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Quality of Life in cancer patients :

The medical oncologist's standpoint

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Our specials today

- Definitions
- Why should medical oncologists be interested in QoL ?
- Tools for QoL assessment in cancer patients
- Where do we go from here ?

A few definitions

Quality of Life definition

WHO 1948

Health is a state of complete physical, mental and social well-being and not merely the absence of infirmity and disease

WHO 1998

Quality of life can be defined as a multidimensional construct that includes “performance and enjoyment of social roles, physical health, intellectual functioning, emotional state, and life satisfaction or well-being.”

Aspects of the QoL

- Multidimensionnal :
  - physical
  - emotional
  - psychological
  - social
  - spiritual

- Subjective

- It expresses a value judgement : life as a whole or in some aspects is « good » or « bad », « better » or « worse »

My job ?

How do I look like?

Pain ?

My family ?

Survival ?

Fatigue ?

Disease evolution ?

Money problems ?

I feel depressed

My friends ?

Difficult to concentrate

Autonomy ?

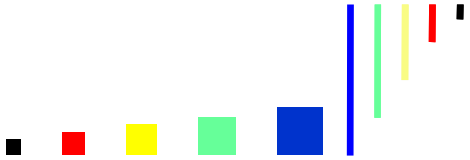
Should I continue the treatment ?

Patient reported outcomes (PRO)

= Self evaluation by the patient

- of his symptoms : quantification
  more objective

- of his QoL



Do not mistake

- Clinical benefit (CB) = CR + PR + SD

- No QoL data !

Why should medical oncologists

be interested in QoL ?

1. Personal reasons

- Because we like to be a « good » physician
  not only curing patients
  but improving patient's satisfaction
  « you should know my doctor, she (he) is very good »

- Because we don't like patients suffering, complaining,

- Because we are evaluated by patients mostly on QoL criteria !

2. Because it is our job ! ! !

1. One of the fundamental goals of medical care is the improvement of quality of life for all those who need and seek care.

« Mon premier souci sera de rétablir, de préserver ou de promouvoir la santé dans tous ses éléments, physiques et mentaux, individuels et sociaux ….

Je ferai tout pour soulager les souffrances. Je ne prolongerai pas abusivement les agonies. »

Le serment d'Hippocrate

2. Because it is our job ! ! !

2. Most of the time, physician decisions are based, at least partially, on symptoms and QoL criteria

3. Lack of a better efficacy endpoint

- Sometimes we can't cure patients !

  Then, the only improvement we can provide to patients is a better QoL

  - with oncologic treatments
  - with palliative care

- Even if we can cure patients,

  - the disease and the treatments may alter QoL
  - we should help to restore it

4. Endpoint of clinical trials

- Classical endpoints of clinical trials : objective !
  - OS / PFS
  - RR
  - side effects : CTC
  - biomarkers

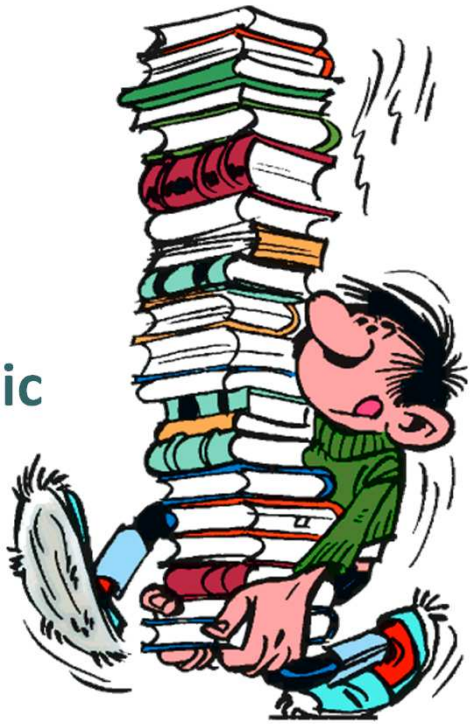
- More recently (2007), FDA requirement for PRO in clinical trials

- Requirement for drug registration

Tools for QoL assessment

Many validated tools

- Generic tests : validated across all diseases
  - QLQ-C30 (EORTC)
  - FACT-G
  - SF-36
  - ….
- Specific : type of cancer
  - population : geriatric / paediatric

