Taking the data and findings into the real-world setting

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Targeted therapy and mutation analyses are all the rage as we try to expand our ever burgeoning pipeline of biologic or targeted therapies so that we can either complement or even replace chemotherapy. Each year at this time, practicing oncologists keenly await the release of new clinical and therapeutic data at the annual meeting of the American Society of Clinical Oncology. Yet I am reminded that some things never change, even in this exciting era of molecular targeting. For example, after one has delivered a diagnosis of cancer in the curative setting, after surgery a patient will still ask if he/she will need further (adjuvant) therapy. Likewise, in the advanced setting, when a patient needs and receives therapy, the question becomes, "how am I doing, is it working?" Perhaps the first targeted therapy in the adjuvant setting was tamoxifen, some 40 years ago, which was offered only to women with the target estrogen receptor. Now we have the permutations of luminal A or luminal B estrogen- or progesterone-receptor–positive, or HER2/neu, or triple negative (basal) breast cancer, as well as DNA testing options for the disease. In colon cancer we have the KRAS mutation and in lung cancer the EGFR, ALK, or ROS-1 rearrangements to guide our therapy decisions.

What about patients with advanced disease who want to know how they're doing? Frequent imaging testing has been replaced with real-time analyses such as those for serologic tumor markers in many solid tumors or as reported by Shah (p. 179) and Savona (p. 171), the BCR-ABL mutation in chronic myeloid (or myelogenous) leukemia. Shah's review describes hematologic and cytogenetic testing, molecular monitoring, and mutational analysis as integral to managing CML, and she emphasizes the importance of regular assessments of treatment response and minimal residual disease (MRD) in monitoring disease control during protracted active treatment. In his review, Savona discusses the relevance of recent clinical research on MRD in CML for the community oncologist and how the findings have informed changes in clinical practice guidelines. He notes, however, that patient history and comorbidities, previous therapy response, and drug efficacy and safety, should also be considered before a therapy is changed.

We know about the enrollment in clinical trials of some seriously ill ED patients – those with stroke, for example – but little is known about the willingness of patients with advanced cancer to participate in palliative care research. On page 158, Grudzen and colleagues report on the residual barriers to the enrollment in the ED setting of advance-stage cancer patients in palliative care trials. They found that patient refusal, symptom burden, and diagnostic disparities were the more common barriers, though family and/or physician refusal, and the patient being unaware of illness or disease stage were also factors. To increase participation in these studies, the investigators suggest developing strategies to address the barriers and training for overcoming ED-specific obstacles.

Likewise, how does performance status change in real world oncology for patients before and after their first course of chemotherapy? Paoli and colleagues (p. 163) analyzed data from electronic medical records and found that the change in performance status is measurable and does change, but often not by very much, largely because of the available supportive care medications and services to assist patients.

We hope you enjoy this month's issue of The Journal of Community and Supportive Oncology – as a printed publication, online in digital form, or as an app. Our redesigned Web site at www.jcso-online.com features all our 2014 content to date, as well the archived issues of Community Oncology and The Journal of Supportive Oncology, which merged to form JCSO. Next, we plan to invite you to Follow, Friend and/or Like us online. One of our fellows recently asked me why I still have textbooks in my office. Good question. Pretty soon, the answer will be nostalgia.

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