

TURIN,
October
25th-27th
2018
Starhotels
Majestic

GIORNATE CARDIOLOGICHE TORINESI



MANAGEMENT OF CARDIOTOXICITY: ORGANIZATIONAL PROPOSALS

The General practitioner: is he in charge
for long-term follow-up?

ANDREA PIZZINI – FIMMG - SIMG



Examples of late effects chemotherapy and radiotherapy

Organ system	Late effect of chemotherapy (agents)	Late effect of radiotherapy
Bone and soft tissues	Avascular necrosis (corticosteroids)	Short stature Atrophy Fibrosis Osteonecrosis Second cancers
Cardiovascular	Cardiomyopathy (anthracyclines, trastuzumab)	Pericardial effusion Pericarditis Coronary artery and peripheral vascular disease
Pulmonary	Pulmonary fibrosis Interstitial pneumonitis (bleomycin)	Pulmonary fibrosis Decreased lung volumes
Central nervous system	Leukoencephalopathy (methotrexate)	Neurocognitive impairment Radiation necrosis Second malignancies
Peripheral nervous system	Peripheral neuropathy Hearing loss (cisplatin, taxanes, vinca alkaloids)	Brachial plexopathy Lumbosacral plexopathy
Hematological	Myelodysplastic syndromes and secondary leukemias (alkylating agents)	Myelodysplasia
Renal	Decreased creatinine clearance (cisplatin, methotrexate)	Decreased creatinine clearance Hypertension
Genitourinary	Bladder fibrosis Hemorrhagic cystitis Bladder cancer (cyclophosphamide)	Bladder fibrosis Contractures
Gastrointestinal	Abnormal liver function tests Hepatic fibrosis Cirrhosis (methotrexate)	Malabsorption Stricture Radiation proctitis Second cancers
Pituitary	-	Growth hormone deficiency Pituitary deficiency Metabolic syndrome Obesity Diabetes
Thyroid	Hypothyroidism (sunitinib)	Hyperthyroidism Hypothyroidism Thyroid nodules Thyroid cancer
Gonadal	Men	
	Sterility (alkylating agents)	Sterility Leydig cell dysfunction
	Women	
	Sterility Premature menopause (alkylating agents)	Ovarian failure Early menopause
Ophthalmologic	Cataracts (steroids)	Cataracts Retinopathy
Skin	-	Second cancers



