Asian Society of Gynecologic Oncology

Discussion and Q&A:

When to Stop Chemotherapy for Gynecologic Cancer Patients

Ga Won Yim

Dongguk University Ilsan Hospital

2024-2-22

What does the current guideline say?

ASCO American Society of Clinical Oncology Choosing Wisely; Last Reviewed 2021

2012

Five Things Patients and Physicians Should Question (2012)

1. **Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, and no strong evidence supporting the clinical value of further anti-cancer treatment.**

   - Cancer directed treatments are likely to be ineffective and more toxic for solid tumor patients who meet the above-stated criteria.
   - Exceptions may include when disease characteristics (e.g., an extremely chemosensitive tumor, or a sensitive and targetable alteration in the tumor) suggest a high likelihood of a response to therapy that may reverse functional limitations related to the cancer.
   - While this Choosing Wisely statement originally referred to cytotoxic chemotherapy, it also applies to novel, purportedly less-toxic treatments such as immunotherapy and off-label targeted therapy in patients who meet the above-stated criteria.

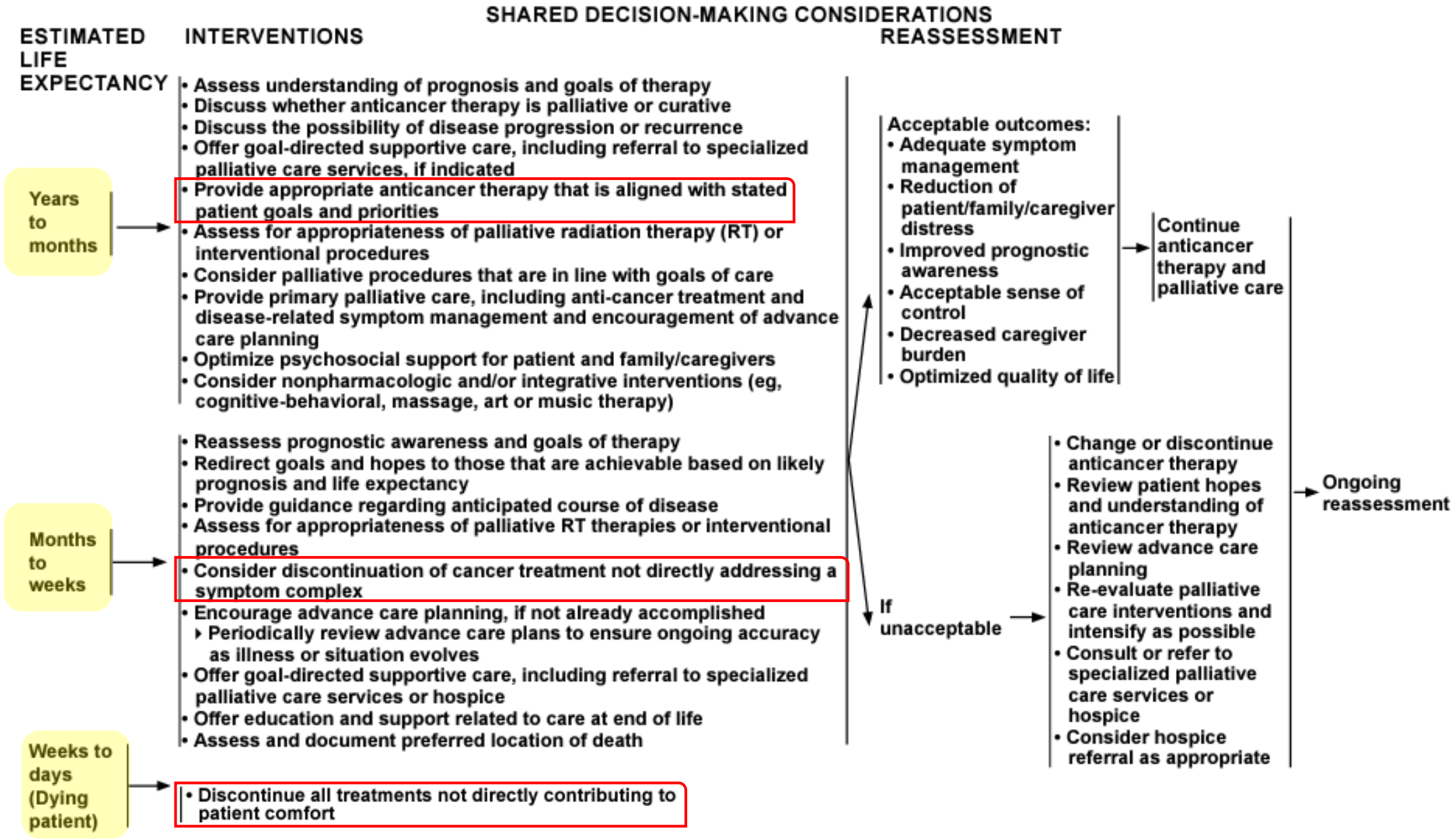
Choosing Wisely Canada™

2017

When is it time to think about stopping cancer treatment?

