An Experience with Managing Cancer Patients Reportedly Previously Informed of the Absence of Additional Available Antineoplastic Therapeutic Options

George River^a Stephanie Moore^a Jennifer Tucker^a Maurie Markman^b

^aCancer Treatment Centers of America, Southwestern Regional Medical Center, Tulsa, Okla., and ^bCancer Treatment Centers of America, Eastern Regional Medical Center, Philadelphia, Pa., USA

Key Words

Cancer management · Antineoplastic therapy · Second opinion

Abstract

Over the past 5 years, a small group of cancer patients who stated their physicians had determined there were no additional available antineoplastic therapeutic options (including potential investigational strategies) were seen for a 'second opinion' in a cancer hospital-based oncology program and subsequently experienced what can reasonably be characterized as having achieved meaningful 'clinical benefit' (functioning at a fairly high level for a minimum 1 year in the work, home, and/or family environments) following the further delivery of a variety of treatment approaches. While recognized to be limited (or even simply 'anecdotal'), this experience emphasizes several clinically relevant conclusions, including the overall utility of a 'second-opinion' strategy and the potential that the reported statement of an individual practitioner or cancer program that all rational options have been attempted may be inaccurate.

© 2014 S. Karger AG, Basel

Introduction

It is well recognized that during the cancer journey it is unfortunately common that cancer patients no longer have treatment strategies available based on nationally recognized

Maurie Markman
Cancer Treatment Centers of America
Eastern Regional Medical Center
Philadelphia, PA 19124 (USA)
E-Mail maurie.markman@ctca-hope.com

‘treatment guidelines’, there are no reasonable ‘non-guideline’ approaches considered to be medically appropriate, or the individual is either not eligible for participation in a clinical trial or a study is simply not accessible in a given setting.

When cancer patients are informed there are no additional reasonable treatment options available, it is not surprising that there may be a sense of hopelessness and a feeling of abandonment. Over the past several years a number of individuals who self-reported having been informed by their oncologists that they were in such a clinical situation sought a ‘second opinion’ in a cancer hospital-based oncology program (Cancer Treatment Centers of America, Southwestern Regional Medical Center, Tulsa, Okla., USA). One major purpose of the visit was to inquire regarding the availability of other rational therapeutic options, versus a strategy that focused exclusively on providing essential comfort (e.g., pain management) measures.

We report here the brief clinical histories of a very small group of patients primarily managed by one oncologist (G.R.) at this center over the preceding 5 years whose subsequent clinical course challenges the conclusion that the reported pronouncement (as understood by the patient/family) of the absence of therapeutic options by an individual clinician is necessarily accurate.

Case 1

C.K., a 56-year-old female, had developed progressive abdominal pain which led to an ovarian cancer-type surgery in 2006, with removal of large amounts of cancer in the abdomen, confirmed to be a malignant gastrointestinal stromal tumor. Imatinib was initiated, but the patient experienced almost immediate gastrointestinal distress and abnormal liver function which persisted despite appropriate dose reductions. Although possible treatment with sunitinib was discussed no additional therapy was initiated. The patient was informed the prognosis was very poor, but no referral for a second opinion was offered.

The patient was first seen at our center in November 2008, quite distressed regarding the absence of options. Sunitinib was initiated, and while side effects were encountered, she was able to continue treatment. The patient remained clinically stable until early 2012 when evidence of locally progressive disease led to the successful performance of chemoembolization. Antineoplastic drug therapy was changed on several occasions due to a variety of side effects, and chemoembolization was repeated in September 2013. The patient is currently receiving regorafenib and remains fully functional more than 5 years after being informed of her anticipated very poor prognosis.

Case 2

M.M., a 58-year-old male, was diagnosed with metastatic colon cancer with documented disease in his liver in June 2012. The patient reported that his medical oncologist had informed him that he would be dead within 1 year without treatment and within 2 years if he received aggressive systemic antineoplastic therapy.

When seen at our center the patient was documented to have bilateral liver metastases. He was started on a standard combination chemotherapy regimen, followed by single-agent maintenance treatment (capecitabine), achieving an excellent objective and symptomatic

response while experiencing relatively moderate but tolerable side effects. Of note, during treatment and continuing until the present, the patient has been able to work full-time.

Case 3

P.C., a 64-year-old female, was diagnosed with node-positive cecal carcinoma in 2007. She received adjuvant chemotherapy but unfortunately experienced recurrence in early 2008. Additional chemotherapy was poorly tolerated and surgical exploration in June 2009 confirmed progressive cancer. At this point the patient stated she was informed she had 3 months to live.

The patient underwent surgical resection of several mesenteric masses when first seen at our center. Chemotherapy was again initiated, but when subsequent evidence of local recurrence was noted, an additional surgical resection (November 2009) was undertaken. A subsequent surgery (June 2010) performed to repair a defect in the abdominal wall and to help manage a local infection revealed no active cancer. The patient continues to be observed without active therapy.

