Supportive Care For Hematological Malignancies

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Supportive care

- Definition
- Why we need supportive care?
- Cost of supportive care
- Guidelines and adherence
- Best location
- Designing of treatment units & Easy access
- Satellite services, home care
- Religious factors

- Government financial aids
- Age groups
- Long term follow up programs
- Palliative care & hospice care
- Educational programs
Not 1 man show!
WHO, When, What
Definition

“the provision of the necessary services for those living with or affected by cancer to meet their informational, emotional, spiritual, social or physical need during their diagnostic treatment or follow-up phases encompassing issues of health promotion and prevention, survivorship, palliation and bereavement

...Definition

....In other words, supportive care is anything one does for the patient that is not aimed directly at curing his disease but rather is focused at helping the patient and family get through the illness in the best possible condition. Clearly this type of help would need to be broad in scope and as varied as the individuals requiring it”

Supportive care is for...
Medical Supportive Care

<table>
<thead>
<tr>
<th>Disease &amp; treatment</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Febrile Neutropenia</td>
<td>Oral Mouth Care and Mucositis</td>
</tr>
<tr>
<td>Tumor Lysis Syndrome</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Organ dysfunction Emergencies</td>
<td>Radiation Side Effects</td>
</tr>
<tr>
<td>The Acute Abdomen</td>
<td>Prevention of Infection</td>
</tr>
<tr>
<td>Thrombotic Disorders</td>
<td>Hematopoietic Growth Factors</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Central Venous Catheters Care</td>
</tr>
<tr>
<td>Nausea and Vomiting</td>
<td>Transfusion Support</td>
</tr>
</tbody>
</table>
Why we need supportive care?

How can we convince the decision maker about it?
BRIEF REPORT

Improved Outcome in Pediatric AML Due To Augmented Supportive Care

Wasil Jastaniah, MBBS, FRCPC,1,2* Mohammed Burhan Abrar, PhD,1 and Taha M. Khattab, PhD1

Fig. 1. The cumulative incidence of treatment-related mortality (TRM) between era1 (1996–2002) and era2 (2003–2011) is shown in “A.” The 5-year disease-free survival (DFS) between era1 and era2 is shown in “B.” Dotted lines and survival rates in italic presented in “B” correspond to 6-month DFS of 68.4 ± 10.7% in era1 and 86.1 ± 5.8% in era2.

Pediatr Blood Cancer DOI 10.1002/pbc
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Era 1

From 1996 to 2002 (era1), supportive care strategies included
• Hickman catheters,
• blood products,
• antibiotics,
• antiemetics,
• mouth and skin care, and
• antifungal prophylaxis
Fig. 1. The cumulative incidence of treatment-related mortality (TRM) between era1 (1996–2002) and era2 (2003–2011) is shown in “A.” The 5-year disease-free survival (DFS) between era1 and era2 is shown in “B.” Dotted lines and survival rates in italic presented in “B” correspond to 6-month DFS of 68.4 ± 10.7% in era1 and 86.1 ± 5.8% in era2.

Pediatr Blood Cancer DOI 10.1002/pbc
Cost of supportive care

Expenditures on cancer treatment, total and by type of service, 2001 (adjusted to 2011) & 2011

Cost of supportive care

Mean expenditures on cancer treatment per person with expense, by type of service, 2001 (adjusted to 2011) and 2011

## Guidelines and adherence, FN

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.5% Fully Compliant (6)</td>
<td>6.2% ICU transfer</td>
</tr>
<tr>
<td>40.0% Partially Compliant (4-5)</td>
<td>4.6% inpatient mortality</td>
</tr>
<tr>
<td>18.5% Non-compliant (0-3)</td>
<td>4.6% adverse antibiotic reaction</td>
</tr>
<tr>
<td></td>
<td>9.2% <em>Clostridium difficile</em>, 90 days</td>
</tr>
<tr>
<td></td>
<td>7.7% new VRE, 90 days (60% infection; 40% colonization)</td>
</tr>
</tbody>
</table>
Guidelines and adherence, FN

Drivers of Error

Guidelines and adherence, FN

• Despite FN guidelines, compliance is poor

• mainly driven by vancomycin overuse

• In light of the relatively high rate of adverse drug reactions, new Clostridium difficile and VRE cases,

• further intervention is needed to improve compliance with established NF guidelines
Guidelines and adherence, CINV

Reported barriers/reasons interfering with using guideline-recommended antiemetics

Highly HEC, Moderately MEC: emetogenic chemotherapy

CINV and adherence to antiemetic guidelines, Rebecca Clark-Snow, Supportive Care in Cancer, February 2018, Volume 26, Issue 2, pp 557–564
Where it can be delivered?
Best location

ER vs OPD vs Daycase vs In-patient
Design

• Design of treatment units should address the need of the special population

• Dedicated center vs hospital department
Dedicated center vs hospital dept.

HUTCH NEWS

Patients treated at cancer centers live longer: study

Finding of survival-rate differences between cancer hubs and community hospitals spurs call to ‘figure out the gaps’

Nov. 6, 2015 | By Bill Briggs / Fred Hutch News Service

Even in cancer care, it’s location, location, location.

Patients treated at one of a handful of specialized cancer centers collectively had a 9 percent higher survival rate over five years when compared to cancer patients treated at community hospitals, a recent study showed.

While the study’s authors plan more analysis to better grasp the disparity, they posed several theories to explain the stronger outcomes among 11 “freestanding” cancer hospitals they measured. Those 11 centers included Seattle Cancer Care Alliance, the treatment arm of Fred Hutchinson Cancer Research Center.
Easy access

- where
- Satellite services
- home care
Clinic nurse vs Electronic

- Booking an appointment
- Report symptoms
- Report death
- Full HIS
In one study, 42% of participants reported a significant financial burden. As a result:

- partially filled a 19% prescription
- took less than the prescribed amount of medication 20%
- avoided filling prescriptions 24%
- used their savings 46% to help cover out-of-pocket expenses
- reduced spending 46% on food & clothing
- cut back on leisure activities 68%

(Zafara 2013)
Religious factors

Religion, Spirituality, and Physical Health in Cancer Patients: A Meta-Analysis
Cancer 2015;121:3760-8

Heather S. L. Jim, PhD; James E. Pustejovsky, PhD; Crystal L. Park, PhD; Suzanne C. Danhauer, PhD;
Allen C. Sherman, PhD; George Fitchett, PhD; Thomas V. Merluzzi, PhD; Alexis R. Munoz, MPH; Logan George, MA;
Mallory A. Snyder, MPH; and John M. Salsman, PhD

• R/S was associated with improved
• overall physical health (z 5 0.153, P < .001);
  • this relation was not moderated by socio-demographic or clinical variables.
• associated with physical well-being (z 5 0.167, P < .001),
• functional well-being (z 5 0.343, P < .001), and
• Physical symptoms (z 5 0.282, P < .001)
greater religion/spirituality is associated with better patient-reported physical health
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Greater religion/spirituality is associated with better patient-reported physical health.
Age groups

• Pediatric, adults, geriatrics
Educational programs

Vs WhatsApp
Long term follow up programs

• Cancer survivorship
• App: PROM (patient reported outcome measures)

• Organs dysfunction
• Fertility
• Depression - adolescent and young adult (AYA)
Palliative care & hospice care

Palliative care is aimed at anyone who has been diagnosed with a life-threatening illness.

Hospice care is mostly aimed at patients who have been diagnosed with a terminal illness.
What, when, who