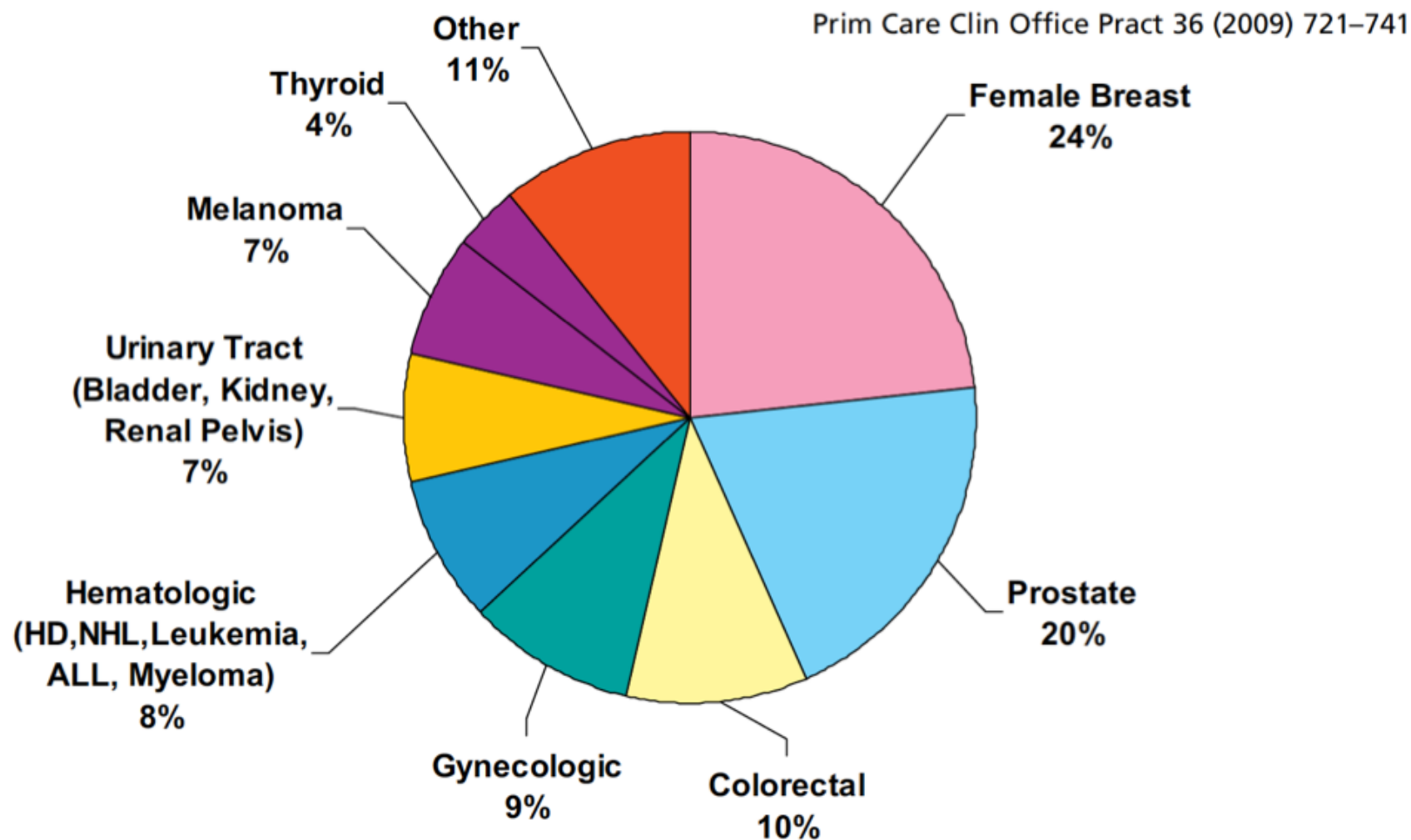
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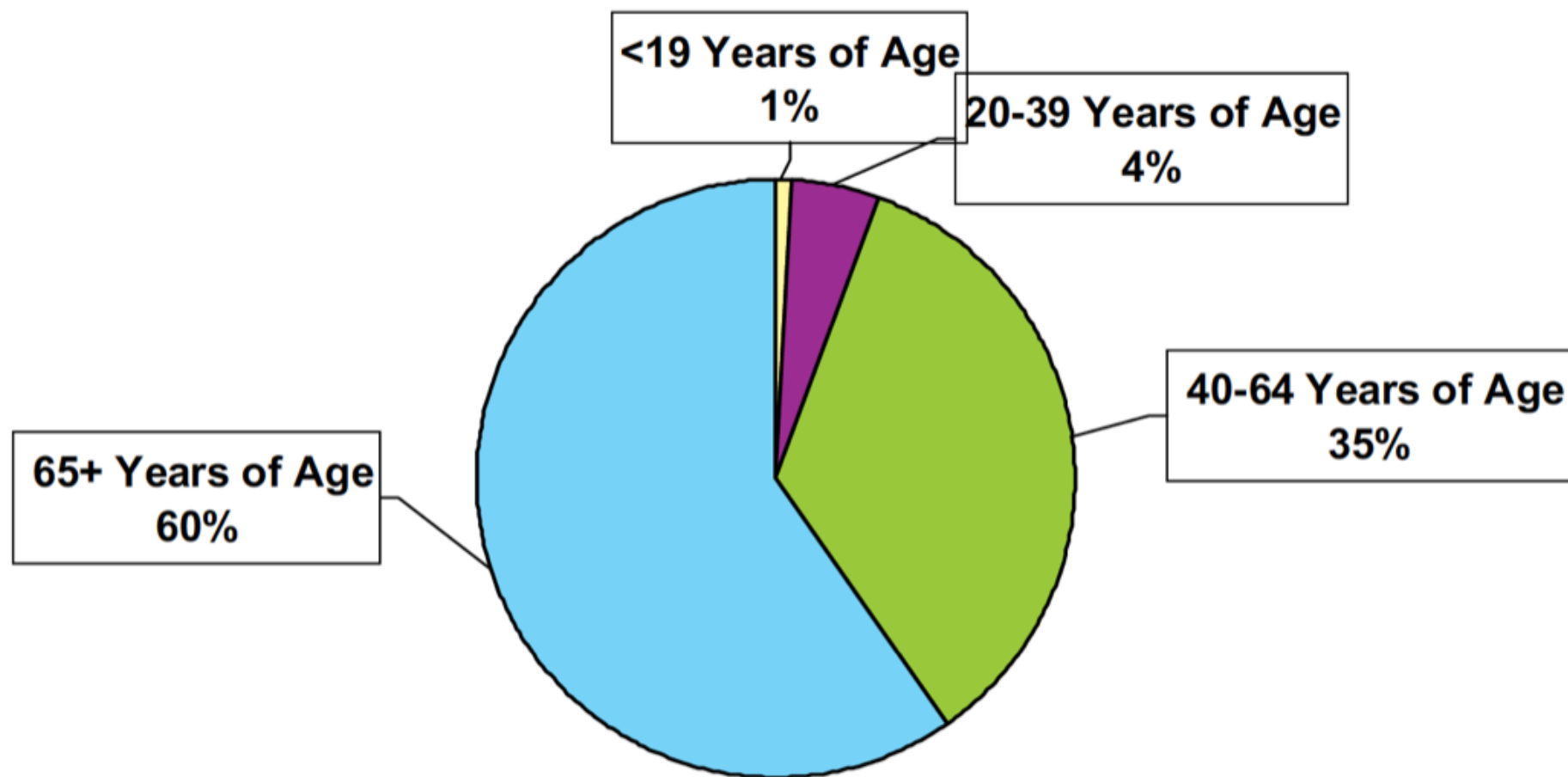


