



Performance Improvement Strategies in Colorectal Cancer Audio Conference

March 10, 2010

OLIVIA FRITZ: Welcome to the community of Practice Teleconference with colorectal cancer experts Dr. Thomas Cartwright and Dr. John Marshall. I'm Olivia Fritz, your moderator for today's discussion. This teleconference is being recording, however resale of the content is prohibited.

During today's call, you will have an opportunity to discuss ways to advance in the care of patients with colorectal cancer and specific process measures to implement in order to improve your practice. This activity has been developed as part of the AMA standardized CME initiative performance improvement strategy in colorectal cancer for which Doctors Cartwright and Marshall have served as faculty experts. Details about this program will be discussed during today's teleconference.

I am pleased to now introduce you to Dr. Cartwright and Dr. Marshall. Dr. Cartwright is Co-Chairman of the U.S. Oncology GI Research Committee and a medical oncologist in private practice in Ocala, Florida. Dr. Marshall is a Professor of Medicine and Oncology and Chief of the Division of Hematology/Oncology at Georgetown University. Dr. Marshall also serves as Associate Director of Clinical Research at Lombardi Comprehensive Cancer Center in Washington, D.C.. Dr. Marshall?

JOHN MARSHALL, MD: Thank you very much for that kind introduction, and thank you all for joining Tom and me tonight for our overview of this program. The program is a community of practice form forum for colorectal cancer, and essentially the goal of our audio conference is to bring together specialists who are interested in the care of patients with colorectal cancer and really to try and focus on some of the advances in the care of these patients.

Particularly tonight focusing on process or systems of care, and that's not really something we do routinely, drilling down on how our practice runs and the like. And so, we've got some insights into this. The state of colon cancer care is really changing quite rapidly, and it's important that we all keep up with this. And so, we have really developed this performance improvement initiative in order to give us a tool, all of us frankly, to incorporate into our practices to do a better job of what we're doing.

So, for those of you who may not be familiar with performance improvement or a PI program, this is an AMA approved CME format in which docs like us who want to work on improving our individual performances and we broke it into stages of first data collection and self assessment, and then after you sort of figure out how you're doing, implementing an improvement plan into your practice. This particular one we're working on tonight focuses on colorectal cancer. We've broke that into three main areas, which are of course, important targets for us in our outcomes based world. They are supportive care and patient safety, the application of evidence based surveillance and the application of evidence based treatment, all of those are really increasingly important to our practices and our payers and the like. So, we thought this was a very good focus for us. And to our knowledge this program is the only performance improvement initiative which is focused solely on the care of patients with colon cancer and is designed for oncologists such as us.

So, to give you a little bit more background, let me turn the phone back over to Dr. Cartwright, who's going to give you a little bit more background on this. Tom, the floor is yours.

THOMAS CARTWRIGHT, MD: Okay. Thank you. As you know, the 2000 national initiative on cancer quality care funded by ASCO found that nearly...that newly diagnosed colorectal cancer patients had a one in five chance of not receiving an element of care consistent with best practices. In 2005, a pilot group evaluated ASCO's coping program and only 78% of colorectal cancer patients received recommended care and significant differences in many core measures were seen across practices. One of the most notable finding that pain assessment and colorectal cancer patients prior to

death were documented anywhere between 15 and 90% of evaluated practices. There have been several other reports about the impact of performance improvement programs and the care of cancer patients. One of the most tangible examples of success include the improvement in harvesting and evaluating the number of lymph nodes seen in colorectal cancer patients. The quality initiative program based on ASCO measures in Ontario, Canada found that using a program like this, they've a much higher percentage of patients undergoing surgery for colorectal cancer, 12 or more lymph nodes were identified.

In Florida, we've been participating in a similar program, the Florida Initiative for Quality Cancer Care. It's about eight practices around the state of Florida working with Moffitt Cancer Center, which is the only comprehensive cancer care center in Florida. And we've developed...and some of the ideas from this program have come out of that program, and we've been doing that for the last couple of years and found that a variety of outcome measures, at least by the fact being able to document and chart are much higher. So, with that said before we begin the question session, Dr. Marshall is going to review the steps for participation in our PI program.

