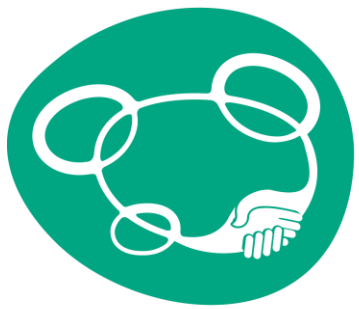

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HOW COVID-19 HAS IMPACTED PROSTATE CANCER CARE MANAGEMENT OF SIDE EFFECTS

Janet Forgenie, RN
Uro-Oncology Clinical Nurse Specialist
University College London Hospital, UK

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DISCLAIMER AND DISCLOSURES

Please Note: Views expressed within this presentation are the personal opinions of the author. They do not necessarily represent the views of the author's institute or the rest of the GU Nurse CONNECT group.

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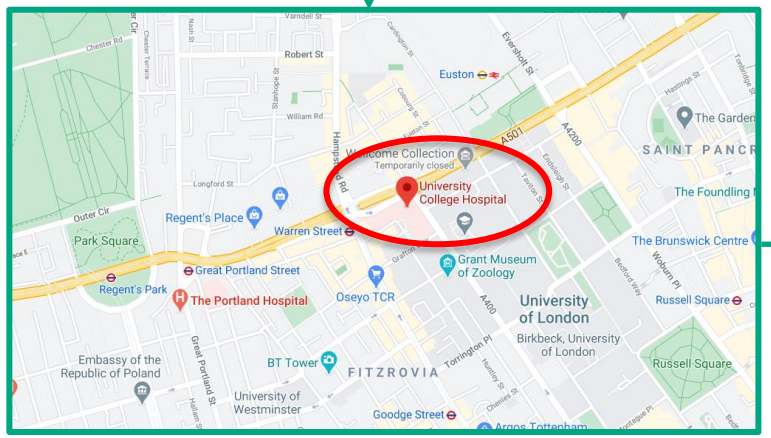
UNIVERSITY COLLEGE LONDON HOSPITAL (UCLH)

SITUATION DURING THE COVID-19 PANDEMIC

Challenges of Central London Hospital;
Travel risks during COVID-19



- Increase ability to use patient transport
- Tx stopped
- COVID screening
- Virtual clinics

- Patients scared to attend hospital for blood tests
- Patients not reporting symptoms
- Sicker patients with reduce community support
- Patients attending clinic with low blood counts/pending MSCC/in pain

Acute Lockdown (March to July 2020):

- Chemo stopped
- Trials paused
- Staff redeployed to front line
- Services reduced
- CNS – important role in management of anxiety

Second Wave (Sept 2020 to present) – Recovery:

- Chemotherapy restarted
- Trials running
- Staff currently back in roles
- COVID screening
- Increased use of enzalutamide
- Ongoing Virtual clinics
- Virtual MDT
- Zoom prostate support group
- Zoom educational seminars for 'Surgical school', 'Radiotherapy school' and a new patient seminar for 'All option Discussion' currently being developed

CNS, clinical nurse specialist; MDT, multidisciplinary team; MSCC, malignant spinal cord compression; Tx, treatment

THE CHALLENGE

In the metastatic setting, chemotherapy known to improve the survival of patients may compromise the immune system

- Male, older population – increase in mortality with COVID-19
- This population of patients known for under reporting symptoms

Balancing the benefit of treating patients with prostate cancer against the infection risks associated with COVID-19

Adapting sequencing of treatment regimes to minimise the risk of COVID-19 infections to patients for a central London Hospital

Patients scared, anxious and confused about contacting healthcare services during the pandemic. Is it safe?

