Spotlight session 7
Management of toxicity of old and new targeted drugs

Matti AAPRO, MD
Genolier
Switzerland
Dr Aapro is/was a consultant for Amgen, BMS, Celgene, Clinigen, Eisai, Genomic Health, GSK, Helsinn, Hospira, JnJ, Novartis, Merck, Merck Serono, Mundipharma, Pfizer, Pierre Fabre, Roche, Sandoz, Tesaro, Teva, Vifor

and has received honoraria for lectures at symposia of Amgen, Bayer Schering, Cephalon, Chugai, Eisai, Genomic Health, GSK, Helsinn, Hospira, Ipsen, JnJ OrthoBiotech, Kyowa Hakko Kirin, Merck, Merck Serono, Mundipharma, Novartis, Pfizer, Pierre Fabre, Roche, Sandoz, Sanofi, Tesaro, Taiho, Teva, Vifor

No responsibility accepted for involuntary errors or omissions. The list may be incomplete, and does not reflect consultancy for NGOs, Universities, Governmental agencies, and others.
Management of toxicity

A key factor for success

yet this is your only time for this topic

Temel et al. NEJM 2010
Zimmermann et al. Lancet 2014
Bakitas et al. Early Versus Delayed Initiation of Concurrent Palliative Oncology Care: Patient Outcomes in the ENABLE III Randomized Controlled Trial. J Clin Oncol. 2015
IT IS ALMOST ALL

on ESMO.ORG
Palliative and supportive care

**Treatment of Dyspnoea in Advanced Cancer Patients: ESMO Clinical Practice Guidelines**

Authors: *M. Kloke* and *N. Cherny*

view details

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Palliative and supportive care

**Central Venous Access in Oncology: ESMO Clinical Practice Guidelines**

Authors: *B. Sousa, J. Furlanetto, M. Hutka, P. Gouveia, R. Wuerstlein, J. M. Mariz, D. Pinto, and F. Cardoso*

view details
ESMO Clinical Practice Guidelines for the Management of Refractory Symptoms at the End of Life and the Use of Palliative Sedation

Author: N. I. Cherny

ESMO Clinical Practice Guidelines on Palliative Care: Advanced Care Planning

Authors: D. Schrijvers and N. I. Cherny
Palliative and supportive care

Cancer, Pregnancy and Fertility: ESMO Clinical Practice Guidelines

Published in 2013 – Ann Oncol 2013; 24 (Suppl 6): vi60-vi70.
Authors: F. A. Peccatori, H. A. Azim, Jr. R. Orecchia, H. J. Hoekstra, N. Pavlidis, V. Kesic, G. Pentheroudakis

Management of Chemotherapy Extravasation: ESMO Clinical Practice Guidelines

Authors: J. A. Pérez Fidalgo, L. García Fabregat, A. Cervantes, A. Margulis, C. Vidali, F. Roila

Cardiovascular Toxicity Induced by Chemotherapy, Targeted Agents and Radiotherapy: ESMO Clinical Practice Guidelines

Published in 2012 – Ann Oncol 2012; 23 (Suppl 7): vii155-vii166.
Palliative and supportive care

Management of Cancer Pain: ESMO Clinical Practice Guidelines

Authors: C. I. Ripamonti, D. Santini, E. Maranzano, M. Bertil, F. Rolli

view details
(/Guidelines/Supportive-Care/Management-of-Cancer-Pain)

Management of Venous Thromboembolism (VTE) in Cancer Patients: ESMO Clinical Practice Guidelines

Authors: M. Mandalà, A. Falanga and F. Rolli

view details
(/Guidelines/Supportive-Care/Management-of-Venous-Thromboembolism-VTE-in-Cancer-Patients)

Management of Oral and Gastrointestinal Mucositis: ESMO Clinical Practice Guidelines

Authors: D. E. Peterson, R.-J. Bensadoun, F. Rolli

view details
(/Guidelines/Supportive-Care/Management-of-Oral-and-Gastrointestinal-Mucositis)

