Primary Care Management of Colorectal Cancer

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Primary Care Management of Colorectal Cancer Survivors

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**In compliance with accreditation, we require the following disclosures to the session audience:**

<table>
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<tr>
<th>Category</th>
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<td>Research Support/P.I.</td>
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<td>Honoraria</td>
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<td>Scientific Advisory Board</td>
<td>Roche, Sanofi, Celgene, Amgen</td>
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Presentation includes discussion of the following off-label use of a drug or medical device: N/A
Outline

- Review advances in the management of CRC
- Discuss short and long term toxicities related to treatment
- Survivorship
  - Monitoring for recurrence
  - Psychosocial issues
  - Other health issues
Colorectal Cancer:
A wide spectrum of outcomes

Stage I-III

Stage IV resectable

Stage IV unresectable
CASE 1

- 52 y.o female noted found to have colon cancer on screening colonoscopy

- CT scan shows no evidence of metastatic disease

- Undergoes resection- T3N1 moderately differentiated adenocarcinoma (2/14 lymph nodes positive)
Case 1 continued

- Patient receives adjuvant FOLFOX for 12 cycles (6 months)

- Issues with peripheral neuropathy affecting hands and feet

- Also significant fatigue
Case 1 continued

- Restating CT scan normal
- After 1 year of follow up, repeat colonoscopy normal
- CT scan at 1 year normal
- Fatigue resolved, peripheral neuropathy improved but still noticeable
CASE 2

- 61 y.o male presents with abdominal bloating
- CT scan shows lung, liver, and nodal metastasis
- CEA 300, ECOG PS 1
Case 2 continued

- Started on 1\textsuperscript{st} line FOLFIRI-Bevacizumab
  - Good response initially
  - Remain on treatment for 16 cycles
  - After 16 cycles CT shows Disease Progression
Case 2 continued

- Changed to FOLFOX second line
  - Initially stable disease
  - Progressive disease after 10 cycles
Case 2 continued

- KRAS Wild Type
  - Given panitumumab
  - Initially partial response
  - Progressive disease after 14 cycles
Case 2 continued

- ECOG remains 1

- Options:
  - Best supportive care
  - Clinical trials (phase I?)
Agents available for the treatment of CRC in 2000

BSC  5-FU
Agents now available for the treatment of CRC

- BSC
- 5-FU
- Irinotecan
- Oxaliplatin
- Bevacizumab
- Cetuximab
- Regorafenib
- Panitumumab
Overall Survival for all Pts Referred with mCRC at BCCA

Median OS: 13.8 mos (03/04) to 17.3 mos (06)
**Chemotherapy for metastatic disease**

- Median OS: 18.6 mos (03/04) to 23.6 mos (06)

**No chemotherapy for metastatic disease**

- Median OS: 6.1 mos (03/04) to 5.9 mos (06)
Metastatic CRC patients: Long term survival

![Graph showing survival probability over time for different groups of patients based on prognostic scores.]

<table>
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<tr>
<th>Prognostic Group</th>
<th>Score</th>
<th>3yOS (%)</th>
<th>5yOS (%)</th>
<th>Median OS (months)</th>
<th>HR (95%CI)</th>
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<tr>
<td>Good</td>
<td>0-3</td>
<td>35.7</td>
<td>22.8</td>
<td>33.6</td>
<td>Ref</td>
<td>Ref</td>
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<tr>
<td>Moderate-good</td>
<td>4-5</td>
<td>33.9</td>
<td>11</td>
<td>25.9</td>
<td>1.47 (1.0-2.1)</td>
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<tr>
<td>Moderate-poor</td>
<td>6-8</td>
<td>14.7</td>
<td>6.4</td>
<td>17.1</td>
<td>2.31 (1.6-3.3)</td>
<td>&lt;0.0001</td>
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<tr>
<td>Poor</td>
<td>9-15</td>
<td>2</td>
<td>0</td>
<td>10.4</td>
<td>5.92 (4.0-8.7)</td>
<td>&lt;0.0001</td>
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Benefit of Metastasectomy

Product-Limit Survival Estimates
With Number of Subjects at Risk

- Resection/Chemo
- Resection/No Chemo
- No Resection/Chemo
- No Resection/No Chemo

Survival Probability vs. Survival time

548 195 82 39 26 15 9 7 6 5 4 3 3 3 2
1238 879 515 288 140 75 46 28 18 12 8 8 6 4 4 4
39 27 21 13 9 7 6 5 3 2 1 1 1 1 1 0
257 248 215 179 115 75 55 42 32 18 8 7 4 4 4 2

Survival time
Treatment of CRC

- Major advances in adjuvant and metastatic setting in last decade
- Patients are living significantly longer
- Some new agents associated with long term toxicity
- Metastasectomy associated with long term survival
What Does “Cancer Survivor” Mean?

