# SOINS ONCOLOGIQUES DE SUPPORT

Le 11 JUIN 2024

**Palais de la Bourse**

**Sophie MORIN Médecin de SOS**

**INSTITUT BERGONIE**

## 4E POST-ASCO EN NOUVELLE-AQUITAINE

# Liens d’intérêts

- Aucun (de Queen B à Queen T…!)

# La star

Des SOS à l’ASCO

2024 ASCO ANNUAL MEETING

# Comparative Effectiveness Trial of Early Palliative Care Delivered via Telehealth versus In Person among Patients with Advanced Lung Cancer: The REACH PC Trial

Joseph A. Greer PhD & Jennifer S. Temel MD on behalf of:

Chardria Trotter MPH MBA, Vicki A. Jackson MD MPH, Simone Rinaldi APN-BC, Mihir Kamdar MD, Areej El-Jawahri MD, Nora Horick MS, Kedie Pintro MS, Dustin Rabideau PhD, Josephine Feliciano MD, Isaac Chua MD MPH, Konstantinos Leventakos MD, Stacy Fischer MD, Toby C. Campbell MD, Michael W. Rabow MD, Finly Zachariah MD, Laura C. Hanson MD, Sara F. Martin MD, Maria Silveira MD, and the REACH PC Investigators



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# Enhancing Access to Early Palliative Care

## ASCO Guidelines for Early Palliative Care

- Recommend integrating palliative care from diagnosis of advanced cancer
- Limited scalability

## A Promising Solution: Telehealth

- Overcomes access barriers
- Reduces financial toxicity

**Study Question:**

Is the effect of delivering early palliative care via secure video equivalent to in-person care for patients with advanced lung cancer?


PRESENTED BY: Joseph Greer, PhD
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Sanders JJ et al. J Clin Oncol. May 15, 2024
Patel KB et al. JAMA Netw Open. 2023;6(1)

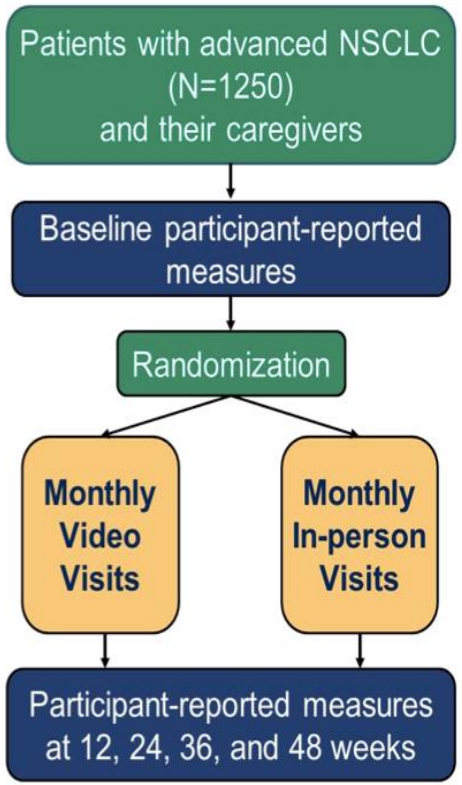
## Study Aims and Design

### Primary Aim:

- To evaluate the equivalence of the effect of delivering early palliative care using video versus in-person visits on patient-reported quality of life

### Secondary and Exploratory Aims:

- Satisfaction with care
- Caregiver attendance at study visits
- Mood symptoms





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## Study Procedures

- Enrollment: 6/14/2018 to 5/4/2023
- Random assignment (1:1) to groups
- Technology provided if needed
- Intervention:
  - Monthly palliative care visits
  - Initial in-person encounter in video group to establish rapport
  - Clinician documentation of topics discussed during visits

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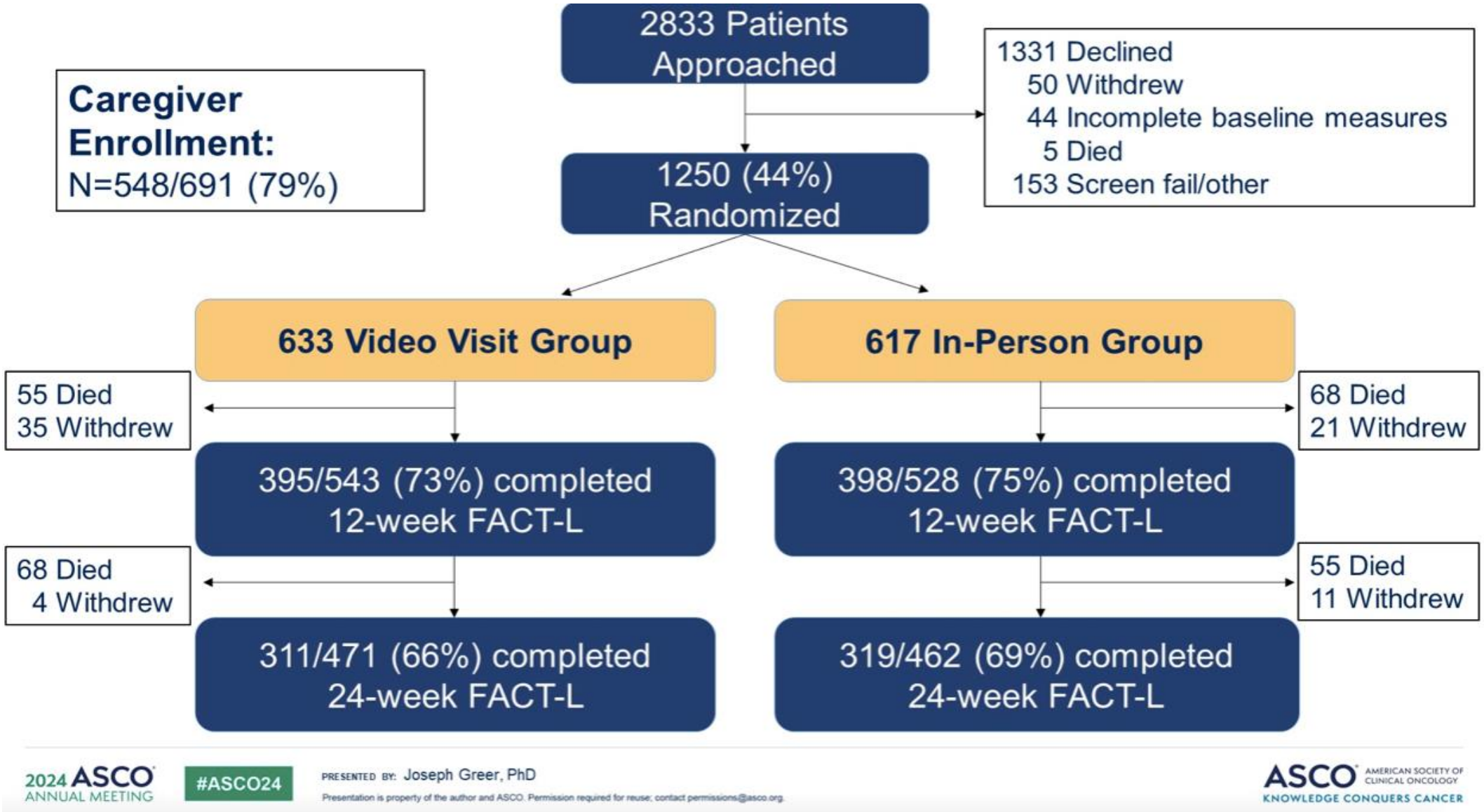
Caregiver Enrollment:
N=548/691 (79%)
2833 Patients Approached
1331 Declined
50 Withdrew
44 Incomplete baseline measures
5 Died
153 Screen fail/other
1250 (44%) Randomized
633 Video Visit Group
617 In-Person Group
55 Died
35 Withdrew
68 Died
21 Withdrew
395/543 (73%) completed 12-week FACT-L
398/528 (75%) completed 12-week FACT-L
68 Died
4 Withdrew
55 Died
11 Withdrew
311/471 (66%) completed 24-week FACT-L
319/462 (69%) completed 24-week FACT-L
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## Patient Characteristics

