Pre-congress seminar PRC / EAPC-RN

Cancer Cachexia

Florian Strasser

Kantonsspital St.Gallen

Cancer Cachexia: Assessment and Classification
„content and assessment methodology: PRO‘s“

Cancer Cachexia Framework: key „agreed-on“ features

Experiences from clinical data sets, education, trial design

Challenges to move towards consensual assessment

Patient-reported Outcomes

Next step: formal consensus on assessment

1: Fearon K & Strasser F, et al. Lancet Oncology 2011; 5th february

Cancer Cachexia Framework: key features with „agreement“

From „Anorexia/Cachexia Syndrome“ to

„Muscle loss relevant for physical function, not reversible by nutrition, caused by decreased intake and alt. metabolism“

Domains: Muscle/(Fat)
Nutritional Intake & „Appetite“-Symptoms
Catabolic tumor, inflammation, and hormones
Neuro-muscular and emotional function

Phases reaching from early to refractory (late??) cachexia

Severity described by weight loss and BMI

Fearon K & Strasser F, et al. Lancet Oncol2011

Cancer Cachexia Framework[1]: 16 Months later
Experiences from clinical patient data collections

. few longitudinal, full domains, standard clinical mgmt[2]
. few cachexia clinics, full domains, standard clinical mgmt[3]
. Specialized clinical labs[4]
. Longitudinal, some domains, mgmt usual care[5]
. Cross-sectional, some domains, mgmt usual care[6]

→ Muscle loss → survival
→ Nutritional intake: malnutrition or cachexia?
→ Appetite may re-considered as symptom ≠ Nintake
→ Tumorbiology (dynamics, responsiveness) important

1: Fearon K & Strasser F, et al. Lancet Oncology 2011; 5th february
2: Edinburgh-group , Montreal-group, (both completed, not fully analysed)
3: MDACC (E. DelFabbro; S. Dalal); St.Gallen (not fully analysed)
4: Toronto-group (various publications)
5: Alberta-group (many publications), others
6: EPCRC-CSA-Data; other by several groups (Oslo, Rotterdam, ...)

Cancer Cachexia Framework[1]: 16 Months later
Experiences from Education and Guidelines

Education for oncologists and oncology nurses
→ Picked-up main concepts
→ different ways to assess domains
→ pre-cachexia makes sense, but intervention lacking

Education for palliative care specialists
→refractory cachexia to focus on alleviation, but ...

Books
→ Introduced, partially

1:

Guideline: EPCRC-cachexia: mainly for refractory cachexia
ESPEN (old): not yet updated, follows 2012
Australia

Cancer Cachexia Framework[1]: 16 Months later
Experiences from Clinical Trials

Ongoing clinical trials

. GTx-Phase III: muscle trial, not (really) cachexia

. Amorelin Ph III: cachexia, global, no mgmt standards

. ActRIIb-PhII: cachexia, OAS ≥ 4mts, not refractory
phys. Fct. (Borg≥4), NI >20kcal/>0.6Pr/kg

. Lena/cach: refractory, inflamm. Cachexia

....

Planned clinical trials pre-MENAC: pre-/cachexia, new IV
domain-"specific"

Endpoints: all combined muscle mass & function
? Food intake, symptoms?

