

Introduction – Oncology Survivorship

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April 22, 2022

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Welcome

- Goals for Today
 - Education
 - Dialogue and networking
 - Program development
- COVID – masks (except while eating, speaking); space out
- Introductions

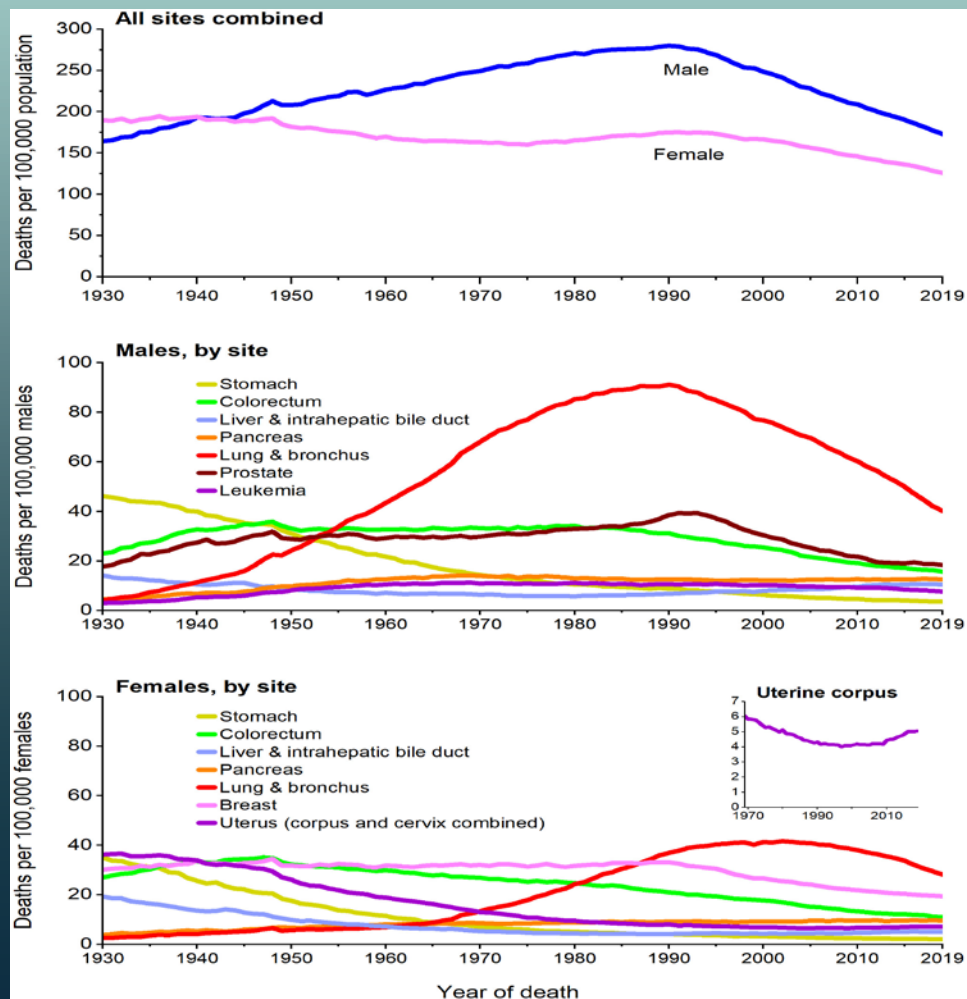
Cancer Survivorship

- Common meaning – having no sign of cancer after finishing treatment
 - Cancer-free
- IOM/ACS/NIH– someone who has been diagnosed with cancer (**ACS**)
 - Anywhere in cancer course – diagnosis to end of life
 - Life after cancer/Living with cancer

Phases of Survivorship

- Acute survivorship
 - Diagnosis through end of initial treatment. Focused on cancer treatment.
- Extended survivorship
 - End of treatment through several months after; Transition, recovering from symptoms
- Permanent/late survivorship
 - Long-term effects of cancer and treatment