| Characteristic | Video Visit Group N (%) | In-Person Group N (%) |
|---|---|---|
| Age, Mean Years (SD) | 65.5 (10.9) | 65.5 (10.6) |
| Woman | 356 (56%) | 318 (52%) |
| American Indian/Alaskan Native | 4 (<1%) | 4 (<1%) |
| Asian | 32 (5%) | 32 (5%) |
| Black or African American | 57 (9%) | 72 (12%) |
| Native Hawaiian/Pacific Islander | 2 (<1%) | 4 (<1%) |
| White | 524 (83%) | 502 (82%) |
| Other | 21 (3%) | 10 (2%) |
| Hispanic or Latino/x | 29 (5%) | 30 (5%) |
| Married/Partnered | 420 (67%) | 409 (67%) |
| Single/Divorced/Widowed/Other | 210 (33%) | 203 (33%) |

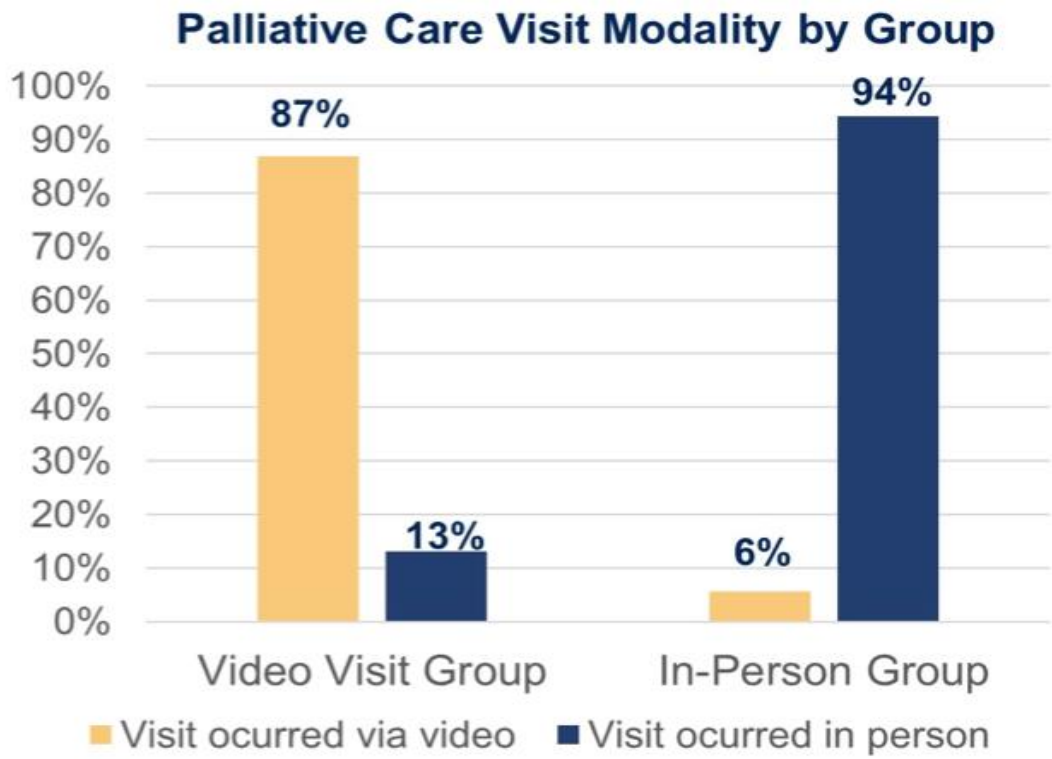
## Clinical Characteristics

| Characteristic | Video Visit Group, N (%) | In-Person Group, N (%) |
|---|---|---|
| ALK | 28 (4%) | 26 (4%) |
| EGFR | 113 (18%) | 102 (17%) |
| ROS | 6 (<1%) | 0 (0%) |
| RET | 11 (2%) | 7 (1%) |
| Other or no mutation | 475 (75%) | 482 (78%) |
| Platinum-based doublet chemo (± 3rd agent) | 257 (41%) | 277 (45%) |
| Radiation | 138 (22%) | 123 (20%) |
| Oral targeted therapy | 126 (20%) | 114 (19%) |
| Immunotherapy alone | 93 (15%) | 72 (12%) |
| Single agent IV chemotherapy | 7 (1%) | 8 (1%) |
| Concurrent chemotherapy and radiation | 4 (<1%) | 5 (<1%) |
| No treatment | 8 (1%) | 18 (3%) |