Survivorship: Adult Cancer Survivors

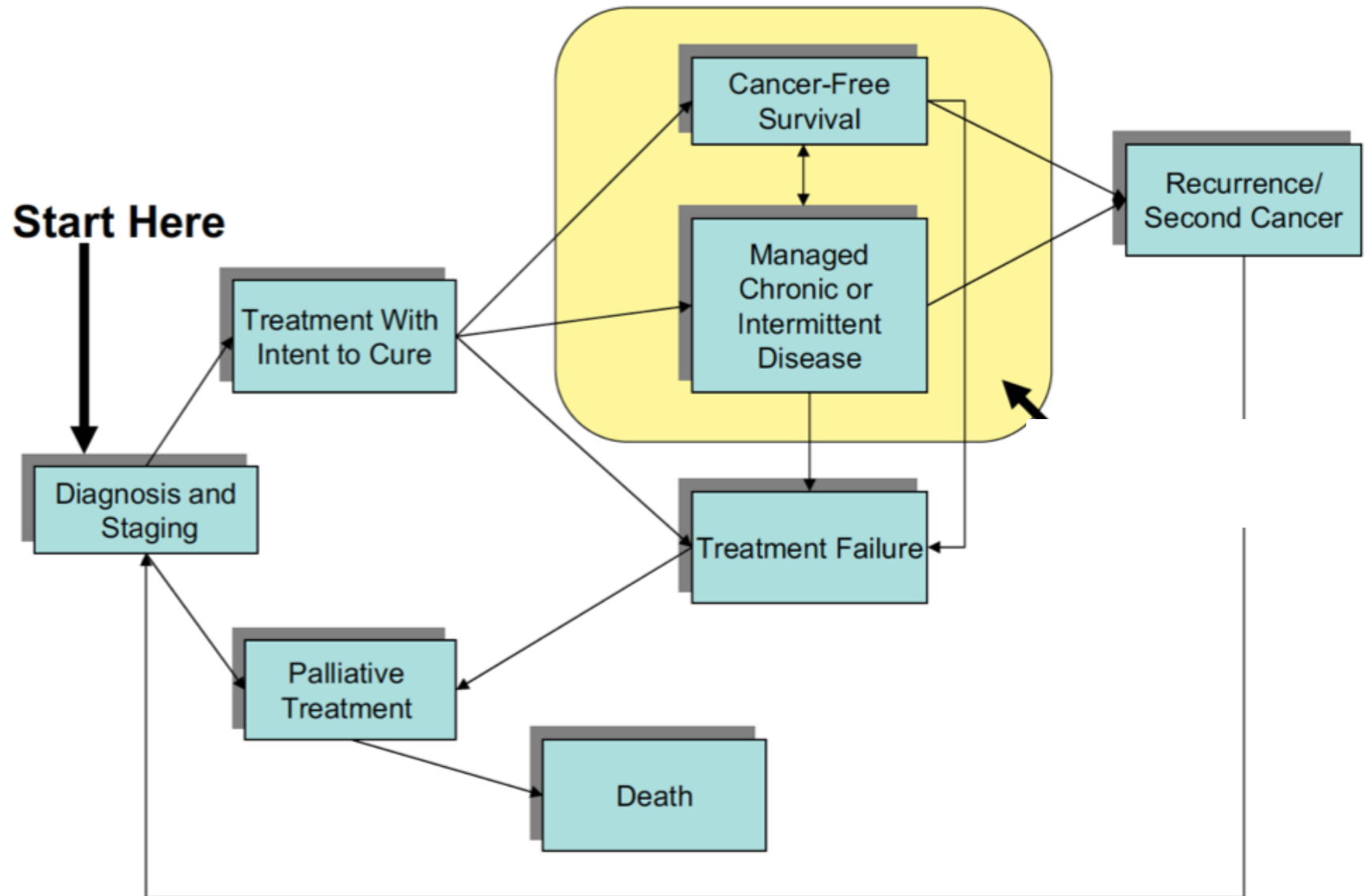


Survivorship: Adult Cancer Survivors

Prim Care Clin Office Pract 36 (2009) 721–741



Cancer Care Trajectory



REVIEW

Primary Care Physicians' Perspectives of Their Role in Cancer Care: A Systematic Review

