

# Supportive Care for Cancer Patients: Progress and Challenges

Harold J. Burstein, MD, PhD

Dr. Burstein is Assistant Professor of Medicine, Harvard Medical School, and a medical oncologist in the Breast Oncology Center, Dana-Farber Cancer Institute, Boston, Massachusetts.



**S**upportive care for patients with cancer has changed dramatically in recent years. Two key factors have driven the tremendous progress in helping patients endure their treatments. First, there has been growing awareness

that patients with cancer need and deserve appropriate supportive care. Supportive care is truly a patient-centered enterprise and reflects the priority now given to the quality of life and daily function of people suffering from cancer. Patients and their families expect to enjoy reasonably well-preserved quality of life during cancer treatment, and these expectations are both appropriate and increasingly realistic.

Second, this focus on the patient's treatment experience has been matched by the availability of new drugs to help minimize treatment-related side effects of chemotherapy. Newer antiemetic medications introduced in the 1990s revolutionized oncology practice and helped move chemotherapy from the inpatient to the outpatient setting for most solid tumor types and many lymphomas and leukemias. The advent of the growth factor era in the late 1990s furthered this trend, reducing the need for hospitalization from infectious complications and helping to minimize fatigue and preserve functioning in patients with anemia. With growth factors and other supportive care, most cancer patients can expect to feel bearably well during chemotherapy treatment, free from disabling nausea and vomiting, unlikely to be hospitalized for febrile neutropenia, and less likely to need red blood cell transfusions.

It is evident that good supportive care saves

lives. It saves lives through the prevention of the rare—but dreaded—fatal complications of chemotherapy, such as life-threatening dehydration or febrile neutropenia. But it also saves lives by extending the reach of beneficial chemotherapy into broader clinical groups of patients and by enabling the development of valuable but intensive treatment regimens. Consider several advances for common tumors that all hinge on reliable supportive care. Platinum-based chemotherapy may improve survival for early-stage lung cancer, but it would be unworkable without good supportive measures in such patients. Dose-dense adjuvant chemotherapy for breast cancer improves disease-free and overall survival compared with standard chemotherapy schedules. Such dose-dense regimens are only feasible with growth-factor support. Finally, survival with advanced colorectal cancer has been improved in part with intensive chemotherapy programs, which would be impractical without excellent supportive care and attention to gastrointestinal symptoms.

For all these reasons, it is clear that good supportive care matters enormously to patients and their families. Indeed, because chemotherapy regimens are theoretically the same when delivered across the country, with the same doses and schedules, it is principally good patient education and support that distinguish the well-practiced art of oncology from indifferent, uninspired care. Any oncologist can prescribe regimen “ABC.” A good oncologist helps the patient get through “ABC” in good shape.

Because most chemotherapy drugs are associated with some degree of gastrointestinal, mucosal, and bone marrow toxicity, almost all patients with cancer are at jeopardy for these side effects and therefore merit consideration for supportive measures. Chemotherapy regimens come and go, but supportive treatments are now a permanent fixture of cancer therapy. The advent of many important drugs to minimize chemotherapy-related side effects has unequivocally helped patients cope better with their treatment.

Correspondence to: Harold J. Burstein, MD, PhD, 44 Binney Street, Dana Building D1210, Boston, MA 02115; telephone: (617) 632-3800; fax: (617) 632-1930; e-mail: hburstein@partners.org

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These treatments, however, also create new challenges: how to select patients for therapy, how to gauge efficacy, how to measure quality of life, and how to establish appropriate guidelines for utilization. These many challenges continue to be addressed through well-done clinical trials and other investigations. The abstracts discussed in this supplemental issue of *The Journal of Supportive Oncology*, which were presented at the 41<sup>st</sup> Annual Meeting of the American Society of Clinical Oncology (ASCO) from May 13–17, 2005, highlight the broad range of important clinical trials and research in the field of chemotherapeutic supportive care.

### The Challenges Ahead

This issue focuses on the management of myelosuppression, anemia, and mucositis. These chemotherapeutic effects continue to vex patients and caregivers, despite the availability of newer drugs that can minimize these toxicities. The success of those drugs has meant that marrow suppression in particular is frequently not a treatment-limiting problem for patients with cancer. But challenges persist, particularly in establishing which patients should receive and how best to employ growth factors.

The business considerations also loom large. Because of the widespread need for supportive care, there are great costs and potentially vast profits to be borne through these medical treatments. More so than many cancer treatments, the use of supportive growth factors has been affected by issues of reimbursement, state regulation, and direct-to-patient marketing. Oncologists have long wrestled with how to ensure treatment for those patients without extensive financial resources, for whom reimbursement is vital. Caregivers have also encountered patients who have seen ads on television for supportive care treatments and who wonder whether those treatments are appropriate for their care.

Such issues are a mixed blessing. Although reimbursement issues and direct marketing sometimes make for awkward conversations, they also have encouraged doctors to think about how to apportion medical resources and how to justify these treatments through cost analyses. These is-

ues have also made patients more aware of the opportunities available for supportive care and have helped to destigmatize chemotherapy treatment.

A particular challenge for supportive care is to establish appropriate guidelines for treatment based on symptoms and reasonable thresholds. For nausea and vomiting, the goal is to have no such treatment-related side effects. For myelosuppression, however, there are changing thresholds. Recently, the National Comprehensive Cancer Network Myeloid Growth Factors Panel endorsed a lower threshold for recommending prophylactic use of granulocyte colony-stimulating factor. The panel chose a level of a 20% risk of febrile neutropenia as warranting prophylactic treatment, which is a lower bar than the 40%–45% level previously endorsed by the ASCO Growth Factors Expert Panel. Nonetheless, both measures are entirely arbitrary—most patients would certainly prefer a 0% risk of febrile neutropenia.

Setting thresholds for such a goal means balancing understandable clinical desires with reasonable and affordable clinical expectations. This challenge is most marked in the case of treatment for chemotherapy-related fatigue and chemotherapy-related anemia. On the one hand, maintaining hemoglobin levels clearly helps reduce fatigue. On the other hand, there are many other contributors to fatigue, and all clinicians are aware of the imprecise relationship between fatigue, anemia, and treatment with erythropoietic agents for any given patient.

### Conclusion

The many reports summarized in this issue of *The Journal of Supportive Oncology* provide an opportunity to reflect on new approaches to helping patients cope better with chemotherapy. The growing awareness of supportive care and the chemotherapeutic options for controlling the side effects of treatment have raised the standard of patient quality of life to new heights. Patients and their families judge the treatment of their cancer not only by its curative effect but also by its toxicity. Now more than ever, we have the chance to integrate supportive therapies for these toxicities further into the best oncologic care.