# Intervention Delivery & Fidelity

**Number of Palliative Care Visits by 24 Weeks**
Mean (SD)

| Video Visit | In-Person |
|---|---|
| 4.7 (2.5) | 4.9 (2.7) |





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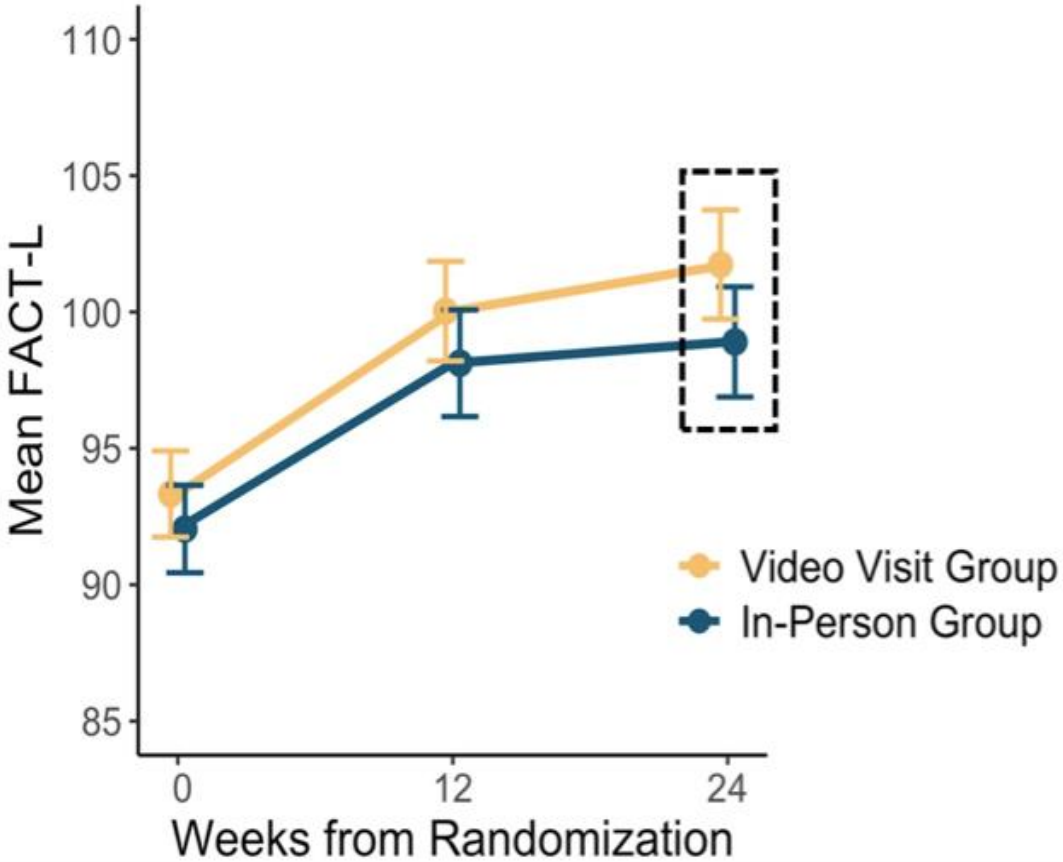
# Primary Outcome: Patient Quality of Life (QOL)

*Higher scores indicate better QOL (range: 0-136)*




**Adjusted Mean FACT-L at 24 Weeks:**

- Video Visit Group: **99.7**
- In-Person Group: **97.7**

Difference (90% CI): **2.0 (0.1, 3.9)**

p=**0.04 for equivalence**



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# Secondary Outcomes at Week 24

| Outcome Measure | Video Visit Group Estimated Mean/Proportion | In-Person Group Estimated Mean/Proportion | Difference 95% (CI) | P |
|---|---|---|---|---|
| **Satisfaction with Care†** | | | | |
| Patient report, mean | 41.3 | 41.0 | 0.3 (-1.0, 1.7) | >0.99 |
| Caregiver report, mean | 37.2 | 36.8 | 0.4 (-1.5, 2.3) | >0.99 |
| **Attendance of Caregiver at Visits** | | | | |
| proportion | 36.6% | 49.7% | -13.0% (-17.6, -8.6) | <0.001 |

†*Higher scores on the Satisfaction and Care Delivery Questionnaire indicate greater satisfaction*


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# CONCLUSION

## Equivalence de la télé consultation en SOS

- Mise en valeur la TELEMEDECINE
- Etude de SOS
- Changement de pratiques :

Développer la téléconsultation/télémédecine pour une offre de SOS plus écologique, économique et équitable sur la région

- *Discussion sur l'indication clinique à une téléconsultation*

2024 ASCO ANNUAL MEETING

# Multi-Site Randomized Trial of Stepped Palliative Care for Patients with Advanced Lung Cancer

Jennifer S. Temel MD, Vicki A. Jackson MPH, MD, Areej El-Jawahri MD, Simone P. Rinaldi MSN, ANP-BC, ACHPN, Laura A. Petrillo MD, Pallavi Kumar MD, Kathryn A. McGrath MD, Thomas W. LeBlanc MD, Arif H. Kamal MD, Christopher A. Jones MD, Dustin J. Rabideau PhD, Nora Horick MS, Kedie Pintro MS, Emily R. Gallagher Medeiros RN, Kathryn E. Post PhD, RN, ANP-BC, Joseph A. Greer PhD

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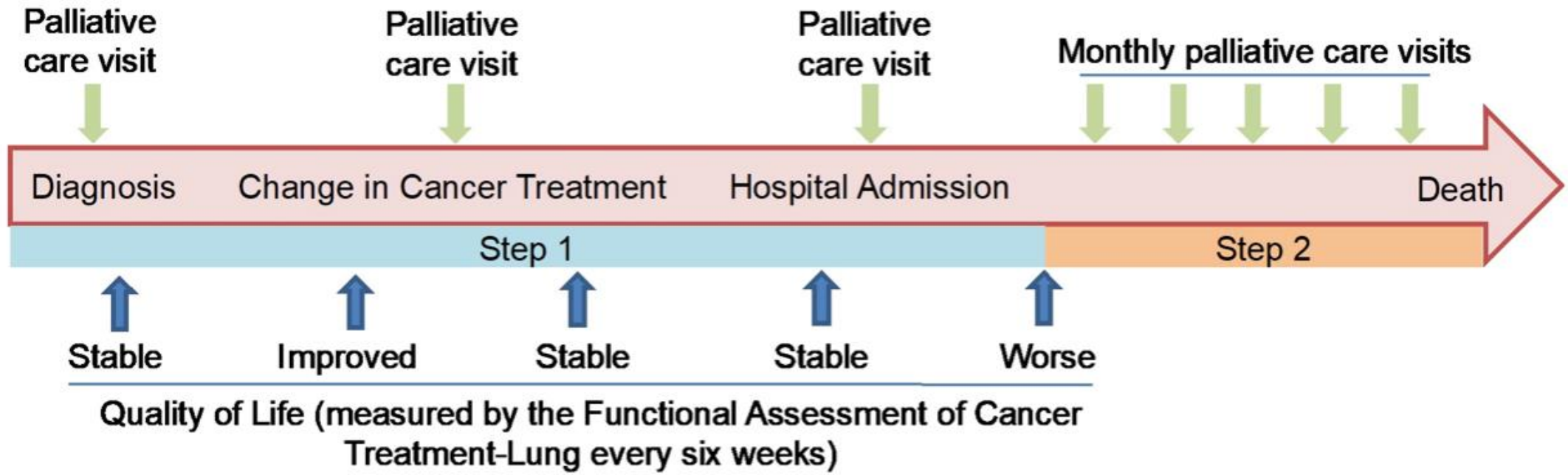
# Early Integrated Palliative Care Models Require Substantial Resources

- Interventions delivered by specialty-trained palliative care physicians or advanced practice providers.
- Insufficient number of clinicians for monthly visits with all patients diagnosed with serious cancer.

**Study Question**

Can a stepped palliative care intervention tailored to a patient's illness course and care needs achieve the same effect as an early integrated palliative care model while utilizing fewer palliative care resources?