Trends in Cancer Mortality Rates, 1930-2019



Survivorship Statistics

- 3 million cancer survivors in US, 1970
- 16.9 million cancer survivors in US, as of January 2019
- 22.2 million cancer survivors in US, projected by 2030
- Approximately 39.5% of people in US will have cancer at some point
- Numbers increasing due to aging, screening, improved cancer survival

Age Groups

- 2/3 of cancer survivors ≥ 60 years old
- Approximately 6% ≤ 40 years old
- Survivors of pediatric cancer - long term health effects
- Adolescent-Young adult (AYA) – unique risks; transitional period

Lost in Transition

- Unmet patient needs after cancer treatment
 - Suboptimal surveillance guideline compliance, cancer screening, preventive care
 - Multiple studies highlight poor communication between oncologist and PCP
- From Cancer Patient to Cancer Survivor: Lost in Transition – IOM, 2006
 - Establish survivorship as a distinct phase of cancer care
 - Patients should get a care summary and followup plan (survivorship care plans)
 - Guidelines to define quality survivorship care
 - Surveillance – for cancer recurrence and secondary cancers
 - Prevention – of recurrent and new cancers, and late effects
 - Assessment of medical and psychological late effects of cancer and treatment, and appropriate interventions

Survivorship Care Plan

The American College of Surgeons-Commission on Cancer (CoC) directs our Cancer Committee to determine who should receive a plan

- Re-focused on patients with multimodality treatment
- Followed the lead from disease specific teams and clinic nursing staff
- Currently focused on Breast cancer, Gyn –Onc, Multimodality H&N cancer, Sarcoma, FWB and FMF patients

Survivorship Care Plan

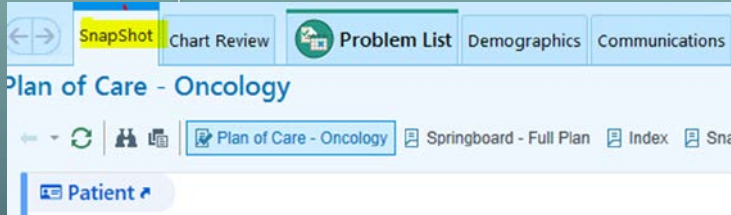
- **Survivorship Care Plans (SCP) Elements**
 - Treatment summary
 - Follow-up and surveillance
 - Recommendations for risk reduction & health promotion
 - May share plan with patient, PCP and collaborating providers
- **Eligible Patients**
 - Completed first line of curative treatment
- **Timing of delivery**
 - No longer than 6 months after treatment completion

Survivorship Care Plan Example

Breast Cancer Treatment Summary and Follow-Up Care Plan	
General Information	
Patient Name	Sandra C Budzinski
Patient ID	00432467
Phone	414-788-1124 (home) 414-788-1124 (work)
Date of Birth	6/9/1961
Care Team Information	
Cancer Center Facility	Cancer Care Center, Menomonee Falls Hospital, Menomonee Falls, WI
Cancer Center Contact Information	414-805-0505 or 262-257-5100
Primary Care Provider	Scott D Fenske, MD
Medical Oncologist	Chaudhary, Lubna N, MD
Radiation Oncologist	Shukla, Monica E, MD
Surgical Oncologist	Cortina, Chandler S, MD
Plastic and Reconstructive Surgeon	No care team member to display
Cancer Diagnosis Information	
Diagnosis, Staging and Tumor Grade Information	Primary Site: Breast (Left)
<small>*Staging is based on the size of the tumor, if lymph nodes are involved and if the cancer has spread beyond the breast. The grade is how abnormal the cancer cells look under the microscope.</small>	Clinical Stage: Stage 0 (cT(DCIS), cN0, cM0) - Ductal Carcinoma In Situ: grade 2

- Where Can You FIND the SCP?