DR. MARSHALL: Thanks, Thomas. So, the way this was set up is really three phases to the process and there are five CME credits available for each step and a bonus five credits if you do the entire thing. So, it's broken out that way. So, the first stage or stage A is really for you to perform a retrospective analysis of ten patient charts and complete a short data collection form for each chart. Now, these are going to be colorectal cancer patients. These can be done by physician or by a proxy. And we've sort of estimated in our pilots study that this takes about five to ten minutes to do for each form. So, this is not a major time commitment for you or your proxy.

So, in addition to the chart review you also do need to complete a brief self assessment of your current practice patterns, and this additional questionnaire takes about five to ten minutes. So, pretty straight forward, identify five to ten patient charts, see how you're doing, and do a self assessment. Once that's been completed, you would then receive a summary of your practice patterns relative

to those of your peers. So, in other words you get sort of a snap shot of how are you doing relative to your other peers out there on these national standards.

And then there's a second part, stage B, where after reviewing your results you design an improvement plan to implement to change your processes or to improve your processes in the areas that you need. There's complimentary CME certified implementation guide with tools for improving the care, and participants who participate in this activity get an extra 1.5 CME credits beyond the five that are available for this part two. So, the CMEs can really pile up nicely for you as you go through all of this.

And then as a final stage, stage C, you'll get...you'll again find ten patients, but this time for patients that you saw after you started the program. In other words, how much did you learn through all of this? Similar data collection form is completed for each patient, and this can also be completed by a proxy of yours. After stage C is done—so you've gone through your first ten, your review, your second ten—you're going to get a summary of your current practice patterns related, relative to your colleagues and peers out there. And then once all this is done, data collected through this program can be used to completed the American Board of Internal Medicine self directed practice improvement module and satisfy the practice improvement requirement for the maintenance of certification.

So, you know, I think this is good all around for all of us to do, and you get a lot of bang for your buck both in CME as well as the AVIM aspects. Dr. Cartwright, anything else you want to throw in there about the process of what we're talking about?

DR. CARTWRIGHT: No, not really. I think you've covered it pretty well. I agree, I think this will be a useful program for everybody to evaluate their practices and subsequently hopefully improve the quality of care we deliver to our patients. So, I think at this point we can probably turn it back over to the moderator to being the question and answer portion.

MS. FRITZ: Thank you, doctors. At this time, we will begin the question and answer session. If you ask a question, please press zero followed by a one on your touch tone phone. Questions will be answered in the order they are received. If you have a question please press zero followed by a one now. Please pause to access whether we receive live questions in the queue. While we pause, Med-IQ received several questions in advance for this teleconference. At this time, Sarah will share a question that was submitted by one of your colleagues.

SARAH: Thank you, Olivia. Dr. Cartwright, as we speak about process measures we received a question from a participant who states he or she has limited control over the number of lymph nodes that are sampled at a surgery. Can you suggest some ways that an oncologist can impact this?

DR. CARTWRIGHT: That's a good question, and you know, there's really three possibilities when less than 12 lymph nodes are identified. Could it be that the surgeon that didn't do a wide enough resection? Was it the pathologist that didn't take the time to identify the lymph nodes? And some people just have fewer lymph nodes, and it may be patient factors. I'm not sure there's any one simple answer to this. We review a lot of these, most...a lot of patients like this at our weekly tumor board meeting. The pathologist comes. We try to get the surgeons to come, and if less than 12 lymph nodes are identified, we try to find out why. You know, we talk to the pathologist. The pathologist, you know, always says it's not his fault, it's the surgeon's fault. The surgeon says vice versa. And sometimes it's really nobody's fault. It's just a matter of patients are different and some have less than 12 lymph nodes. But if there's one surgeon that's consistently identifying—it's generally the same pathologist—so, if it's one surgeon that's consistently identifying less than 12 lymph nodes, then that person just sort of stands out, and typically just responds to, I guess peer pressure.