Case 4

R.M., a 44-year-old male, was diagnosed with a carcinoid tumor and liver metastases in 1993. He was treated with octreotide, several hepatic embolizations and subsequently sunitinib (without response). The patient was reportedly informed there was nothing more that could be done for his disease in early 2010.

When first seen at our center his bilateral liver metastases were treated with chemoembolization. For the last 4 years his local recurrences have been successfully managed with external beam radiation and liver-directed radioisotope therapy.

Case 5

T.J., a 45-year-old female, was found to have node-positive adenocarcinoma of the gall bladder in 2009. She developed recurrent disease in November 2011 and required a percutaneous biliary stent. External beam radiation to the porta hepatis and combination chemotherapy were administered, but the obstruction persisted. The patient reported she was informed that nothing more could be done.

When seen at our center in February 2012 the serum bilirubin was 7.6 mg/dl. Following additional local interventions biliary drainage was improved with the bilirubin falling into the normal range. A subsequent balloon dilatation was successful in favorably impacting a stricture, allowing for the removal of a percutaneous stent and elimination of narcotic pain medications. Local management continues 2 years after the patient was informed no further interventions were possible.

Case 6

F.S., a 57-year-old male with no smoking history, was diagnosed with adenocarcinoma of the lung in December 2009 managed with a lobectomy and adjuvant platin-based

chemotherapy. In February 2011 a lung biopsy revealed a bronchoalveolar carcinoma. Erlotinib was administered, but with evidence of progressive cough and shortness of breath the patient stated he was informed there was nothing more that could be done.

When first seen at our center in early 2012 it was determined that the current symptoms were likely related to lung damage from aspiration due to acid reflux. Aggressive anti-aspiration therapy led to a marked decrease in pulmonary symptoms. The patient was subsequently treated with several chemotherapy regimens and at the present time remains relatively symptom free and in a clinical remission 2 years after reportedly being informed there was nothing more that could be done to improve his condition.

Case 7

K.G., a 46-year-old female, was diagnosed with widely metastatic breast cancer to bone (spine and ribs) in November 2008. She was started on hormonal therapy and received radiation to a number of bony lesions. The patient was reportedly informed chemotherapy was not indicated. In addition the patient underwent an oophorectomy. She remained clinically stable until mid-2010 when severe diffuse bone pain developed. Additional hormonal therapy was administered without evidence of pain relief. At this time the patient was reportedly informed there was nothing more that could be done.

The patient came to our center in January 2011 in severe pain. Bone marrow biopsy revealed the presence of metastatic cancer. Chemotherapy was initiated. Although there was an initial response, the disease was demonstrated to have progressed in the liver in October 2011. The patient underwent chemoembolization which stabilized her liver lesions. Unfortunately, the disease subsequently progressed in early 2013. The patient died in March 2013, 2 years after reportedly being informed there was nothing that could be done for her progressive breast cancer.

Discussion

While admittedly completely speculative, one of the reasons the patients discussed in this report elected to leave their original oncologists, seek a second opinion, and subsequently receive therapy at a different center is the observation that with an increasing reliance on computer algorithms and treatment guidelines, coupled with time pressures, there has been a distressing reduction in the effort undertaken by many clinicians to analyze and consider management approaches that may provide clinically meaningful (even if limited in duration) outcomes for the often difficult and highly complex problems encountered among cancer patients.

If one accepts the statements reported by these patients (and we have no reason to do otherwise), their previous almost certainly well-intentioned medical oncologists spent very little time with them in the examination room (often less than 15 min) and far more time recording 'data' (possibly as required for billing purposes).

The American Society of Clinical Oncology has issued generally helpful guidelines designed to assist busy clinicians in their decision-making processes [1]. Unfortunately, overreliance on such scripted statements has the potential to seriously exacerbate the concern that all reasonable options have *not* been considered. For example, consider the following admonition: 'Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-

based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment' [1].

The question to be asked here is who should be making these decisions? It is absolutely appropriate for a clinician at a point in the natural history of a given patient's cancer to express the opinion that further therapy designed to impact the future progression of the malignancy is not indicated, and may even be harmful (e.g., produce serious side effects without any positive impact on the cancer). However, in the opinion of the authors of the current report, the decision to follow this 'recommended' course of action versus possible alternative approaches *must be made by the patients* in consultation with their family, other advisors, and physicians rather than by the oncologists alone.

In summary, while we cannot know what information the oncologists actually gave the individual patients presented in this report regarding the status of their disease and available therapeutic options, from the patient's perspective the doctor/patient communication was surely inadequate and objective data (summarized in this report) suggest clinically meaningful therapeutic options remained available. A 'second opinion', requested by the patient/family or suggested by the primary oncologist, may be helpful in the decision-making process.

Reference

- 1 Cox JV: Five pieces of silver. J Oncol Pract 2012;8:133–135.