Erythropoiesis-Stimulating Agents in the Treatment of Anaemia in Cancer Patients: ESMO Clinical Practice Guidelines

Published in 2010 — Ann Oncol 2010; 21 (Suppl 5): v244-v247.
Authors: D. Schrilvers, H. De Samblanx, F. Rolli

view details

Prevention of Chemotherapy and Radiotherapy-Induced Nausea and Vomiting: ESMO Clinical Practice Guidelines


view details
(/Guidelines/Supportive-Care/Prevention-of-Chemotherapy-and-Radiotherapy-Induced-Nausea-and-Vomiting)
Old and new targeted drugs?

WHAT TARGETED DRUGS CAN YOU CITE?
A long, long list...of toxicities

- *the classical chemotherapy toxicities of:*
  - alopecia, myelosuppression, mucositis, nausea, and vomiting
- *are replaced/complemented by*
  - vascular, dermatologic, endocrine, coagulation, immunologic, ocular, and pulmonary toxicities.

- *Bhave M, Akhter N, Rosen ST. Cardiovascular toxicity of biologic agents for cancer therapy. Oncology (Williston Park). 2014;28:482-90*
Spotlight session 7
Management of toxicity of old and new targeted drugs

- The obvious: hormonal agents
- Some targeted (or not) toxicities
  - Not too far: mucositis / stomatitis
  - A neglected issue: diarrhea
  - Even more neglected: anorexia..so-called nausea

- Bottom-line
YOU ARE FRUSTRATED?

• Something is clearly missing…
Spotlight session 7
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• **Immunotherapy**
• Some targeted (or not) toxicities
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- Bottom-line
Is hormone therapy really harmless?

Matti S. Aapro
IMO
Genolier
Switzerland
<table>
<thead>
<tr>
<th>Strategy</th>
<th>No.</th>
<th>Mean follow-up</th>
<th>Absolute decrease in recurrence</th>
<th>Absolute decrease in BC mortality</th>
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</thead>
<tbody>
<tr>
<td><strong>Upfront</strong></td>
<td>9.856</td>
<td>5.8 yrs</td>
<td>At 5 yrs</td>
<td></td>
</tr>
<tr>
<td>ATAC</td>
<td>9.856</td>
<td>5.8 yrs</td>
<td>2.9% (SE=0.7%) 2P&lt;.00001</td>
<td>1.1% (SE=0.5%) 2P=.1</td>
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<tr>
<td>BIG 1-98</td>
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<tr>
<td><strong>Sequential</strong></td>
<td>9.015</td>
<td>3.9 yrs</td>
<td>At 3 yrs from treatment divergence</td>
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</tr>
<tr>
<td>ARNO</td>
<td>9.015</td>
<td>3.9 yrs</td>
<td>3.1% (SE=0.6%) 2P&lt;.00001</td>
<td>0.7% (SE=0.3%) 2P=.02</td>
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<td>ABCSG-8</td>
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<tr>
<td>ITA</td>
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</table>
Which one to use?

<table>
<thead>
<tr>
<th>Condition</th>
<th>In favor of AIs (%)</th>
<th>In favor of tamoxifen (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot flashes</td>
<td>(-5.3)</td>
<td>(6.6)</td>
</tr>
<tr>
<td>Weight gain*</td>
<td>(-1.8)</td>
<td>(2.7)</td>
</tr>
<tr>
<td>Vag. bleeding</td>
<td>(-3.9)</td>
<td>(0.8)</td>
</tr>
<tr>
<td>Vag. discharge</td>
<td>(-9.2)</td>
<td></td>
</tr>
<tr>
<td>Endo Ca</td>
<td>(-0.4)</td>
<td></td>
</tr>
<tr>
<td>Ischemic cerebrovascular acc.</td>
<td>(-1.1)</td>
<td></td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>(-1.4)</td>
<td></td>
</tr>
<tr>
<td>Deep vein thrombosis</td>
<td>(-0.7)</td>
<td></td>
</tr>
</tbody>
</table>