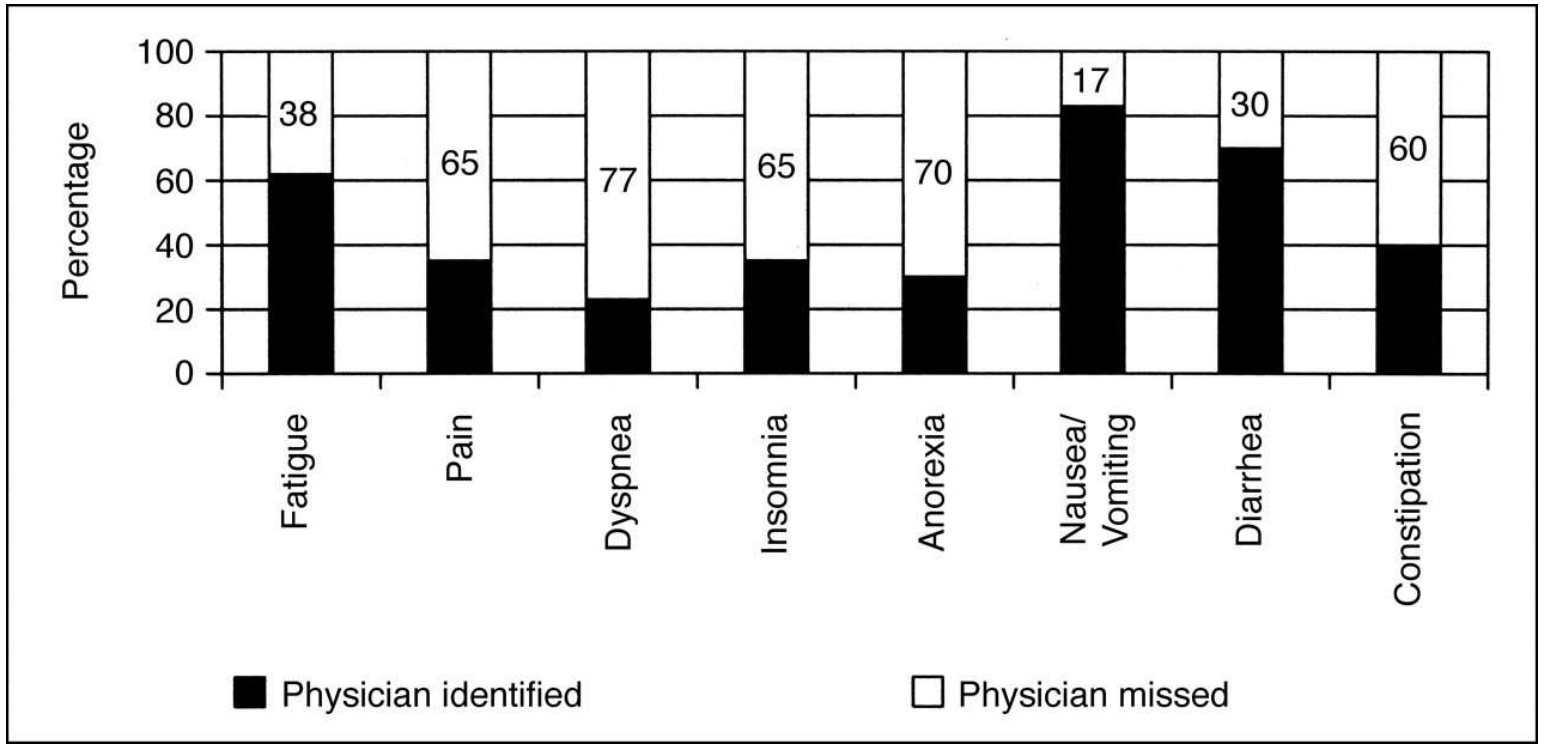


Investigated items

- **Physical :** pain, mobility, sleep, sexual function, fatigue
- **Psychological :** anxiety, depression, adjustement to illness
- **Social :** personal relationships, social and leisure activities,
- **Occupational :** employment, self care

Who should report ?