- Cancer survivors typically refer to:
  - Patients who are alive and well more than 2 to 5 years following their initial cancer diagnosis date
  - Patients who have completed all of their active anti-cancer therapies (e.g. chemotherapy, radiation, surgery)
  - Patients without any current evidence of the cancer coming back
  - (However, definitions can vary)
Who Are Our Cancer Survivors?

• More than 1 in 3 Canadians will be diagnosed with cancer at some point in their lifetime

• About 1.1 million Canadians report having a personal history of cancer

• Number of cancer survivors will increase sharply over the next 2 to 3 decades

• Majority of patients diagnosed with cancer will be elderly (age >70 years)

• Most common: breast, prostate, and colorectal
Why is cancer survivorship care important?

- Aging general population
- Better treatment → better outcomes
- More complex complications
For many colorectal cancer patients, cancer is now a CHRONIC disease...
What are Reasons for Our Success?

- Improved colorectal cancer screening
  - More people are routinely getting stool tests and colonoscopies
- New drugs and better treatments
  - More effective for cancer and less toxic for the body
- More coordinated follow-up to detect when cancers come back
- Increased patient engagement and knowledge
- Prevention of second cancers
But What Are the Potential Costs?

• Interpersonal relationships
  • Partner/spouse/family/peers/colleagues

• Emotional and mental health
  • Anxiety/depression

• Other medical conditions
  • High blood pressure

• Return to school and employment
  • Missed work and finances
BC Cancer Agency Focus Group

• What are the important issues to you as colorectal cancer patients and survivors?
Main Concern #1

1. Wanting more information from the health care team regarding diagnosis, treatment, and survival

“As a patient, you’re trying to organize things and plan for the big picture, right? The medical system is exactly opposite. In other words, we will do this first test and see how it goes... and then we can go to step 2, you know, once we know how the first test goes. But you’re trying to think about steps 5, 6, and 7 several months out.”
What Is Being Done?

1. Wanting more information from the health care team regarding diagnosis, treatment, and survival

- Developing patient-related materials
- Improving BC Cancer Agency website – www.bccancer.bc.ca
- Pamphlets from Canadian Cancer Society, etc.
- Involving family and friends for support and during physician visits
- Communication between members of health care team critical
Main Concern #2

2. Significant distress from (physical) side effects

“*I had it (peripheral neuropathy) in my hands and I still have it in my feet, even a year later.*”

“I still wear gloves most of the time as a precaution. *If I am driving in the car and it is cold outside, I just always carry a pair of gloves with me.*”
What Is Being Done?

2. Significant distress from (physical) side effects

• Group teaching sessions before treatment
• Talking with nurses before/during/after your treatment
• Education of health care team about management of side effects
• Ongoing studies to look at better ways to control or reduce the severity of side effects
Main Concern #3

3. Challenges adjusting to life after treatment

“I withdrew personally from everybody for at least a year. I needed a lot of time trying to get my head around it all... and recover.”

“It just felt like you were a ball being dropped.”

“When you’re done, there’s nothing. It was kind of like bang, that’s it. You’re out of here. You’re not important any more... that’s kind of how you feel.”
What Is Being Done?

3. Challenges adjusting to life after treatment

- Patient and family counselling
- Social work
- “Cancer Transitions” program
- Communication within health care team critical
What Have We Learned?

• Survivorship care is often neglected by physicians and patients
  • Unclear **which** physicians to approach for help

• Cancer recurrence, second cancers, and cancer treatment side effects are most concerning to cancer survivors
  • Unsure about **what** and **when** tests should be done

• Some patients lack understanding and support during follow-up care
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Who Does What?

- Survivors want their physicians to help with the following:
  - Is the cancer going to come back (e.g. recurrence) and if so, when?
  - When are the side effects going to disappear (e.g. toxicities)?
  - What about all of my other medical conditions (e.g. comorbidities)?
  - Who is going to prevent me from developing other cancers and other problem (e.g. preventive health)?
Patient and Physician Roles

Patient

Family Physician

Oncologist
Physician Roles

- Most patients prefer a “shared” care model; this is also most logistically feasible

- **Oncologist:**
  - Side effects of cancer treatment
  - Look for cancer recurrence

- **Family physician:**
  - Look for cancer recurrence
  - Take care of other medical conditions
  - Screening for other cancers
  - Refer back to oncologist when necessary
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The First Month (Radiation)

• Physical
  • Fatigue
  • Burn-like skin irritations and a higher risk for infection
  • Pain and swelling

• Psychosocial
  • Coping with the return to a normal routine
The First Year (Chemo)

- **Physical**
  - Fatigue
  - Taste changes
  - Numbness and tingling of fingers and toes (also known as “peripheral neuropathy”)

- **Mental**
  - Chemo-fog or chemo-brain

- **Psychosocial**
  - Coping with the return to a normal routine
Chemotherapy Induced Neuropathy

Hands

Feet

Long term neurotoxicity
**Prevention of CIPN**

There are no established agents recommended for the prevention of CIPN in patients with cancer undergoing treatment with neurotoxic agents. This is based on the paucity of high-quality, consistent evidence and a balance of benefits versus harms.