Changing the way patients are reviewed in clinics

- MDT meetings
- Monitoring blood results
- Administration of LHRHa

Medical team

Redeployment

Sickness

Reduced services

Treatments halted/delayed

Trials suspended

Primary care – reduced service

Community support, ie palliative care/district nursing services reduced

Family/social support

Loss of support groups

Isolation

Affects of COVID-19 infection

LHRHa , luteinizing hormone-releasing hormone analogue; MDT, multidisciplinary team

UNIVERSITY COLLEGE LONDON HOSPITAL – RESPONSE

Restarting chemotherapy as pandemic is ongoing

Introducing new pathway to incorporate a COVID-19 screen 48 hours prior to chemotherapy

2-day pathway instead on same day treatment and clinic

Hospital transport to avoid public transport through central London

Prostate cancer patients in the CSPC setting not commencing docetaxel

Enzalutamide instead of docetaxel in the newly diagnosed metastatic disease setting (abiraterone if intolerant of enzalutamide)[1]

Remote MDT

Working from home for Telephone clinics to aid social distancing for healthcare professionals

Most prostate cancers are slow growing

Hormones have been used to 'hold' disease while patients are waiting for radical treatment

Virtual clinics

- Monitoring PSA less frequently
- Virtual new patient clinics
- CNS follow-up phone calls for newly diagnosed patients

Many prostate cancers are slow growing – monitor less frequently

However, some prostate cancer are aggressive and need close monitoring

Alternate face-to-face with virtual clinic

Posting medication enzalutamide/abiraterone to reduce necessity for hospital visit

Increased referral to CNS-led services to reduce patient numbers in the chemotherapy clinics

- Prostate support group via Zoom
- Exercise programme for patients on ADT virtually
- Radiotherapy seminar via YouTube
- Education seminars
- Surgical school
- Radiotherapy school
- All options for discussion via YouTube

ADT, androgen deprivation therapy; CNS, clinical nurse specialist; CSPC, castration sensitive prostate cancer; MDT, multidisciplinary team; NHS, national health service; PSA, prostate specific antigen

1. https://www.nice.org.uk/guidance/ng161/resources/interim-treatment-change-options-during-the-covid19-pandemic-endorsed-by-nhs-england-pdf-8715724381.Accessed 07-Dec-2020;
2. Personal Communication, Janet Forgenie

MANAGEMENT OF SIDE EFFECTS

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ADT

All patients starting **ADT** should be initiated on calcium and vitamin D supplements [1]
- calcium 1000-1200 mg/day + vit D 400-1000 IU/day
- This may be adjusted depending on calcium/vitamin levels

DEXA scan to assess osteopenia:
- Normal bone density: 3-yearly DEXA scan
- Osteopenia: yearly DEXA scan

Weight bearing exercise should be encouraged

Denosumab, zoledronic acid or alendronate therapy should be considered for femoral neck/total hip or lumber spine T-Score between -1.0 + -2.5 (indicating osteopenia) by DEXA
AND
the FRAX assessment indicates a 10-year probability of hip fracture ≥3% or a 10-year probability of major osteoporotic fracture ≥ 20% [1]

Low Mood – increased risk of depression which may increase the longer patients are on Tx[2]
Chemotherapy + bad news can also affect mood
Physical activity/exercise helps improve overall well-being
Poor concentration – keeping a diary of symptoms:
- What helps and what makes it worse
- Use of memory aids
- Mental exercises, e.g. crosswords/sudoku
- Reduce stress – relaxation techniques
- Learning new habits – better diet

Hypertension[3,4] – ADT is associated with an increased risk of heart failure in men without known cardiovascular disease; it is therefore recommended to lower BP + cholesterol to reduce the risk of death from cardiovascular disease
- Life style change: physical activity/weight loss
- Stop smoking/reduce alcohol/healthy diet

Hot Flushes[5] –
Offer medroxyprogesterone (20 mg/day) initially for 10 weeks
Consider cyproterone acetate (50 mg BD for 4 weeks)
Alternatively referral for consideration of acupuncture but no good-quality evidence to support

ADT, androgen deprivation therapy; BD, twice a day; BP, blood pressure; DEXA, dual-energy X-ray absorptiometry; FRAX, fracture risk assessment tool; NCCN, National Comprehensive Cancer Network; NHS, national health service; OD, once daily; Tx, treatment

1. NCCN Guidelines Version 3.2020, Prostate Cancer; 2. Dinh K, et al. J Clin Oncol. 2016;34(16):1905-12; 3. Haque R, et al. Br J Cancer. 2017;117(8):1233-40; 4. Bhatia N, et al. Circulation 2016; 133; 537-541; 5. NICE guideline [NG131] 2019: https://www.nice.org.uk/guidance/ng131/chapter/Recommendations. Accessed 07-Dec-2020

EXERCISE AND ITS BENEFITS

ADVICE FOR PATIENTS

In the past people being treated for a chronic illness, such as cancer, were often told by their doctor to rest and reduce their physical activity. This is good advice if movement causes pain, rapid heart rate, or shortness of breath.