Go to the Epic SnapShot




Toward the bottom of the page you will see Survivorship Text Box. Click on Treatment Summary (even if it is incomplete)

Oncology Treatment Summary-Survivorship Care


Active Problems

Malignant neoplasm of right breast in female, estrogen receptor positive (*) (HCC)


 Treatment Summary

Completed on 2/2/2022

Speak with your Department/Division leader to have treatment and Services preferences added to your profile. A cancer survivor can type in the search “Primary Care for Cancer Survivors”



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TREATMENT & SERVICES

Primary Care for Cancer Survivors

Virtual Visit

AGES SEEN

Adult

Senior

LANGUAGES SPOKEN

English

HOSPITAL AFFILIATIONS

Froedtert Hospital

[Schedule Online Now](#)

CALL FOR AN APPOINTMENT

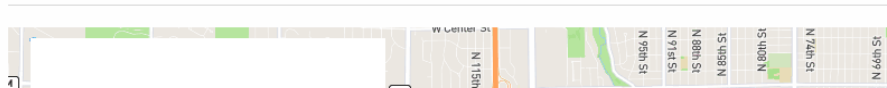
Established Patients Call

414-805-6850

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ABOUT

[OVERVIEW](#)



Survivorship Care Barriers

- Lack of prospective, comparative evidence of benefit
 - Comparing survivorship interventions to usual care, other interventions
- Lack of a trained (dedicated) workforce
 - Oncology providers prioritize treatment; Lack of well-coordinated collaborations
- Lack of reimbursement for survivorship care
 - Especially time-consuming components – counseling, care coordination, etc
- Lack of a cohesive health care system
 - Diverse patient experiences may require coordination of a lot of resources

Halpern, ASCO ed book, 2016

How should we approach this at MCW?

- Children's Hem Onc has survivorship programs – transition clinic, etc
- Froedtert –
 - Survivorship care plans – delivered by primary cancer team
 - Survivorship resources in Cancer Center – psych-onc, nutrition, social work, etc
 - Variable utilization of these
 - Variable communication, coordination, with PCP's
- Working on a potential strategy for survivorship coordination
- Partnership F&MCW primary care network – medical home for survivors?

Questions to Ponder

- What help do I need to care for cancer survivors in my clinic?
- What are the biggest barriers?
- Am I interested in additional education or engagement on this topic? If so, what should that look like?
- Research ideas?



DIVIDER PAGE

Cancer Follow-up: Oncologist Perspective

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Cancer Treatment Course

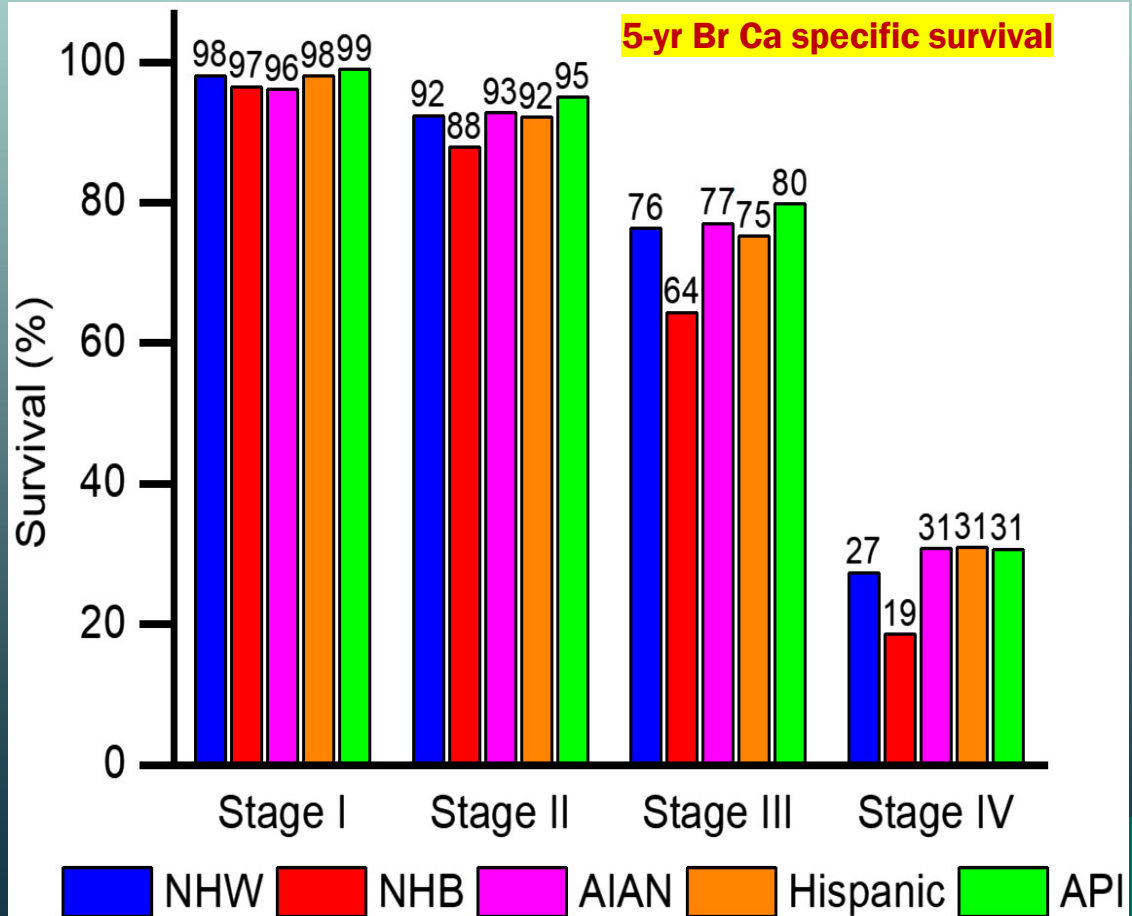
- Presentation
- Diagnosis
- **Treatment plan and administration**
 - Limited course – curative
 - Ongoing – palliative
- Follow-up

