Ineffective oncology therapy vs. quality of life in advanced cancer

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Quality in oncological treatment

- Clear concept, applied in medicine, after being verified in various fields…
- Quality offered vs. expected quality.
- Providers' perception vs. patients' perception.
- Extremely high level of expectation from patients.
- The medical field - zero tolerance for errors.

Multidisciplinary / multimodal cancer treatment

- Reference level regarding the quality of care in oncology.
- Transition to personalized therapy…
- Choosing the most suitable therapeutic sequences for each patient!
  - The most expensive drugs?
  - Cutting-edge therapeutic technologies?
- JUST treatments that can benefit and improve or at least preserve a level of quality of life!
  - Sometimes the cancer patient only needs (palliative) care!

Tumour board in oncology

- Necessity, in the 21st century.
- Multimodal cancer therapy: oncological surgery + medical oncology + radiotherapy.
- The patient as a whole, not just the treatment part of each specialty.
- Oncological therapy = a whole / collaboration between specialists.
- Patient benefits: guaranteed minimum level, different locations, etc.
- Medical advantages: professionalism, common language, medico-legal!

Decision in tumour board

- Assumed by the whole team.
- Takes into account the possibility of applying some therapies:
  - Limitation of irradiation (previously irradiated patient)
  - Limitation of chemotherapy etc.
- Communicated, discussed and accepted by the informed patient!

- N.B. - The patient's right to a second opinion!

Multidisciplinary team in cancer treatment

- COMPULSORY !
- Correct diagnosis and staging of each case!
- Evaluation in tumour board:
  - oncology surgeon,
  - medical oncology specialist,
  - radiation therapy specialist.
- At least for patients with advanced disease – the palliative care specialist !

A series of 6 cases …

to discuss, or just meditate, on the optimal decision!

Case 1

- Male patient, 40 years old, suddenly…
- Unresectable brain tumour (2 opinions!)
- However: suboptimal resection (R1), without oncological value.
- Postoperative bleeding, reintervention, postoperative stroke…
- He returns home with right hemiparesis, ECOG = 3.
- Palliative care (discussions on chemotherapy...)
- Death after 3 months.

Discuss case 1

- The very high cost of the intervention, in a private hospital.
- The decision to accept the intervention: the patient's (especially) and the family's.
- Alternatives: gamma-knife…..
- Correctly informed patient: yes (doctor!)
- Questions for the doctor who performed the operation...
    - No tumour board.

Case 2

- Male patient, 68 years old, treated for iron deficiency anaemia.
- Sub occlusive colon tumour, M1 HEP.
- Right hemicolectomy.
- But: liver full of M1 (much worse than preop. CT scan said).
- Evolution without surgical complications, discharged.
- Progressive liver failure, no chemotherapy..
- Death within a month!

Discuss case 2

- The difficulty of the therapeutic decision.
- Informed consent, both the patient and the family even insisted on surgery…
- Alternatives: endoscopic stenting. It would have prevented the occlusion, it would probably not have influenced the anaemia.
- After the patient's death, the family expressed their displeasure because he was operated on...
    - Tumour board evaluation was done.

Case 3

- Female patient, 38 years old.
- Locally advanced breast cancer, chemo treated, then operated.
- Almost a year of good evolution, no complaints.
- Then a single metastasis in the cerebellum (3 cm.)
- Without swallowing, PEG was needed, ECOG 3.
- Operated, without any improvement or oncological benefit.
- Death in 3 weeks.
- No tumour board at this stage.

Discuss case 3

- High surgery costs (private hospital), debts for the family...
- 2 opinions contraindicated the intervention (!)
- Alternatives: palliative care.
- Correct and constant communication with the family.
- The life-saving neurosurgeon was discovered with the help of social media, promotion and fundraising campaign for the operation...
- The family's motivation (after the patient's death): the desperation to save her at any cost!

Case 4

- Male patient, 48 years old.
- Cancer of the esogastric junction, M1 HEP (3 lesions) , M1 PULL uncertain.
- Significant nutritional deficit.
- Total esogastrectomy and triple liver metastasectomy.
- Serial postoperative complications (fistula).
- Death in 6 weeks, after numerous medical procedures.

Discuss case 4

- The operation did not bring quality and shortened life.
- Correctly informed patient, he even insisted on the operation.
- Alternative: gastrostomy/ jejunostomy and palliative care.
- Did the fact that the patient and the surgeon were good friends matter in the decision-making process?
- Tumour board was done, after discussions, surgery was chosen...
  - The opinion for palliative care was not taken into account...

Case 5

- Female patient, 54 years old.
- Neglected breast cancer, locally advanced, M1 HEP, M1 PULL.
- Puncture biopsy.
- Aggressive salvage chemotherapy.
- ECOG 3, combination between the evolution of the disease (M1 HEP) and the side effects of chemotherapy.
- Death during the 3rd series of chemotherapy.

Discuss case 5

- Pressure from the family to save the patient.
- Communication deficits.
- The patient was not included in the decision-making process, but signed the consent...
- The family knew about the patient's illness, which they neglected. Then suddenly the desire to save her appears... unresolved conflicts in the family.
- Tumour board wasn’t done.

Case 6

- Female patient, 51 years old.
- Locally advanced cervical cancer (T3N1M0), radiotherapy and chemotherapy, operated, 6 months good evolution.
- Pelvic exenteration for invasive recurrence in the pelvis.
- Colostomy, double nephrostomy.
- 1 month in hospital!
- Death in 2 months postoperatively.

Discuss case 6

- Quality of life ? Triple stoma !
- Would survival have been longer without the second surgery?
- Oncological benefit = 0, suboptimal resection (R1).
- Informed consent of the patient (+/-…)
- Alternatives: palliative care, maybe some chemotherapy.
    - Tumour board was done (second time).
    - The opinion for palliative care was not taken into account...

The importance of communication in oncology

- Patient and family, as a care unit.
- A second opinion... sometimes the need for a second opinion!
- Informed consent - real or just formal?
- Did the patient / family fully understand the consequences of performing or not performing the treatment?
- The role of palliative care – the often ignored non-medical aspects!

Therapeutic standard

- It ensures a guaranteed minimum level for all patients.
- We discuss cutting-edge technologies, state-of-the-art drugs and the transition from multimodal treatment to personalized therapy in oncology.
- But let's not forget that each patient must benefit from a correct / complete diagnosis and access to the most suitable therapeutic scheme for that case...
  - Could be a classic treatment or even just palliative care, for some / many patients!

Ethical dilemmas

- The correct evaluation in the tumour board.
- The choice of treatment and who did it.
- Communication with the patient and family.
- Presentation of therapeutic options.
- Second opinion.
- Other considerations: -clinical studies,
  -pharma industry,
  -medical equipment manufacturers etc.

Before conclusions …

- The desire / expectations to cure or treat cancer at any cost.
- Disease staging and prognosis.
- Consequences and side effects of therapy.
- The need for patient care.
- The importance of communication issues in oncology.
- The need for realistic expectations vs. oncological disease.
- Ethical dilemmas regarding performing or refraining from a certain treatment.

Instead of conclusions

- Personalized cancer treatment = being able to give each patient the type of care needed !
- The optimal risk / benefit ratio - will always be a challenge.
- A basic principle of palliative care is to focus on what can still be done, what can still help.
- And the Hippocratic Oath reminds us: "primum non nocere..."

Thank you !

- *About* - oncological surgery,
  - palliative care,
    - quality management in health care…

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