Renae A. Lawrence^{1,2}, Jordana K. McLoone, PhD, B Psych^{1,2},

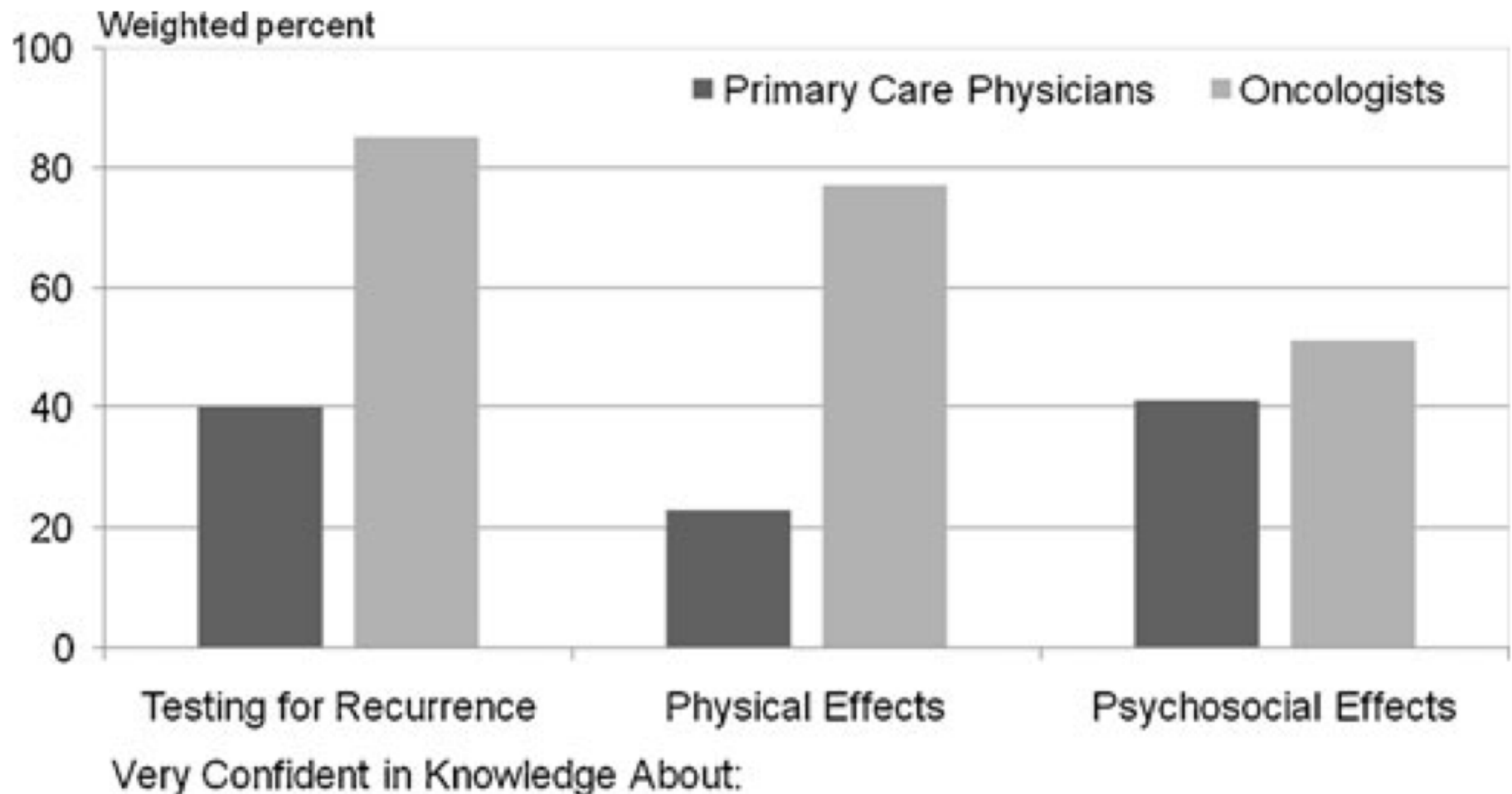
Barriers to PCP Delivery of Cancer Care

Barrier	Quantitative results	Qualitative results
Expertise or formal training	• Lack of expertise or skill identified by 52–75 % of PCPs^{49,64} • Lack of skill in discussing emotions identified by 13 % of PCPs⁷¹ • Limited formal knowledge of survivorship care identified by 47 % of PCPs⁴⁰ • Desire for formal training in breast cancer follow-up identified by 58 % of PCPs⁵⁰	• Lack of skill and specialist knowledge identified as barrier^{52,66} • Inability to remain informed on developments in oncology identified as barrier⁶⁶
Time and workload pressure	• Increased workload pressure/limited time if involvement was to be increased identified by 36–87 % of PCPs^{49,64,72} • Limited time for discussing emotions identified by 38 % of PCPs⁷¹	• Lack of time identified as barrier⁵²
Remuneration or funding	• Insufficient budget or increased cost identified by 79–83 % of PCPs^{49,72}	• Poor remuneration identified as barrier⁵²
Patient trust	• Patient preference or expectation for specialist-led care identified by 65–72 % of PCPs^{44,64}	
Resources including guidelines	• Lack of standards for providing survivorship care identified by 53 % of PCPs⁴⁰ • Inadequate access to mental health referrals for providing survivorship care identified by 46 % of PCPs⁴⁰	• Lack of general resources identified as barrier⁵²; specifically: – Knowledge of multidisciplinary professionals available to provide care⁴⁷ – Communication from oncologists⁶⁰ – Specific patient information, e.g. surveillance plans⁶⁰ – Guidelines, e.g. for screening, treatment and follow-up⁶⁹
Medicolegal risk	• Medicolegal risk identified by 83 % of PCPs⁷²	

Differences Between Primary Care Physicians' and Oncologists' Knowledge, Attitudes and Practices Regarding the Care of Cancer Survivors

J Gen Intern Med 26(12):1403-10 2011

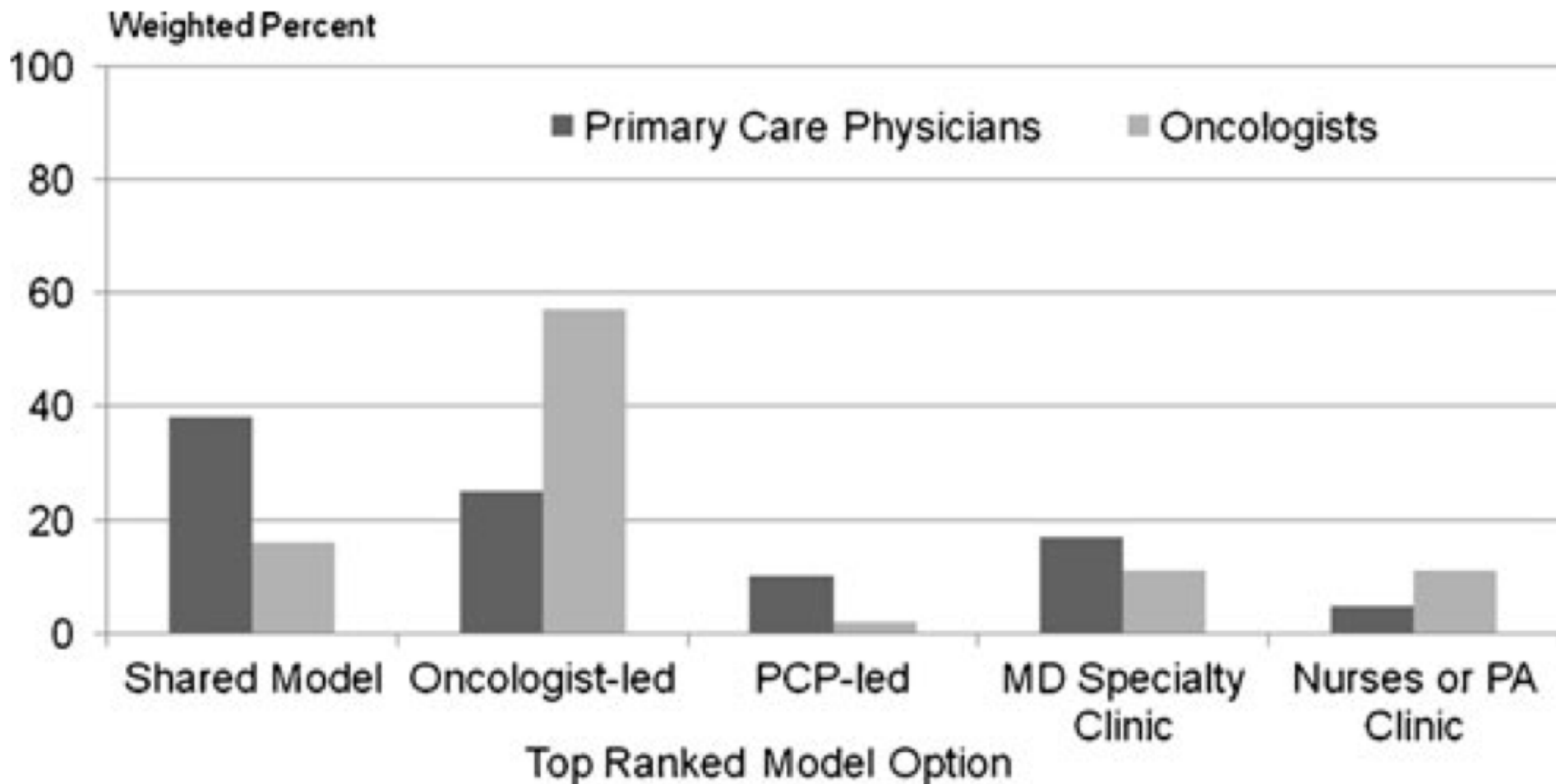
Arnold L. Potosky, PhD¹, Paul K. J. Han, MD², Julia Rowland, PhD³, Carrie N. Klabunde, PhD⁴,



