Soins Oncologiques de Support (SOS)

Dr Amandine Quivy

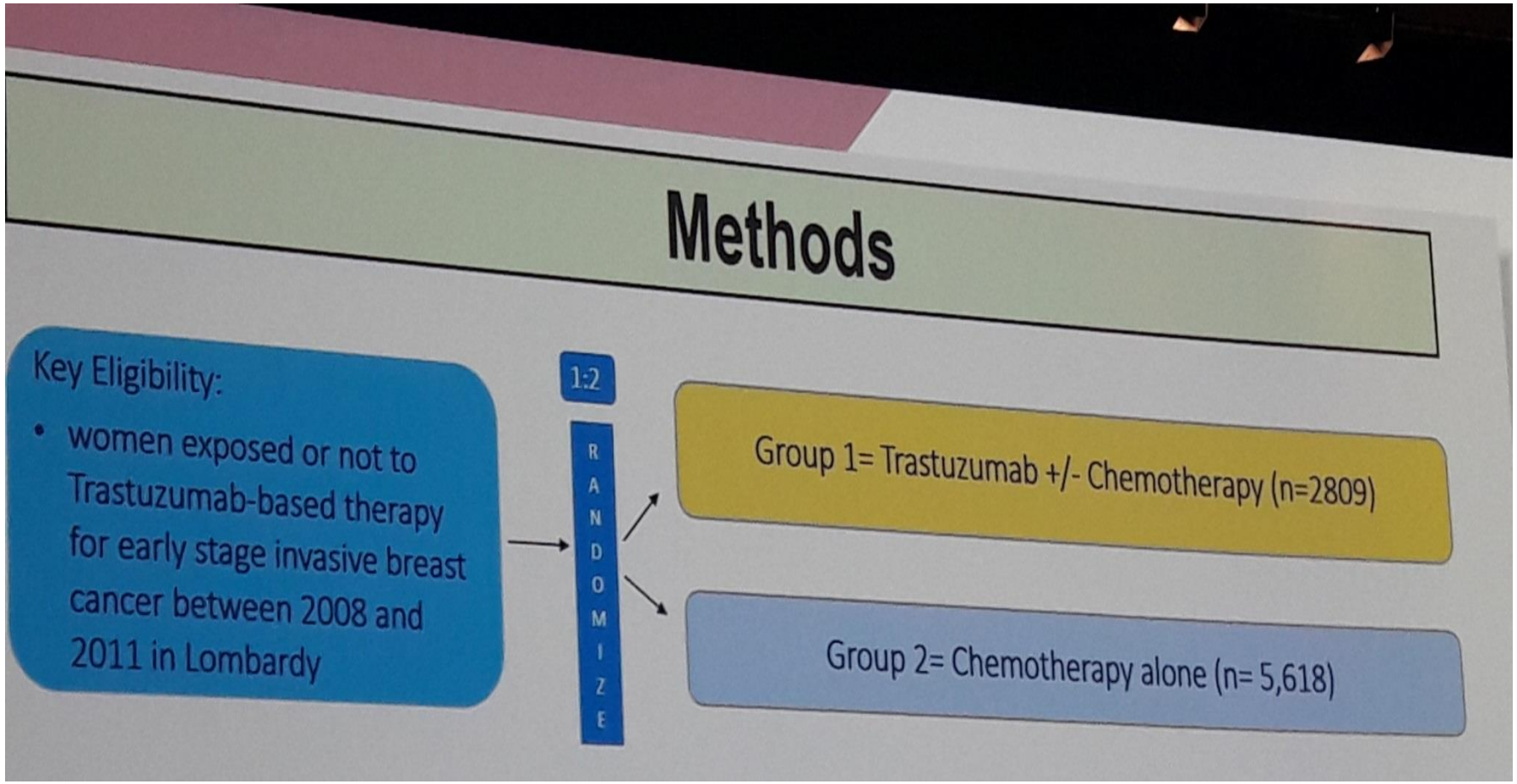
CHU Bordeaux

15 octobre 2019

BARCELONA 2019 ESMO congress

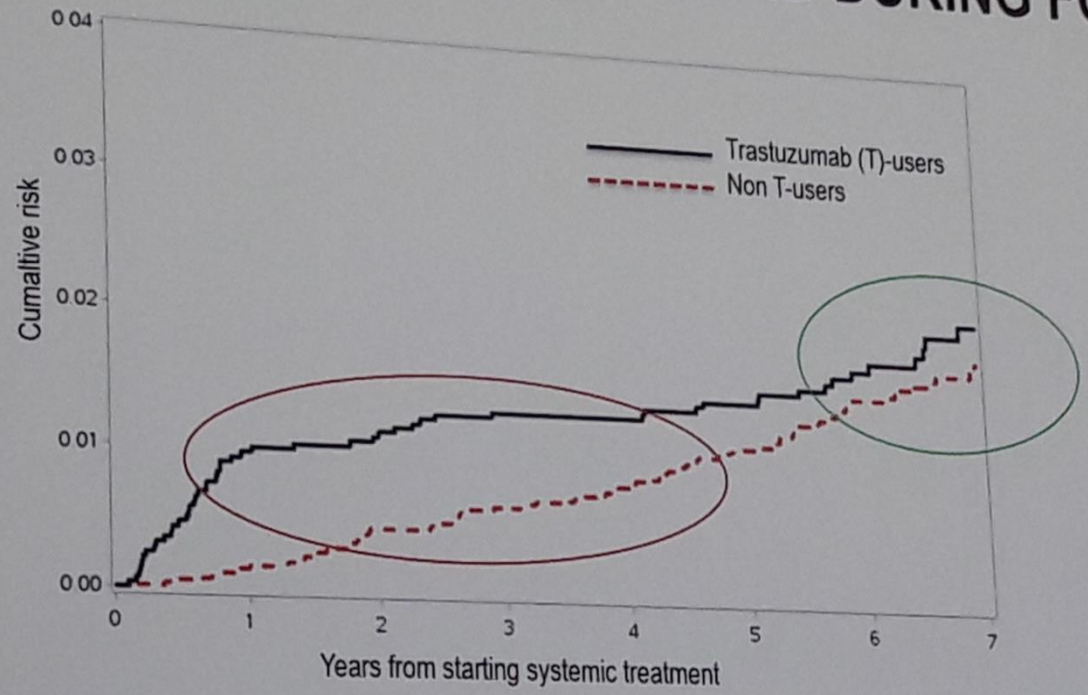
ONCO NOUVELLE-AQUITAINE
Réseau Régional de Cancérologie

Cardiotoxicité des traitements



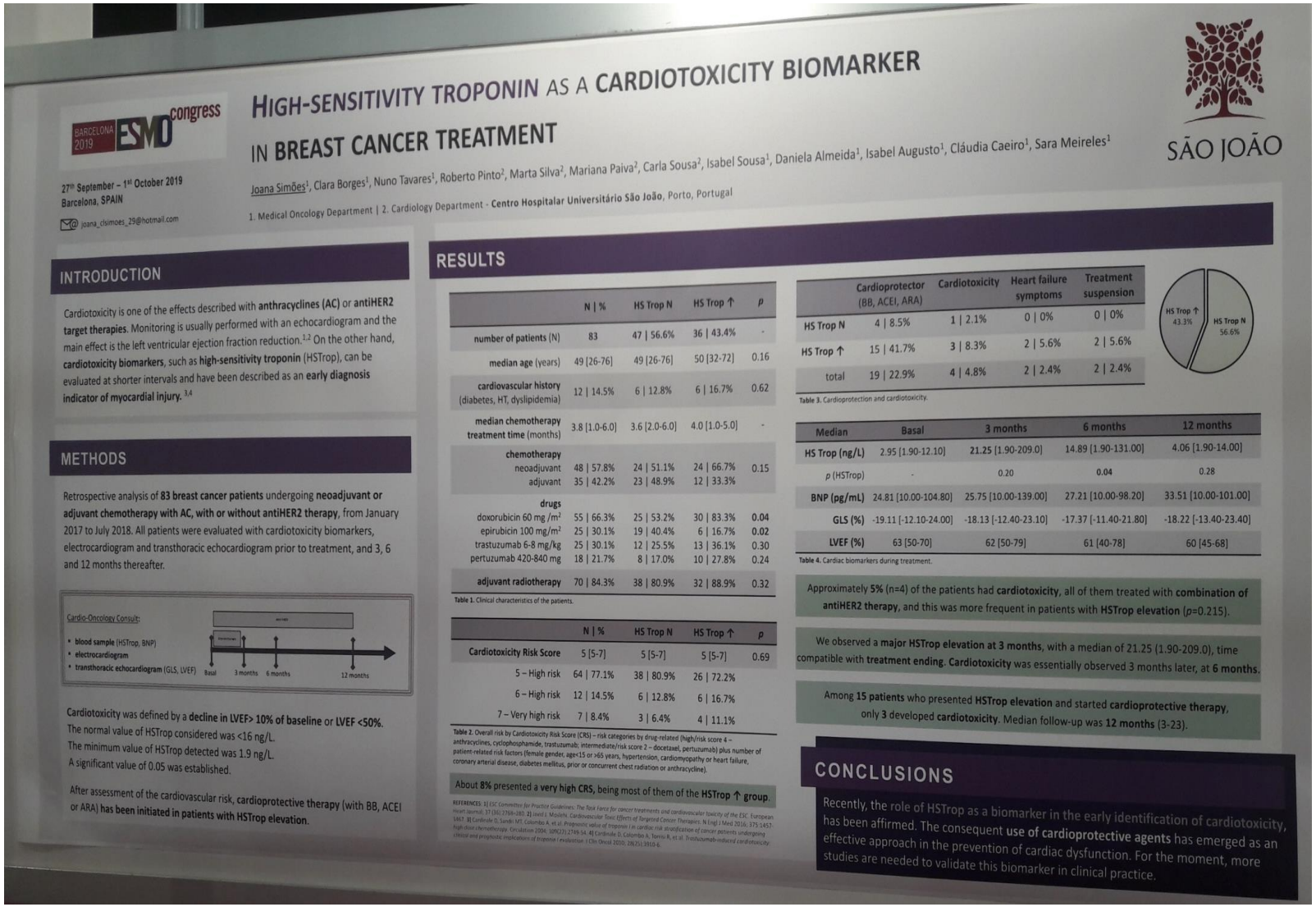
Long term follow-up report of symptomatic cardiac events in 2,809 breast cancer patients treated with adjuvant trastuzumab in real world practice. Di Cosimo S. et al. ESMO 2019 Abs.#17530.

INCREASED RISK OF SYMPTOMATIC CARDIAC EVENTS, BUT THE EXCESS OF RISK DISAPPEARED DURING FOLLOW UP



However, the T-user excess risk disappeared after 1 year of T. Thus, the hazard ratio [HR] of 9.96 (95%CI
26.2) during the first year, became 1.41 (95%CI 0.99-2.02) during the entire F/U period.

Risque augmenté
chez ≥ 65 ans
et si ≥ 1 FDR CV



HIGH-SENSITIVITY TROPONIN AS A CARDIOTOXICITY BIOMARKER IN BREAST CANCER TREATMENT

Joana Simões[1], Clara Borges[1], Nuno Tavares[1], Roberto Pinto[2], Marta Silva[2], Mariana Paiva[2], Carla Sousa[2], Isabel Sousa[1], Daniela Almeida[1], Isabel Augusto[1], Cláudia Caeiro[1], Sara Meireles[1]

1. Medical Oncology Department | 2. Cardiology Department - Centro Hospitalar Universitário São João, Porto, Portugal

joana_clsimoes_29@hotmail.com

27th September – 1st October 2019
Barcelona, SPAIN

INTRODUCTION

Cardiotoxicity is one of the effects described with **anthracyclines (AC)** or **antiHER2 target therapies**. Monitoring is usually performed with an echocardiogram and the main effect is the left ventricular ejection fraction reduction.[1,2] On the other hand, **cardiotoxicity biomarkers**, such as **high-sensitivity troponin** (HSTrop), can be evaluated at shorter intervals and have been described as an **early diagnosis indicator of myocardial injury.**[3,4]

METHODS

Retrospective analysis of **83 breast cancer patients** undergoing **neoadjuvant or adjuvant chemotherapy with AC, with or without antiHER2 therapy**, from January 2017 to July 2018. All patients were evaluated with cardiotoxicity biomarkers, electrocardiogram and transthoracic echocardiogram prior to treatment, and 3, 6 and 12 months thereafter.