# Stepped Care Model of Early Palliative Care

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# Study Design and Aims

- Multi-site randomized controlled trial of stepped palliative versus early integrated palliative care (monthly palliative care visits).
- **Primary Aim**: To establish the non-inferiority of stepped palliative care on patient quality of life at 24 weeks, as measured by the Functional Assessment of Cancer Therapy-Lung (FACT-L), with a non-inferiority margin of - 4.5 points.
- **Secondary Outcomes**:
  - Palliative care utilization as measured by number of visits.
  - Patient-reported communication about end-of-life care.
  - Hospice utilization as measured by length of stay in hospice.


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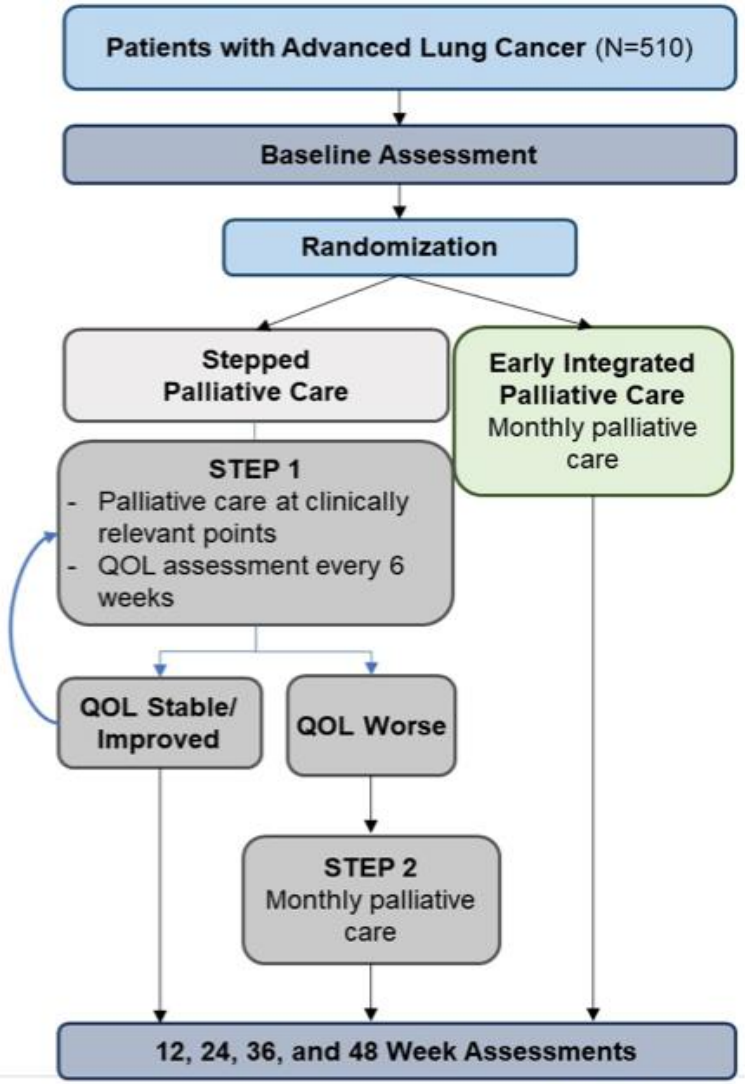
# Study Procedures

- Research assistants reviewed health records to identify eligible patients.
- After clinician approval, research assistant approached and consented patients.
- Patients were randomized 1:1 to study group.
- Research assistants collected patient-reported outcomes throughout the study.
- Enrollment period 2/12/18 – 12/15/22.





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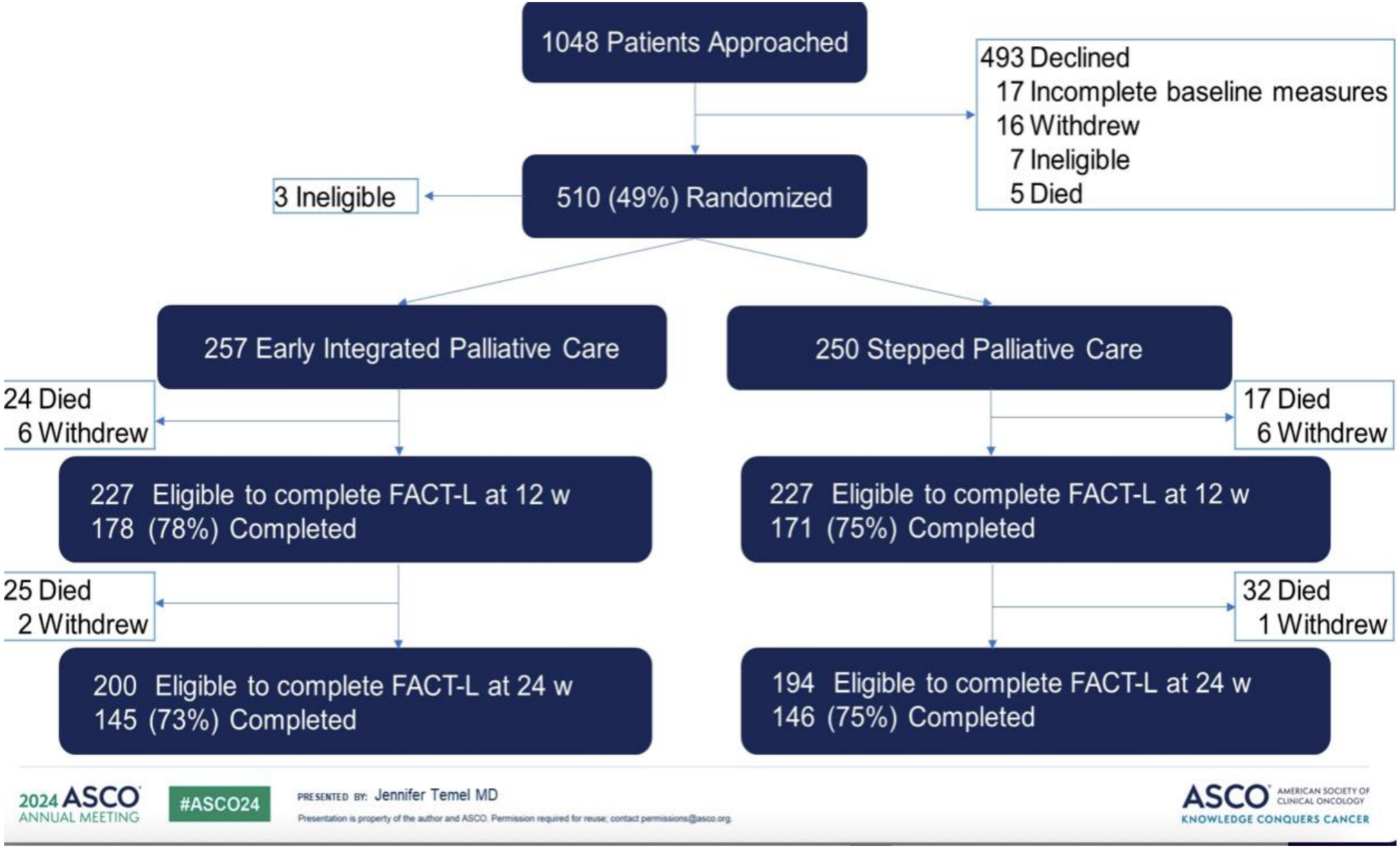
1048 Patients Approached
493 Declined
17 Incomplete baseline measures
16 Withdrew
7 Ineligible
5 Died
3 Ineligible
510 (49%) Randomized
257 Early Integrated Palliative Care
250 Stepped Palliative Care
24 Died
6 Withdrew
17 Died
6 Withdrew
227 Eligible to complete FACT-L at 12 w
178 (78%) Completed
227 Eligible to complete FACT-L at 12 w
171 (75%) Completed
25 Died
2 Withdrew
32 Died
1 Withdrew
200 Eligible to complete FACT-L at 24 w
145 (73%) Completed
194 Eligible to complete FACT-L at 24 w
146 (75%) Completed
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## Participant Characteristics