If you have had three different treatments and your cancer has grown or spread, more treatment usually will not help you feel better or increase your chance of living longer. Instead, more treatment could cause serious side effects that shorten your life and reduce the quality of the time you have left.

NCCN 2023 v.2


SHARED DECISION-MAKING CONSIDERATIONS
ESTIMATED LIFE EXPECTANCY
INTERVENTIONS
REASSESSMENT
Years to months
• Assess understanding of prognosis and goals of therapy
• Discuss whether anticancer therapy is palliative or curative
• Discuss the possibility of disease progression or recurrence
• Offer goal-directed supportive care, including referral to specialized palliative care services, if indicated
• Provide appropriate anticancer therapy that is aligned with stated patient goals and priorities
• Assess for appropriateness of palliative radiation therapy (RT) or interventional procedures
• Consider palliative procedures that are in line with goals of care
• Provide primary palliative care, including anti-cancer treatment and disease-related symptom management and encouragement of advance care planning
• Optimize psychosocial support for patient and family/caregivers
• Consider nonpharmacologic and/or integrative interventions (eg, cognitive-behavioral, massage, art or music therapy)
Acceptable outcomes:
• Adequate symptom management
• Reduction of patient/family/caregiver distress
• Improved prognostic awareness
• Acceptable sense of control
• Decreased caregiver burden
• Optimized quality of life
Continue anticancer therapy and palliative care
Months to weeks
• Reassess prognostic awareness and goals of therapy
• Redirect goals and hopes to those that are achievable based on likely prognosis and life expectancy
• Provide guidance regarding anticipated course of disease
• Assess for appropriateness of palliative RT therapies or interventional procedures
• Consider discontinuation of cancer treatment not directly addressing a symptom complex
• Encourage advance care planning, if not already accomplished
‣ Periodically review advance care plans to ensure ongoing accuracy as illness or situation evolves
• Offer goal-directed supportive care, including referral to specialized palliative care services or hospice
• Offer education and support related to care at end of life
• Assess and document preferred location of death
If unacceptable
• Change or discontinue anticancer therapy
• Review patient hopes and understanding of anticancer therapy
• Review advance care planning
• Re-evaluate palliative care interventions and intensify as possible
• Consult or refer to specialized palliative care services or hospice
• Consider hospice referral as appropriate
Ongoing reassessment
Weeks to days (Dying patient)
• Discontinue all treatments not directly contributing to patient comfort

ESMO 2021

SPECIAL ARTICLE

Care of the adult cancer patient at the end of life: ESMO Clinical Practice Guidelines☆