Cardiotoxicity was defined by a **decline in LVEF> 10% of baseline** or **LVEF <50%**.
The normal value of HSTrop considered was <16 ng/L.
The minimum value of HSTrop detected was 1.9 ng/L.
A significant value of 0.05 was established.

After assessment of the cardiovascular risk, **cardioprotective therapy** (with BB, ACEI or ARA) **has been initiated in patients with HSTrop elevation.**

RESULTS

	N | %	HS Trop N	HS Trop ↑	*p*
number of patients (N)	83	47 | 56.6%	36 | 43.4%	-
median age (years)	49 [26-76]	49 [26-76]	50 [32-72]	0.16
cardiovascular history (diabetes, HT, dyslipidemia)	12 | 14.5%	6 | 12.8%	6 | 16.7%	0.62
median chemotherapy treatment time (months)	3.8 [1.0-6.0]	3.6 [2.0-6.0]	4.0 [1.0-5.0]	-
chemotherapy				
neoadjuvant	48 | 57.8%	24 | 51.1%	24 | 66.7%	0.15
adjuvant	35 | 42.2%	23 | 48.9%	12 | 33.3%	
drugs				
doxorubicin 60 mg /m²	55 | 66.3%	25 | 53.2%	30 | 83.3%	**0.04**
epirubicin 100 mg/m²	25 | 30.1%	19 | 40.4%	6 | 16.7%	**0.02**
trastuzumab 6-8 mg/kg	25 | 30.1%	12 | 25.5%	13 | 36.1%	0.30
pertuzumab 420-840 mg	18 | 21.7%	8 | 17.0%	10 | 27.8%	0.24
adjuvant radiotherapy	70 | 84.3%	38 | 80.9%	32 | 88.9%	0.32

Table 1. Clinical characteristics of the patients.

	N | %	HS Trop N	HS Trop ↑	*p*
Cardiotoxicity Risk Score	5 [5-7]	5 [5-7]	5 [5-7]	0.69
5 – High risk	64 | 77.1%	38 | 80.9%	26 | 72.2%	
6 – High risk	12 | 14.5%	6 | 12.8%	6 | 16.7%	
7 – Very high risk	7 | 8.4%	3 | 6.4%	4 | 11.1%	

Table 2. Overall risk by Cardiotoxicity Risk Score (CRS) – risk categories by drug-related (high/risk score 4 – anthracyclines, cyclophosphamide, trastuzumab; intermediate/risk score 2 – docetaxel, pertuzumab) plus number of patient-related risk factors (female gender, age<15 or >65 years, hypertension, cardiomyopathy or heart failure, coronary arterial disease, diabetes mellitus, prior or concurrent chest radiation or anthracycline).

About **8%** presented a **very high CRS**, being most of them of the **HSTrop ↑ group**.

	Cardioprotector (BB, ACEI, ARA)	Cardiotoxicity	Heart failure symptoms	Treatment suspension
HS Trop N	4 | 8.5%	1 | 2.1%	0 | 0%	0 | 0%
HS Trop ↑	15 | 41.7%	3 | 8.3%	2 | 5.6%	2 | 5.6%
total	19 | 22.9%	4 | 4.8%	2 | 2.4%	2 | 2.4%

Table 3. Cardioprotection and cardiotoxicity.

Median	Basal	3 months	6 months	12 months
HS Trop (ng/L)	2.95 [1.90-12.10]	**21.25** [1.90-209.0]	14.89 [1.90-131.00]	4.06 [1.90-14.00]
p (HSTrop)	-	0.20	**0.04**	0.28
BNP (pg/mL)	24.81 [10.00-104.80]	25.75 [10.00-139.00]	27.21 [10.00-98.20]	33.51 [10.00-101.00]
GLS (%)	-19.11 [-12.10-24.00]	-18.13 [-12.40-23.10]	-17.37 [-11.40-21.80]	-18.22 [-13.40-23.40]
LVEF (%)	63 [50-70]	62 [50-79]	61 [40-78]	60 [45-68]

Table 4. Cardiac biomarkers during treatment.

Approximately **5%** (n=4) of the patients had **cardiotoxicity**, all of them treated with **combination of antiHER2 therapy**, and this was more frequent in patients with **HSTrop elevation** (*p*=0.215).

We observed a **major HSTrop elevation at 3 months**, with a median of 21.25 (1.90-209.0), time compatible with **treatment ending**. **Cardiotoxicity** was essentially observed 3 months later, at **6 months**.

Among **15 patients** who presented **HSTrop elevation** and started **cardioprotective therapy**, only **3** developed **cardiotoxicity**. Median follow-up was **12 months** (3-23).

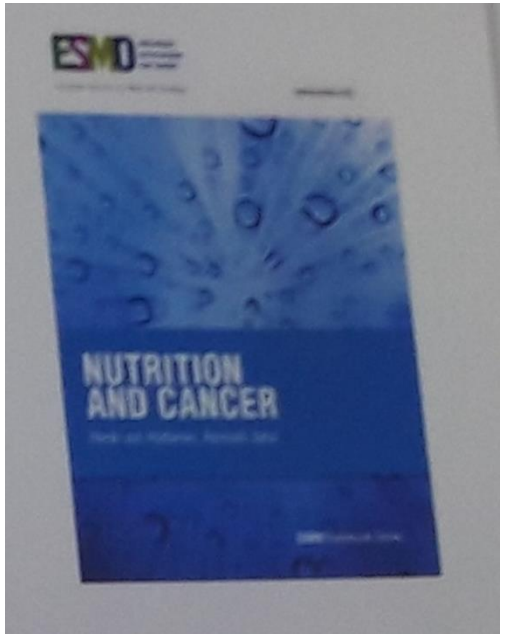
CONCLUSIONS

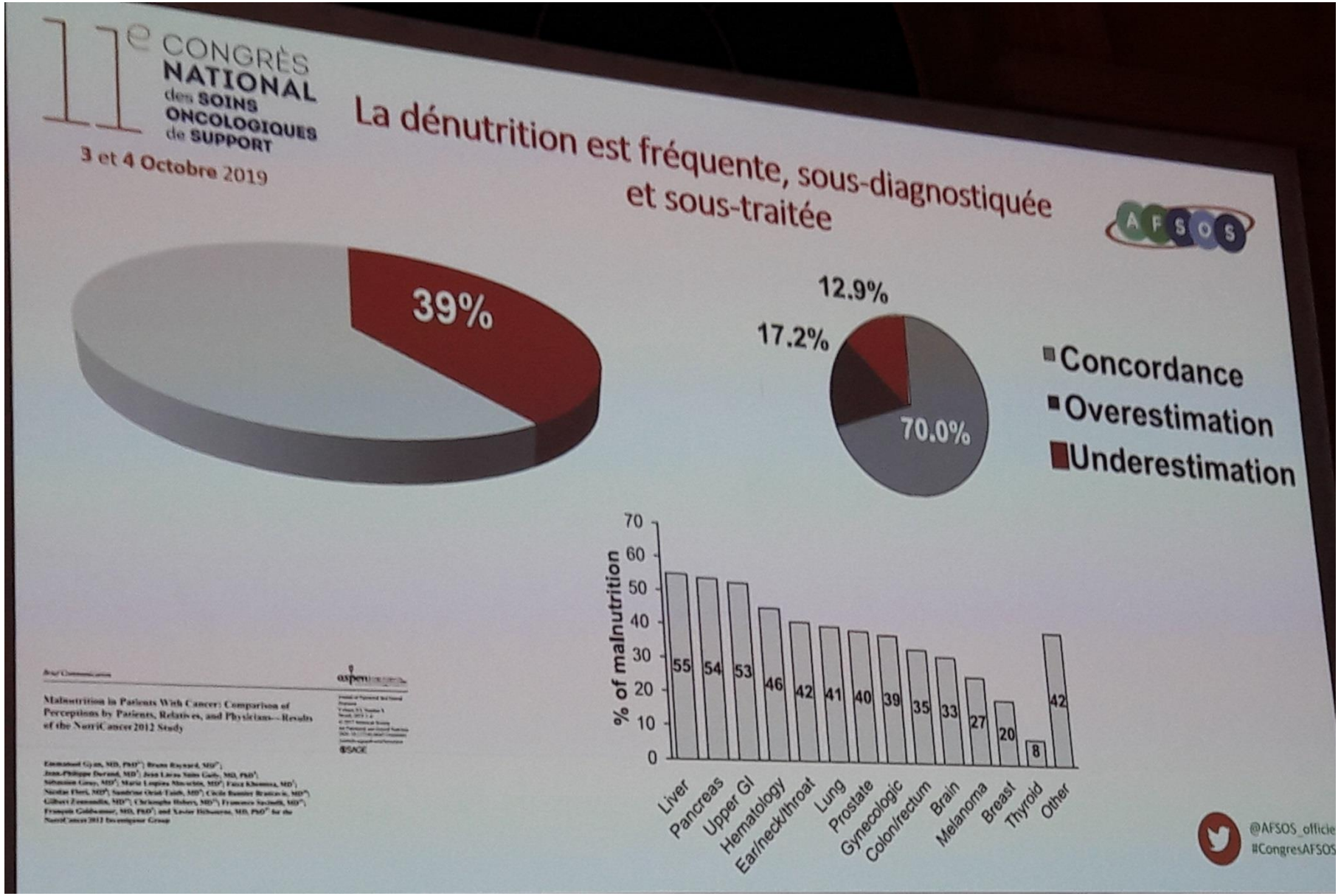
Recently, the role of HSTrop as a biomarker in the early identification of cardiotoxicity, has been affirmed. The consequent **use of cardioprotective agents** has emerged as an effective approach in the prevention of cardiac dysfunction. For the moment, more studies are needed to validate this biomarker in clinical practice.

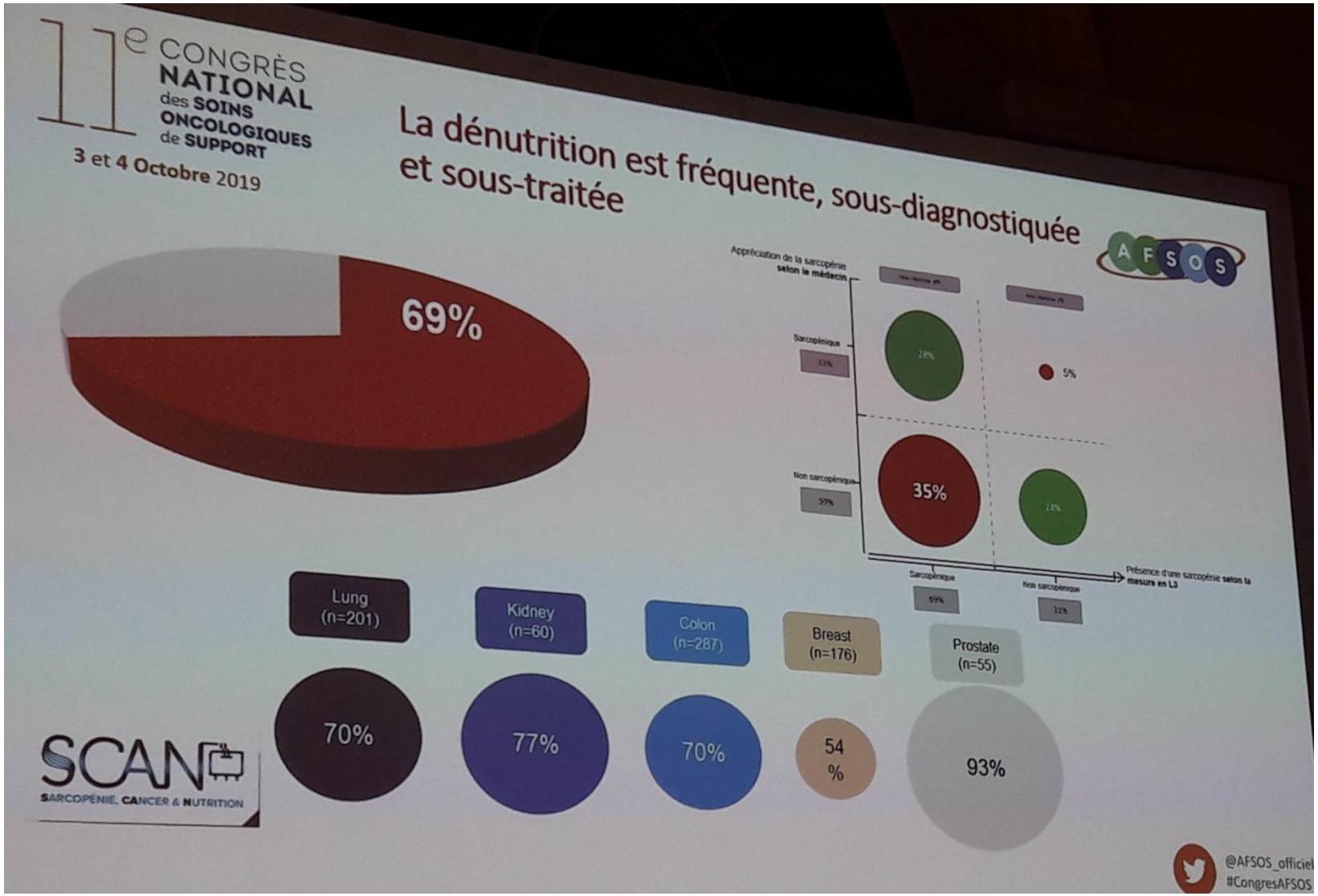
REFERENCES: 1) *ESC Committee for Practice Guidelines: The Task Force for cancer treatments and cardiovascular toxicity of the ESC.* European Heart Journal; 37 (36): 2768–280. 2) Javid J. Moslehi. *Cardiovascular Toxic Effects of Targeted Cancer Therapies.* N Engl J Med 2016; 375:1457-1467. 3) Cardinale D, Sandri MT, Colombo A, et al. *Prognostic value of troponin I in cardiac risk stratification of cancer patients undergoing high-dose chemotherapy.* Circulation 2004; 109(22):2749-54. 4) Cardinale D, Colombo A, Torrisi R, et al. *Trastuzumab-induced cardiotoxicity: clinical and prognostic implications of troponin I evaluation.* J Clin Oncol 2010; 28(25):3910-6.