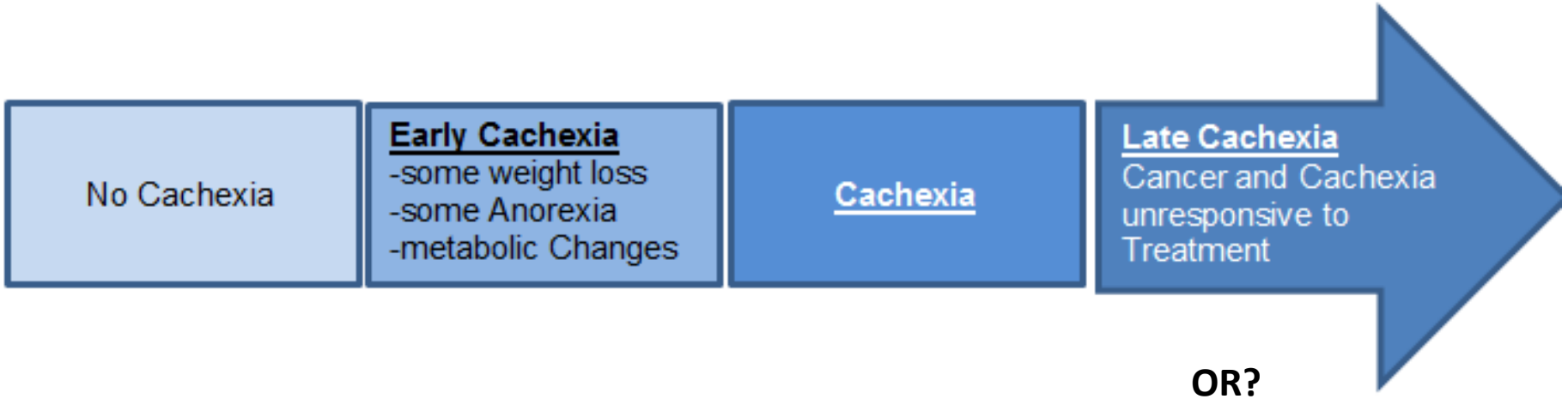
Challenges to move towards consensual assessment
Phases: Biology of cachexia versus Severity

Biological driven Tumor not responsive and/or catabolic active	„late“ cachexia Prognosis < 3 mts „severe“ cachexia

Pat. 43j, Pancreas-ca, Adeno, liver mets,
Bili 36; 4 mts 8% WL, BMI 22; CRP 82

Pat. 53, SCC-HN, refuses chemoth, last tx >2j, WL 18%, 6 mts,
BMI 19, incident pain, PS 3, CRP 2, god waits, family ready

→ Which variables drive clinical judgment?



OR?

Refractory cachexia	Cancer disease: pro-catabolic and not responsive to anticancer treatment. Low performance score. <3 months expected survival

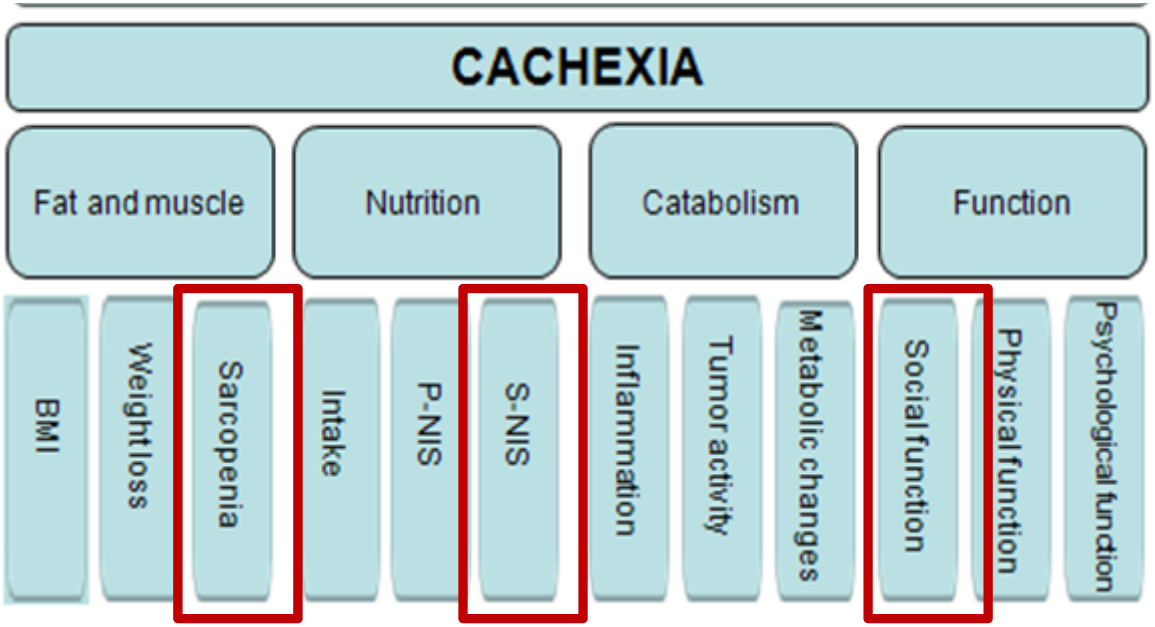
Challenges to move towards consensual assessment
Domains: Clinical Mgmt Standards vs Domains