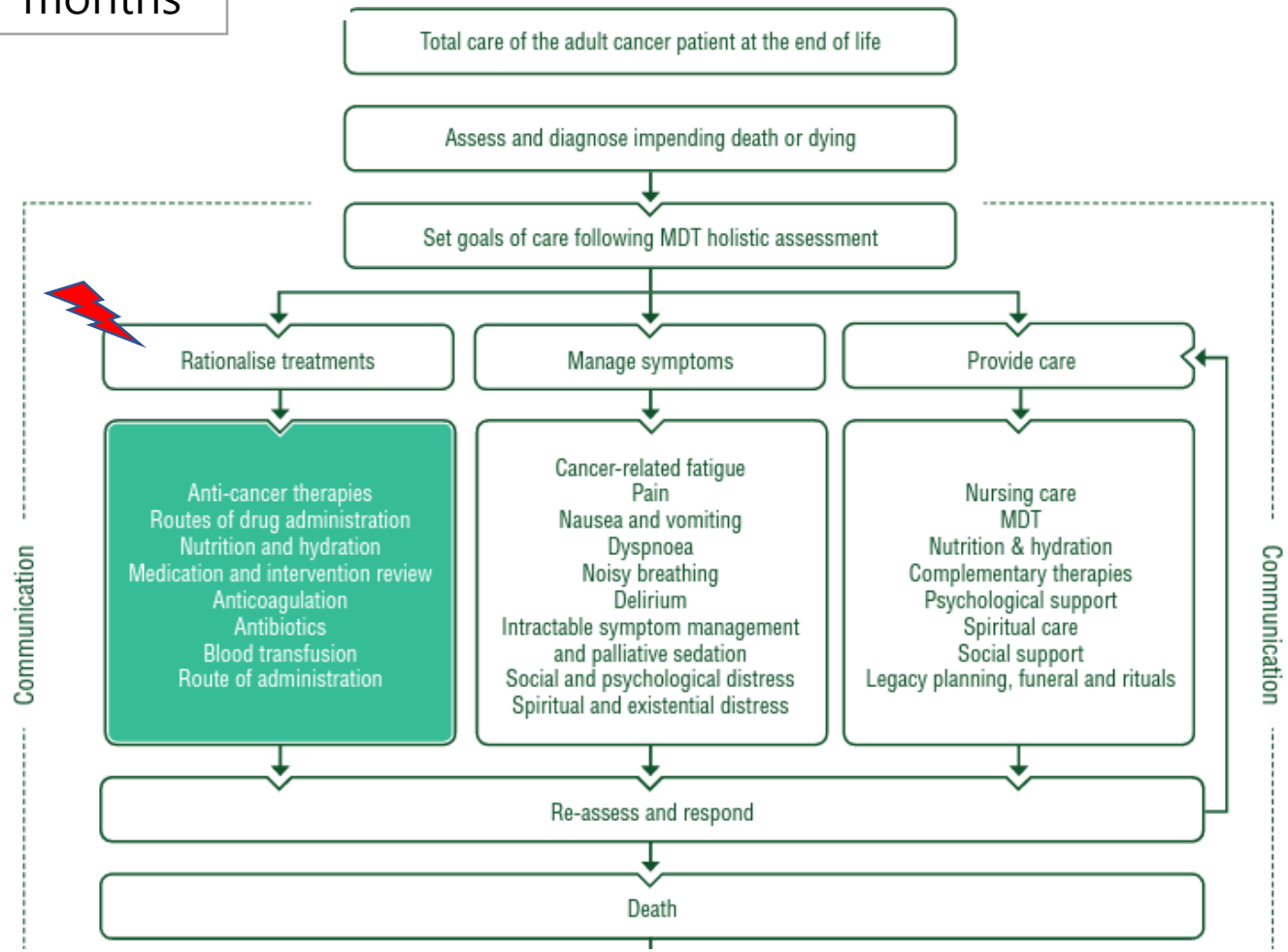
" Last few weeks or months"

Anticancer therapies

Chemotherapy (ChT) in the last month of life is associated with adverse outcomes including poor quality of care, emergency department attendance, cardiopulmonary resuscitation, mechanical ventilation and with dying in an intensive care unit.[27] Radiotherapy (RT) offers limited benefit for patients with poor PS [e.g. European Cooperative Oncology Group (ECOG) grade 4] and is not recommended in the last month of life.[28,29] Single-fraction RT may provide effective symptomatic relief for metastatic bone pain within 2 weeks, or tumour-related bleeding within 2 days.[30] Use of immunotherapy at EoL is associated with increased risk of dying in hospital and potential for significant financial hardship.[31] Immune checkpoint inhibitors should not be used at the EoL.[32]

Recommendations

- ChT and immunotherapy should not be used in the last weeks of life [IV, D].
- RT may have symptomatic benefit for pain or bleeding but is not recommended in the last days of life [III, D].