Intérêt du dosage de la troponine HS comme biomarqueur précoce de la cardiotoxicité des anthracyclines et des anti HER2

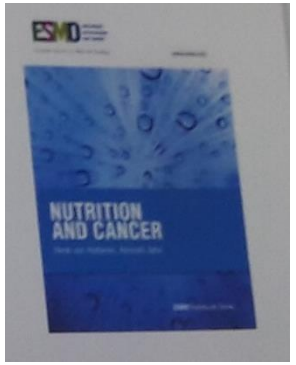
Dénutrition/Sarcopénie



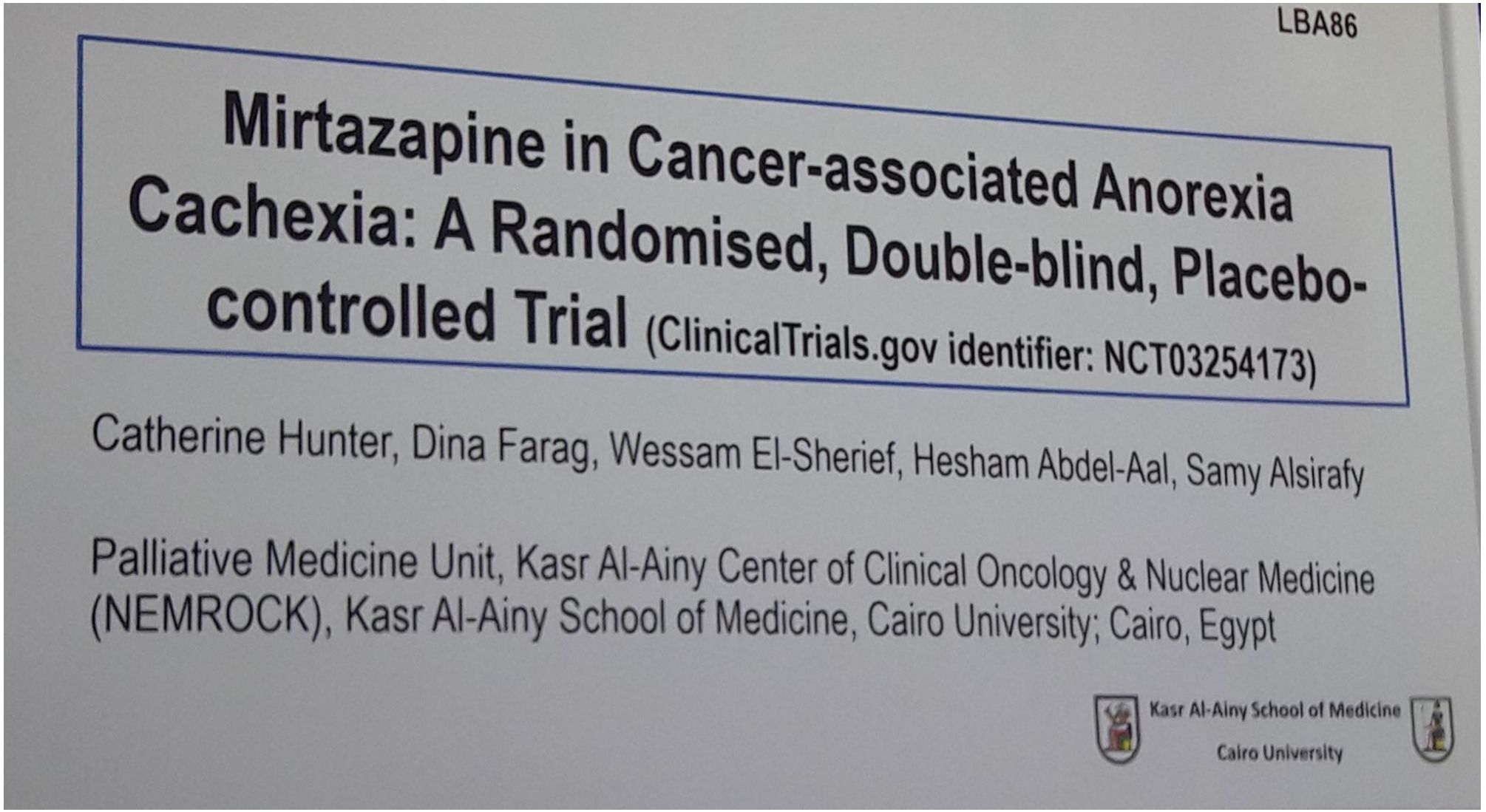

11e CONGRÈS NATIONAL des SOINS ONCOLOGIQUES de SUPPORT
3 et 4 Octobre 2019
La dénutrition est fréquente, sous-diagnostiquée et sous-traitée
AFSOS
39%
12.9%
17.2%
70.0%
Concordance
Overestimation
Underestimation
Malnutrition in Patients With Cancer: Comparison of Perceptions by Patients, Relatives, and Physicians—Results of the NutriCancer 2012 Study
SAGE
% of malnutrition
0
10
20
30
40
50
60
70
55
54
53
46
42
41
40
39
35
33
27
20
8
42
Liver
Pancreas
Upper GI
Hematology
Ear/neck/throat
Lung
Prostate
Gynecologic
Colon/rectum
Brain
Melanoma
Breast
Thyroid
Other
@AFSOS_officie
#CongresAFSOS

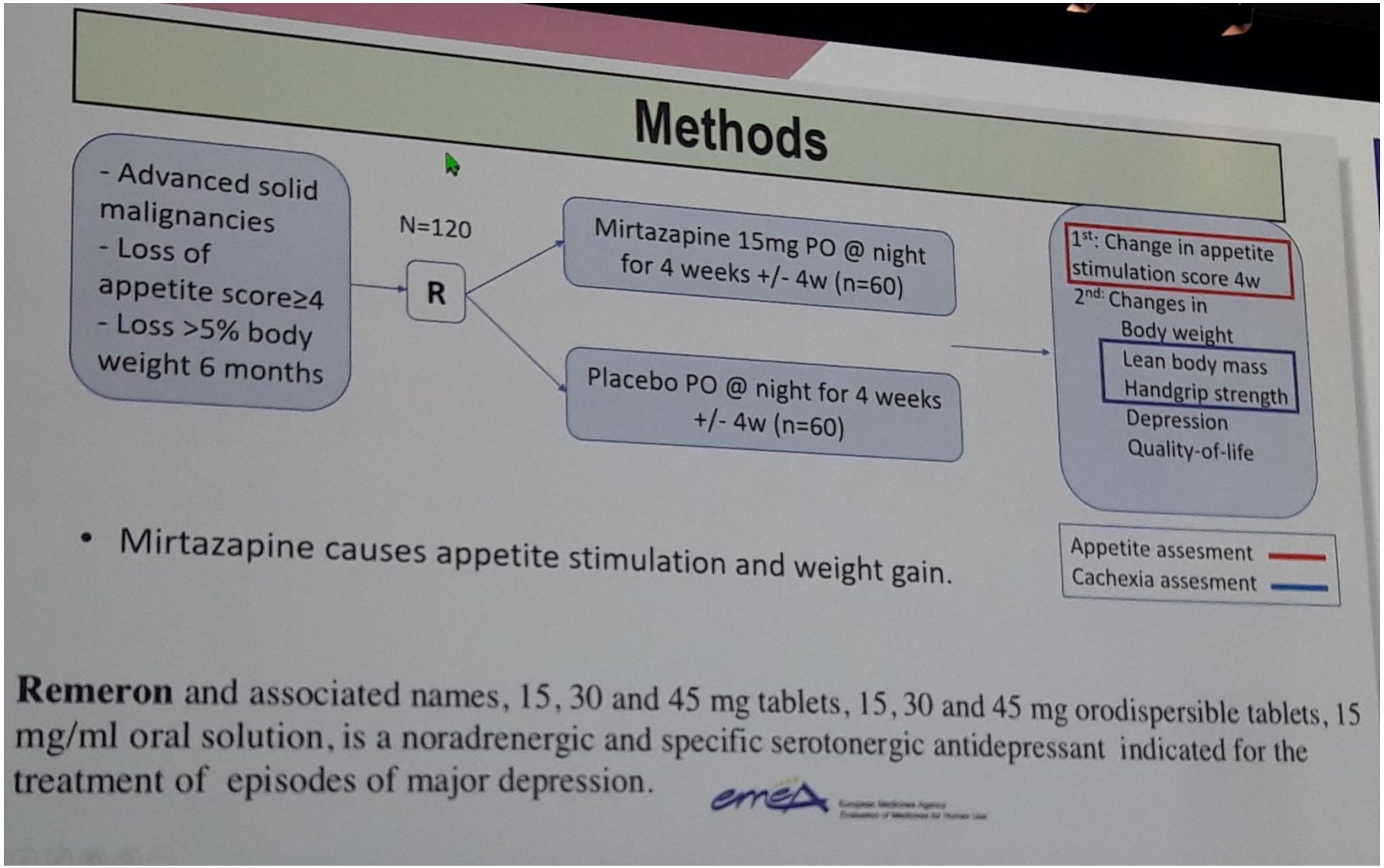

11e CONGRÈS NATIONAL des SOINS ONCOLOGIQUES de SUPPORT
3 et 4 Octobre 2019
La dénutrition est fréquente, sous-diagnostiquée et sous-traitée
69%
Appréciation de la sarcopénie selon le médecin
Sarcopénique
Non sarcopénique
28%
5%
35%
28%
Présence d'une sarcopénie selon la mesure en L3
Sarcopénique
Non sarcopénique
69%
31%
AFSOS
Lung (n=201)
Kidney (n=60)
Colon (n=287)
Breast (n=176)
Prostate (n=55)
70%
77%
70%
54 %
93%
SCAN
SARCOPÉNIE, CANCER & NUTRITION
@AFSOS_officiel
#CongresAFSOS