Treatment Decision Factors

- Staging
 - Quantify extent, spread of cancer
 - Key factors that stratify risk of recurrence, death
 - Varies from cancer to cancer – often stage 1 is limited, stage 4 disseminated
- Treatment Intent
 - Curative
 - Palliative

Breast CA TNM staging

ANATOMIC STAGE/PROGNOSTIC GROUPS			
Stage 0	Tis	N0	M0
Stage IA	T1*	N0	M0
Stage IB	T0	N1mi	M0
	T1*	N1mi	M0
Stage IIA	T0	N1**	M0
	T1*	N1**	M0
	T2	N0	M0
Stage IIB	T2	N1	M0
	T3	N0	M0
	T3	N2	M0
Stage IIIA	T0	N2	M0
	T1*	N2	M0
	T2	N2	M0
	T3	N1	M0
	T3	N2	M0
Stage IIIB	T4	N0	M0
	T4	N1	M0
	T4	N2	M0
Stage IIIC	Any T	N3	M0
Stage IV	Any T	Any N	M1



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DeSantis, CA Can Jrn Clin 2019;69

**MEDICAL
COLLEGE
OF WISCONSIN**

Treatment Planning

- Multi-disciplinary – Surgeon, Med Onc, Rad Onc, Nursing, Psych Onc, etc
- Tumor Board
- Curative Plan – 34 y/o woman with stage 3 breast cancer, ER+, Her-2 neg
 - Preoperative chemotherapy AC x 4, weekly paclitaxel (20 weeks total)
 - Surgery
 - Adjuvant radiation, 4-5 weeks
 - Tamoxifen v ovarian suppression/AI, 10 years