Fractures of hip, spine, wrist

Musculoskeletal disorders

In favor of tamoxifen


*Proportion with ≥10% gain in body weight from baseline to year 2.
## Safety profile

<table>
<thead>
<tr>
<th>Tamoxifen</th>
<th>Aromatase inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endometrial cancer</td>
<td>Musculoskeletal events</td>
</tr>
<tr>
<td>Thromboembolic events</td>
<td>Decreased bone mineral densitometry and bone fractures</td>
</tr>
<tr>
<td></td>
<td>Cardiovascular events</td>
</tr>
</tbody>
</table>

**Comorbidities**

- Thromboembolism?
- Osteoporosis?
- Ischemic heart disease?
- Arthralgia?
Specific subpopulations might be at higher risk

- ATAC: in women with preexisting heart disease (7.5% of the total trial population) the incidence of cardiovascular events was 17% with anastrozole and 10% with tamoxifen

- MA.17: In multivariate analyses, a treatment interaction was found with cardiovascular disease and a detrimental effect was observed with letrozole administration ($P < .001$) among patients who had cardiovascular disease at baseline

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DO NOT FORGET, not only AIs...

HORMONE DEPRIVATION...

( in premenopausal women and males )
Bone loss induced by ADT for prostate cancer is rapid and clinically significant

Bone loss at 1 year (%)

- Naturally occurring bone loss:
  - Normal men: 0.5%
  - Postmenopausal women > 55 yrs: 1.0%
  - Menopausal women < 55 yrs: 2.0%
  - AI Therapy in postmenopausal women: 2.6%

- CTIBL:
  - AI Therapy + GnRH agonist in premenopausal women: 4.6%
  - Premature menopause secondary to chemotherapy: 7.4%
  - Premature menopause secondary to chemotherapy: 7.7%

References:
ESMO clinical practice guideline: Bone health in cancer patients

- Clinicians treating cancer patients need to be aware of:
  - Treatments to reduce skeletal morbidity in metastatic disease
  - Strategies to minimise cancer treatment-induced skeletal damage
- ESMO guidelines “provide a framework for maintaining bone health in patients with cancer”
OTHER TARGETED AGENTS in BrCA

- Trastuzumab cardiotoxicity: followup guidelines the role of lisinopril and other agents
- CDK4/6 and mTOR inhibition
Management of CDK Inhibitor-Induced Neutropenia

Neutropenia is the most common toxicity associated with CDK 4/6 inhibition and is not generally associated with febrile neutropenia, although an increase in infections has been reported.

Treatment should be delayed until neutrophils have recovered to at least 1000/µL; dose reduction can also be considered.

(LoE: 2A)
Management of Noninfectious Pneumonitis (NIP)

NIP is an uncommon complication of mTOR inhibition.

Patient education is critical to ensure early reporting of respiratory symptoms.

Treatment interruption and dose reduction are generally effective for grade 2 symptomatic NIP with use of systemic steroids and treatment discontinuation for grade 3 or greater toxicity.

(LoE: 2A)
Pulmonary Adverse Event Management Algorithm for I-O therapy

Rule out non-inflammatory causes. If non-inflammatory cause, treat accordingly and continue I-O therapy. Evaluate with imaging and pulmonary consultation.