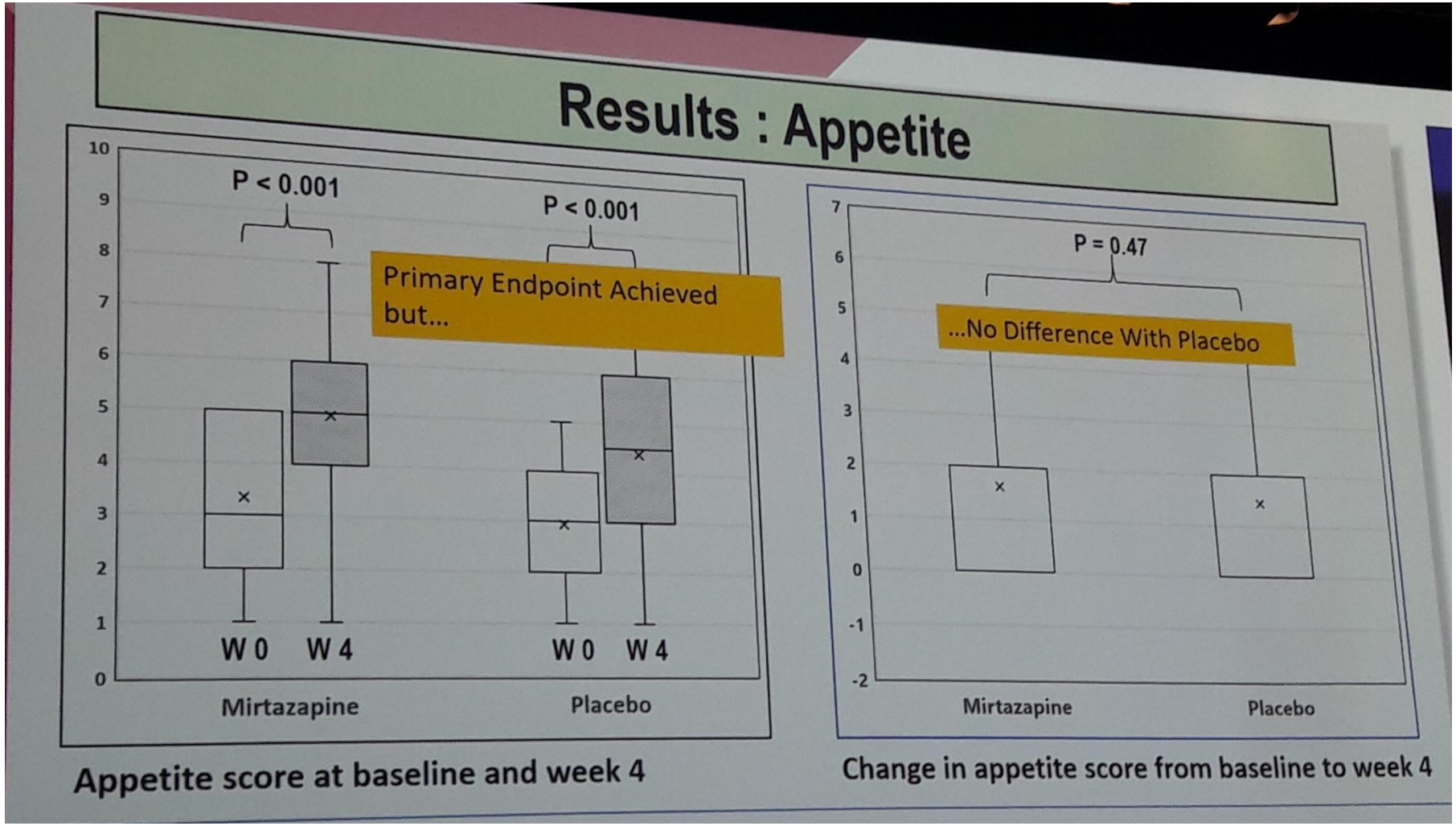
Recommendations:



- La prise en charge nutritionnelle est fondamentale au sein des SOS
- Elle nécessite une approche multidisciplinaire et multiprofessionnelle
- **Dépistage systématique de tous les patients: % perte de poids, IMC, EVA des ingestas, évaluation masse musculaire (handgrip, coupe scan L3)**
- Mise en place d'un support nutritionnel selon le degré de dénutrition
- Suivi/réévaluation
- Importance de l'APA associée pour la prise en charge de la sarcopénie


LBA86
Mirtazapine in Cancer-associated Anorexia Cachexia: A Randomised, Double-blind, Placebo-controlled Trial (ClinicalTrials.gov identifier: NCT03254173)
Catherine Hunter, Dina Farag, Wessam El-Sherief, Hesham Abdel-Aal, Samy Alsirafy
Palliative Medicine Unit, Kasr Al-Ainy Center of Clinical Oncology & Nuclear Medicine (NEMROCK), Kasr Al-Ainy School of Medicine, Cairo University; Cairo, Egypt
Kasr Al-Ainy School of Medicine
Cairo University


Methods
- Advanced solid malignancies
- Loss of appetite score≥4
- Loss >5% body weight 6 months
N=120
R
Mirtazapine 15mg PO @ night for 4 weeks +/- 4w (n=60)
Placebo PO @ night for 4 weeks +/- 4w (n=60)
1st: Change in appetite stimulation score 4w
2nd: Changes in
Body weight
Lean body mass
Handgrip strength
Depression
Quality-of-life
• Mirtazapine causes appetite stimulation and weight gain.
Appetite assesment
Cachexia assesment
Remeron and associated names, 15, 30 and 45 mg tablets, 15, 30 and 45 mg orodispersible tablets, 15 mg/ml oral solution, is a noradrenergic and specific serotonergic antidepressant indicated for the treatment of episodes of major depression.
emea


Results : Appetite
P < 0.001
P < 0.001
Primary Endpoint Achieved but...
W 0
W 4
W 0
W 4
Mirtazapine
Placebo
Appetite score at baseline and week 4
P = 0.47
...No Difference With Placebo
Mirtazapine
Placebo
Change in appetite score from baseline to week 4

BARCELONA 2019 ESMO congress

NOUVELLE-AQUITAINE
Réseau Régional de Cancérologie

MTEV

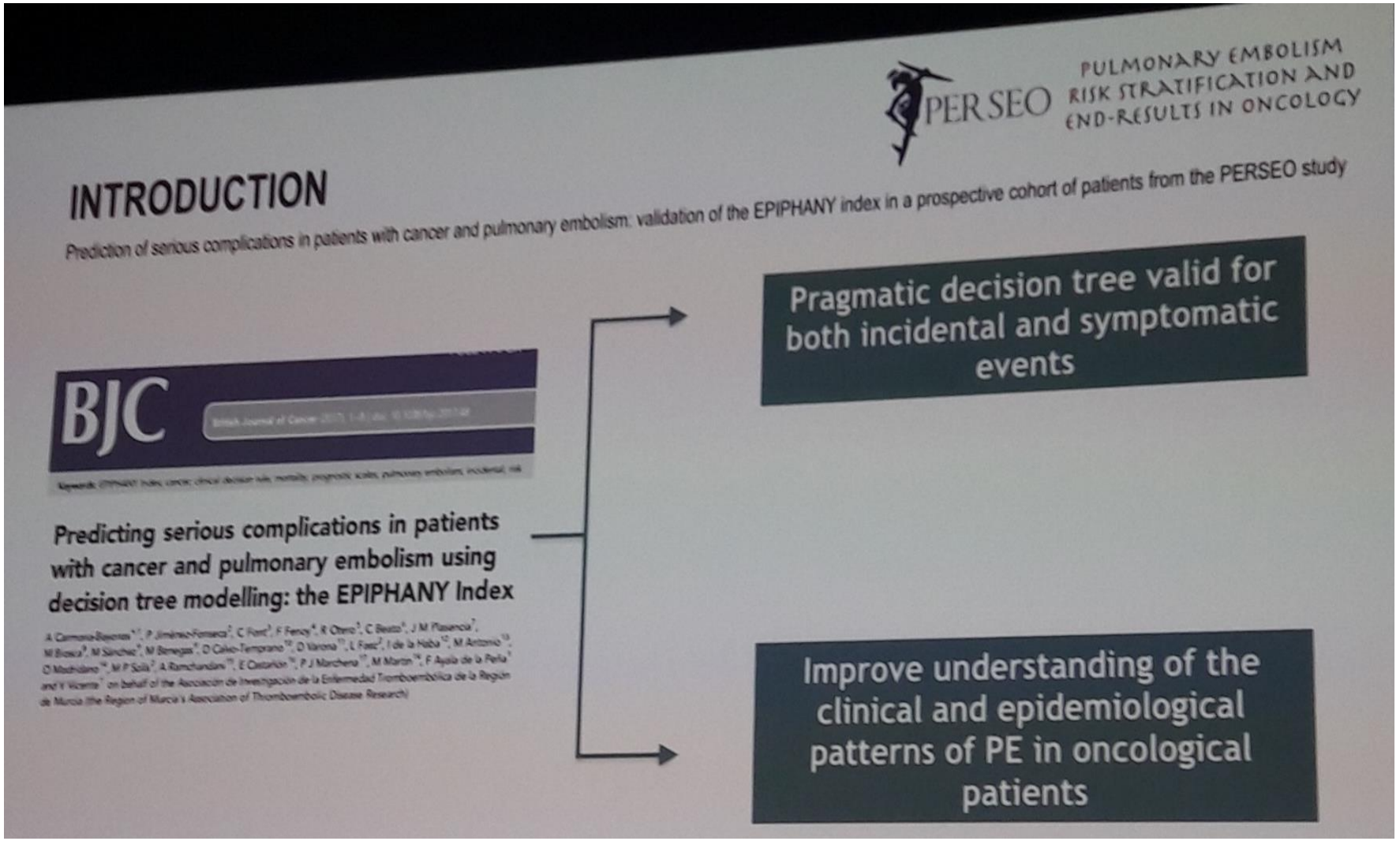
- 2ème cause de mortalité après le cancer
- Evènement grave chez tout patient ayant un cancer
- Surtout en phase métastatique et dans les 3 premiers mois de traitement du cancer

PREDICTION OF SERIOUS COMPLICATIONS IN PATIENTS WITH CANCER AND PULMONARY EMBOLISM: VALIDATION OF THE EPIPHANY INDEX IN A PROSPECTIVE COHORT OF PATIENTS FROM THE PERSEO STUDY

Manuel Sánchez Cánovas, Ana Fernández Montes, Roberto Morales Giménez, Mónica Cejuela Solís, Diego Casado Elía, Eva Coma Salvans, David Gómez Sánchez, Cristina Sánchez Cendra, Silvia Sequero López, Mayra Orrillo Sarmiento, Virginia Arrazubi Arrula, Marina Justo de la Peña, Mercedes Biosca Gómez de Tejada, David Fernández Garay, Alejandro Bernal Vidal, Diana Moreno Muñoz, Eva Martínez de Castro, Paula Jimenez-Fonseca, Alberto Carmona Bayonas

PERSEO

PULMONARY EMBOLISM RISK STRATIFICATION AND END-RESULTS IN ONCOLOGY


PERSEO
PULMONARY EMBOLISM RISK STRATIFICATION AND END-RESULTS IN ONCOLOGY
INTRODUCTION
Prediction of serious complications in patients with cancer and pulmonary embolism: validation of the EPIPHANY index in a prospective cohort of patients from the PERSEO study
BJC
Predicting serious complications in patients with cancer and pulmonary embolism using decision tree modelling: the EPIPHANY Index
Pragmatic decision tree valid for both incidental and symptomatic events
Improve understanding of the clinical and epidemiological patterns of PE in oncological patients