| Characteristic | Early Integrated PC (N=257) | Stepped PC (N=250) |
|---|---|---|
| Age, Mean Years (SD) | 66.1 (11.1) | 66.8 (9.2) |
| Woman | 130 (51%) | 130 (52%) |
| American Indian or Alaskan Native | 2 (<1%) | 2 (<1%) |
| Asian | 11 (4%) | 3 (1%) |
| Black or African American | 28 (11%) | 29 (12%) |
| Native Hawaiian or Pacific Islander | 0 (0%) | 0 (0%) |
| White | 212 (83%) | 215 (86%) |
| Hispanic or Latino/x | 5 (2%) | 3 (1%) |
| ECOG PS 0 | 64 (25%) | 61 (24%) |
| ECOG PS 1 | 153 (60%) | 153 (61%) |
| ECOC PS 2 | 40 (16%) | 36 (14%) |

PC = palliative care, ECOG PS = Eastern Cooperative Group Performance Status

# Disease Characteristics

| Characteristic | Early Integrated PC (N=257) | Stepped PC (N=250) |
|---|---|---|
| Non-Small Cell Lung Cancer | 203 (79%) | 194 (78%) |
| Small Cell Lung Cancer | 47 (18%) | 53 (21%) |
| Mesothelioma | 7 (3%) | 3 (1%) |
| ALK | 10 (4%) | 11 (4%) |
| EGFR | 39 (15%) | 37 (15%) |
| ROS | 2 (<1%) | 3 (1%) |
| RET | 2 (<1%) | 1 (<1%) |
| Other or no mutation | 204 (79%) | 198 (79%) |
| Platinum-based chemotherapy (+/- 3rd agent) | 116 (45%) | 128 (51%) |
| Radiation | 38 (15%) | 54 (22%) |
| Oral targeted therapy | 50 (20%) | 40 (16%) |
| Immunotherapy alone | 39 (15%) | 22 (9%) |
| Single agent intravenous chemotherapy | 9 (4%) | 3 (1%) |

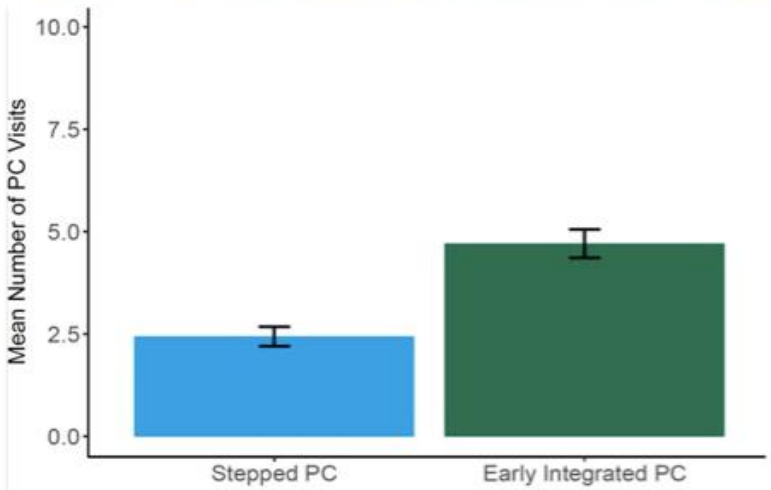
# Intervention Delivery

## Number of PC Visits by Week 24

Adjusted means: **2.4 vs 4.7 visits per patient**

Difference (95% CI): **-2.3 (-2.7, -1.8)**

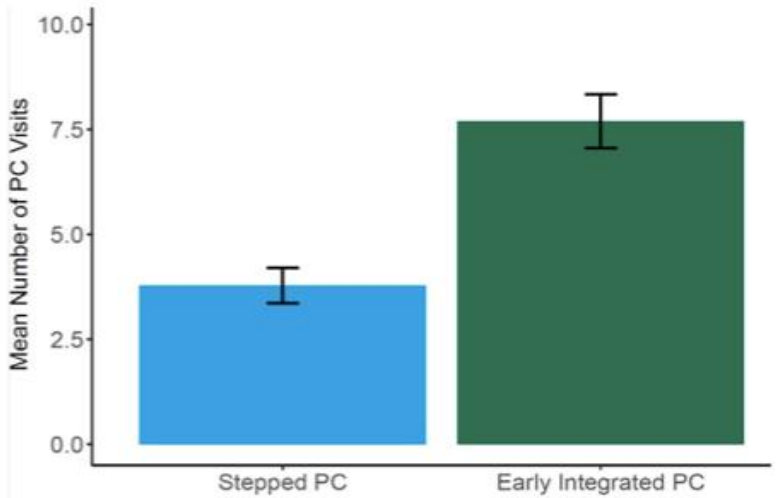
**p < 0.001 for superiority (secondary outcome)**