Grade of Pneumonitis (NCI CTCAE v4)

Grade 1
Radiographic changes only
- Consider delay of I-O therapy
- Monitor for symptoms every 2-3 days
- Consider Pulmonary and Infectious Disease (ID) consults

Grade 2
Mild to moderate new symptoms
- Delay I-O therapy
- Pulmonary and ID consults
- Monitor symptoms daily, consider hospitalization
- 1.0 mg/kg/day methylprednisolone IV or oral equivalent
- Consider bronchoscopy, lung biopsy

Grade 3-4
Severe new symptoms; New/worsening hypoxia; Life-threatening
- Delay I-O therapy per protocol
- Hospitalize
- Pulmonary and ID consults
- 24 mg/kg/day methylprednisolone IV or IV equivalent
- Add prophylactic antibiotics for opportunistic infections
- Consider bronchoscopy, lung biopsy

Follow-up
- Re-image at least every 3 weeks
  If worsens:
  - Treat as Grade 2 or 3-4
- Re-image every 1-3 days
  If improves:
  - When symptoms return to near baseline, taper steroids over at least 1 month and then resume I-O therapy per protocol and consider prophylactic antibiotics
  If not improving after 2 weeks or worsening:
  - Treat as Grade 3-4

If improves to baseline:
- Taper steroids over at least 6 weeks
If not improving after 48 hours or worsening:
- Add additional immunosuppression (e.g. infliximab, cyclophosphamide, intravenous immunoglobulin (IVIG), or mycophenolate mofetil)
Management of Endocrine Toxicities of mTOR Inhibition

Hyperglycemia and hyperlipidemia are common sub-acute complications of mTOR inhibition. Evaluation of preexisting diabetes or hyperglycemia at baseline is essential. Regular careful monitoring of glycemia and lipid panel is needed to identify these toxicities.

Management of grade 1 and 2 hyperglycemia includes treatment with oral antidiabetics and basal insulin, in accordance with international recommendation for diabetes mellitus treatment.

Statins are indicated to treat grade 2 and 3 hypercholesterolemia, and fibrates should be introduced if triglyceride level >500 mg/dL. Treatment interruption and dose reduction are generally effective for grade 2 and 3. Treatment should be discontinued for grade 4 toxicity. (LoE: 2A)

\(^{a}\) Added by Aapro: ! Drug interaction leading to lower AUC of everolimus.
Adverse event management in patients with advanced cancer receiving oral everolimus: focus on breast cancer

M. Aapro1, F. Andre2,3, K. Blackwell4, E. Calvo5, M. Jahanzeb6, K. Papazisis7, C. Porta8, K. Pritchard9 & A. Ravaud10

1Multidisciplinary Oncology Institute, Clinique de Genolier, Genolier, Switzerland; 2French National Institute of Health and Medical Research (INSERM), Université Paris Sud, Orsay; 3Department of Medical Oncology, Institut Gustave Roussy, Villejuif, France; 4Department of Medicine/Medical Oncology, Duke University Medical Center, Durham, USA; 5Melanoma Program, Centro Integral Oncológico Clara Campal and Clinical Research, START Madrid, Madrid, Spain; 6Sylvester Comprehensive Cancer Center, Miller School of Medicine, University of Miami, Miami, USA; 7Department of Medical Oncology, Euromedica General Clinic, Thessaloniki, Greece; 8Department of Medical Oncology, IRCCS, San Matteo University Hospital Foundation, Pavia, Italy; 9Sunnybrook Odette Cancer Centre and the University of Toronto, Toronto, Canada; 10Department of Medical Oncology, Hôpital Saint-Andre, Bordeaux University Hospital, Bordeaux, France
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What Immunotherapy Agents can you cite?
Know your Immune Checkpoint Antibodies?