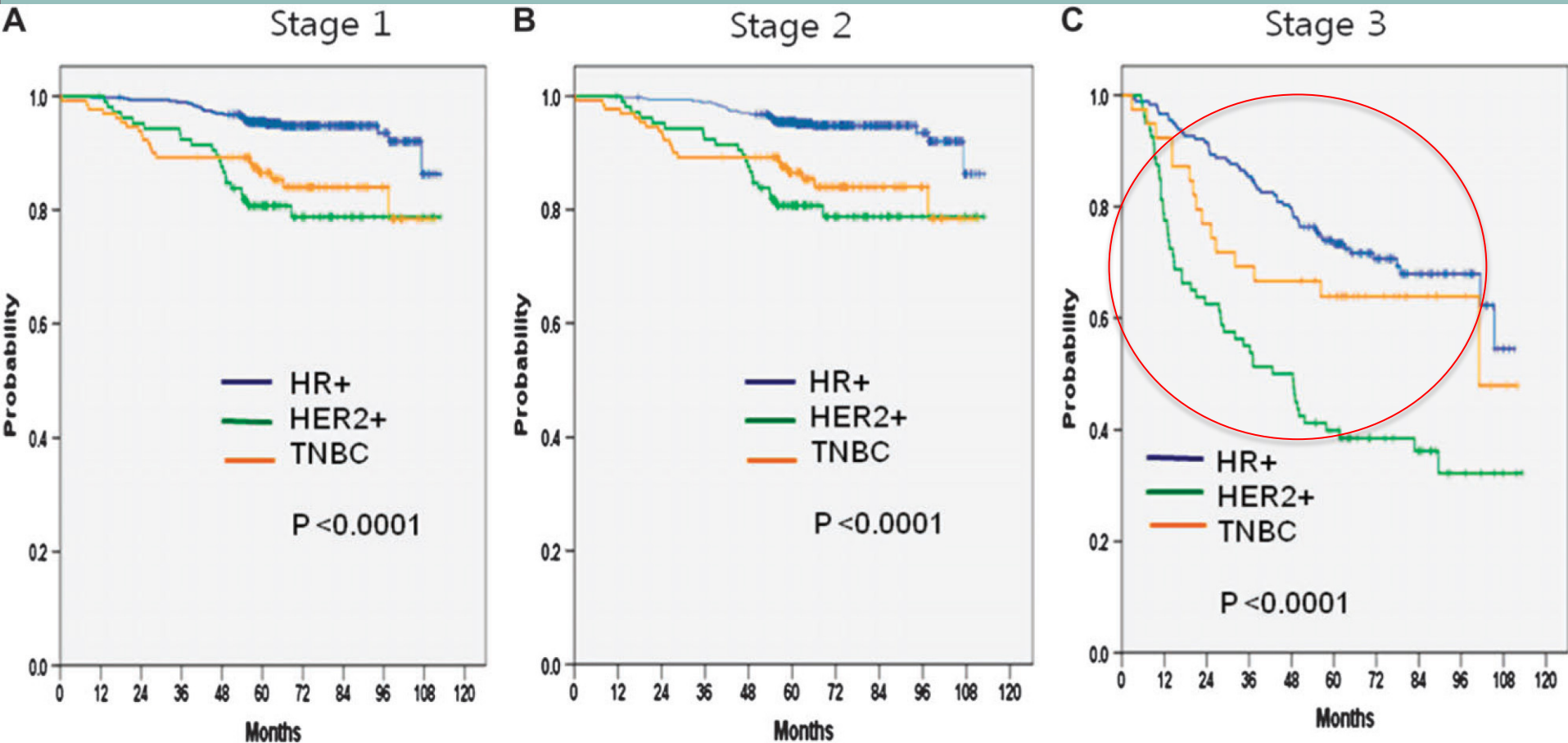
Cancer Follow-Up

- Often every 3-4 months, initially
- Components of Follow-up
 - Surveillance
 - Recurrence – local or distant/metastatic
 - Subsequent primary cancers
 - Assessment for late treatment effects
 - Physical
 - Psychosocial
 - Prevention – cancer recurrence, subsequent primary

Monitoring for Recurrence

- Timing and location of recurrence vary by tumor type
 - ER+ breast cancer – bone metastases most common; liver, lung, brain less common
 - Colon cancer – liver metastases most common; lung, peritoneum less common
 - High grade cancers – typically recur first 2-3 years
 - Low grade cancers – may recur later
- History/exam are key in followup

RFS by breast cancer subtype





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NCCN Guidelines Version 2.2022 Invasive Breast Cancer

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SURVEILLANCE/FOLLOW-UP

Exam:

- History and physical exam 1–4 times per year as clinically appropriate for 5 y, then annually

Genetic screening:

- Periodic screening for changes in family history and genetic testing indications and referral to genetic counseling as indicated, [see NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic](#)

Post surgical management:

- Educate, monitor, and refer for lymphedema management, [see NCCN Guidelines for Survivorship: Lymphedema](#).