Clinical Mgmt standards Settings of care S-NIS / Co-morbidities	Various domains „found“ in same patient, incuding different biologies

Pat. 53, SCC-HN, refuses chemoth, last tx >2j, WL 18%, 6 mts, BMI 19, incident pain, PS 3, CRP 2, god waits, family ready

→ Is a domain – description approach helpful to guide mgmt?
→ Can symptom clusters and collections of variables guide?

Vrgl. Pat. bone met lumbal, plexus infiltration left leg, drug addict, existential suffering, anxiety, infection-delir, venous puncture hurts



S-NIS:
SECONDARY
nutitrion impact
symptoms:
Complications of
cancer / treatment
≠ cachexia

Function:
Phenomenology of
the biology **NOT**
impact

OR?

Diagnosing Cancer Cachexia

Screening: Weight loss, BMI, Appetite & Fatigue)

Rule out: Secondary nutrition-impact symptoms

Cachexie "Staging" SIPP

Storage *kg, edema⁺*	Weight loss: compared to usual weight, duration, fluid retention/obesity
Intake *%kcal/EW*	Anorexia, early satiety, chemosensory % normal intake, 1-2 day dietary record,
Potential *Dynamics,CRP*	Tumor [catabolic] activity, Prognosis C-reactive protein
Performance *KPS,Grip,ERD*	Physical functioning, muscle strenght Psychosocial conseqens. & motivation

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Challenges to move towards consensual assessment
Domains: Riskfactors for difficult mgmt versus impact

Physical and/or emotional function decreased Co-morbidities (wheelchair)	Impact of cachexia on physical functioning, on emotions, social role

Pat. 72, RCC, mediastinal, kidney, CRP 210, WL 14.5% / 4 mts, refractory to chemo (3 lines), PS 2, active physical, motivated

→ Is the domain „Potential“ and indicator of (un-) responsiveness of cachexia to multimodal treatment?
→ Impact of the syndrome on various function ≠ same!

Patient-reported Outcomes

→ Is it possible to ask EVERYTHING PATIENT?

Muscle & Fat	Perceived weight loss: not bad by pat. perceived muscle mass if edema..
Perceived nutritional intake	- not same as appetite - not equal: measured
Catabolic drive	Inflammation symptoms Tumor-resistance related symptoms (??)
Performance	Ability of patient to perform physical activ. Patient concious control of eating, moving

Refractory Cancer Cachexia

Biology of cancer and and associated catabolism
(is part of definition of cachexia)

Time left to achieve outcomes (muscle, function) too short
(self-fullfilling prophecy in severe malnutrition)

Other care priorities: no performance physical & emotional

Assessment: next steps

Consensus of clinical & academic experts needed

- Agreements — Principles of framework (Performance?)
  Basic/Screening – Clinical Priority - Research
  Secondary-NIS: are NOT cachexia
- Domains — are from the framework (no new domains)
- Assessments — those used in data collections / trials
  no new SLR‘s of all possible domains
- Consensus — formal Delphi, Levels A/B/C
  Experts: defined (clinical >30%, published)
  . as 2009-2011; new persons
- Results — Clinical flow recommendation
  Management of S-NIS, before diagnosis
  Tool: setting, limits, time frames; validate

7.2012 – 12.2012 ?