INTRODUCTION

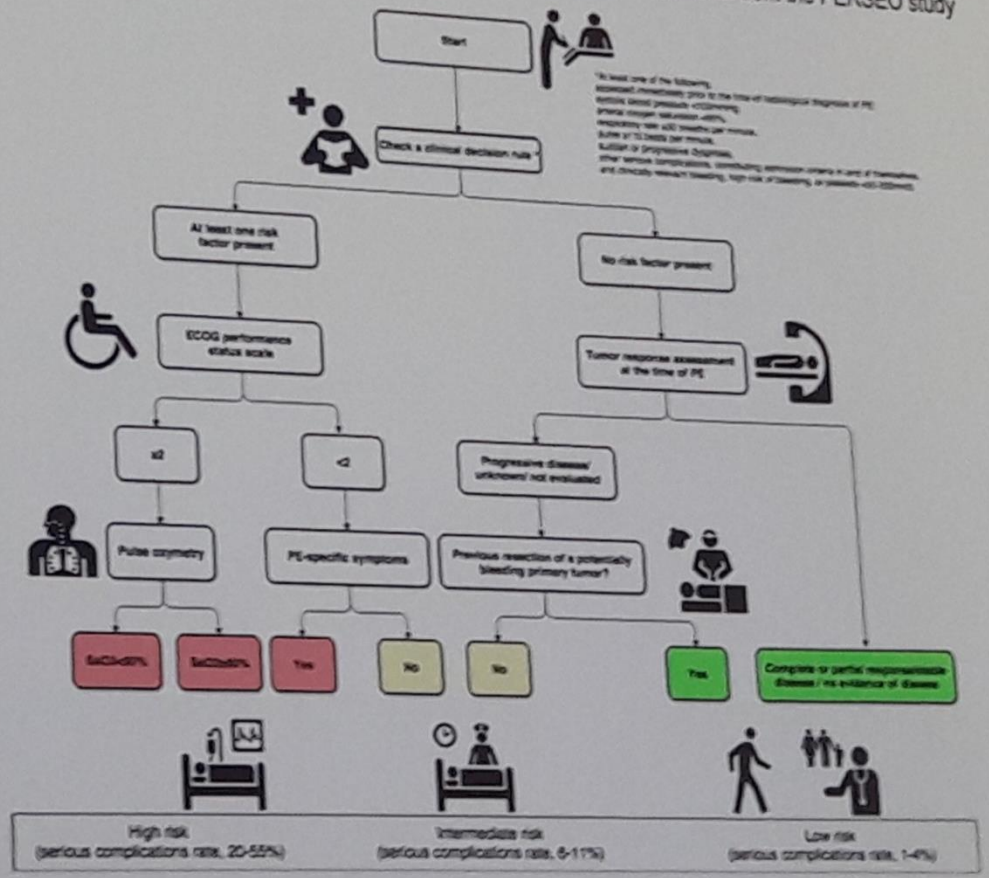
Prediction of serious complications in patients with cancer and pulmonary embolism: validation of the EPIPHANY index in a prospective cohort of patients from the PERSEO study

PERSEO PULMONARY EMBOLISM RISK STRATIFICATION AND END-RESULTS IN ONCOLOGY

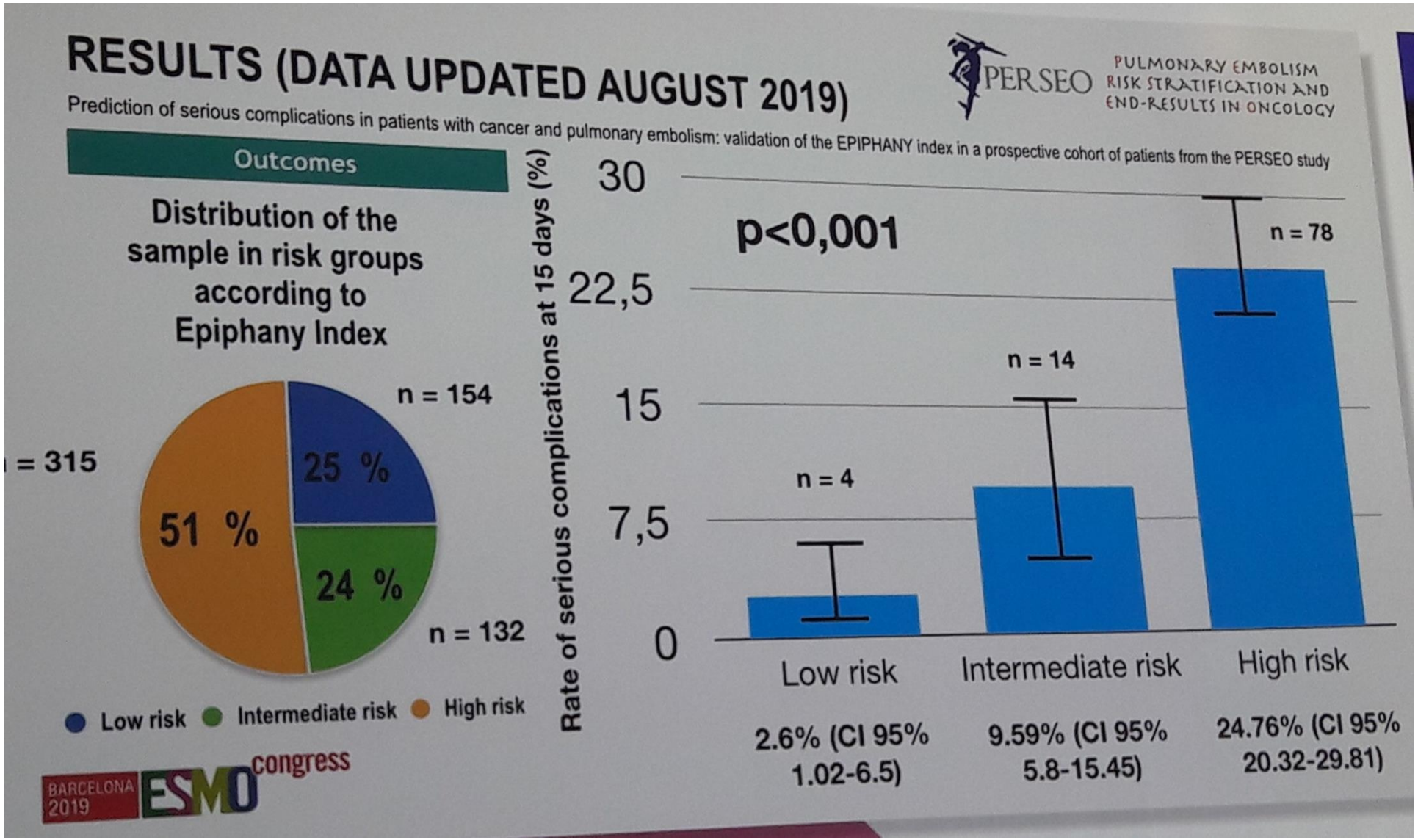
Clinical decision rule:

- SBP < 100 mmHg
- StO2 < 90%
- RR ≥ 30 bpm
- HR ≥ 110 bpm
- Sudden or progressive dyspnoea
- Clinically relevant bleeding
- High risk of bleeding
- Platelets < 50000
- Other serious complications that constituting admission criteria

End-point: 15-day serious complications rate



9 - Carmona Bayonas, A. et al. Key points to optimizing management and research on cancer-associated thrombosis. Clin Transl Oncol. 2018 Feb;20(2):119-126

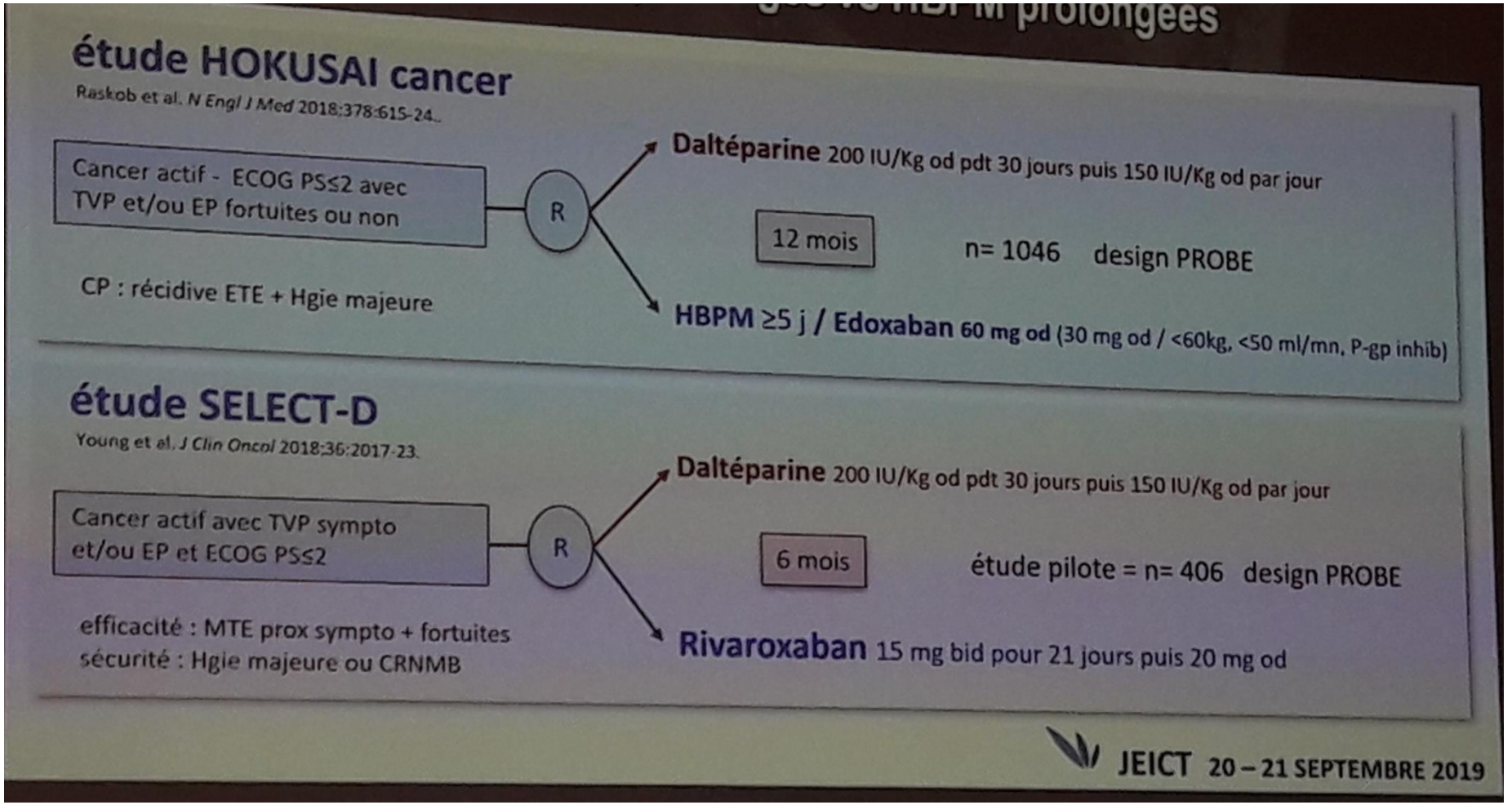

RESULTS (DATA UPDATED AUGUST 2019)
PERSEO PULMONARY EMBOLISM RISK STRATIFICATION AND END-RESULTS IN ONCOLOGY
Prediction of serious complications in patients with cancer and pulmonary embolism: validation of the EPIPHANY index in a prospective cohort of patients from the PERSEO study
Outcomes
Distribution of the sample in risk groups according to Epiphany Index
n = 154
= 315
25 %
51 %
24 %
n = 132
Low risk
Intermediate risk
High risk
Rate of serious complications at 15 days (%)
30
22,5
15
7,5
0
p<0,001
n = 78
n = 14
n = 4
Low risk
Intermediate risk
High risk
2.6% (CI 95% 1.02-6.5)
9.59% (CI 95% 5.8-15.45)
24.76% (CI 95% 20.32-29.81)
BARCELONA 2019 ESMO congress