## Number of PC Visits by Week 48

Adjusted means: **3.8 vs 7.7 visits per patient**

Difference (95% CI): **-3.9 (-4.6, -3.1)**




PC = palliative care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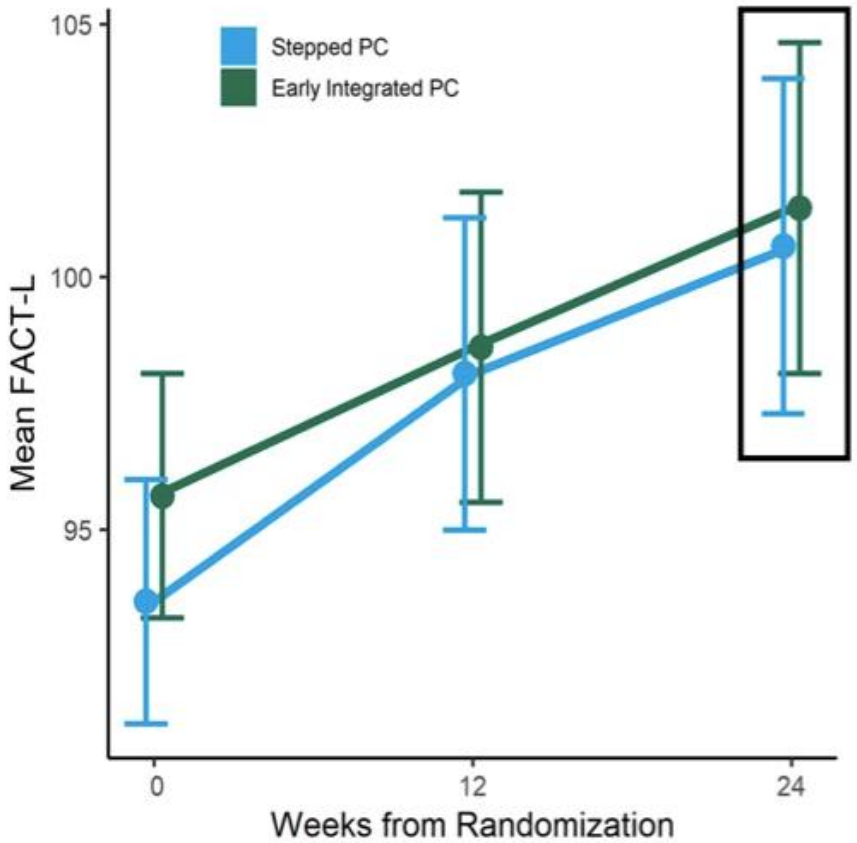
# Quality of Life




## Quality of Life at Week 24

Adjusted means: **100.6 vs 97.8**

Difference (lower one-sided 95% CL): **2.9 (-0.1)**

Non-inferiority margin: **-4.5**

**p < 0.001 for non-inferiority (primary outcome)**

*Higher scores indicate better quality of life*

PC = palliative care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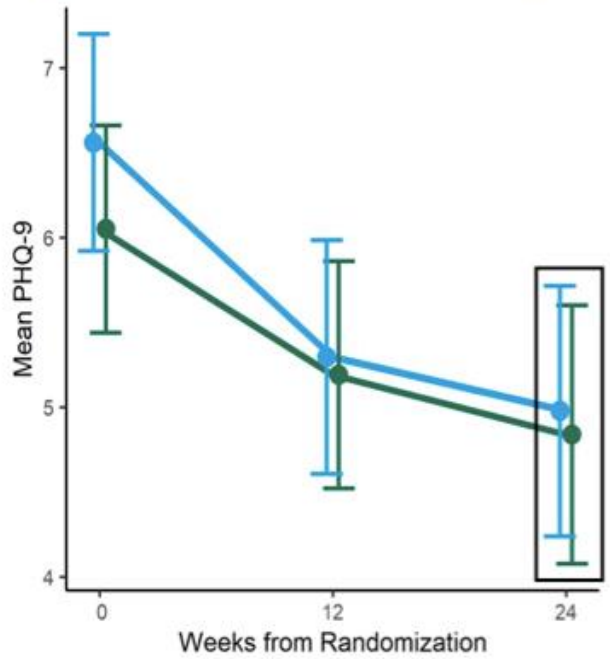
# Depression and Coping at Week 24

## Depression

Difference (95% CI): **-0.4 (-1.3, 0.5)**

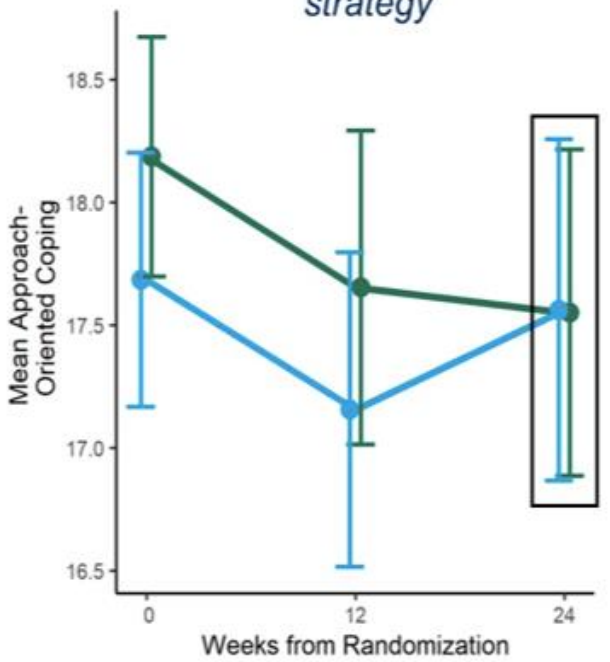
*Higher scores indicate worse depression*




## Approach-Oriented Coping

Difference (95% CI): **0.2 (-0.7, 1.0)**

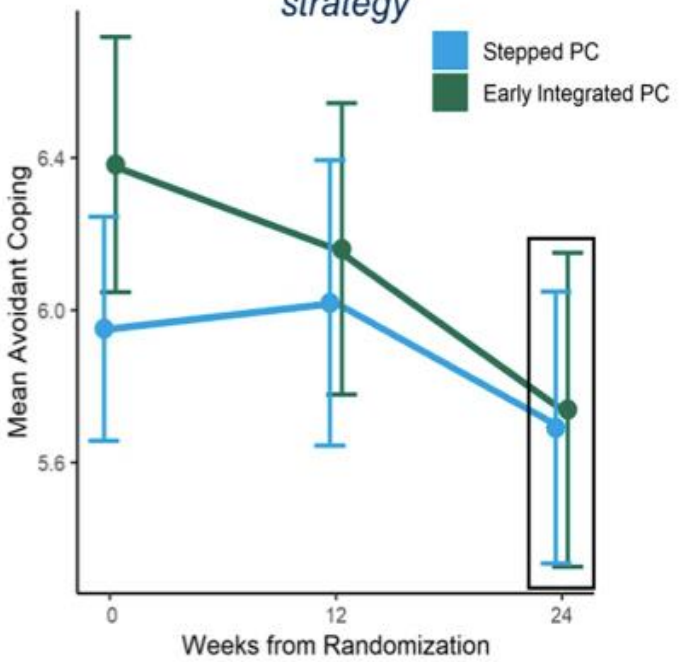
*Higher scores indicate greater use of strategy*