Doctors are poor judge of the QoL of their patients !



Fromme, J Clin Oncol, 2005

Who should report ?

“Given its inherently subjective nature, consensus was quickly reached that quality of life ratings should, whenever possible, be elicited directly from patients themselves. “

Aaronson, QoL and pharmacoeconomics in clinical trials, 1996

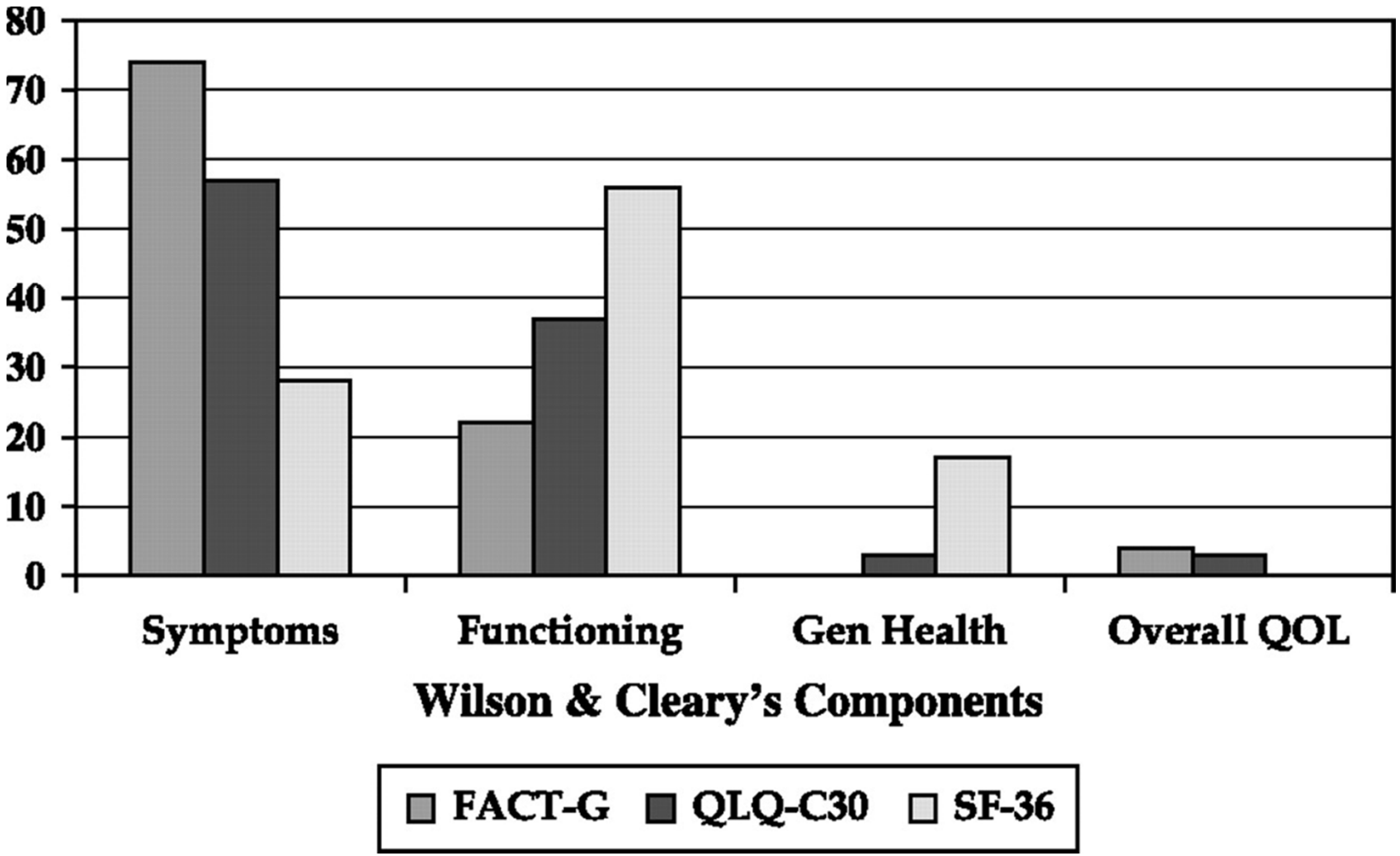
Choice about how to fill the questionnaire

- Face to face interview (trained interviewers)
- Telephone interviewers
- Self report questionnaires
- Pencil and paper
- Computer / touch screen

Choice of the test

- Depending on the population / the disease
- depending on what you look for
- no gold standard

What is measured in each test ?