However, new research has shown that exercise is not only safe and possible during cancer treatment, but it can improve how well you function physically and your quality-of-life.[1]

Too much rest can lead to loss of body function, muscle weakness and a reduced range of movement.

Therefore more and more cancer centres are looking at ways to encourage cancer patients to become more physically active during and after cancer treatments.

Benefits – advice for patients:

- Keep or improve your physical abilities
- Improve balance, lower risk of falls and broken bones
- Keep muscles from wasting due to inactivity
- Lower the risk of heart disease
- Lessen the risk of osteoporosis
- Improve blood flow to your legs and lower the risk of blood clots
- Make you less dependent on others for help with normal activities in your daily life
- Improve your self-esteem
- Lower the risk of being anxious and depressed
- Lessen nausea
- Improve your ability to keep social contacts
- Lessen symptoms of tiredness
- Help you control your weight
- Improve your quality-of-life

Exercise should be based on what is safe and works for the individual.

It should be something the patient likes doing.

Any exercise plan should take in to account any exercise the patient has previously done, what they can do now, and any physical problems or limits they may have.

Hart N, et al. Current Opinion in Supportive and Palliative Care 2017; 11; 247-257; Cormie P, et al. Prostate Cancer Prostatic Dis 2013; 16, 328–335; Brown M, et al. Pilot Feasibility Stud 2019; 5: 102

PATIENT EXERCISE CIRCUIT & HOME PROGRAMME

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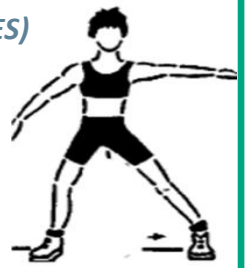
CIRCUITS

Exercise 1: Legs
Marching on spot
or
Toe taps
or
Step-ups (4”-8” step)

1 minute active recovery

Exercise 2: Arms
(FEET MOVING AT ALL TIMES)
Arm side lift with side step
&
Arm forward lift with marching
(Progress 0.5-2 kg weights)



active recovery

Exercise 3: Legs
Seated – knee extension
or
Sit to stand
or
Squat exercise

1 minute active recovery

Exercise 4: Arms
(FEET MOVING AT ALL TIMES)
Breast stroke swim with marching
&
Single arm punch overhead
(Progress 0.5-2 kg weights)

1 minute active recovery

Exercise 5: Legs
Side steps / march
or
Static bike cycle
or
Treadmill walk

1 minute active recovery

Exercise 6: Arms
(FEET MOVING AT ALL TIMES)
Elbow bends with marching
&
Single arm forward punch
(Progress 0.5-2 kg weights)

1 minute active recovery

Walking ‘recovery’ *or* *Seated ‘recovery’*
(with heel pumps)

CIRCUITS

Principles of your circuit workout

Practice each exercise for between 1.5-3 minutes as able, with 1 minute of walking or seated heel “pumps” before moving on to the next exercise.
By alternating from ARM exercises (green boxes) to LEG exercises (red boxes) you will balance your workout and avoid fatigue.

Exercise effort should be **MODERATE**, you should be able to **talk and exercise**

Pilot exercise programme for prostate cancer patients at University College London Hospitals (Personal communication, Janet Forgenie)
https://www.bug.uk.com/download.php?id=bugbaun2017/J%20Forgenie%202017%20prostate%20presentation.pdf. Accessed 07-Dec-2020

MANAGEMENT OF SIDE EFFECTS

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Chemotherapy

Painful neuropathy – ASCO guidelines recommend duloxetine for treatment of chemotherapy-induced peripheral neuropathy[1]
Dose 60 mg OD, discontinue if no response after 2 months
Review at least every 3 months; max dose 120 mg OD (BNF)