Imaging:

- Mammography every 12 mo^{bbb}
- Routine imaging of reconstructed breast is not indicated
- [See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic](#)
- For patients receiving anthracycline-based therapy, see [NCCN Guidelines for Survivorship](#) for echocardiogram recommendations.

Screening for metastases:

- In the absence of clinical signs and symptoms suggestive of recurrent disease, there is no indication for laboratory or imaging studies for metastases screening.

Endocrine therapy:

- Assess and encourage adherence to adjuvant endocrine therapy
- Patients on tamoxifen:
 - ▶ Age-appropriate gynecologic screening
 - ▶ Routine annual pelvic ultrasound is not recommended
- Patients on an aromatase inhibitor or who experience ovarian failure secondary to treatment should have monitoring of bone health with a bone mineral density determination at baseline and periodically thereafter^{ccc}

Lifestyle:

- Evidence suggests that active lifestyle, healthy diet, limited alcohol intake, and achieving and maintaining an ideal body weight (20–25 BMI) may lead to optimal breast cancer outcomes

Communication:

- Coordination of care between the primary care provider and specialists is encouraged. Additionally, a personalized survivorship treatment plan including personalized treatment summary of possible long-term toxicity and clear follow-up recommendations is recommended. [See NCCN Guidelines for Survivorship](#)

Engagement:

- Patients frequently require follow-up encouragement in order to improve adherence to ongoing screening and medication adherence

[See
Recurrent
Disease
\(BINV-18\)](#)

^{bbb} Studies indicate that annual mammograms are the appropriate frequency for surveillance of breast cancer patients who have had BCS and RT with no clear advantage to shorter interval imaging. Patients should wait 6 to 12 months after the completion of RT to begin their annual mammogram surveillance. Suspicious findings on physical examination or surveillance imaging might warrant a shorter interval between mammograms.

^{ccc} The use of estrogen, progesterone, or selective estrogen receptor modulators to treat osteoporosis or osteopenia in patients with breast cancer is discouraged. The use of a bisphosphonate (oral/IV) or denosumab is acceptable to maintain or to improve bone mineral density and reduce risk of fractures in postmenopausal (natural or induced) patients receiving adjuvant aromatase inhibitor therapy. Optimal duration of either therapy has not been established. Duration beyond 3 years is not known. Factors to consider for duration of anti-osteoporosis therapy include bone mineral density, response to therapy, and risk factors for continued bone loss or fracture. There are case reports of spontaneous fractures after denosumab discontinuation. Patients treated with a bisphosphonate or denosumab should undergo a dental examination with preventive dentistry prior to the initiation of therapy, and should take supplemental calcium and vitamin D.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



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NCCN Guidelines Version 1.2022 Colon Cancer

