Radiation Oncology Consultants

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ROC December 2014 Newsletter

Choosing Wisely® is an evidence-based campaign which is sponsored by the ABIM Foundation, intended to improve patient care. More than 60 specialty societies have participated in this endeavor, to assist patients make appropriate decisions about their care.

Over the past two years, ASTRO (the American Society for Radiation Oncology) has presented two lists of 5 items for the *Choosing Wisely*® campaign. These items are intended to promote dialogue between providers and patients about appropriate patient care. The aim is to ensure that patients choose care that is necessary, supported by evidence, free from harm and not duplicative of tests or procedures which have already been performed. These 10 ASTRO endorsed measures include 3 on breast cancer and 2 regarding prostate cancer, which will be covered in a subsequent newsletter. This issue will cover 3 measures on palliative care and one each for gynecologic and lung cancers.

Palliative care

Don't initiate non-curative radiation therapy without defining the goals of treatment with the patient and considering palliative care referral.

- Well-defined goals of therapy are associated with improved quality of life and better understanding on the part of patients and their caregivers.
- Palliative care can be delivered concurrently with anti-cancer therapies.
- Early palliative care intervention may improve patient outcomes, including survival.

Don't routinely use extended fractionation schemes (>10 fractions) for palliation of bone metastases.

- Studies suggest equivalent pain relief following 30 Gy in 10 fractions, 20 Gy in 5 fractions, or a single 8 Gy fraction.
- A single treatment is more convenient but may be associated with a slightly higher rate of retreatment to the same site.
- Strong consideration should be given to a single 8 Gy fraction for patients with a limited prognosis or with transportation difficulties.

Comment: ROC physicians led multiple national and international prospective randomized studies evaluating short-course palliative radiation therapy for bone metastases. A single treatment with radiation is still one of the most effective methods of providing relief from a painful bone metastasis.

Don't routinely add adjuvant whole brain radiation therapy to stereotactic radiosurgery for limited brain metastases.

• Randomized studies have demonstrated no overall survival benefit from the addition of adjuvant whole brain radiation therapy (WBRT) to stereotactic radiosurgery (SRS) in the management of selected patients with good performance status and brain metastases from solid tumors.
• The addition of WBRT to SRS is associated with diminished cognitive function and worse patient-reported fatigue and quality of life. These results are consistent with the worsened self-reported cognitive function and diminished verbal skills observed in randomized studies of prophylactic cranial irradiation for small cell or non-small-cell lung cancer.
• Patients treated with radiosurgery for brain metastases can develop metastases elsewhere in the brain. Careful surveillance and the judicious use of salvage therapy at the time of brain relapse allow appropriate patients to enjoy the highest quality of life without a detriment in overall survival. Patients should discuss these options with their radiation oncologist.

Comment: Quality of life is an important consideration in patients with brain metastases. Stereotactic radiosurgery is important in improving quality of life <u>and</u> disease control in patients with a few brain metastases. For patients with diffuse brain metastases, whole brain radiation therapy is still an effective palliative treatment. ROC physicians have led multiple prospective randomized trials evaluating the role of Memantine and hippocampal-sparing radiation therapy in improving quality of life in these patients.

Gynecologic cancer

Don't recommend radiation following hysterectomy for endometrial cancer patients with low-risk disease.

• Patients with low-risk endometrial cancer including no residual disease in hysterectomy despite positive biopsy, grade 1 or 2 with <50% myometrial invasion and no additional high risk features such as age >60, lymphovascular space invasion or cervical involvement have a very low risk of recurrence following surgery.
• Meta-analysis studies of radiation therapy for low-risk endometrial cancer demonstrate increased side effects with no benefit in overall survival compared with surgery alone.

Lung cancer

Don't routinely offer radiation therapy for patients who have resected non-small-cell lung cancer (NSCLC) negative margins N0-1 disease.

• Patients with early stage NSCLC have several management options following surgery. These options include: observation, chemotherapy and radiotherapy.
• Two meta-analysis studies of post-operative radiotherapy in early NSCLC with node negative or N1 disease suggest increased side effects with no benefit for disease-free survival or overall survival compared t o observation.
• Patients with positive margins following surgery may benefit from post-operative radiotherapy to improve local control regardless of status of their nodal disease.

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