So, I think, you know, if the surgeon or the pathologists are not aware of this information—I think most people are—pointing it out to them and discussing it at tumor board and...so, I think it's just an individual. You probably have to individualize each case with the surgeon and the pathologist. But I think if you look at many institutions

around the country, looking at the number of lymph nodes that have been identified, I think more and more it's going up; at least I hope that's the case.

MS. FRITZ: Thank you, doctor. Again, as a reminder to our participants, if you would like to ask a question, please press zero, one on your touch tone phone. At this time, we will return to Sarah with another pre-asked question.

SARAH: Thank you, Olivia. Dr. Marshall, another colleague of yours asks in our practice there's limited availability of mental health providers for treating our patients with significant emotional distress. What can I do?

DR. MARSHALL: Well, apart from taking Paxil yourself, it is quite a challenge. And, you know, we've got a new set of standards that really are asking us to measure distress in all our patients, sort of as a newer vital sign after pain and the like. And when you find it, then what are you going to do about it? There's certainly things out in the community that are out there to help folks, but frankly they take a lot of our resources and a lot of our time. So, this is a thing we're struggle with even in our own cancer center where we are now piloting just for a month long session of measuring distress using a distress meter. The NCCN produced a distress meter, a very simple tool. And we're just trying to find out how common is it that patients have high levels of stress that would ordinarily require intervention, you know, beyond what an oncology practice is designed to measure.

So, you know, it's an outstanding question. I wish I could wave a magic wand and say that there is this kind of help out there for all folks. We all patch this together with duct tape, as far as I can tell. A social worker here, a psychiatrist there, you know, one of our nurses, or our staff, or even us doing a lot of this emotional support. So, not an easy answer to what is probably a bigger problem than we realize.

MS. FRITZ: Thank you, sir. And Sarah, please go ahead with another question.

SARAH: Sure. Dr. Cartwright, one of our participants would

like you please to clarify how staging relates to treatment, and how do the new staging guidelines change what we're already doing?

DR. CARTWRIGHT: Well, yeah. The new staging guidelines which were issues by or published by the American Joint Commission on Cancer were just published earlier this year. The new staging manual, if anybody has seen it, is probably about twice the size of the old staging manual. There's actually quite a few changes not only in colon cancer, but many other cancers. And the reason for these changes was to update the staging to correlate or correspond to what we see with the prognosis. For example, in the old colon cancer staging system, patients with stage 3A actually had a better prognosis than stage 2B. We typically routinely give adjuvant chemotherapy to stage three patients. We're not always entirely sure what to do with stage two patients. But this new staging system has clarified. Stage two is now divided into 2A, B, and C. There is some changes in stage three. But it's basically to update the staging manual and the staging system to better correlate with the prognosis and treatment outcome, and this way we can not only design trials, but recommend treatment to patients that correlate better with their, you know, more modern prognosis. So, yeah, I mean, the new staging system is quite...it's much more detailed, complicated. It took me a long time to learn the old one. I don't know how long it's going to take me to learn the new one, but it does look like it's a significant improvement.

MS. FRITZ: Thank you. And again, as a reminder to our participants to ask a question live, please press zero followed by a one now. And Sarah, I will turn it back to you for another pre-submitted question.

SARAH: Okay, thank you. Dr. Marshall, could you please comment. We have a participant who would like to better understand the relationship between KRAS and treatment options. Would you please explain a little bit more.

DR. MARSHALL: No, glad to do that. So, this is really one of the most important molecular changes that has occurred in colorectal cancer. And it's the discovery really that KRAS is an important determinant of whether an EGFR agent has a chance of working or not. You're very familiar with ER/PR

and HER2 in breast cancer, your EGFR mutations in lung cancer are emerging. The same is true in colon cancer. We knew when we gave cetuximab and panitumumab to patients, only a small subset of patients were clearly benefiting. And those patients were benefiting a lot, but we didn't know which ones. And of course, we started by measuring EGFR receptors because if an antibody is going to work, it's got to hit the receptor, but that turns out to be the wrong thing to measure. As in colon cancer, about 40% of all colon cancer patients have a mutation in their RAS gene, which is essentially stuck in the on position. So, when RAS is below if you will, or downstream from the receptor. So, you can block that receptor all you want because downstream, the RAS gene is going to be stuck on and keep firing, meaning the antibodies won't work.