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Health Care of Young Adult Survivors of Childhood Cancer: A Report from the Childhood Cancer Survivor Study

ANNALS OF
FAMILY MEDICINE

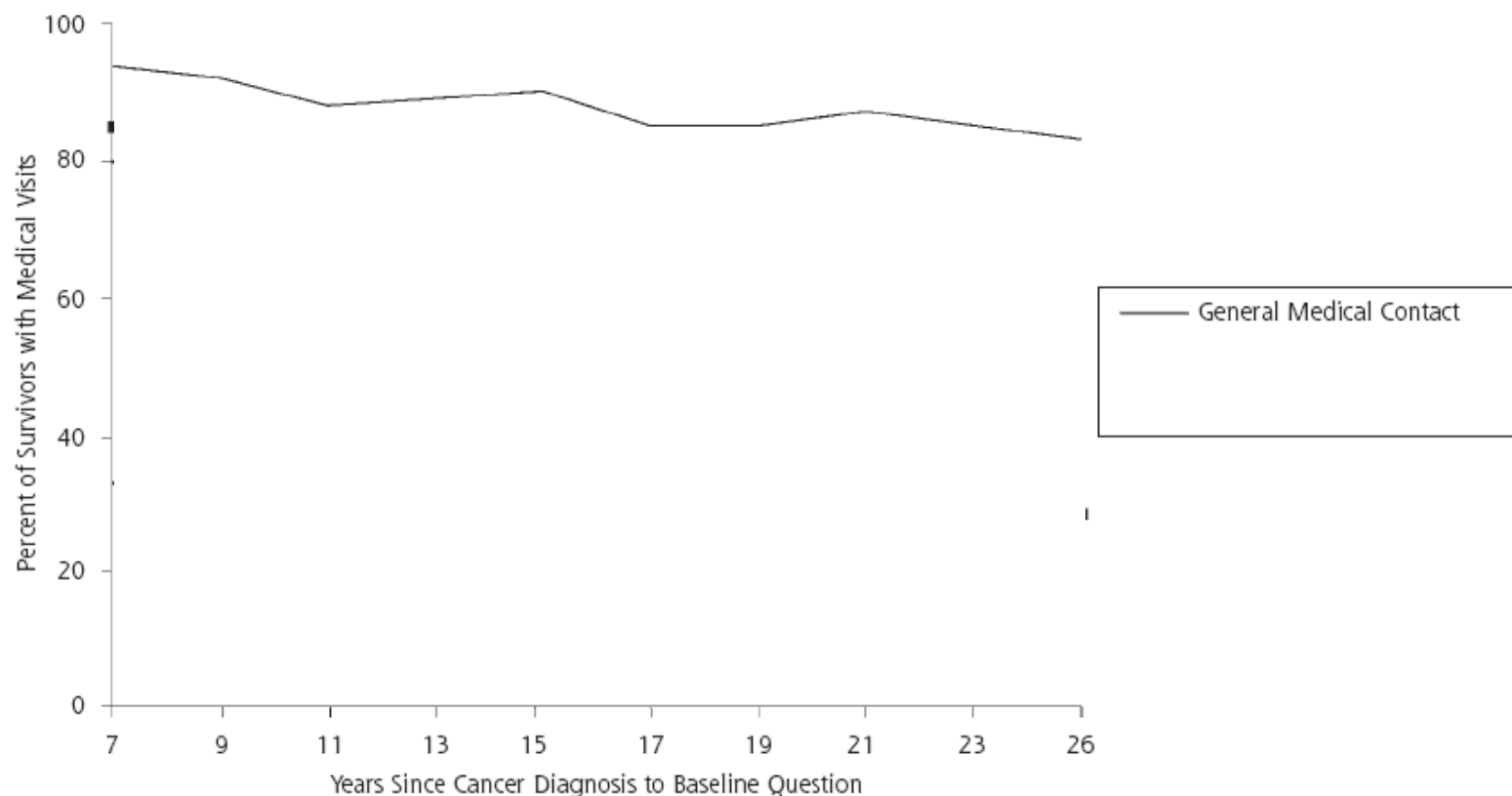
Ann Fam Med 2004;2:61-70.