**Anti-CTLA-4**
- Ipilimumab (BMS)
- Tremelimumab (AZ)

  Approved

**Anti-PD-1**
- Nivolumab (BMS)
- Pembrolizumab (MSD)

  Approved

**Anti-PD-L1**
- Atezolizumab (MPDL3280A)
- Durvalumab (MEDI4736)
- Avelumab (PF-06834635 /MSB0010718C)

Courtesy of S. Champiat

B. Besse, 2015
Some toxicities of I-O

<table>
<thead>
<tr>
<th>Checkpoint protein inhibition: CTLA-4</th>
<th>Checkpoint protein inhibition: PD-1</th>
<th>Checkpoint protein inhibition: PD-L1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fevers, chills, and lethargy&lt;sup&gt;82&lt;/sup&gt;</td>
<td>Fevers, chills, and lethargy&lt;sup&gt;68-72&lt;/sup&gt;</td>
<td>Fevers, chills, and lethargy&lt;sup&gt;81,82&lt;/sup&gt;</td>
</tr>
<tr>
<td>Maculopapular&lt;sup&gt;82&lt;/sup&gt;</td>
<td>Maculopapular&lt;sup&gt;68-72&lt;/sup&gt;</td>
<td>Maculopapular&lt;sup&gt;81,82&lt;/sup&gt;</td>
</tr>
<tr>
<td>Diarrhea and colitis with ulceration&lt;sup&gt;62&lt;/sup&gt;</td>
<td>Diarrhea and colitis with ulceration: uncommon&lt;sup&gt;68-72&lt;/sup&gt;</td>
<td>Diarrhea and colitis with ulceration: rare&lt;sup&gt;81,82&lt;/sup&gt;</td>
</tr>
<tr>
<td>Elevated LFTs&lt;sup&gt;62&lt;/sup&gt;</td>
<td>Elevated LFTs uncommon&lt;sup&gt;68-72&lt;/sup&gt;</td>
<td>Elevated LFTs rare&lt;sup&gt;81,82&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hypophysitis, thyroiditis, and adrenal insufficiency&lt;sup&gt;62&lt;/sup&gt;</td>
<td>Hypophysitis, thyroiditis more common, adrenal insufficiency&lt;sup&gt;68-72&lt;/sup&gt;</td>
<td>Hypophysitis, thyroiditis more common, adrenal insufficiency&lt;sup&gt;81,82&lt;/sup&gt;</td>
</tr>
<tr>
<td>Neuropathy, nephritis, Guillain-Barré, myasthenia gravis, sarcoid, and thrombocytopenia all rare&lt;sup&gt;62,63&lt;/sup&gt;</td>
<td>Pneumonitis not common; neuropathy, Guillain-Barré, myasthenia gravis, nephritis, all rare&lt;sup&gt;68-72&lt;/sup&gt;</td>
<td>Pneumonitis rare; anemia rare&lt;sup&gt;81,82&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Weber JCO 2015
Hepatic Toxicity

- Hepatotoxicity is reported in 3–9% of patients receiving ipilimumab and in 4–10% of patients receiving anti-PD-1 antibodies, with grade 3 or 4 toxicity in 1%
- On biopsy hepatic inflammation with ballooning degeneration with diffuse lymphocytic infiltrates. Immunohistochemistry demonstrated predominantly CD4+ cells in the periportal regions and CD8+ cells in hepatic lobules
- Exclude other causes (viral, disease, etc)
- Grade 1 and 2 hepatic toxicity requires close monitoring of the LFTs and in case of grade 2 hepatic toxicity persisting for more than 5-7 days intermediate dose steroids and liver biopsy should be considered
- **Grade 3 or 4** should be treated with iv high dose steroids. If no improve within 48 h immunosuppression with mycophenolate mofitel should be considered.
- A case report describes successful use of anti-thymocyte globulin in a patient with severe ipilimumab related hepatic failure
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## Just an example: hormonal versus modulated hormonal Rx

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<th>EVE + EXE (n = 482), %</th>
<th>PBO + EXE (n = 238), %</th>
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<tbody>
<tr>
<td></td>
<td>Grade</td>
<td>Grade</td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>1</td>
</tr>
<tr>
<td>Stomatitis</td>
<td>59</td>
<td>29</td>
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<tr>
<td>Rash</td>
<td>39</td>
<td>29</td>
</tr>
<tr>
<td>Fatigue</td>
<td>37</td>
<td>18</td>
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<tr>
<td>Diarrhea</td>
<td>34</td>
<td>26</td>
</tr>
<tr>
<td>Nausea</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>31</td>
<td>19</td>
</tr>
<tr>
<td>Weight decreased</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>Cough</td>
<td>26</td>
<td>21</td>
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<tr>
<td>Pneumonitis*</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>Hyperglycemia*</td>
<td>14</td>
<td>4</td>
</tr>
</tbody>
</table>

*Incidence <25%, but AE of special interest.
Management of Mucositis/Stomatitis

Mild toothpaste and gentle hygiene are recommended for the treatment of stomatitis.