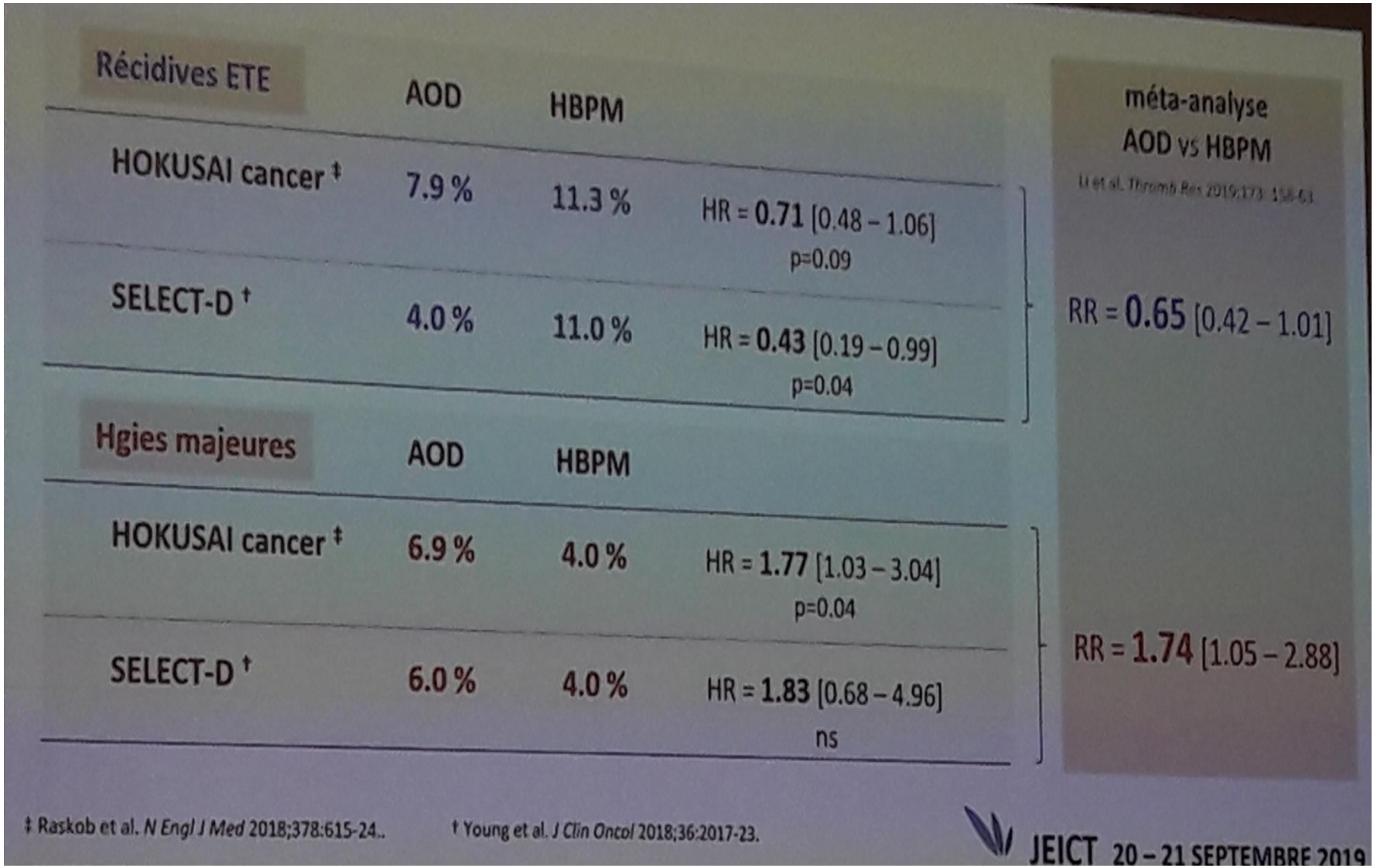
Recommandations SPLF 2019

- **<u>Traitement des six premiers mois:</u>**
  - Il est recommandé de traiter les malades atteints de cancer actif et d'une thrombose veineuse proximale ou d'une embolie pulmonaire par une **héparine de bas poids moléculaire sans relais par AVK pendant les six premiers mois** de traitement. (**Grade 1+**).

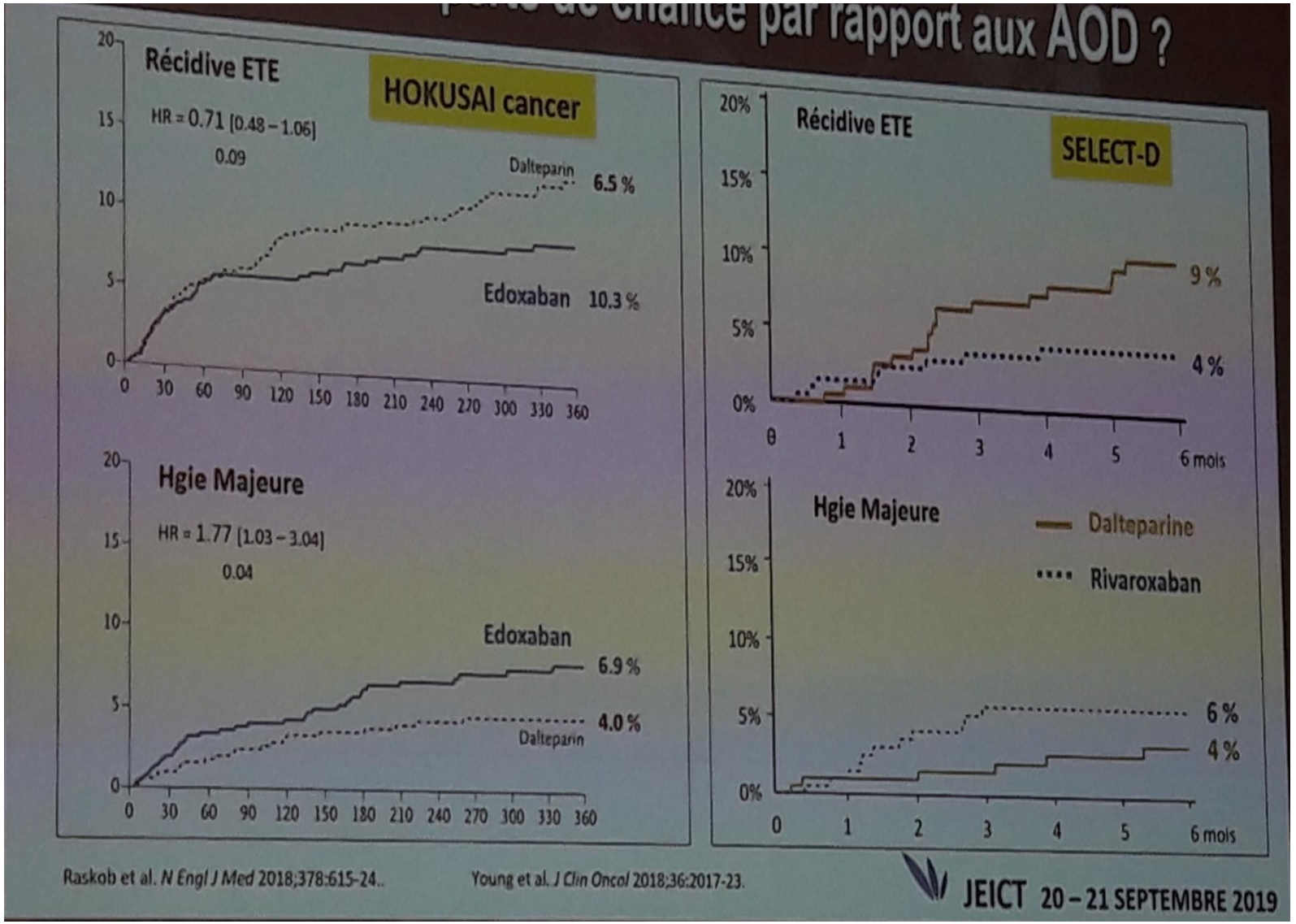
  - En cas d'intolérance aux HBPM, quand le risque hémorragique est faible et hors cancers uro et digestif, il est suggéré un anticoagulant oral direct plutôt qu'un AVK (Grade 2+).

Place des AOD en situation curative





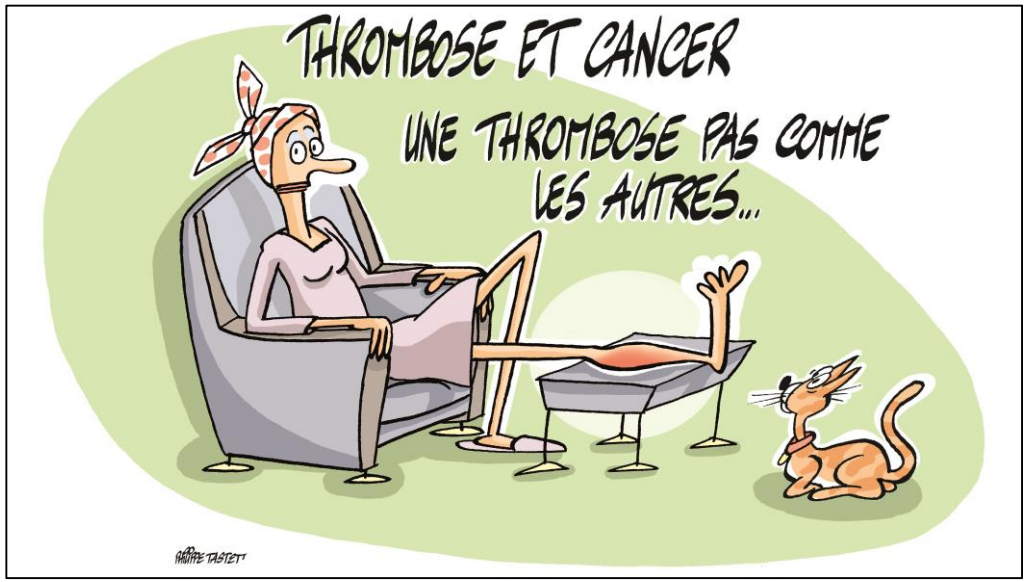
Pas d'efficacité supérieure des AOD par rapport aux HBPM
Risque hémorragique augmenté surtout dans cancers digestifs et urologiques



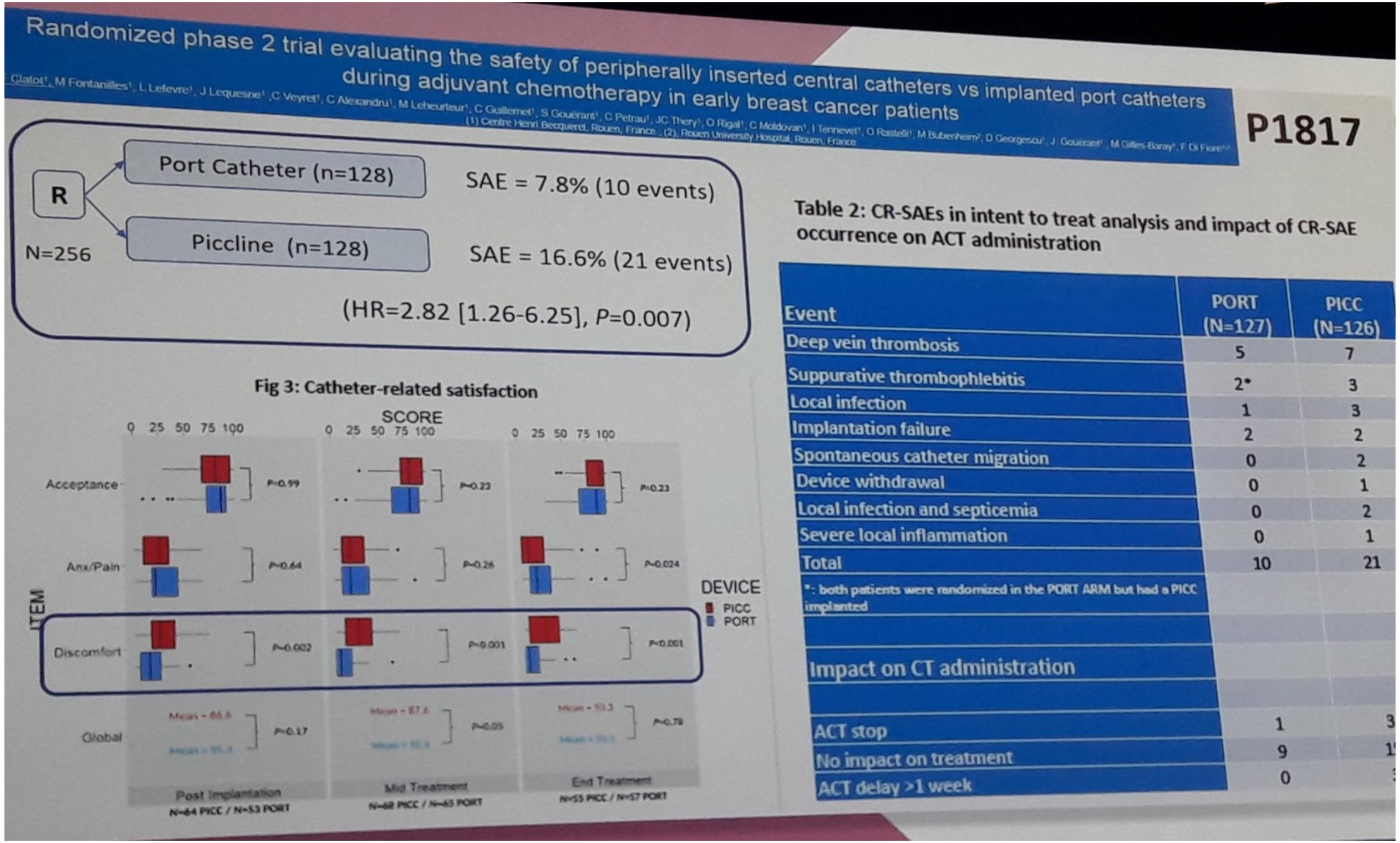
Pas de place pour les AOD en situation curative dans les 6 1ers mois