## Avoidant Coping

Difference (95% CI): **0.0 (-0.5, 0.5)**

*Higher scores indicate greater use of strategy*



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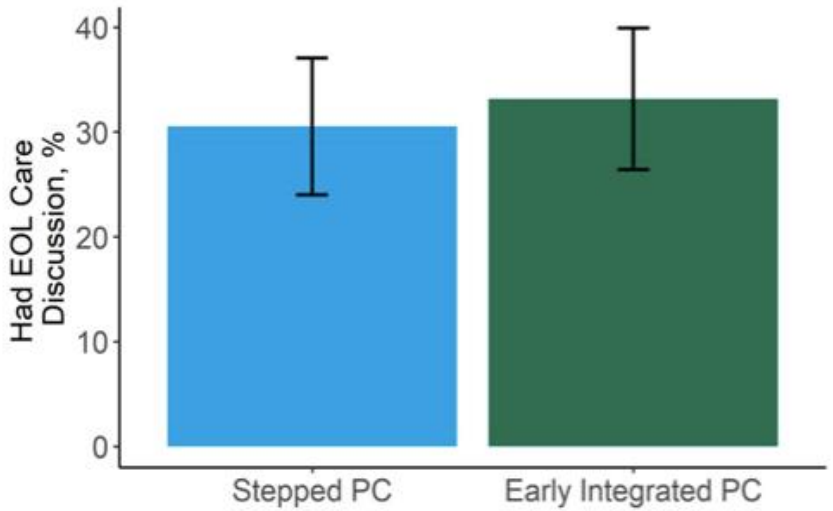
# Patient-Reported End-Of-Life Discussion




*Bars represent "Yes" responses*

## End-of-Life Discussion

Difference (lower one-sided 95% CL): **-2.6% (-10.4%)**

Non-inferiority margin: **-10%**

**p = 0.09* for non-inferiority (secondary outcome)**

** significant at pre-specified 0.15 significance level*

PC = palliative care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# CONCLUSION

**BRAVO TEMEL ENCORE !**

## Modèle de Soins Palliatifs plus EVOLUTIF et ECONOME

- Evolution de pratiques de suivi palliatif et SOS

- *Step 1 : Suivi ?*
- *Step 2 : Accentuation des visites sur les derniers mois de vie avec travail de coordination ville hôpital*

- E SANTE et IDEC ?

ON PRÉPARE LE TERRAIN POUR 2024
DELIGNE

2024 ASCO ANNUAL MEETING

# Risk Prediction Model for Taxane-Induced Peripheral Neuropathy (TIPN) in Patients with Early-Stage Cancer Receiving Taxane Therapy: SWOG S1714

Meghna S. Trivedi, Joseph M. Unger, N. Lynn Henry, Amy K. Darke, Daniel L. Hertz, Thomas H. Brannagan, Stephanie J. Smith, Bryan P. Schneider, William J. Irvin Jr, Amanda R. Hathaway, Amy C. VanderWoude, Vinay K. Gudena, Paula Cabrera-Galeana, Mary Orsted, Michael LeBlanc, Michael J. Fisch, Dawn L. Hershman

SWOG CANCER RESEARCH NETWORK

NCI National Clinical Trials Network
a National Cancer Institute program

NCI Community Oncology Research Program
A program of the National Cancer Institute of the National Institutes of Health



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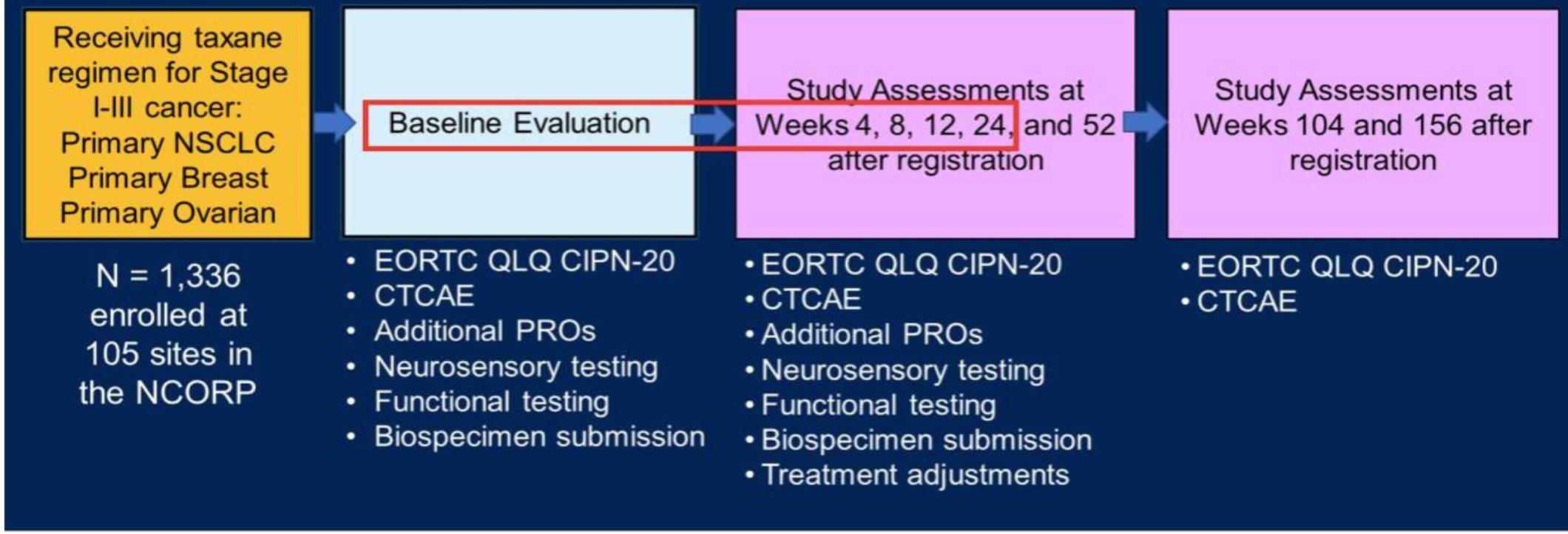
# S1714: A prospective observational cohort study to develop a predictive model of taxane-induced peripheral neuropathy in cancer patients

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PRESENTED BY: Meghna S. Trivedi, MD, MS

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NCT# 03939481

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# RESULTS: Training Set



- In the training set, adverse risk factors for TIPN were:
  - Receipt of paclitaxel (vs docetaxel)
  - Stage 2/3 (vs 1) disease
  - Planned duration of taxane >12 weeks (vs ≤12 weeks)
  - Comorbidity: (≥1 vs none)
    - Diabetes, autoimmune disease, or moderate kidney disease
  - Race/Ethnicity: (vs non-Hispanic White or Asian)
    - Black, Native American, Pacific Islander, multiple race
    - Hispanic ethnicity

| | Overall cohort N=1278 | Low risk: 0-1 risk factors N=267 (35%) | High risk: ≥ 2 risk factors N=501 (65%) | p value |
|---|---|---|---|---|
| % experiencing TIPN | 62% | 48.7% | 70.9% | <.001 |