So, you test KRAS in any patient in whom you're thinking about giving an EGFR monoclonal antibody, cetuximab, or panitumumab. Generally, this is going to be metastatic disease. There's newer and newer data about first, second, and third line with the EGFR drugs. So, in our practice we're routinely checking it in almost every metastatic patient, so we know if that drug's on the table, or those drugs are on the table or not. So far we haven't been able to demonstrate that RAS is a prognostic marker. So, meaning just having a RAS mutation doesn't necessarily mean your cancer is more aggressive. It just means that those drugs are not - -. So, anybody—the rule of thumb—anybody that you're going to be using an EGFR monoclonal antibody in, you need to know their KRAS.

SARAH: Thank you, Dr. Marshall. Dr. Cartwright, can you please comment on the role of the genomic assay in stage two colorectal cancer?

DR. CARTWRIGHT: Okay. Yeah. Genomic Health just released a...it's called Oncotype DX for stage two colon cancer. Just by way of background, I think most oncologists are familiar with the Oncotype DX test for breast cancer. It's a 21 gene assay that's used to help choose or help determine whether an ER positive node negative breast cancer patient would benefit from adjuvant chemotherapy. And the Oncotype DX score in breast cancer is used mainly for that subset of patients. You get a score, a number. If it's high, there's a high risk of the patient recurring.

If it's low, the risk is low. And the test in breast cancer is not only prognostic, but also predictive. That is, patients with a high score are likely to benefit from chemotherapy, low score not so.

Now, the genomic assay, the Oncotype DX test for colon cancer I think was just released or approved by Genomic Health in January this year, just a couple of months ago. So, people have just started using it. It's mainly designed for stage two colon cancer patients, node negative patients. As I mentioned earlier, stage two colon cancer patients generally have a good prognosis. Some of these patients do benefit from adjuvant chemotherapy, but we really don't know how to identify these patients, completely anyway at this point. So, the genomic assay, I think it's a 15 gene for the colon cancer. It's a little bit different than breast cancer. It's not predictive. It doesn't predict whether the chemotherapy's going to help or not. It just gives a little better idea of the prognosis in stage two colon cancer patients.

So, I think it's something...I think as it's just been approved in the last couple of months, I think oncologists are just starting to use it, and exactly what its role is, how it's going to be used will probably be defined over the next several years. I've seen in the last couple of months a couple of stage two patients. One was an elderly woman in her 80s that had significant comorbidities. She told me she wasn't going to take chemotherapy no matter what I said, and so there's really no reason to order this test. In a younger person who you feel is high risk, you're probably giving them adjuvant chemotherapy anyways. So, it's helpful in the large gray zone in the middle, people maybe in their 60s or 70s to help determine whether it's a good idea to give them adjuvant chemotherapy.

SARAH: Thank you, Dr. Cartwright. Dr. Marshall, our next question comes from a colleague who asks something Dr. Cartwright just touched a little bit on. This participant says I have a high percentage of elderly patients with multiple comorbidities. Can you comment on how you approach these cases?

DR. MARSHALL: Talking about adjuvant versus metastatic and the like, I try not to be that absolute based on a patient's comorbidities. I mean, you sort of know a patient who can tolerate some chemotherapy. You kind of look at them and

make decisions. To be a little bit probably more gentle with your chemotherapy, consider some slight dose reductions at the outset mainly because you don't have the wiggle room that you normally would in a patient who is quite sick. So, I think, you know, age, comorbidities, and all of these factor are beginning to take a larger role in our patient populations. And so, how best to incorporate decision making? You know, I find the adjuvant one the hardest.

