International Symposium on Supportive Care in Cancer, MASCC/ISOO 2013, Berlin, Germany

What was hot at MASCC/ISOO Annual Meeting this year?

Plenary “Management of Tumor Related Symptoms”, 28.06.2013

It is widely accepted that people living with a diagnosis of cancer experience higher levels of psychological distress than the general population. “However, cancer is a heterogeneous condition, and recent evidence suggests that although high levels of psychological distress are seen at the time of diagnosis and treatment, people with advanced disease may have similar high rates of anxiety and depression,” said Gary Rodin, Toronto, Canada. Recent research has detected a twelve-fold in increase in suicide (and four-fold increase of cardiovascular mortality) following diagnosis of fatal cancer (Fang F et al. NEJM, 2012). High levels of psychological distress in cancer patients have been directly linked to a decrease in quality of life, reduced medical adherence and increased physical distress. The high prevalence of psychosocial distress in cancer patients is well known. Studies showed that more than one third of cancer patients have symptoms of psychological distress (Fallowfield L et al. Br J Cancer 2001; Werner A et al. Psycho-oncology 2011). On the other hand, data suggests that psychiatric morbidity (anxiety and depression) experienced by patients with cancer often remains unrecognized and therefore untreated. Doctors need communication skills training to elicit problems during consultations. Tools monitoring patients’ distress levels including measures of physical symptoms, such as pain, fatigue and nausea, as well as measures of psychological symptoms such as depression and anxiety, and social difficulty are needed. Rodin’s research group has developed the Distress Assessment and Response Tool (DART) which uses the Edmonton Symptom Assessment System (ESAS) for physical symptoms (each visit), the Social Difficulties Inventory (SDI-21) for practical concerns, Patient Health Questionnaire (PHQ-9) for depression and the Generalized Anxiety Subscale (GAD-7) for anxiety. “We also screen if the patients need some more support or if they have suicidal intentions”, said Rodin. The web-based electronic distress screening tool is linked to an interprofessional distress response Care Path, graded to the individual patient’s level of distress.

Psychosocial research in palliative care has grown in rigor and volume over the past several decades, and a variety of novel interventions and screening tools like DART have been developed and evaluated. However, the findings from this research have only just begun to
have an impact on clinical practice in palliative care, Rodin explained. By ensuring that the assessment and treatment focus targets both physical and psychological suffering, cancer care can become more holistic and patient-centered. Rodin closed his lecture with the words of Aristotle: “The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated”.

Most testicular patients survive their cancer therapy. Larry Einhorn, Indianapolis, USA explained the importance of maintaining activity and nutrition in testicular cancer patients. Einhorn pioneered the development of the life-saving medical treatment in 1974 for testicular cancer, increasing the survival rate from 10% to 95%. “Good nutrition and activity are very important for these survivors”. Einhorn said that there are no randomized controlled studies concerning the effects of exercise in men treated for testicular cancer. Nevertheless, a Norwegian study demonstrated that 43% of testicular cancer survivors versus 37% of healthy controls participated in moderate or more physical activity. Einhorn concluded: “I recommend activity to my patients because of prevention and regeneration effects.”

According to the NCCN Guidelines „all cancer patients should be screened for palliative care issues at their first visit with their oncologist and at subsequent, clinically relevant times. “Is screening for palliative care issues in radiooncology reasonable? This question was tackled by the team of the Interdisciplinary Center Palliative Care, Würzburg, Germany, headed by Birgitt van Oorschot. Until now, there was no systematic symptom and distress screening process, neither in the department of medical oncology nor in the radiooncology department. In February and March 2013, 173 patients were screened (77.2 %) in the radiooncology unit. Oorschot said: “There is a high need for secondary assessment in 7 out of 10 patients”.

Furthermore, researchers noticed a higher symptom burden in selected groups (treatment intention palliative, gastrointestinal cancer, physician overestimation of general condition). In the palliative group, there was a higher level of anxiety, pain and fatigue. The new BUKA-project sponsored by the German Cancer Aid is starting in September 2013. The Distress Assessment and Response Tool (DART) will be used as screening tool in patients with advanced and metastatic disease in the department of radiooncology. “We need to create a culture of screening”, van Oorschot said. For the successful implementation of the screening process, a number of unsolved questions such as who is responsible for the secondary assessments and the treatment of symptoms still need to be solved.

Plenary “International Perspectives on Survivorship and Rehabilitation for People with Cancer”, 29.06.2013
Current strategies for survivorship care as well as rehabilitation strategies after the completion of primary cancer therapy were discussed in the session chaired by Hans Helge Bartsch, Freiburg, Germany and Paul Jacobsen, Tampa, USA. As shown by the presentations by Carrie Stricker, Philadelphia, USA, and Jennifer Jones, Toronto, Canada, comprehensive support programs for cancer long term survivors and their families have been available at the big oncology centers in the US and Canada for a long time. These survivorship care programs do not focus exclusively on direct somatic symptoms of patients and psychosocial consequences of cancer and cancer treatment, but also include preventive strategies to improve physical and psychosocial functioning as well as facilitate social reintegration. Besides, close relatives of cancer patients are offered numerous counseling and other support programs.

Comparing cancer rehabilitation structures and programs in various European countries, Bartsch pointed out that there are considerable differences regarding cancer rehabilitation structures and the components of survivorship care. These disparities revealed by the European Cancer Health Indicator Project (EUROCHIP) are due to different social security systems as well as differing perceptions and treatments of acute and subacute consequences of cancer therapy in the medical systems of these European countries. There are also substantial differences with regard to the extent to which rehabilitative and supportive care aspects were taken into account in the national cancer plans of the Euro countries. In comparison with other countries in Europe and the world, Germany is characterized by a dense infrastructure of rehabilitation centers and quality-assured rehabilitation programs for cancer patients with a special emphasis on a holistic approach to the management of physical and psychosocial effects of cancer and tumor treatment. In the discussion of the working group "cancer survivorship" it became apparent that a closer international cooperation within the MASCC can be beneficial for all parties involved.