CE Ferrans , JNCI, 2007

Methodological problems

- Numerous assessments / little standardisation
- Need for more standardisation
  - comparison between QoL assessments
  - correlation with objective outcomes
- Need of reproducible scales in clinic, easy to use.

Where do we go from here ?

Wider use of QoL assessment

- QoL assessment should not be restricted to studies for weak treatments only
- Interest in treatments improving objective outcomes also
- Better QoL assessments
  - better questionnaires : ex : oncogeriatric …
  - validation of questionnaires / correlation with prognosis
  - physician and caregivers involvment

Better use of QoL assessment in studies

- Specific methodology for QoL evaluation in studies :

  - what is the minimal difference for a significant benefit?

  - what is a palliative response ?

  - how long should the palliative response be ?

  - correlation with other outcomes

Better use of QoL and of PRO in clinic

Interest in routine practice :

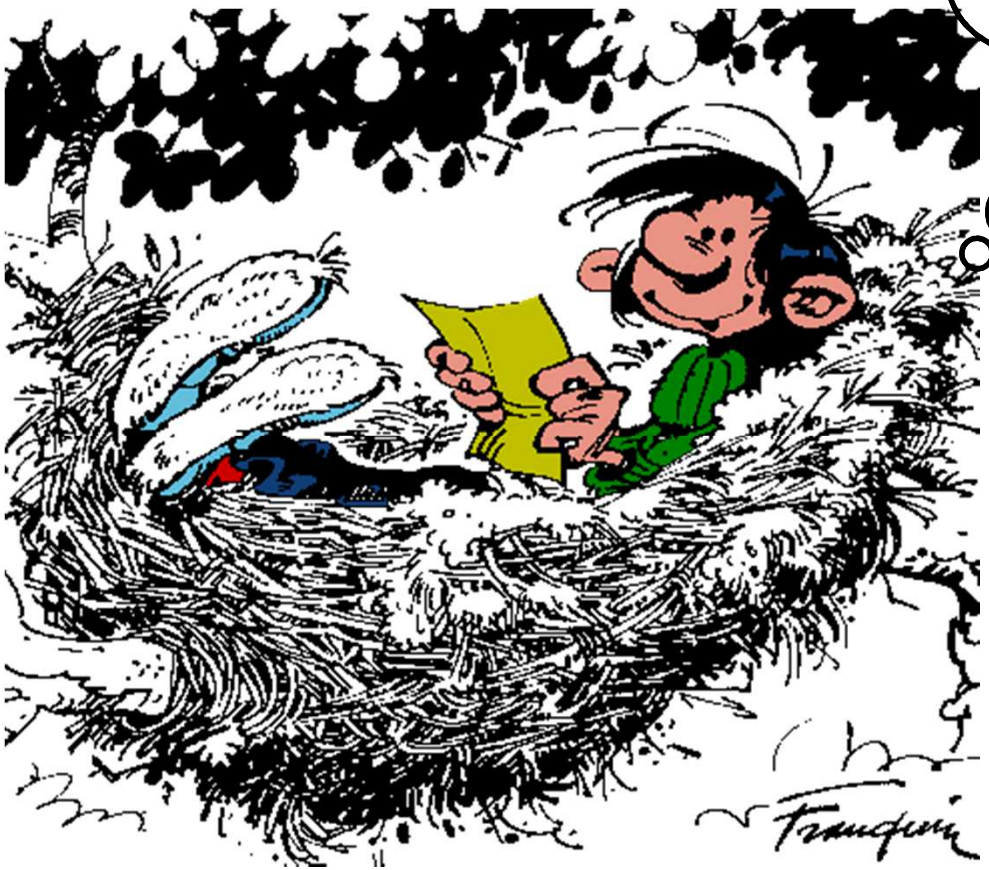
- To pay more attention to QoL and symptoms