I've got a current stage three patient, three positive nodes, poorly differentiated, but he's right around 80. He's pretty fit, but you know, he likes to sit in his armchair and watch t.v. Most of the time, former smoker, little coronary disease, but you hate not to give a guy like that adjuvant therapy who is frankly, you know, likely going to live another five to ten years, you know, if something else didn't come along. So, in his case, he was quite eager to try some chemotherapy, did not want more aggressive say folfox based chemotherapy, and opted more for a Xeloda type regimen. And even there traditional Xeloda dosing can be quite hard on a patient in this age group, so we did some dose modifications now in his setting in particular.

So, but I have another patient in whom, you know, was actually from northern Michigan, moved down to live with her daughter when she was diagnosed with metastatic colon cancer. And the oncologist up in Michigan had said no, I'm not touching you, you know, I'm sorry. And frankly, she's been on chemotherapy for two and a half years now, doing fine. So, you know, you never know in a way, so you kind of...to me, I keep those windows open and see...start slowly and creep in, but a lot of times you'd be surprised at just how well those patients will do with chemotherapy.

SARAH: Thank you, Dr. Marshall. We have another participant who would like you please, Dr. Cartwright, to comment on the role of cetuximab, bevacizumab, and panitumumab in metastatic cancer and where to put these agents into treatment.

DR. CARTWRIGHT: Well, that's a good question. At this point, none of them have a definite role in early stage or adjuvant patients, although there are studies looking at that. Typically the agents are given in combination with chemotherapy. Most oncologists use avastin first line

typically with folfox chemotherapy, although occasionally folfiri or even an Xeloda based regimen. Although there is data now both with erbitux and with vectibix that it's effective first line, especially in KRAS wild type patients. And so, which one we choose kind of depends on a little bit on habit. It depends on the patient's functional status, comorbidities we talked about before. A patient that has a recent thromboembolic event, a history of bleeding, hypertension, you may shy away from avastin, and if they're KRAS wild type, use one of the EGFR drugs. Often we give chemotherapy alone second line, although there is some evidence—although it's not the greatest evidence—that avastin can be continued second line. Now, there's good data with vectibix given in combination with chemotherapy from the European conference. A lot of times these drugs are reserved—especially erbitux and vectibix—are reserved for third line patients either as single agents, or erbitux in combination with irinotecan. You know, vectibix, if you go just by the FDA label, it's approved for third line patients that have failed both an oxaliplatin and an irinotecan based regimen. So, there's a lot of new data. Exactly how these drugs are sequenced, I don't think there's necessarily an absolute right or wrong way. There is actually reasonable evidence that patients that are exposed to all the different drugs at some point, and that's not just the different biologicals, but the different chemotherapies, have a better prognosis or a longer survival. The untreated survival of a stage four colon cancer patient is about six months. With five FU or Xeloda as single agents, it's about a year. Adding in most of these drugs or the vast majority of them, many patients with stage four disease we are seeing survivals in the two to three year range now. And a few patients that have stage four disease can be made potentially resectable with these agents and even curable. So, it's a great question and it's something that almost has to be individualized for each patient.

MS. FRITZ: Thank you, doctors. And again, as a final reminder to our audio participants, if you would like to ask a question, please zero, one now.

[Short pause]

MS. FRITZ: And with no further questions, I will turn it back to the doctors for any final comments for today's



conference.

DR. MARSHALL: This is John. Just thanks everybody for joining in. We hope you participate in our quality improvement initiative and hope you find it useful. And let us know if you do.

MS. FRITZ: Thank you, gentlemen. This concludes today's CRC community of practice teleconference provided by Med-IQ in collaboration with Oncology Today and supported by an educational grant from Sanofi-Aventis U.S. More than 100 specialists have enrolled in performance improvement strategies in colorectal cancer to self assess and improve their CRC processes of care. To join them or to learn more, please visit www.pi-iq.com/crc. Thank you for your time and commitment to improving CRC patient care.