Early intervention is recommended.

For > grade 2 stomatitis, delaying treatment until the toxicity resolves and considering lowering the dose of the targeted agent are also recommended.

Although steroid mouthwash is being studied for prevention of stomatitis, there are not yet published data.

(LoE: Expert opinion)
Management of oral and gastrointestinal mucosal injury: ESMO Clinical Practice Guidelines for diagnosis, treatment, and follow-up

D. E. Peterson¹, C. B. Boers-Doets², R. J. Bensadoun³ & J. Herrstedt⁴, on behalf of the ESMO Guidelines Committee*

¹Department of Oral Health and Diagnostic Sciences, School of Dental Medicine, Program in Head and Neck Cancer and Oral Oncology Program, Naug Comprehensive Cancer Center, UConn Health, Farmington, USA; ²Department of Clinical Oncology, Leiden University Medical Center, Leiden and IMPAQTT, Wormer, The Netherlands; ³Centre de Haute Energie (CHE), Nice, France; ⁴Department of Oncology, Odense University Hospital, University of Southern Denmark, Odense, Denmark
Mascc / Isoo Clinical Practice Guidelines for the Management of Mucositis Secondary to Cancer Therapy

Rajesh V. Lalla, DDS, PhD; Joanne Bowen, PhD; Andrei Barasch, DMD, MDSc; Linda Elting, PhD; Joel Epstein, DMD, MSD; Dorothy M. Keefe, MD; Deborah B. McGuire, PhD, RN; Cesar Migliorati, DDS, MS, PhD; Ourania Nicolatou-Galitis, DDS, MSc, DrDent; Douglas E. Peterson, DMD, PhD; Judith E. Raber-Durlacher, DDS, PhD; Stephen T. Sonis, DMD, DMSc; Sharon Elad, DMD, MSc; and The Mucositis Guidelines Leadership Group of the Multinational Association of Supportive Care in Cancer and International Society of Oral Oncology (Mascc/Isoo).

Background: Mucositis is a highly significant, and sometimes dose-limiting, toxicity of cancer therapy. The goal of this systematic review was to update the Multinational Association of Supportive Care in Cancer and International Society of Oral Oncology (Mascc/Isoo) Clinical Practice Guidelines for mucositis. Methods: A literature search was conducted to identify eligible published articles, based on predefined inclusion/exclusion criteria. Each article was independently reviewed by 2 reviewers. Studies were rated according to the presence of major and minor flaws as per previously published criteria. The body of evidence for each intervention, in each treatment setting, was assigned a level of evidence, based on previously published criteria. Guidelines were developed based on the level of evidence, with 3 possible guideline determinations: recommendation, suggestion, or no guideline possible. Results: The literature search identified 8279 papers, 1032 of which were retrieved for detailed evaluation based on titles and abstracts. Of these, 570 qualified for final inclusion in the systematic reviews. Sixteen new guidelines were developed for or against the use of various interventions in specific treatment settings. In total, the Mascc/Isoo Mucositis Guidelines now include 32 guidelines: 22 for oral mucositis and 10 for gastrointestinal mucositis. This article describes these updated guidelines. Conclusions: The updated Mascc/Isoo Clinical Practice Guidelines for mucositis will help clinicians provide evidence-based management of mucositis secondary to cancer therapy. Cancer 2014;120:1453–61. © 2014 The Authors. Cancer published by Wiley Periodicals, Inc. on behalf of American Cancer Society. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

