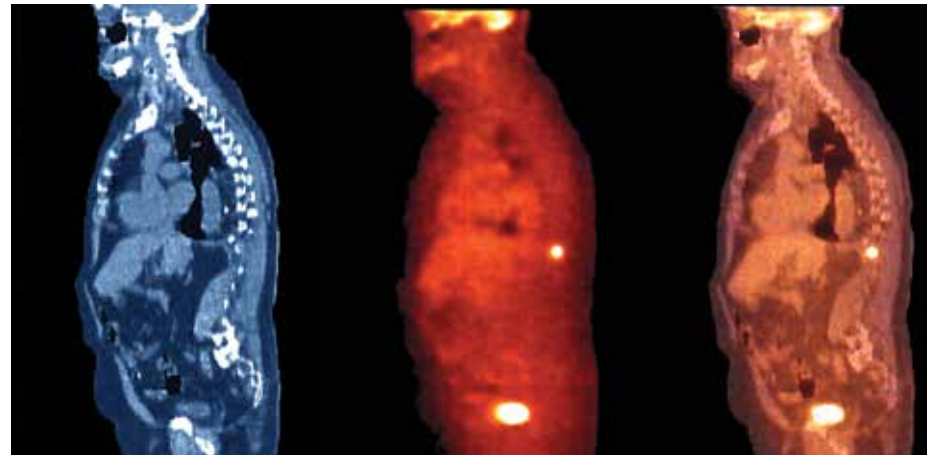
‘Index patients’ aid mCRPC guideline

THE AMERICAN Urological Association (AUA) developed its new clinical guideline on castration-resistant prostate cancer (CRPC) by creating six index patients to represent the most common clinical scenarios encountered when managing the disease, and establishing the recommendations with these patients in mind.

Citing the significant increase in FDA-approved therapeutic agents for use in men with metastatic CRPC (mCRPC), the AUA’s CRPC panel chair, Michael S. Cookson, MD, of Vanderbilt University in Nashville, Tennessee, and coauthors sought to assist practitioners in the clinical decision-making process. They developed the index patients based on the presence or absence of metastatic disease, the degree of symptoms, the patients’ performance status (as defined by the Eastern Cooperative Oncology Group [ECOG] scale) and prior treatment with docetaxel-based chemotherapy.

The guideline statements are divided into sections that relate to each of the six given types of index patients. For example, for Index Patient 1—a man with asymptomatic, nonmetastatic CRPC—clinicians are advised to recommend observation with continued androgen deprivation. Index Patient 4—a man with symptomatic mCRPC with poor performance status and no prior docetaxel chemotherapy—should not be offered sipuleucel-T therapy, but may be offered treatment with abiraterone plus prednisone, or ketoconazole plus steroid or radionuclide therapy if he is unable or unwilling to receive abiraterone plus prednisone, or docetaxel or mitoxantrone in select cases, specifically when the performance status is directly related to the cancer.



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Colored PET scan reveals metastatic prostate cancer (bright white) in a rib.

The AUA has also released guidelines covering the following areas:

- **Early detection of prostate cancer** As reported at www.OncologyNurseAdvisor.com (“New Prostate Cancer Screening Guidelines from AUA Emphasize Targeted Patient Screening,” May 7, 2013), this guideline panel, chaired by H. Ballentine Carter, MD, of the Johns Hopkins Hospital in Baltimore, Maryland, recommends against prostate-specific antigen (PSA) screening in men younger than 40 years; does not recommend routine screening in men aged 40 to 54 years at average risk; and strongly recommends shared decision-making for men aged 55 to 69 years who are considering PSA screening, and proceeding based on a man’s values and preferences. The panel noted that the greatest benefit of screening appears to be for men in this age group.
- **Follow-up care for renal cancer** Among other recommendations set forth by Sherri Machele Donat, MD, of Memorial Sloan-Kettering

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The AUA developed its new clinical guideline on mCRPC by creating six index patients to represent the most common clinical scenarios encountered.

Elderly can benefit from palliative radiotherapy

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Older patients experience significant benefit from radiotherapy, according to research presented at ESTRO.

RESEARCHERS have recommended that palliative radiotherapy be considered for elderly persons with cancer and painful bone metastases after their study showed that these patients demonstrated a meaningful response to this treatment without a reduction in quality of life (QoL).

Palliative treatments may result in lesser outcomes for older persons with cancer than for younger patients due to comorbidity and declining performance. Dr. Paulien Westhoff of the radiotherapy department at the University Medical Center Utrecht, Utrecht, the Netherlands, and colleagues evaluated the effect of age on response to radiotherapy and QoL of patients with painful bone metastases in three age groups: cohort A, 32 to 64 years (520 patients); cohort B, 65 to 74 years (410 patients); and cohort C, 75 years and older (227 patients). The three main types of primary tumors among the men and women were breast (39%), lung (25%), and prostate (23%).

As reported at the 2nd Forum of the European Society for Radiotherapy and Oncology (ESTRO), held in Geneva, Switzerland, April 19-23, 2013, elderly patients had worse performance as measured by Karnofsky Performance Score at inclusion. Baseline QoL revealed significantly more impairment in cohort C compared with the younger groups.