Studio retrospettivo condotto sulla popolazione del “Childhood Cancer Survivor Study” (CCSS): somministrazione di un questionario.

Man mano che passa il tempo dalla diagnosi e dalle terapie, le visite (ogni tipo) calano.



Figure 1. Percentage of adult survivors of childhood cancer with medical visits in a 2-year period by interval from cancer diagnosis to baseline questionnaire.



* Trend significant with $P < .001$ for general physical education, cancer-related medical visit, and cancer center medical visit by Cochran-Armitage trend test.

Health Care of Young Adult Survivors of Childhood Cancer: A Report from the Childhood Cancer Survivor Study

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Man mano che passa il tempo dalla diagnosi e dalle terapie, le visite (ogni tipo) calano.

A 2 anni l'80% ha ancora un contatto medico:

- **71%** visita medico generale
- **42%** visita collegata al cancro
- **19%** visita presso il centro specialistico



Health Care of Young Adult Survivors of Childhood Cancer: A Report from the Childhood Cancer Survivor Study

Il calo delle visite diventa significativo proprio quando comincia a diventare più importante e probabile la comparsa delle complicanze delle terapie eseguite:

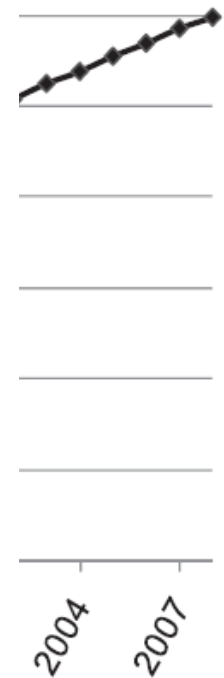
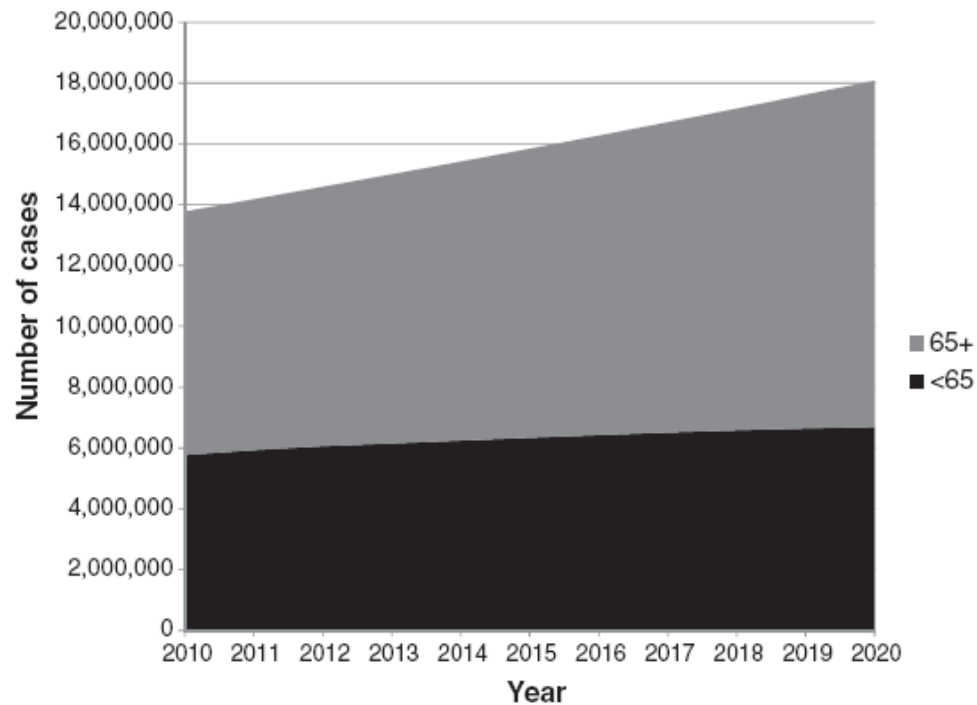
- ✓ cancro secondario
- ✓ patologie cardiovascolari
- ✓ endocrinopatie



Cancer Survivors: A Booming Population

Carla Parry¹, Erin E. Kent^{1,2}, Angela B. Mariotto³, Catherine M. Alfano¹, and Julia H. Rowland¹

Number
12,000,0
10,000,0
8,000,0
6,000,0
4,000,0
2,000,0



NUOVI COMPITI PER IL MEDICO DI FAMIGLIA

La sopravvivenza è aumentata notevolmente; si stima che 2-3 ogni 1000 giovani adulti è un bambino guarito dal cancro.

Tutti i pazienti guariti dal cancro hanno in Italia un Medico di Famiglia.

Poche informazioni sui testi di medicina, sui giornali di informazione, nei corsi di aggiornamento ed ai congressi.



Gruppo eterogeneo che comprende:

- differenti patologie neoplastiche
- diagnosticate a stadi e ad età differenti
- trattati con terapie e con raccomandazioni di screening e sorveglianza che sono in costante e complessa evoluzione

CONSEGUENZE PREVEDIBILI

Tutto questo porta a delle considerazioni conclusive:

- 1) I **centri specialistici** devono dare maggiori informazioni ai pazienti sugli effetti collaterali a lungo-termine delle terapie e sulla necessità di un follow-up al lungo termine
- 2) I **pazienti** debbono essere coinvolti come parte del Team di cura ed avere maggior responsabilità e consapevolezza dei loro rischi
- 3) I **medici di famiglia** devono aver maggiori conoscenze circa questa crescente categoria di pazienti
- 4) Debbono essere previste **maggiori comunicazioni** formali tra centri specialistici e medici di famiglia



Ann Fam Med **2004**;2:61-70.