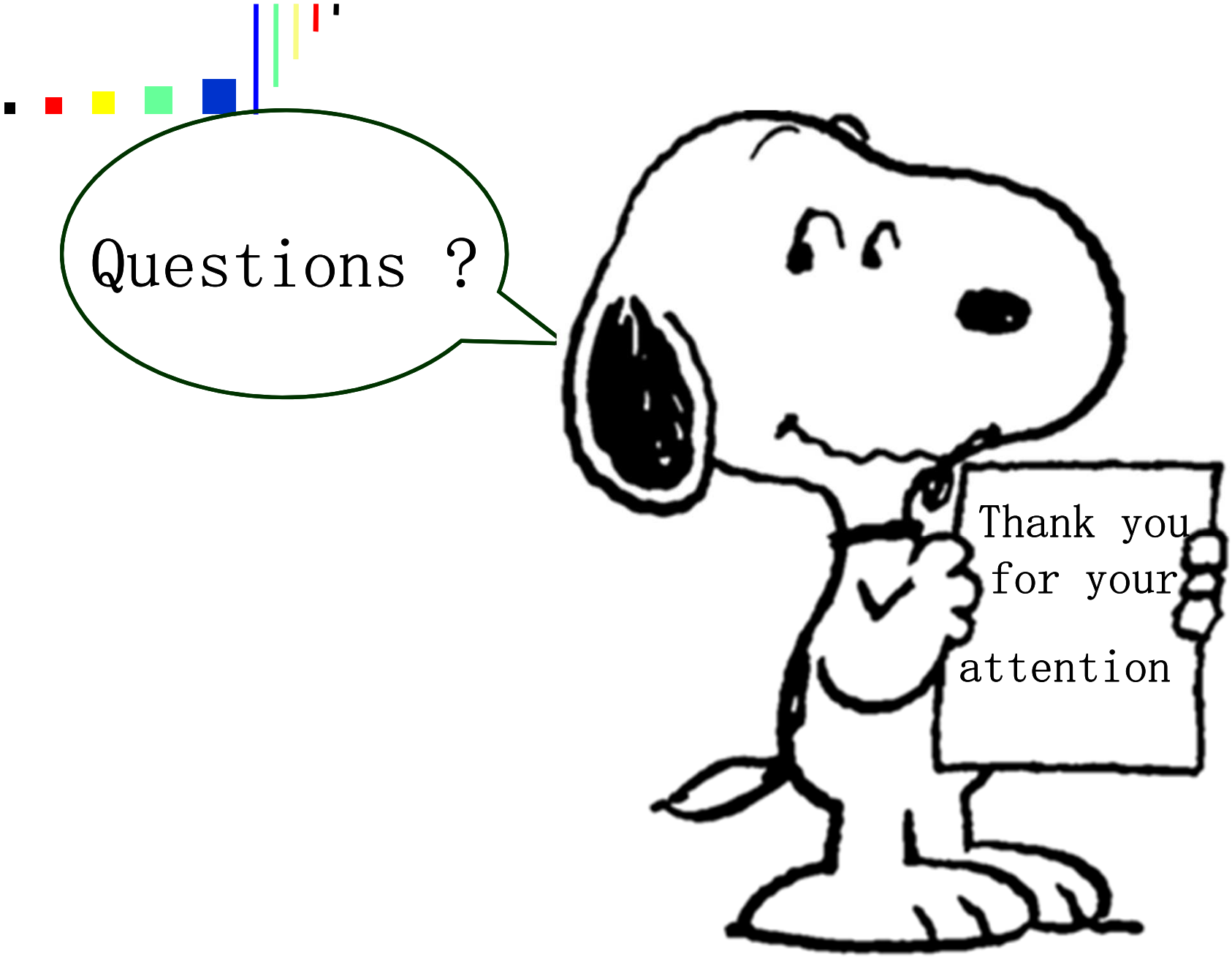
- To better treat symptoms

- To improve patient's adherence to treatment

- To improve patient / physician relationship

-To give voice to the patient !


It was nice talking about QoL !


Questions ?
Thank you
for your
attention