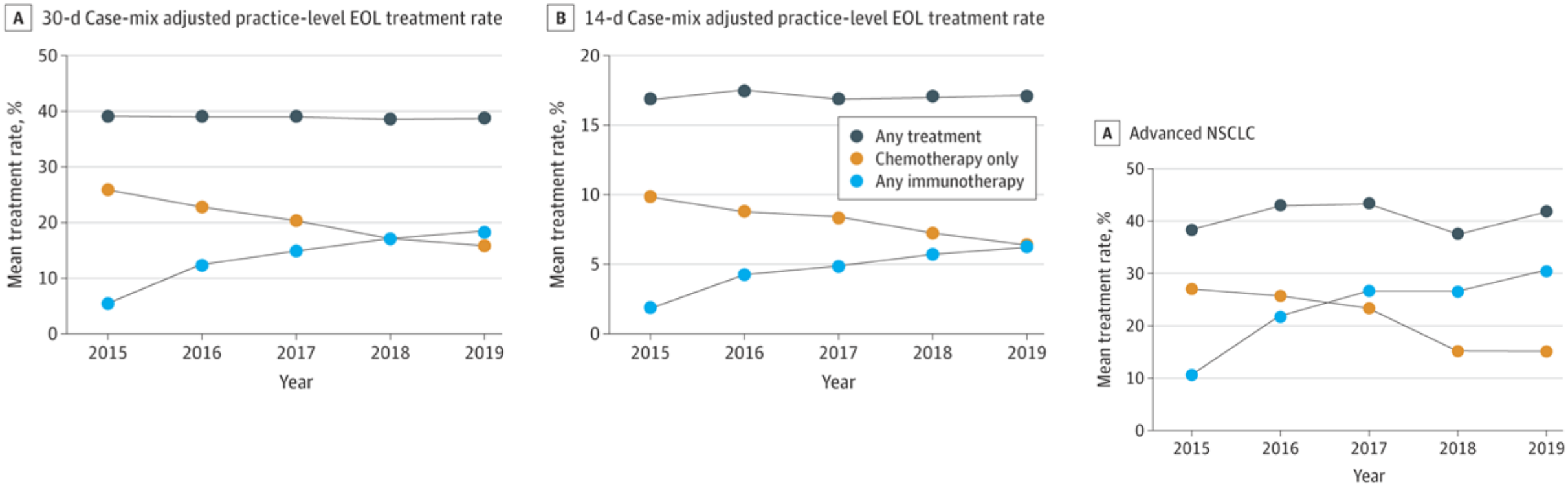
In reality...

October 20, 2022 *JAMA Oncol.* 2022;8(12):1847-1849. doi:10.1001/jamaoncol.2022.4666

Systemic Anticancer Therapy at the End of Life—Changes in Usage Pattern in the Immunotherapy Era

Maureen E. Canavan, PhD, MPH[1]; Xiaoliang Wang, PhD, MPH[2]; Mustafa S. Ascha, PhD[2]; et al

Figure 1. Adjusted Mean Treatment Rates Across All Cancer Types by Treatment Type and Year



Immune Checkpoint Inhibitor Use Near the End of Life Is Associated With Poor Performance Status, Lower Hospice Enrollment, and Dying in the Hospital

American Journal of Hospice & Palliative Medicine®
2020, Vol. 37(3) 179-184

DOI: 10.1177/1049909119862785
journals.sagepub.com/home/ajh
SAGE

Chad Glisch, MD[1], Yuya Hagiwara, MD, MACM[1],

inhibitor use near the end of life. **Results:** Among 157 patients studied, 42 (27%) received a dose of immune checkpoint inhibitor in the last 30 days of life. Those who received treatment in the last 30 days of life had lower hospice enrollment (19 [45%] vs 78 [69%], $P = .007$) and higher rates of dying in the hospital (23 [56%] vs 33 [29%], $P = .002$). The percentage of patients with Eastern Cooperative Oncology Group (ECOG) ≥3 at the time of last immune checkpoint inhibitor dose was higher in the group that received immune checkpoint inhibitor treatment in the last 30 days of life (11 [26%] vs 9 [8%], $P = .003$). Lack of traditional chemotherapy after immune checkpoint inhibitor, ECOG ≥3, and lack of hospice enrollment were independently associated with receiving immune checkpoint inhibitor in the last 30 days of life. **Conclusion:** Immune checkpoint inhibitor use in the last 30 days of life is common and associated with poor performance status, lower hospice enrollment, and dying in the hospital.

Table 4. Multivariate Models With Logistic Regression Analysis of Factors Associated With Receiving End-of-Life Immune Checkpoint Inhibitor.

Variable	ICI Treatment Given End of Life, OR (95% CI)
Chemotherapy after ICI (reference = no)	0.09 (0.09-0.45)
Hospice enrolled (reference = no)	0.30 (0.12-0.76)
ECOG ≥3 (at time of last immune checkpoint inhibitor dose; reference: ≤2)	4.35 (1.29-14.68)

Abbreviations: CI, confidence interval; ECOG, Eastern Cooperative Oncology Group; ICI, immune checkpoint inhibitor; OR, odds ratio.