CONCLUSIONI:

La medicina di famiglia fornisce le cure mediche a questo crescente gruppo di popolazione ad alto rischio.

Per ottimizzare ciò è auspicabile e critico che i centri specialistici ed i medici di famiglia sviluppino metodi per una comunicazione efficace e longitudinale – e si può aggiungere formale ed istituzionalizzata.



FOLLOW UP E GESTIONE DEI CHILDHOOD CANCER SURVIVORS
-ADULTI GUARITI DA UN TUMORE DELL'ETA' PEDIATRICA -
REALTA' EMERGENTE IN MEDICINA GENERALE



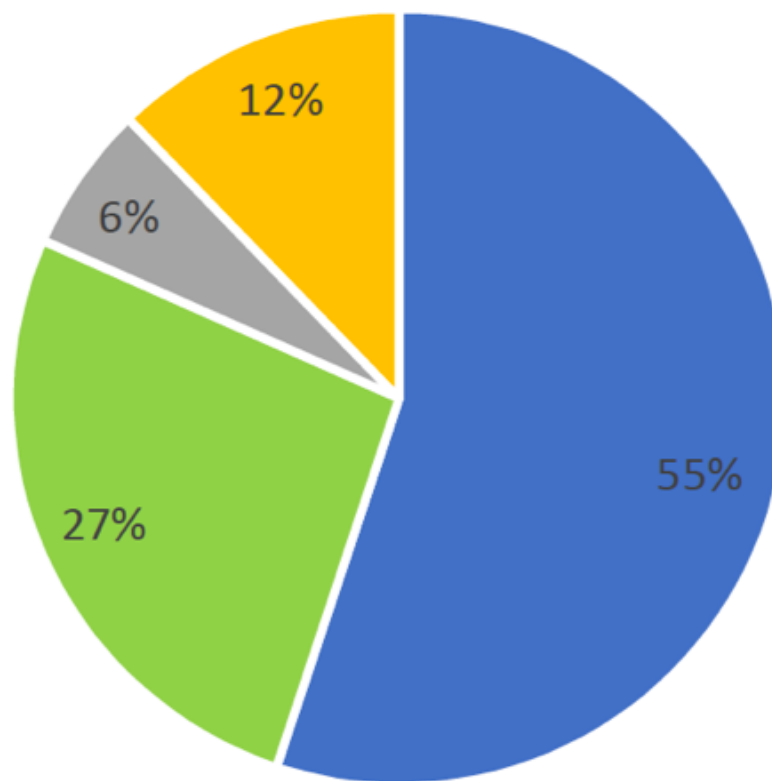
TESI PER IL CORSO IN FORMAZIONE SPECIFICA IN MEDICINA
GENERALE
TRIENNIO 2014-2017

Dott.ssa Gloria Amaniera

Risultati di una Tesi svolta nel Corso di Formazione Specifica in Medicina Generale della Regione Piemonte

Sono stati intervistati 150 Medici di Famiglia

Da quali patologie sono stati affetti



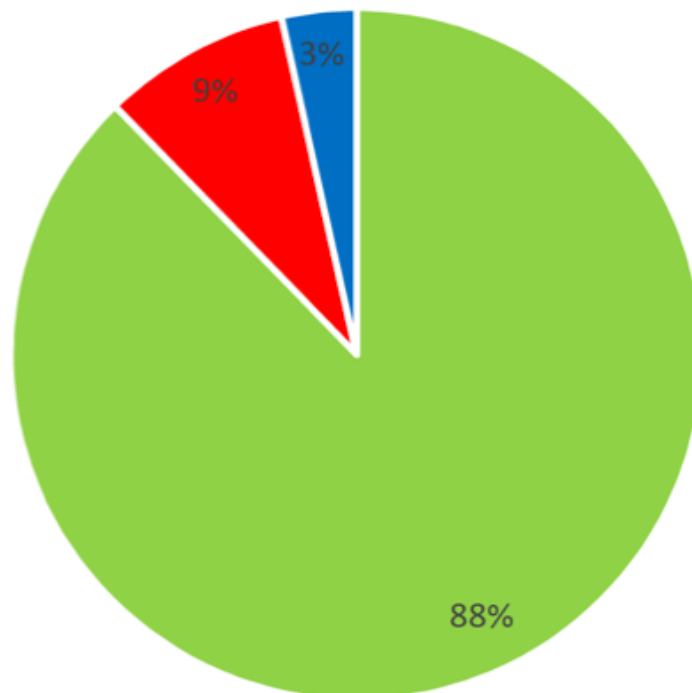
■ Tumori ematologici

■ Tumori solidi (rene, encefalo,..)

■ Sarcomi

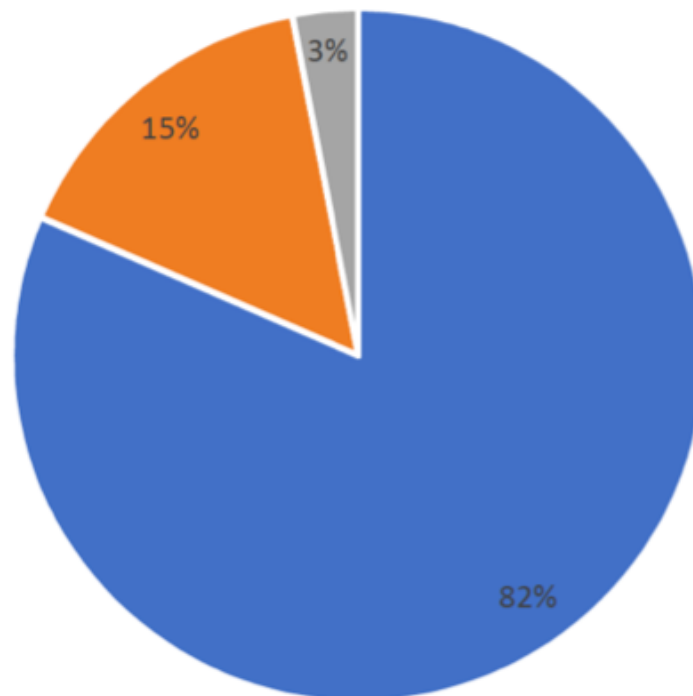
■ Seminoma

Sulla base della tua esperienza professionale, ritieni:



- Di non essere adeguatamente formato a tale scopo, ma interessato ad eventuali iniziative di formazione in tal senso
- Di essere formato per gestire correttamente il monitoraggio clinico a lungo termine di un CCS
- Che non sia necessaria una formazione "ad hoc" per gestire questo tipo di paziente

Se ti fosse affidato un paziente di questo tipo



- Preferirei una gestione integrata fra MMG e centro specialistico ospedaliero
- Preferirei che il follow-up fosse completamente affidato a strutture "dedicate", in ambito ospedaliero
- Preferirei gestire autonomamente il paziente

For Patients With Cancer, Cure Is Not Enough

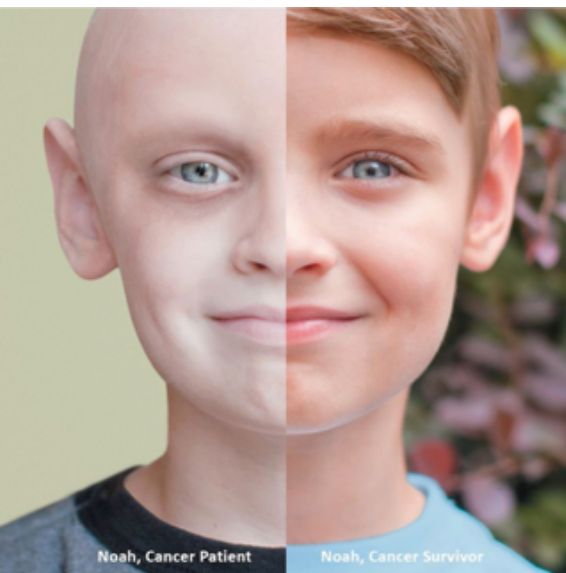
Karen E. Effinger, MD, MS; Michael P. Link, MD

JAMA Oncology Published online November 19, 2015

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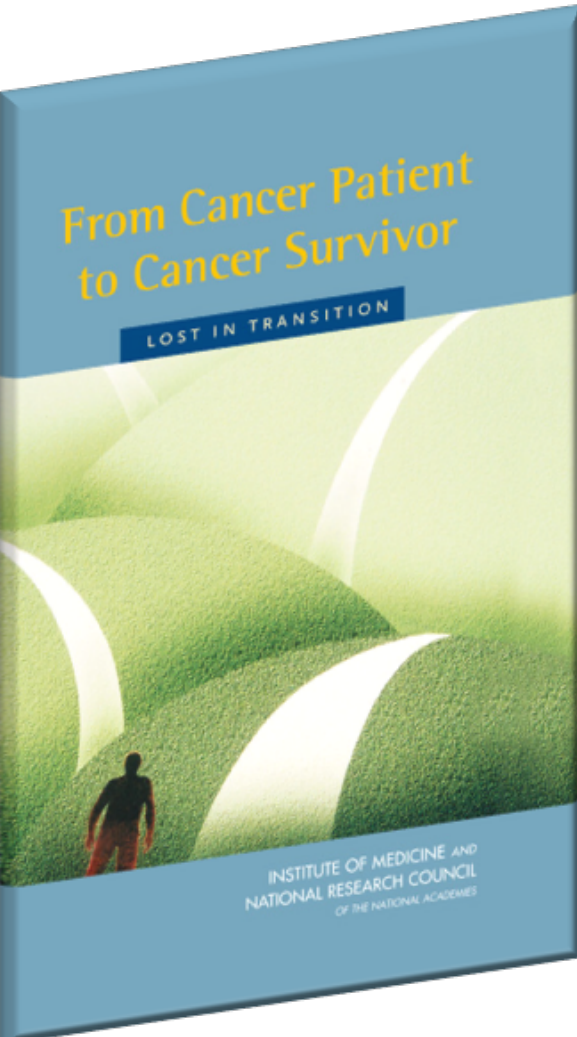


Noah, Cancer Patient

Noah, Cancer Survivor



La Bussola dei Valori



From Cancer Patient to Cancer Survivor

LOST IN TRANSITION

INSTITUTE OF MEDICINE AND
NATIONAL RESEARCH COUNCIL
OF THE NATIONAL ACADEMIES

"The challenge in overcoming cancer is not only to find therapies that will prevent or arrest the disease quickly, but also to map the middle ground of survivorship and minimize its medical and social hazards"

(F. Mullan - physician and cancer survivor, 1985)

This report focuses on survivors of adult cancer during the phase of care that follows primary treatment.

The Optimal Practice of Evidence-Based Medicine Incorporating Patient Preferences in Practice Guidelines

JAMA Published online October 28, 2013

**«Le linee Guida tendono a semplificare l'approccio al Paziente ammalato...
... ma i Medici dovrebbero ricordarsi che prendersi cura dei Pazienti
dovrebbe essere una cosa Complessa.»**



Sir Luke Fildes
The Doctor; 1891