Keywords: mucositis, stomatitis, oral, gastrointestinal, guidelines, Multinational Association of Supportive Care in Cancer and International Society of Oral Oncology (Mascc/Isoo).
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</tr>
<tr>
<td>Hyperglycemia*</td>
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<td>2 1 1 1 &lt;1 0</td>
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Diarrhoea induced by chemotherapy in cancer patients is common, causes notable morbidity and mortality, and is managed inconsistently. Previous management guidelines were based on poor evidence and neglect physiological causes of chemotherapy-induced diarrhoea. In the absence of level 1 evidence from randomised controlled trials, we developed practical guidance for clinicians based on a literature review by a multidisciplinary team of clinical oncologists, dietitians, gastroenterologists, medical oncologists, nurses, pharmacist, and a surgeon. Education of patients and their carers about the risks associated with, and management of, chemotherapy-induced diarrhoea is the foundation for optimum treatment of toxic effects. Adequate—and, if necessary, repeated—assessment, appropriate use of loperamide, and knowledge of fluid resuscitation requirements of affected patients is the second crucial step. Use of octreotide and seeking specialist advice early for patients who do not respond to treatment will reduce morbidity and mortality. In view of the burden of chemotherapy-induced diarrhoea, appropriate multidisciplinary research to assess meaningful endpoints is urgently required.
DIARRHEA on I-O TREATMENTS

- DISCONTINUE TREATMENT ( temporary )
- Refer for emergency endoscopy if severe diarrhea
- Start methylprednisolone, 2 mg/kg; taper-off slowly
- Introduce if needed infliximab ( anti-TNF )
Spotlight session 7
Management of toxicity of old and new targeted drugs

• The obvious: hormonal agents
• Immunotherapy
• Some targeted ( or not ) toxicities
  • Not too far: mucositis / stomatitis
  • A neglected issue: diarrhea
  • Even more neglected: anorexia..so-called nausea

• Bottom-line
Just an example: hormonal versus modulated hormonal Rx

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ESO position paper

doi:10.1093/annonc/mdu085
Published online 25 February 2014

Early recognition of malnutrition and cachexia in the cancer patient: a position paper of a European School of Oncology Task Force

M. Aapro1, J. Arends2, F. Bozzetti3, K. Fearon4*, S. M. Grunberg5,†, J. Herrstedt6, J. Hopkinson7, N. Jacquelin-Ravel1, A. Jatoi8, S. Kaasa9 & F. Strasser10
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Please do not get depressed,

it is not that bad
Management of Cancer-Related Fatigue
Management of Cancer-Related Fatigue

Cancer-related fatigue is frequently experienced by patients with ABC, exerts a deleterious impact on QOL, and limits physical, functional, psychological, and social well-being.

The etiology of this fatigue is complex, so effective management needs to be multidimensional.

It is important to assess it using appropriate PRO measures before implementing various nonpharmacologic (such as exercise: LoE 1 A) and, if needed, pharmacologic (LoE 2 B) interventions.\(^a\)

\(^a\) Details in manuscript.
FATIGUE

- A PRACTICAL APPROACH TO FATIGUE MANAGEMENT IN COLORECTAL CANCER

- Matti Aapro, Florian Scotte, Thierry Bouillet, David Currow, Antonio Vigano

- *In press, Clinical Colorectal Cancer, 2016*
On the other side of the Pacific

MASCC/ISOO 2016
International Symposium on Supportive Care in Cancer
Save The Date...Adelaide, Australia - June 23-25 2016
On the other side of the Atlantic

Ônle conôrês de réfeñçe deś Soins Oncologiques de Support

Congrès National de l’AFSOS 2016

RDV les 12, 13 et 14 octobre 2016
Palais Brongniart

« Intégration précoce des Soins Oncologiques de Support : faisabilité et impacts »
MUCHAS GRACIAS POR SU ATENCION

APLAUDAN Y NO HAGAN PREGUNTA ALGUNA