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PATHOLOGIC STAGE	SURVEILLANCE ^b		
Stage I	<ul style="list-style-type: none"> Colonoscopy^a at 1 y after surgery If advanced adenoma, repeat in 1 y If no advanced adenoma,^{hh} repeat in 3 y, then every 5 yⁱⁱ History and physical examination every 3–6 mo for 2 y, then every 6 mo for a total of 5 y CEA^{jj} every 3–6 mo for 2 y, then every 6 mo for a total of 5 y Chest/abdominal/pelvic CT every 6–12 mo (category 2B for frequency <12 mo) from date of surgery for a total of 5 y Colonoscopy^a in 1 y after surgery except if no preoperative colonoscopy due to obstructing lesion, colonoscopy in 3–6 mo <ul style="list-style-type: none"> If advanced adenoma, repeat in 1 y If no advanced adenoma,^{hh} repeat in 3 y, then every 5 yⁱⁱ PET/CT scan is not indicated Principles of Survivorship (COL-H) 	Serial CEA elevation or documented recurrence	Workup and Treatment (COL-9)
Stage II, III	<ul style="list-style-type: none"> History and physical examination every 3–6 mo for 2 y, then every 6 mo for a total of 5 y CEA^{jj} every 3–6 mo x 2 y, then every 6 mo for a total of 5 y Chest/abdominal/pelvic CT scan every 3–6 mo (category 2B for frequency <6 mo) x 2 y, then every 6–12 mo for a total of 5 y Colonoscopy^a in 1 y after surgery except if no preoperative colonoscopy due to obstructing lesion, colonoscopy in 3–6 mo <ul style="list-style-type: none"> If advanced adenoma, repeat in 1 y If no advanced adenoma,^{hh} repeat in 3 y, then every 5 yⁱⁱ Principles of Survivorship (COL-H) 		
Stage IV	<ul style="list-style-type: none"> History and physical examination every 3–6 mo for 2 y, then every 6 mo for a total of 5 y CEA^{jj} every 3–6 mo x 2 y, then every 6 mo for a total of 5 y Chest/abdominal/pelvic CT scan every 3–6 mo (category 2B for frequency <6 mo) x 2 y, then every 6–12 mo for a total of 5 y Colonoscopy^a in 1 y after surgery except if no preoperative colonoscopy due to obstructing lesion, colonoscopy in 3–6 mo <ul style="list-style-type: none"> If advanced adenoma, repeat in 1 y If no advanced adenoma,^{hh} repeat in 3 y, then every 5 yⁱⁱ Principles of Survivorship (COL-H) 		

^a All patients with colon cancer should be counseled for family history and considered for risk assessment. For patients with suspected Lynch syndrome, FAP, and attenuated FAP, see the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#).

^b [Principles of Imaging \(COL-A\)](#).

^{hh} Villous polyp, polyp >1 cm, or high-grade dysplasia.

ⁱⁱ Kahi C.J, et al. Gastroenterology 2016;150:758-768.

^{jj} If patient is a potential candidate for further intervention.

Note: All recommendations are category 2A unless otherwise indicated.
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Take Home Points - Surveillance

- Variable, depends on several cancer factors (and oncologists)
- Testing detects recurrence – doesn't prevent recurrence
- Ideally, testing only if early detection is beneficial
 - Oligometastatic colon cancer may be cured with resection of mets
- Communication is key to being on same page as oncologist
 - Survivorship care plan *ideally* will lay out monitoring plan
- NCCN Guidelines – good reference
- Downsides to testing – expense, additional workup
- Test of Time . . . 'Let's give it two weeks and reassess'