Clinicians should not offer the following agents for the prevention of CIPN to patients with cancer undergoing treatment with neurotoxic agents:

- Acetyl-L-carnitine (ALC)
- Amifostine
- Amtriptiline
- CaMg for patients receiving oxaliplatin-based chemotherapy
- Diethylthiocarbamate (DDTC)
- Glutathione (GSH) for patients receiving paclitaxel/carboplatin chemotherapy
- Nimodipine
- Org 2766
- All-trans-retinoic acid
- Recombinant human leukemia inhibitory factor (rhuLIF)
- Vitamin E

*Venlafaxine is not recommended for routine use in clinical practice. Although the venlafaxine data support its potential utility, the data were not strong enough to recommend its use in clinical practice, until additional supporting data become available.*

*No recommendations can be made on the use of N-acetylcysteine, carbamazepine, glutamate, GSH for patients receiving cisplatin or oxaliplatin-based chemotherapy, goshajingan (GIG), omega-3 fatty acids, or oxycarbazepine for the prevention of CIPN at this time.*
Treatment of CIPN

For patients with cancer experiencing CIPN, clinicians may offer duloxetine.

No recommendations can be made on the use of:

- ALC, noting that a positive phase III abstract supported its value, but this work has not yet been published in a peer-reviewed journal, and a prevention trial suggested that this agent was associated with worse outcomes.

- Tricyclic antidepressants; however, based on the limited options that are available for this prominent clinical problem and the demonstrated efficacy of these drugs for other neuropathic pain conditions, it is reasonable to try a tricyclic antidepressant (eg, nortriptyline or desipramine) in patients suffering from CIPN after a discussion with the patients about the limited scientific evidence for CIPN, potential harms, benefits, cost, and patient preferences.

- Gabapentin, noting that the available data were limited regarding its efficacy for treating CIPN. However, the panel felt that this agent is reasonable to try for selected patients with CIPN pain given that only a single negative randomized trial for this agent was completed, the established efficacy of gabapentin and pregabalin for other forms of neuropathic pain, and the limited CIPN treatment options. Patients should be informed about the limited scientific evidence for CIPN, potential harms, benefits, and costs.

- A topical gel treatment containing baclofen (10 mg), amitriptyline HCl (40 mg), and ketamine (20 mg), noting that a single trial indicated that this product did decrease CIPN symptoms. Given the available data, the panel felt that this agent is reasonable to try for selected patients with CIPN pain. Patients should be informed about the limited scientific evidence for the treatment of CIPN, potential harms, benefits, and costs.

# The First 5 Years

## Standard Colorectal Cancer Surveillance Guidelines

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<tr>
<th></th>
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</tr>
<tr>
<td>Scope</td>
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*In general, additional tests are NOT routinely required*

- If the patient is not a candidate for metastatectomy, CEA and routine imaging studies are not recommended as there is little to no utility in diagnosing an early metastatic recurrence in an asymptomatic patient.
What Have We Learned?

- Survivorship care is often neglected by physicians and patients
  - Unclear which physicians to approach for help
- Cancer recurrence, second cancers, and cancer treatment side effects are most concerning to cancer survivors
  - Unsure about what and when tests should be done
- Some patients lack understanding and support during follow-up care
Care Team is Critical

Patient

Family Physician

Oncologist
What else can I do?

What is the role of:

- Diet
- Exercise
- Chemoprevention

NCIC CO21
Summary

- Significant improvement in therapy for CRC
- Growing numbers of cancer survivors
- Communication within the health care team is critical
Survey: Primary Care Physicians

Aim:
• To assess awareness about pancreatic cancer among primary care physicians
• To develop ideas and plan strategies on how to improve patient care.

To complete the survey:
• Go to http://pancreascentrebc.ca/
• Click on News & Events

Pancreatic Cancer: GP Survey

15. If a pancreatic lesion is identified on imaging, what would you do next?

- Refer the patient directly to a medical oncologist
- Refer the patient to an internist
- Refer the patient to a general surgeon
Questions?