

Five Things Physicians and Patients Should Question - 2013

The American Society of Clinical Oncology (ASCO) is a medical professional oncology society committed to conquering cancer through research, education, prevention and delivery of high-quality patient care. ASCO recognizes the importance of evidence-based cancer care and making wise choices in the diagnosis and management of patients with cancer. After careful consideration by experienced oncologists, ASCO highlights five categories of tests, procedures and/or treatments whose common use and clinical value are not supported by available evidence. These test and treatment options should not be administered unless the physician and patient have carefully considered if their use is appropriate in the individual case. As an example, when a patient is enrolled in a clinical trial, these tests, treatments and procedures may be part of the trial protocol and therefore deemed necessary for the patient's participation in the trial.

These items are provided solely for informational purposes and are not intended to replace a medical professional's independent judgment or as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their health care provider. New evidence may emerge following the development of these items. ASCO is not responsible for any injury or damage arising out of or related to any use of these items or to any errors or omissions.

1 Don't give patients starting on a chemotherapy regimen that has a low or moderate risk of causing nausea and vomiting antiemetic drugs intended for use with a regimen that has a high risk of causing nausea and vomiting.

- Over the past several years, a large number of effective drugs with fewer side effects have been developed to prevent nausea and vomiting from chemotherapy. When successful, these medications can help patients avoid spending time in the hospital, improve their quality of life and lead to fewer changes in the chemotherapy regimen.
- Oncologists customarily use different antiemetic drugs depending on the likelihood (low, moderate or high) for a particular chemotherapy program to cause nausea and vomiting. For chemotherapy programs that are likely to produce severe and persistent nausea and vomiting, there are new agents that can prevent this side effect. However, these drugs are very expensive and not devoid of side effects. For this reason, these drugs should be used only when the chemotherapy drugs that have a high likelihood of causing severe or persistent nausea and vomiting.
- When using chemotherapy that is less likely to cause nausea and vomiting, there are other effective drugs available at a lower cost.

2 Don't use combination chemotherapy (multiple drugs) instead of chemotherapy with one drug when treating an individual for metastatic breast cancer unless the patient needs a rapid response to relieve tumor-related symptoms.

- Although chemotherapy with multiple drugs, or combination chemotherapy, for metastatic breast cancer may slow tumor growth for a somewhat longer time than occurs when treating with a single agent, use of combination chemotherapy has not been shown to increase overall survival. In fact, the trade-offs of more frequent and severe side effects may have a net effect of worsening a patient's quality of life, necessitating a reduction in the dose of chemotherapy.
- Combination chemotherapy may be useful and worth the risk of more side effects in situations in which the cancer burden must be reduced quickly because it is causing significant symptoms or is life threatening. As a general rule, however, giving effective drugs one at a time lowers the risk of side effects, may improve a patient's quality of life, and does not typically compromise overall survival.

3 Avoid using PET or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.

- PET and PET-CT are used to diagnose, stage and monitor how well treatment is working. Available evidence from clinical studies suggests that using these tests to monitor for recurrence does not improve outcomes and therefore generally is not recommended for this purpose.
- False positive tests can lead to unnecessary and invasive procedures, overtreatment, unnecessary radiation exposure and incorrect diagnoses.
- Until high level evidence demonstrates that routine surveillance with PET or PET-CT scans helps prolong life or promote well-being after treatment for a specific type of cancer, this practice should not be done.

4

Don't perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.

- Since PSA levels in the blood have been linked with prostate cancer, many doctors have used repeated PSA tests in the hope of finding “early” prostate cancer in men with no symptoms of the disease. Unfortunately, PSA is not as useful for screening as many have hoped because many men with prostate cancer do not have high PSA levels, and other conditions that are not cancer (such as benign prostate hyperplasia) can also increase PSA levels.
- Research has shown that men who receive PSA testing are less likely to die specifically from prostate cancer. However when accounting for deaths from all causes, no lives are saved, meaning that men who receive PSA screening have not been shown to live longer than men who do not have PSA screening. Men with medical conditions that limit their life expectancy to less than 10 years are unlikely to benefit from PSA screening as their probability of dying from the underlying medical problem is greater than the chance of dying from asymptomatic prostate cancer.

5

Don't use a targeted therapy intended for use against a specific genetic aberration unless a patient's tumor cells have a specific biomarker that predicts an effective response to the targeted therapy.

- Unlike chemotherapy, targeted therapy can significantly benefit people with cancer because it can target specific gene products, i.e., proteins that cancer cells use to grow and spread, while causing little or no harm to healthy cells. Patients who are most likely to benefit from targeted therapy are those who have a specific biomarker in their tumor cells that indicates the presence or absence of a specific gene alteration that makes the tumor cells susceptible to the targeted agent.
- Compared to chemotherapy, the cost of targeted therapy is generally higher, as these treatments are newer, more expensive to produce and under patent protection. In addition, like all anti-cancer therapies, there are risks to using targeted agents when there is no evidence to support their use because of the potential for serious side effects or reduced efficacy compared with other treatment options.

Abbreviations

CT, computed tomography; PET, positron emission tomography; PSA, prostate-specific antigen.

How This List Was Created

To guide ASCO in developing this list, suggestions were elicited from current ASCO committee members (approximately 700 individuals); 115 suggestions were received. After removing duplicates, researching the literature and discussing practice patterns, the Value in Cancer Care Task Force culled the list to 11 items, which comprised an ASCO Top Five voting slate that was sent back to the membership of all standing committees. Approximately 140 oncologists from its leadership cadre voted, providing ASCO with an adequate sample size and perspective on what oncologists find to be of little value. The proposed 2013 Top Five list was reviewed and finalized by the Value in Cancer Care Task Force and ultimately reviewed and approved by the ASCO Board of Directors and published in the *Journal of Clinical Oncology*. ASCO's disclosure and conflict of interest policies can be found at www.asco.org.

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