Subsequent Primary Cancers

- Risk factors

- Lifestyle

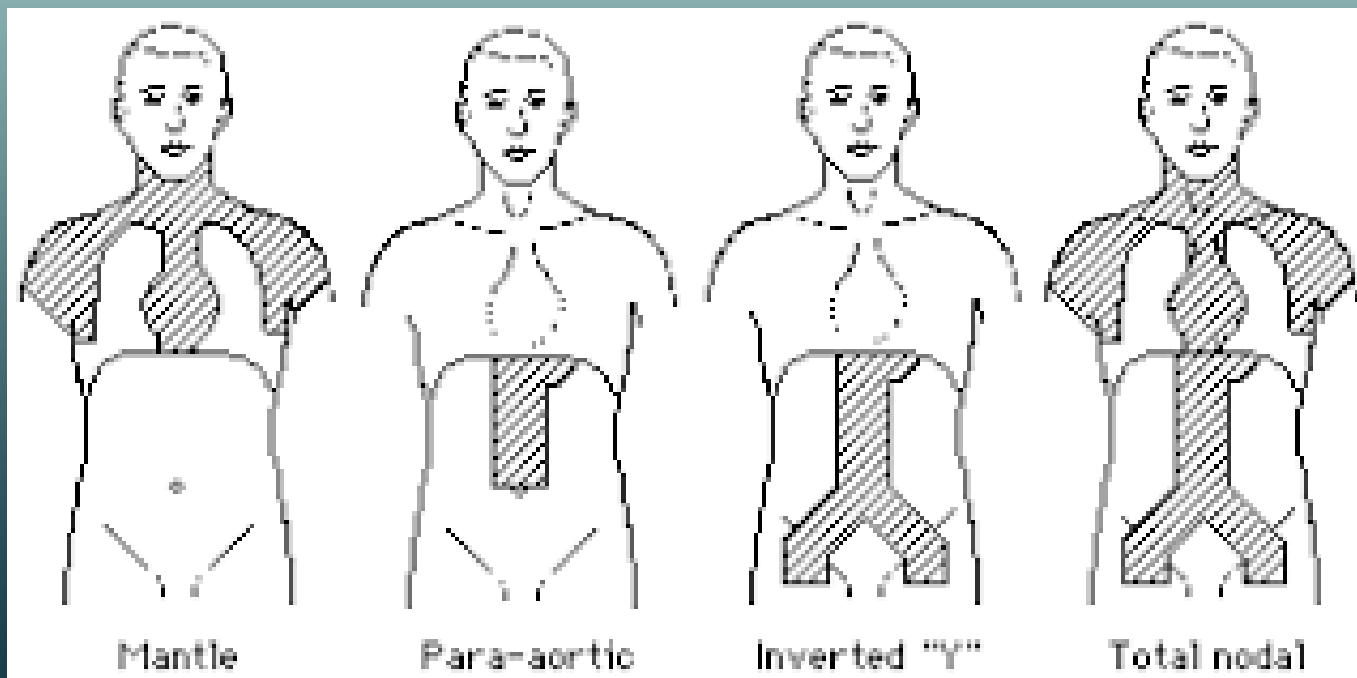
- Smoking – head and neck cancer, lung cancer, bladder cancer, esophagus, stomach, AML
 - Obesity – breast cancer, prostate cancer, colon cancer, esophageal, pancreatic, uterine, liver cancers

- Cancer treatment

- MDS/AML – 2-7 years after alkylating agents, topoisomerase inhibitors, platinum – **annual CBC**
 - Lung cancer, bladder cancer, breast cancer – associated with alkylating agents, esp if concurrent with RT
 - Radiation-associated cancers – 5-15 years after treatment – breast cancer, thyroid cancer
 - **Screening for secondary cancers** (data and guidelines best in AYA cancer survivors, from COG)
 - Females, chest RT – annual mammogram and breast MRI, age 25, or 8 years after RT
 - RT abd/pelvis/spine/TBI – colorectal cancer screening, start at age 30
 - RT Chest/axilla/TBI – consider chest CT

- Genetic risk

Hodgkin Lymphoma RT fields



Late Treatment Effects

- Cardiac issues – chemotherapy or RT related
- Kidney dysfunction
- Premature menopause – osteoporosis, infertility
- Neurologic issues – neuropathy, hearing loss
- Fatigue – multi-factorial, including some of these other effects
- Sexual dysfunction
- Psychological distress
- Cognitive function – ‘chemobrain’
- Social functioning

Prevention

- Cancer recurrence, Second cancers, Other health issues
- Teachable moment
- Diet, physical activity, weight management
 - Physical activity associated with lower breast cancer specific mortality (observational study)
 - Obesity associated w/ increased breast, colon and prostate cancer risk
 - mixed results from intervention studies
 - Red meat, processed meat – increased colon cancer risk
 - Nuts, fiber, low glycemic load – may be associated with lower risk of colon CA recurrence

Prevention (continued)

- Smoking cessation
 - Continued smoking after diagnosis (vs quitting) – higher rates of second cancer, death
 - Increased toxicity from cancer treatment in smokers
 - Consider low-dose CT lung cancer screening in smokers with other cancers
 - Limited data on impact of cessation interventions after cancer diagnosis
- Limit alcohol
 - Higher alcohol intake associated with increased breast CA recurrence
 - In general, moderate-high alcohol intake increases cancer mortality

Summary

- Surveillance guidelines – vary by cancer
- Late toxicities – vary by treatment
- Oncologist – needs to take the lead in establishing follow-up plan
- Opportunities for positive impact in Extended and Late Survivorship