During follow-up, the decline in QoL was similar among the three cohorts. Median survival was 35 weeks in the youngest cohort and 27 weeks in each of the other two. Although elderly patients tended to have less of a response to radiotherapy than younger patients, the response was still significant at 67%, compared with 78% in cohort A and 74% in cohort B. Westhoff's team noted no differences in mean time to response or between treatment arms. In multivariate analysis, only primary tumor and performance score were significantly associated with response. ■

Radiation tweaks reduce xerostomia in oral cancer

A CORRELATION between radiation doses to submandibular glands and the output saliva of those glands has been documented in the largest study to date on the topic, investigators reported at the 2nd Forum of the European Society for Radiotherapy and Oncology (ESTRO), held in Geneva, Switzerland, April 19-23, 2013.

A total of 50 persons with oropharyngeal cancer and no contralateral lymph node metastases underwent treatment with an optimized radiation technique using intensity-modulation radiotherapy (IMRT) with the intention to spare both parotid glands as well as the contralateral submandibular gland, which is the main source of saliva in resting conditions. This was accomplished by administering much lower radiation doses to the contralateral glands (less than 40 Gy) than is used with standard radiotherapy.

Correlation was found between radiation doses to submandibular glands and saliva output.

Saliva flow from the parotid and submandibular glands was measured at 6 weeks and at 1 year by applying citric acid to the patient's tongue and collecting the resulting saliva in specially designed cups. The study participants also responded to a questionnaire addressing their subjective experience of dry mouth.

The trial results were compared with data from a cohort of 52 patients who had received only parotid-gland-sparing IMRT.

"We found that saliva flows from the contralateral submandibular glands were significantly higher at 6 weeks and at 1 year in patients who received a [radiation] dose to the submandibular gland of less than 40 Gy, and this translated into fewer complaints of dry mouth," summarized radiation oncologist and study coinvestigator Dr. Chris Terhaard, of the University Medical Center Utrecht in Utrecht, the Netherlands, in an ESTRO statement. ■

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Index patients

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Cancer Center, New York, New York, and copanelists, the group advised that patients undergoing follow-up for treated or observed renal masses should undergo a history and physical examination directed at detected signs and symptoms of a metastatic spread or local recurrence. These patients should undergo basic laboratory testing including blood urea nitrogen, creatinine, urine analysis, and estimated glomerular filtration rate, and can undergo other laboratory evaluations as well at the clinician's discretion.

- **Use of radiation after prostatectomy** Developed in conjunction with the American Society for Radiation Oncology (ASTRO), these guideline statements include the recommendation that clinicians offer adjuvant radiotherapy (ART) to patients with adverse pathologic findings at prostatectomy because of demonstrated reductions in biochemical recurrence, local recurrence, and clinical progression with adjuvant radiotherapy. This guideline panel was headed by Ian Murchie Thompson, Jr, MD, of the University of Texas Health Science Center at San Antonio (San Antonio, Texas), and Richard Valicenti, MD, MA, of the University of California Davis Comprehensive Cancer Center (Sacramento, California).

All four new guidelines can be found at www.auanet.org/education/aua-guidelines.cfm. ■

Breast IMRT reduces side effects

STUDY FINDINGS deemed practice-changing at an international level by the investigators reporting them indicate that intensity-modulated radiotherapy (IMRT) yields better cosmesis-related outcomes than does standard two-dimensional (2D) radiotherapy in persons with early breast cancer.

"These results … should encourage other [centers] still using 2D standard RT to implement breast IMRT," concluded Dr. Charlotte E. Coles of Addenbrooke's Hospital Oncology Centre in Cambridge, United Kingdom, and her fellow researchers in their study abstract, presented at the 2nd Forum of the European Society for Radiotherapy and Oncology (ESTRO), held in Geneva, Switzerland, April 19-23, 2013.

IMRT, a high-precision form of radiotherapy, can deliver an even dose of radiation, which falls within the range of 95% to 107% of the prescribed dose. As noted in an ESTRO statement, too low a dose raises the risk for tumor recurrence, and too high a dose can cause skin changes and other cosmetic problems that often occur after breast radiotherapy.

Fewer of the IMRT recipients developed skin telangiectasia and suboptimal overall cosmesis.

Coles's team analyzed the radiotherapy treatment plans of 1,145 persons with early breast cancer who had had breast-conserving surgery previously. The plans called for the majority of patients (815 [71%]) to receive an uneven radiation dose with standard 2D radiotherapy. These patients were then randomized to proceed with the 2D treatment or to receive IMRT. The remaining patients, whose plans would not produce an uneven dose of radiotherapy, proceeded to undergo 2D radiotherapy and were followed in the study.

The late normal tissue toxicity outcome was available for 645 members of the full group of patients (57%), and for 465 of the randomized patients (57%). Compared with those undergoing standard radiotherapy, fewer of the IMRT recipients developed skin telangiectasia and suboptimal overall cosmesis. No significant difference between groups was seen in photographically assessed breast shrinkage, breast edema, tumor bed induration, or pigmentation. ■

ONA ASKS …

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Go online to answer our poll question. We'll publish the results and a new question in the next issue.

…AND YOU ANSWERED In the last issue we asked if you used a closed system to administer chemotherapy. All respondents said, "Yes."

100% Yes

0% No