Plaquette Patient
avec carte détachable

Plaquette pour
Professionnels

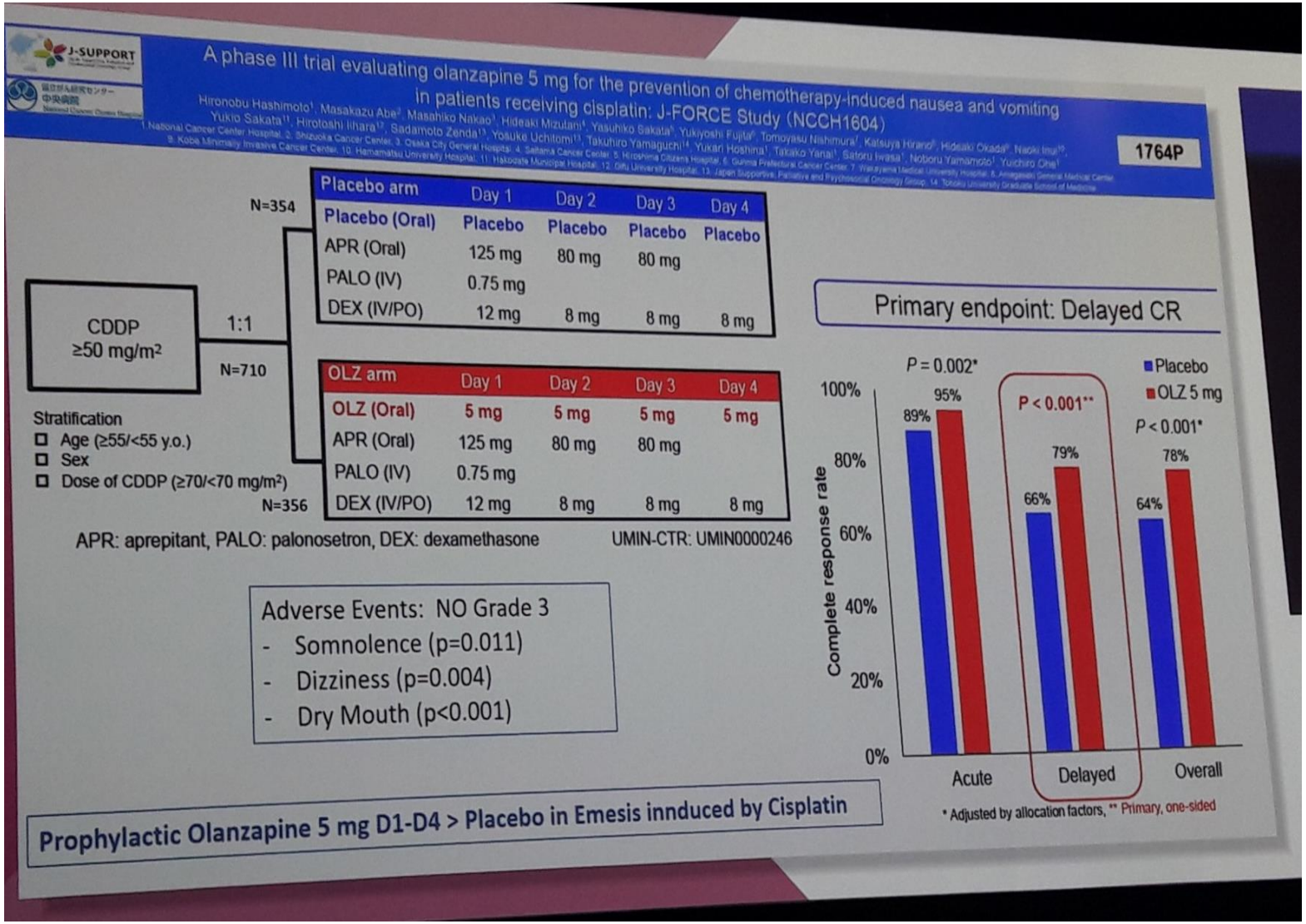


Vidéo pour PS
(Médecins, IDE et pharmaciens)



Comparaison utilisation d'un piccline/CIP :

- **+ D'EIG avec PICC (ETEV, infections)**
- **Inconfort + important avec les PICC**



Intérêt de l'olanzapine associée à la triple association aprépitant + palonosetron + déxa pour la prévention des NVCI sous cisplatine

Médecine Intégrative

Replacer le patient au centre de sa prise en charge

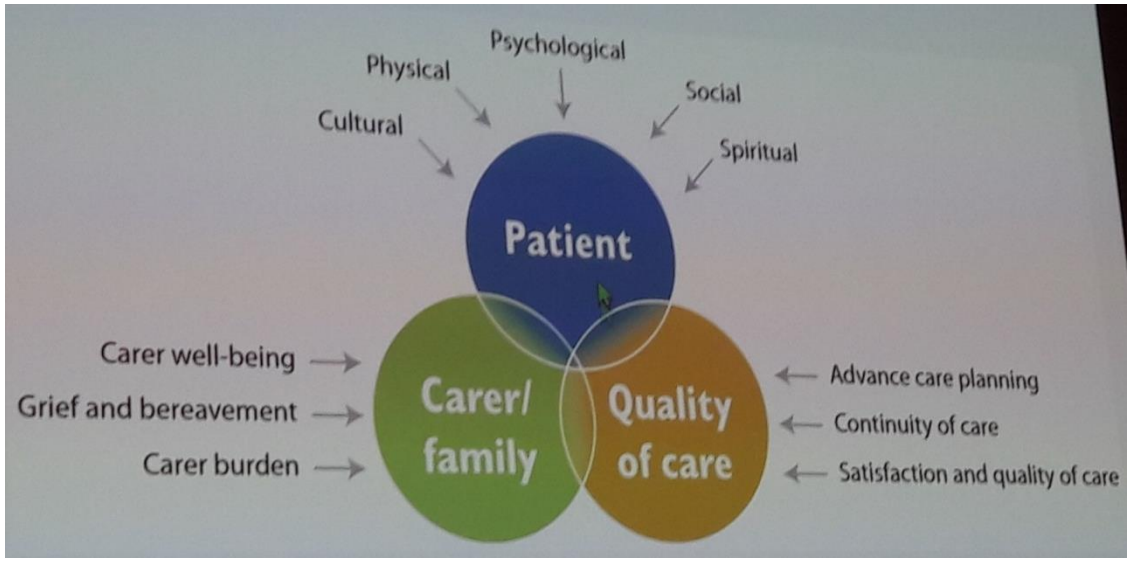
Traiter un patient et non une maladie

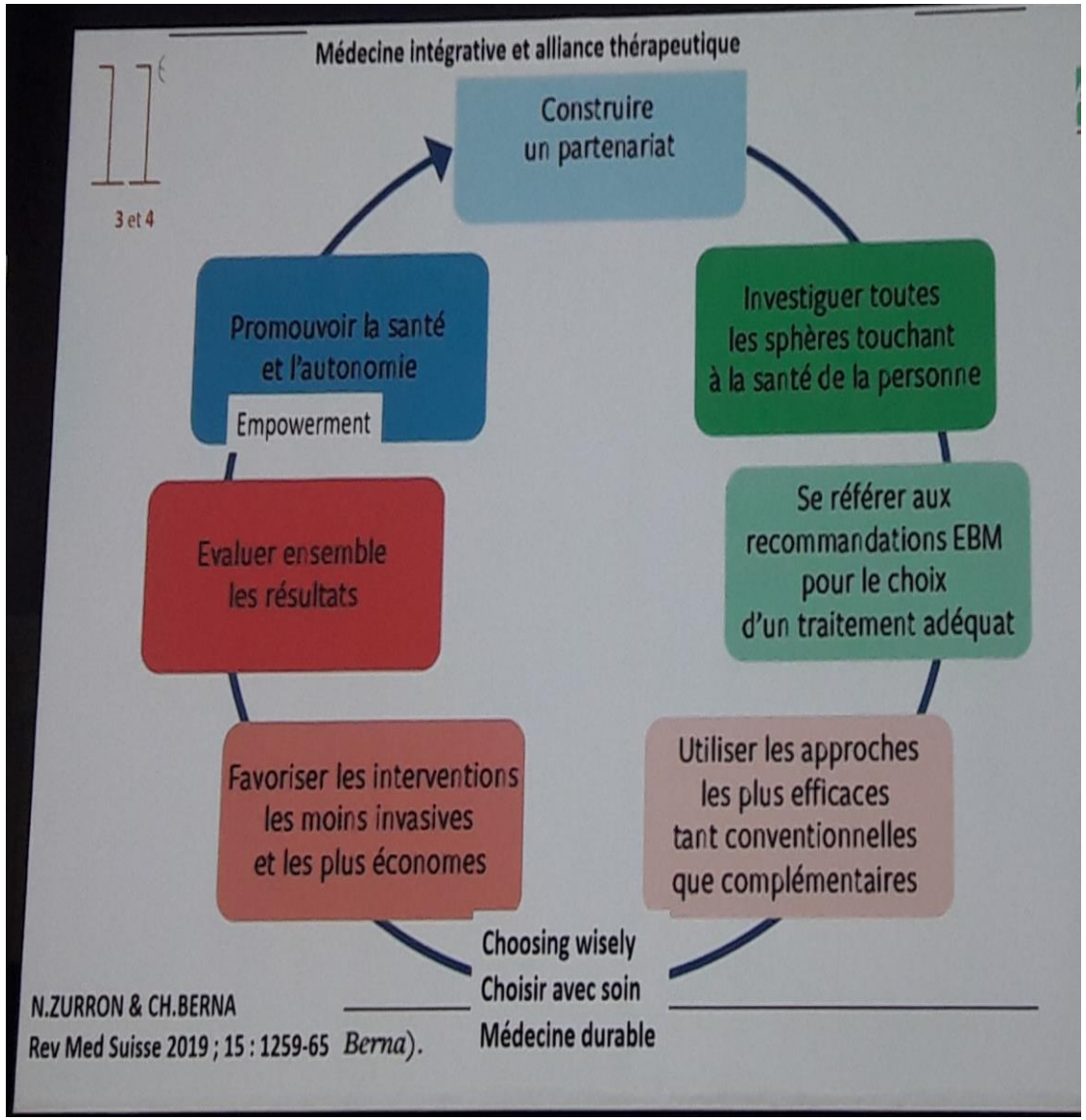
Désir d'implication du patient dans sa prise en charge

