 2017

## Benefits of SCPs

- Can specify where survivor is within in their disease trajectory
- List treatments needed
- Highlight survivorship issues:
  - PCPs who received SCPs were more likely to discuss treatment related toxicities and survivorship issues
  - More awareness of who will do what

## Challenges of SCPs

- Most PCPs are not receiving them
- If they are receiving them, they are not accessible during routine work flow
- Can be bulky, hard to read, unclear how to use



Blanche-Hartigan et al JCO, 2014

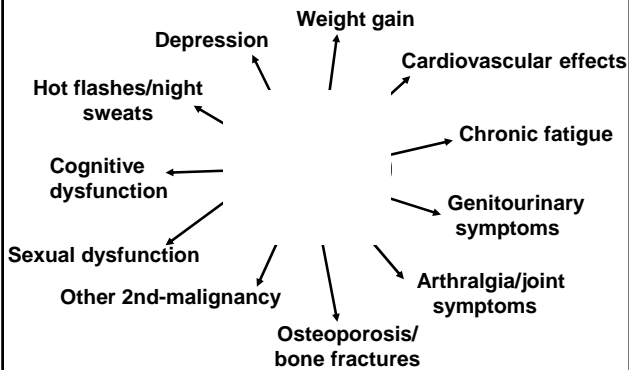
## Summary: strategies to improve communication

- Regular communication between oncologist and PCP can take many forms
- Treatment summaries and care plans can be helpful but not currently being routinely used
- Ongoing initiatives are taking place on how to make them more user friendly and accessible

**Common concerns encountered in the primary care setting with cancer survivors**



## Spectrum of Potential Late Effects



Hayes DF. *N Engl J Med.* 2007;356:2505-2513.

## A challenge for PCPs and oncologists:

- Is this a common ailment or a sign of cancer recurrence or a sign of cancer toxicity
- Confusing for survivors too: who should they call?

## A cancer survivor with back pain

- Musculoskeletal strain?
- Bone metastasis?
- Cord compression?

## A cancer survivor with cough

- All the usual primary care differentials still apply
- Can also be sign of new recurrence
- Toxicities from cancer therapies:
  - Radiation pneumonitis
  - Chemotherapy pneumonitis (Taxanes, bleomycin)
  - Targeted therapy pneumonitis (Everolimus)

## Working up symptoms in cancer survivors: considerations

- **Stage of disease: higher stage higher chance of cancer related burden**
- **Severity and duration of symptoms: more severe, longer duration, not being alleviated by usual measures**
- **Types of therapies received/ongoing therapy: what are long term complications of the cancer therapy received and how they may be impacting symptoms**

## What issues are most commonly seen in primary care office with cancer survivors:

Symptoms/Issues	Common Cancer Therapies
Fatigue	Chemotherapy, radiation, surgery
Anxiety/Depression	Cancer diagnosis and cancer treatment
Weight gain	Chemotherapy induced ovarian failure/cancer treatment
Hypertension	Oral targeted drugs (sunitinib)
Cardiac dysfunction	Trastuzumab (Herceptin) Anthracyclines Immunotherapies
Shortness of breath	Radiation Chemotherapy (Taxanes, Bleomycin, targeted therapies such as everolimus)

## Case 1

- **54 yo female with Stage 2 triple negative breast cancer diagnosed 5 years ago and treated with anthracyclines and taxane chemotherapy. She had no comorbid illness at the time of her cancer diagnosis, though her BMI before diagnosis/treatment was 29. She is being seen today by her PCP for her annual physical.**
  - She denies chest pain, shortness of breath, palpitations, dizziness, edema
  - Her BMI today is 31
  - Exam is notable for BP 136/82, otherwise normal

## Case 1: Oncology perspective

- **Treated with very aggressive chemotherapy**
- **Triple negative breast cancer is associated with early recurrences within first 3-5 years**
- **After 5 years, low chance of recurrence**
- **This patient has a higher chance of dying from cardiovascular disease and other medical comorbidities than from cancer**
- **Health optimization is KEY**

## Case 1: PCP perspective

- Recognition of her increased risk for CV disease
- Addressing her blood pressure and obesity are paramount
- Additional screening to further risk stratify
  - A1c/fasting glucose
  - Lipids

## Case 2

- 70 year old with history of locally advanced prostate cancer treated with radiation and androgen deprivation therapy 3 years ago
- Been doing well but has had increasing back pain for last few weeks
- He did lift a heavy box and been doing more work around the yard
- Taking a few ibuprofens but they upset his stomach

## Case 2: Oncology perspective

- High risk cancer
- Concerned that this may be an early presentation of cord compression
- Plain x-rays are often unrevealing
- Gold standard is an emergent MRI +/- Bone scan
- Lytic lesions will not appear on Bone scan so a negative bone scan does not negative malignant process

## Case 2: PCP perspective

- Differential ranges from benign and self limited (musculoskeletal strain) to complications from previous therapy (compression fracture in setting of osteoporosis as a result of androgen deprivation therapy) to metastatic disease or cord compression
- Thorough neurological exam
- PSA?
- Consider imaging earlier than you otherwise would
- Close follow-up

## Case 3

- 60 year old woman with stage 3 her2 positive breast cancer who has been receiving nearly a year of chemotherapy followed by trastuzumab (Herceptin).
- She is feeling very fatigued
- More dyspnea on exertion
- She did not know whether to call her PCP or her oncologist.

## Case 3: Oncologist perspective

- Broad differential needed for fatigue (treatment, inactivity, anemia,etc) but also need to think about cardiotoxicity from Herceptin as well as occult cardiovascular disease
- Cardiac testing with at least an echocardiogram
- Consider early cardiology referral for any abnormalities on EKG or echo

## Case 3: PCP perspective

- Very broad differential – cancer/treatment, anemia, pain, mood, sleep, nutrition, medications, complications of treatment
- Recognition of cancer related fatigue as a discrete entity

## Case 4

- 70 year old woman with metastatic ovarian cancer with diffuse peritoneal and lung metastasis
- She has been responding to chemotherapy and feels well
- She would like to establish care with a PCP who is in the same network as her oncologist and wants ALL her screening studies ordered.

### **Case 4: Oncologist perspective**

- She is responding well to chemotherapy but she has an incurable cancer with limited life expectancy (at best 5 years or less)
- Screening studies are not beneficial

### **Case 4: PCP perspective**

- Rapport and aligning priorities with the patient
- Focus on preventive care as a whole, not just on cancer screenings
- Discussion of risks and benefits of screening given her overall medical condition at this time

### **Summary: common symptoms and issues**

- Close collaboration between PCP and oncologist is key
- Common things can still happen while cancer complications still need to be ruled out in this population
- Understanding stage of disease and treatment complications can be helpful in the work up

### **Conclusions**

- Cancer survivors benefit from close collaboration between PCP and oncologist
- Health optimization is a priority
- Research is ongoing on how to improve communication and collaboration between PCPs and oncologists and enhance health outcomes of cancer survivors