Current evidence:
Response to immunotherapy: 10-60%

-Solid tumors: 10-20%
-Melanoma and MSI-H tumors: 45-60%

Prognostic factor: Prognostic models

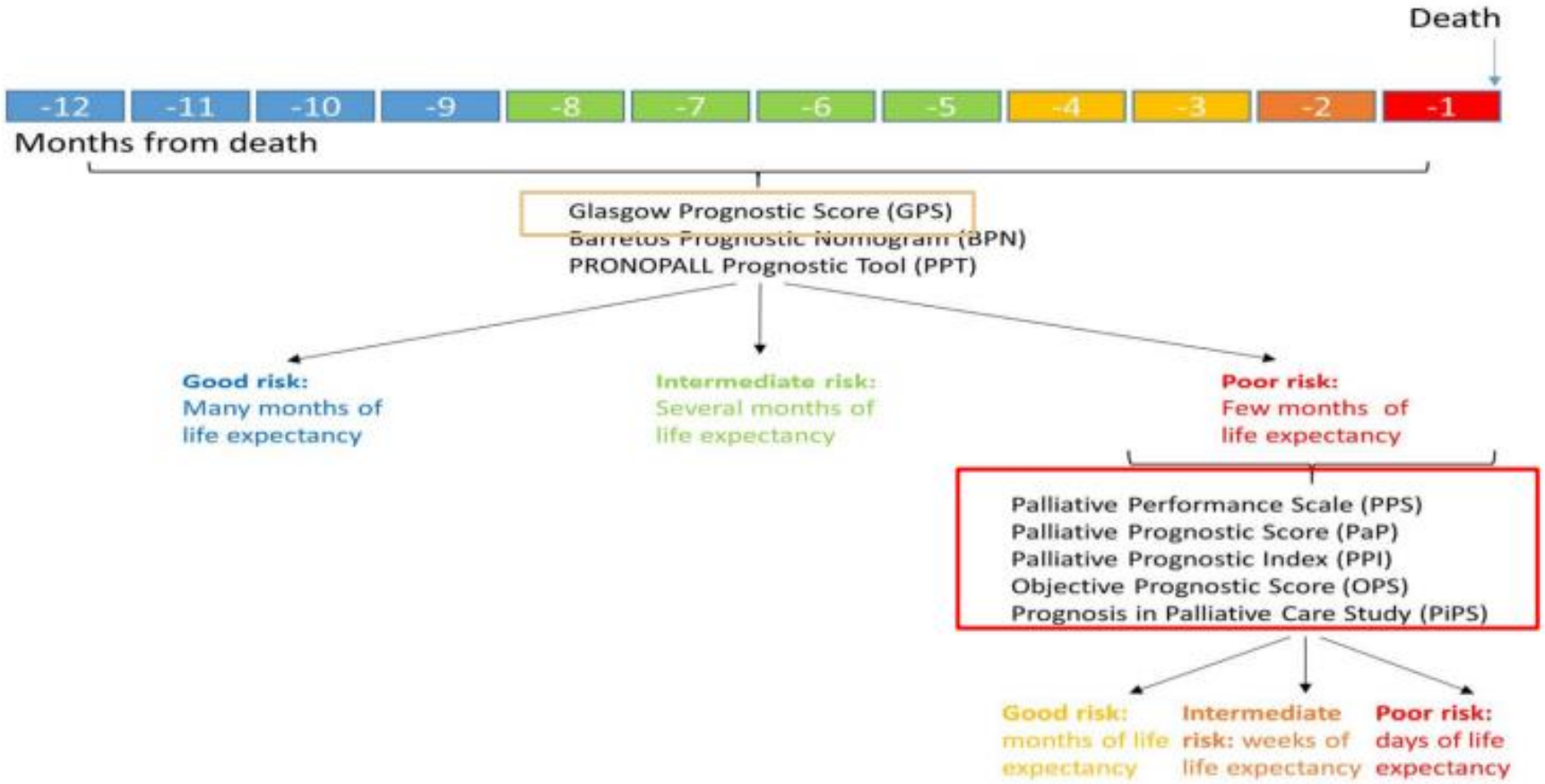


Figure 1. Prognostic models stratify patients into prognostic categories and may help to reduce prognostic uncertainty.

The Glasgow Prognostic Score, Barretos Prognostic Nomogram and PRONOPALL Prognostic Tool were developed for patients with advanced cancer and multiple months of life expectancy. In contrast, Palliative Performance Scale, Palliative Prognostic Score, Palliative Prognostic Index, Objective Prognostic Score and Prognosis in Palliative Care Study Predictor were calibrated for patients with a relatively short survival (i.e. median survival of approximately 1 month). These prognostic models typically stratify patients into good, moderate and poor risk groups.

Hui, Curr Opin Support Palliat Care, 2019

Questions

- What kind of prognostic tools (factors) should we use (consider) in this novel treatment era?
- In your opinion, when is the optimal time to start the EOL discussion? (if not already integrating early palliative care)
- Please give insights on the ‘team approach’ provided by the Japanese *community-based* care system in delivering EOL discussion and timely palliative care.