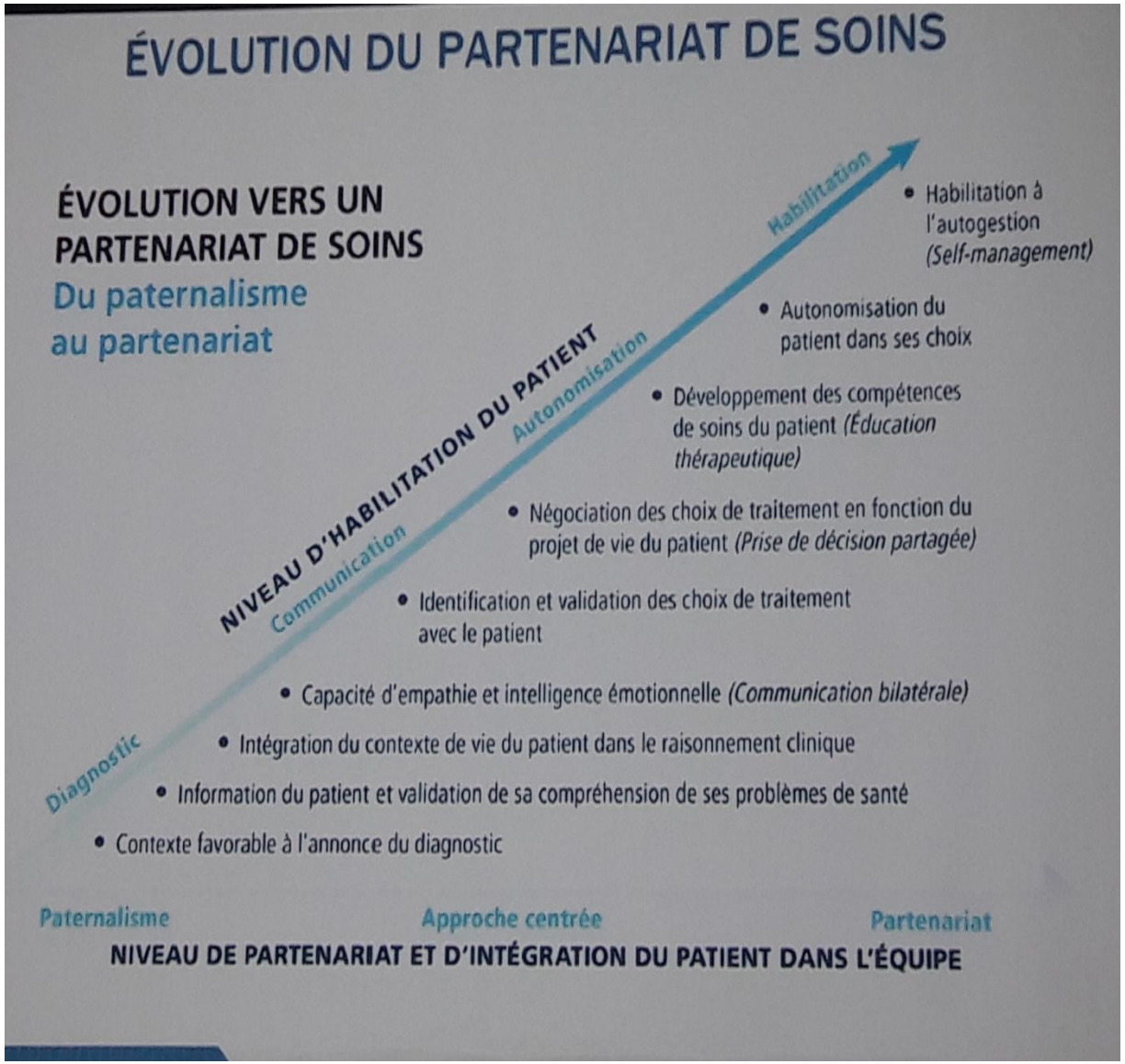
S'intéresser aux ressources du patient, à ses souhaits, ses croyances

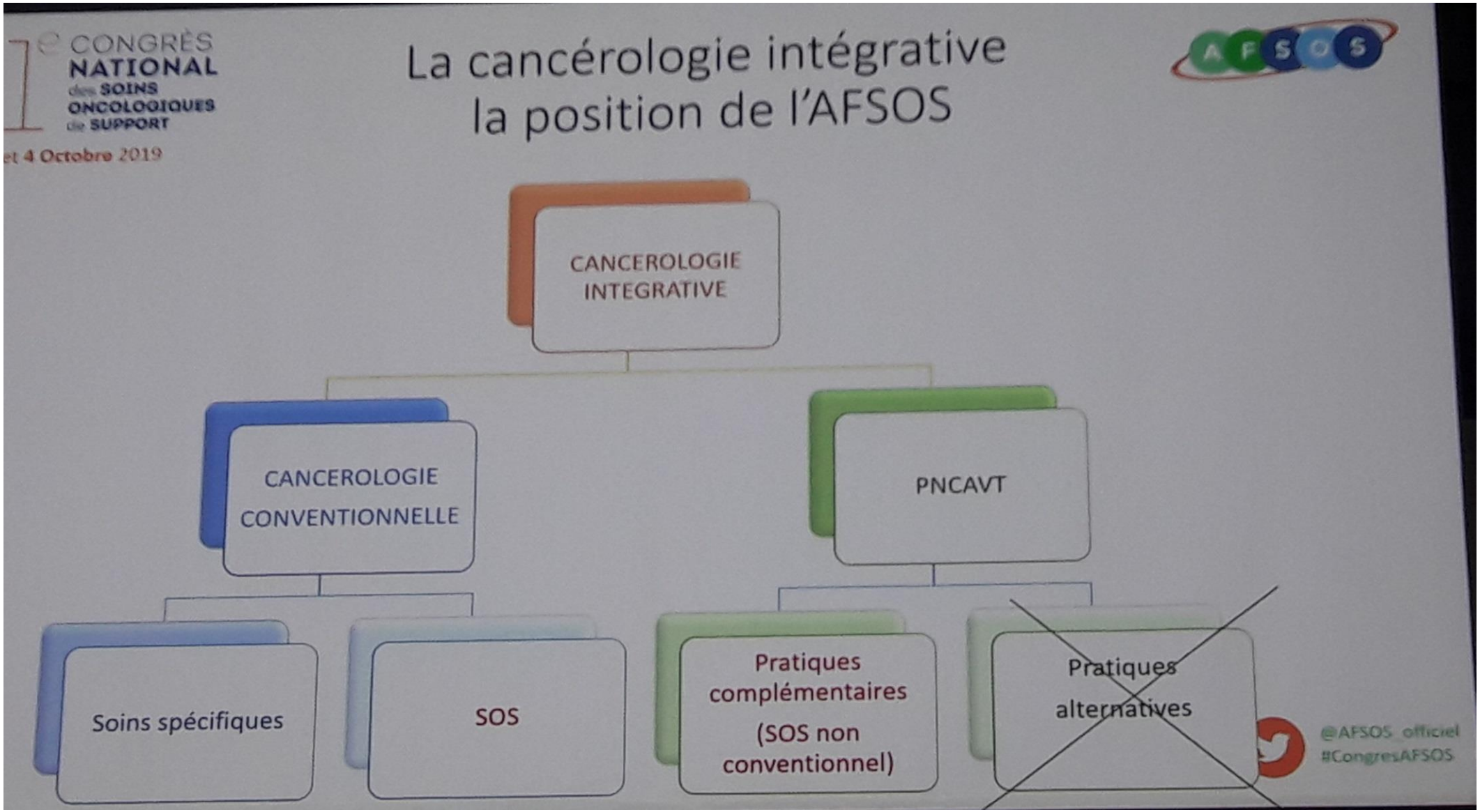
Patient désireux de bien être, de qualité de vie

Renforcer l'alliance thérapeutique




Médecine intégrative et alliance thérapeutique
3 et 4
Construire un partenariat
Investiguer toutes les sphères touchant à la santé de la personne
Se référer aux recommandations EBM pour le choix d'un traitement adéquat
Utiliser les approches les plus efficaces tant conventionnelles que complémentaires
Favoriser les interventions les moins invasives et les plus économes
Evaluer ensemble les résultats
Promouvoir la santé et l'autonomie
Empowerment
Choosing wisely
Choisir avec soin
Médecine durable
N.ZURRON & CH.BERNA
Rev Med Suisse 2019 ; 15 : 1259-65 Berna).


ÉVOLUTION DU PARTENARIAT DE SOINS
ÉVOLUTION VERS UN PARTENARIAT DE SOINS
Du paternalisme au partenariat
NIVEAU D'HABILITATION DU PATIENT
Communication
Autonomisation
Habilitation
Diagnostic
• Habilitation à l'autogestion (Self-management)
• Autonomisation du patient dans ses choix
• Développement des compétences de soins du patient (Éducation thérapeutique)
• Négociation des choix de traitement en fonction du projet de vie du patient (Prise de décision partagée)
• Identification et validation des choix de traitement avec le patient
• Capacité d'empathie et intelligence émotionnelle (Communication bilatérale)
• Intégration du contexte de vie du patient dans le raisonnement clinique
• Information du patient et validation de sa compréhension de ses problèmes de santé
• Contexte favorable à l'annonce du diagnostic
Paternalisme
Approche centrée
Partenariat
NIVEAU DE PARTENARIAT ET D'INTÉGRATION DU PATIENT DANS L'ÉQUIPE

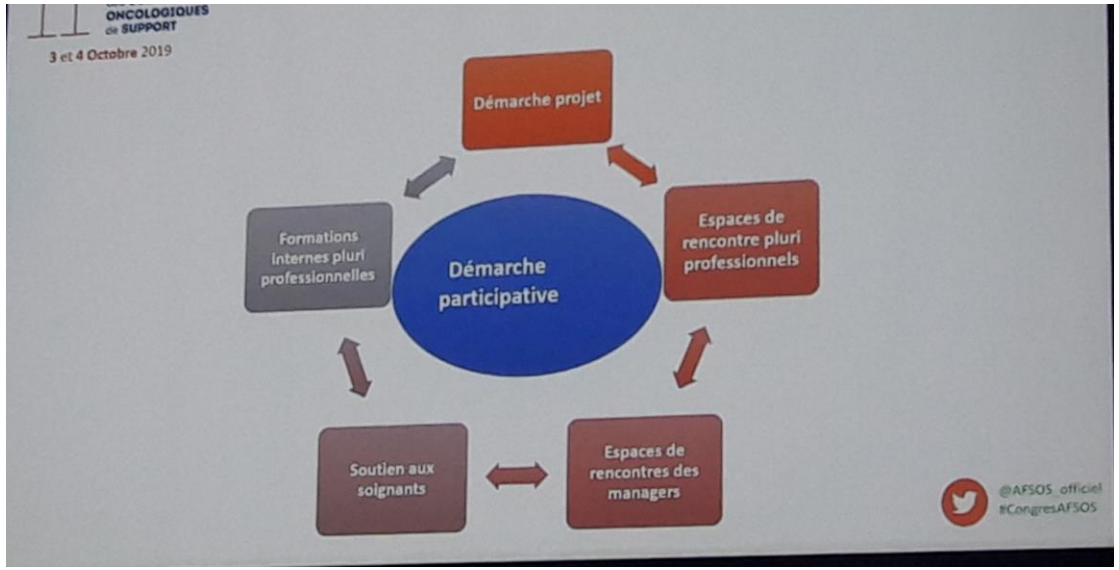

CONGRÈS NATIONAL des SOINS ONCOLOGIQUES de SUPPORT
et 4 Octobre 2019
La cancérologie intégrative
la position de l'AFSOS
AFSOS
CANCEROLOGIE INTEGRATIVE
CANCEROLOGIE CONVENTIONNELLE
PNCAVT
Soins spécifiques
SOS
Pratiques complémentaires (SOS non conventionnel)
Pratiques alternatives
@AFSOS officiel
#CongresAFSOS

Démarche Participative / Prévention du burn out

« Je soigne bien si je vais bien …… »

Amélioration de la qualité de vie au travail

Impact sur la qualité des soins



Profession exposée :

- Annonce mauvaises nouvelles
- Implication émotionnelle
- Long parcours avec le patient et sa famille
- Être à jour des nouveautés scientifiques
- Faire avec les contraintes budgétaires, humaines …….

Solutions :

- Personnelles :
  - Équilibre vie pro/vie perso
  - Suivi medical
  - Sport
  - Yoga/méditation
  - Psychothérapie individuelle, de groupe

- Au sein de l'institution:
  - Formation au sein des études médicales: prendre soin, empathie, communication
  - Formation continue
  - Supervision, suivi psy du travail
  - Techniques de management
  - Staff pluri-professionnel

Questionnaire via le réseau de cancérologie


11e CONGRÈS NATIONAL des SOINS ONCOLOGIQUES de SUPPORT
3 et 4 Octobre 2019
AFSOS
Le Staff pluri professionnel :
un des piliers de la démarche participative
ESPACES DE RENCONTRE
PLURI-PROFESSIONNELS
Démarche Projet
Formation interne
Espaces d'échanges pluri professionnels
Démarche Participative
Soutien aux soignants
Espaces d'échanges entre managers
• RMM
• Staffs cliniques
• RCP(S)
• CREX
• ...
RENCONTRES CENTRÉES SUR LE PATIENT VISANT UNE PRISE EN CHARGE GLOBALE
RENCONTRES CENTRÉES SUR LA DYNAMIQUE DE TRAVAIL ET LA QUALITÉ DES PRATIQUES
•groupes de pairs,
•groupe d'analyse des pratiques,
•groupe de réflexion éthique...

MERCI

et

« SUPPORTIVE CARE MAKES EXCELLENT CANCER CARE POSSIBLE »