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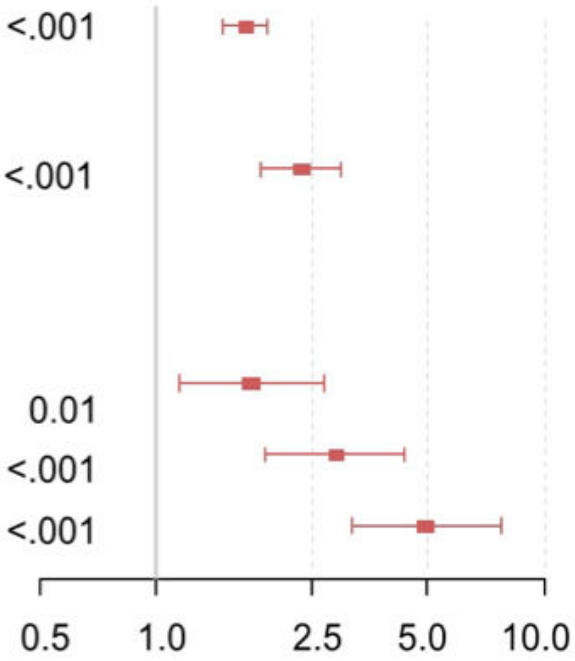
# Odds of TIPN by model type



| Risk Model | Number of Risk Factors | Odds Ratio (95% Confidence Interval) | p-value |
|---|---|---|---|
| **Ordinal Increase** | | | |
| Per Additional Risk Level | Q1 vs. Q2, Q2 vs. Q3, etc. | 1.69 (1.49-1.92) | <.001 |
| **2-level Model** | | | |
| High Risk | >Median vs. <Median | 2.36 (1.86-2.99) | <.001 |
| **4-Level Model (Quartiles)** | | | |
| Low Risk | 0 factors | [reference] | |
| Low-Intermediate Risk | 1 factor | 1.75 (1.14-2.69) | 0.01 |
| High-Intermediate Risk | 2 factors | 2.89 (1.91-4.35) | <.001 |
| High Risk | 3-5 factors | 4.93 (3.17-7.68) | <.001 |

C-statistic for the 4-level risk prediction model: 0.63 (95% CI, 0.60-0.66)





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ALLIANCE FOR CLINICAL TRIALS IN ONCOLOGY

# Alliance 222001: A Randomized, Double-Blind, Placebo-Controlled Study of Oxybutynin versus Placebo for the Treatment of Hot Flashes in Men Receiving Androgen Deprivation Therapy

Brad J. Stish, Gina L. Mazza, Jones T. Nauseef, Michael Sandon Humeniuk, Thomas J. Smith, Cindy Tofthagen, Dayssy Alexandra Diaz Pardo, Christopher Chay, Andrew Huang, Kushal Naha, Scott T. Tagawa, Selina Chow, Lucile L. Adams-Campbell, Paul J. Novotny, Charles L. Loprinzi

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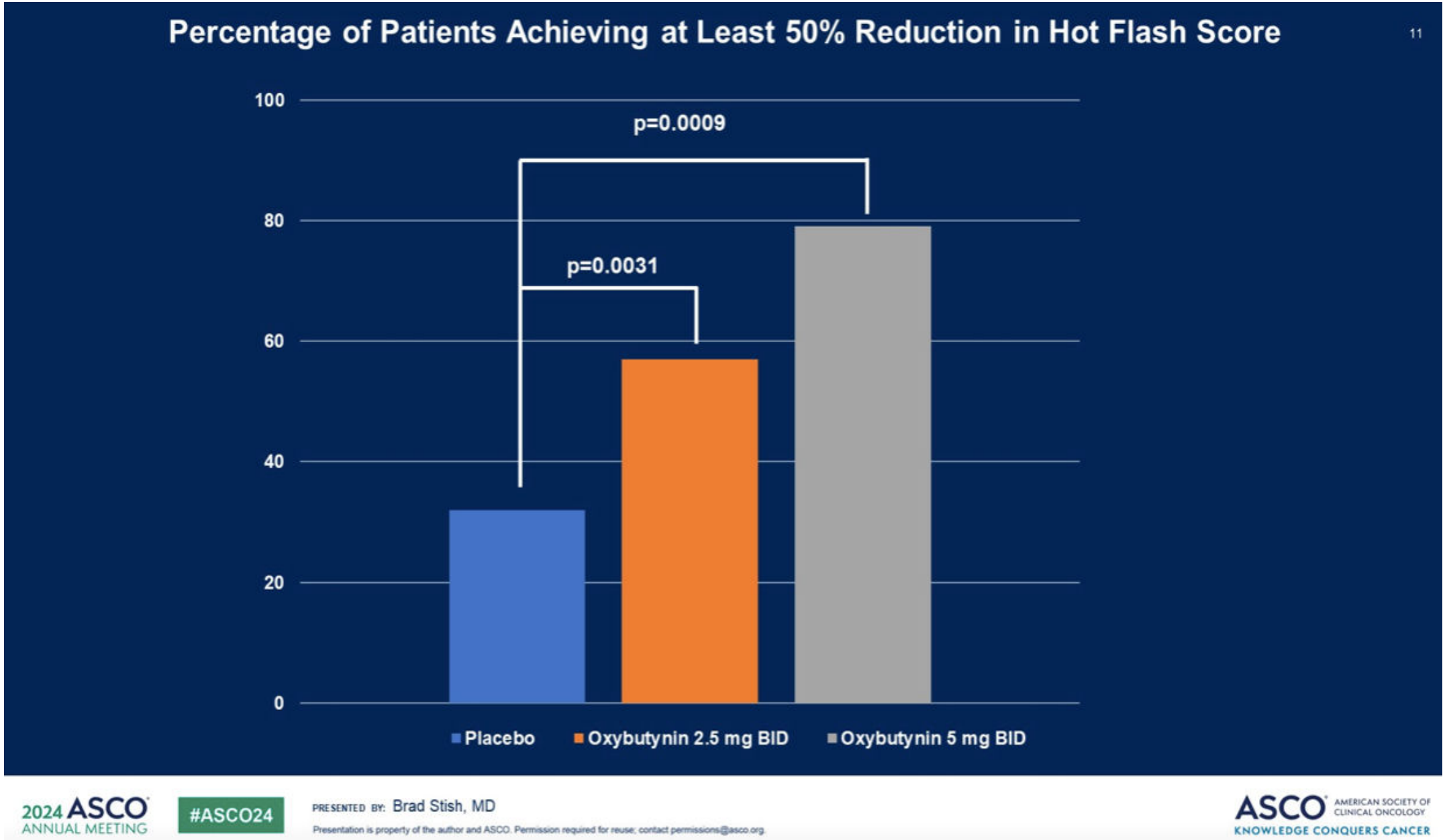
Percentage of Patients Achieving at Least 50% Reduction in Hot Flash Score
11
100
80
60
40
20
0
p=0.0009
p=0.0031
Placebo
Oxybutynin 2.5 mg BID
Oxybutynin 5 mg BID
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