Poor appetite – changes in taste or nausea can lead to poor appetite
- Check weight monitor for significant weight loss
- Refer to dietician for education/support
- Short-term, low-dose dexamethasone to boost appetite 2-4mg OD may help[7]
- Check nausea is controlled[2]

Neutropenia[3] – this is a medical emergency and requires immediate hospital investigations + treatment.
Significant neutropenia: neutrophil count ≤ 0.5 × 10^9/L
It can delay chemotherapy/life threatening/increase risk of COVID-19
Indication – Fever/signs of infection/unwell
Nadir time – median time to nadir ~ 7 days, median duration of severe neutropenia is 7 days[4]
Treat as an acute medical emergency and offer empiric antibiotic therapy immediately
History/assessment – FBC/U+E/LFT, including albumin and C-reactive protein lactate and blood cultures
Temp >38 degrees/clinically sepsis
Educate patient and carer in signs and symptoms; local guidance with AOS (Acute oncology service)

Anaemia – low grade is common in patients on ADT[5], increased risk when on chemo[6]
Signs – Fatigue/SOB/pale
Check FBC
Transfusion – local guidelines
Encourage healthy diet high in protein and iron

ADT, androgen deprivation therapy; ASCO, American Society of Oncology; BNF, British National Formulary; FBC, full blood count; LFT, liver function test; OD, once daily; SOB, shortness of breath; U+E, urea and electrolytes

1. Hershman D, et al. J Clin Oncol. 2014;32(18):1941-67; 2. https://www.cancerresearchuk.org/about-cancer/coping/physically/diet-problems/managing/tips-for-diet-problems?_ga=2.119297737.1774961107.1607382808-1081227050.1607382808. Accessed 07-Dec-2020. 3. https://www.nice.org.uk/guidance/cg151. Accessed -7-Dec-2020; 4. https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/020449s080s082lbl.pdf, accessed 16-Dec-2020; 5. Hicks, B et al. Epidemiology 2017; doi:10.1097/ede.0000000000000678; 6. Groopman J, et al. J Natl Cancer Inst 1999; 91: 1616-34; 7. Dr Ian Back, 2001. Palliative Medicine Handbook 3rd edition: http://lnx.mednemo.it/wp-content/uploads/2007/01/palliative-medicine-handbook-3rd-edition.pdf. Accessed 16-Dec-2020

TAKE-HOME MESSAGE

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COVID-19: is it a short-term problem?

Diagnostic:

- Biopsy without MRI if locally advanced or highly symptomatic
- Staging using CT and/or bone scan
- Commence ADT if radiological evidence of metastatic prostate cancer
- Biopsy can be postponed

Locally Advanced:

- Do not use ADT to postpone RP
- Consider long term ADT + EBRT as an alternative to surgery
- Start immediate neoadjuvant ADT if symptomatic, followed by EBRT 6–12 months later
- Avoid invasive procedures, such as fiducial insertion and or rectal spacers

mCSPC:

- Avoid ADT combined with docetaxel based on the risk of neutropenia and frequent hospital visits
- Offer systemic treatment: ADT + something (e.g. abiraterone plus prednisone or apalutamide or enzalutamide or docetaxel)

mCRPC:

- Treat patients with life-prolonging agents. Base the choice of first-line treatment on the performance status, symptoms, comorbidities, location and extent of disease, patient preference, and on the previous treatment for mCSPC as well as use of medical resources and specific risk during the COVID-19 pandemic
- Chemotherapy should be avoided as much as possible

Virtual clinics here to stay
+
Work from home if you can

Keep yourselves your colleagues and your patients safe and well during this COVID-19 pandemic.
Use your resourcefulness to think of new ways of keeping your service running without increasing the risk to patients/staff and carers

ADT, androgen deprivation therapy; CT, computed tomography; EBRT, external beam radiotherapy; mCSPC, metastatic castration sensitive prostate cancer; MRI, magnetic resonance imaging; RP, radical prostatectomy

Ribal M, et al. Eur Urol. 2020;78(1):21-28

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Email
sam.brightwell
@cor2ed.com

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GI NURSES CONNECT
Bodenackerstrasse 17
4103 Bottmingen
SWITZERLAND

Dr. Froukje Sosef MD

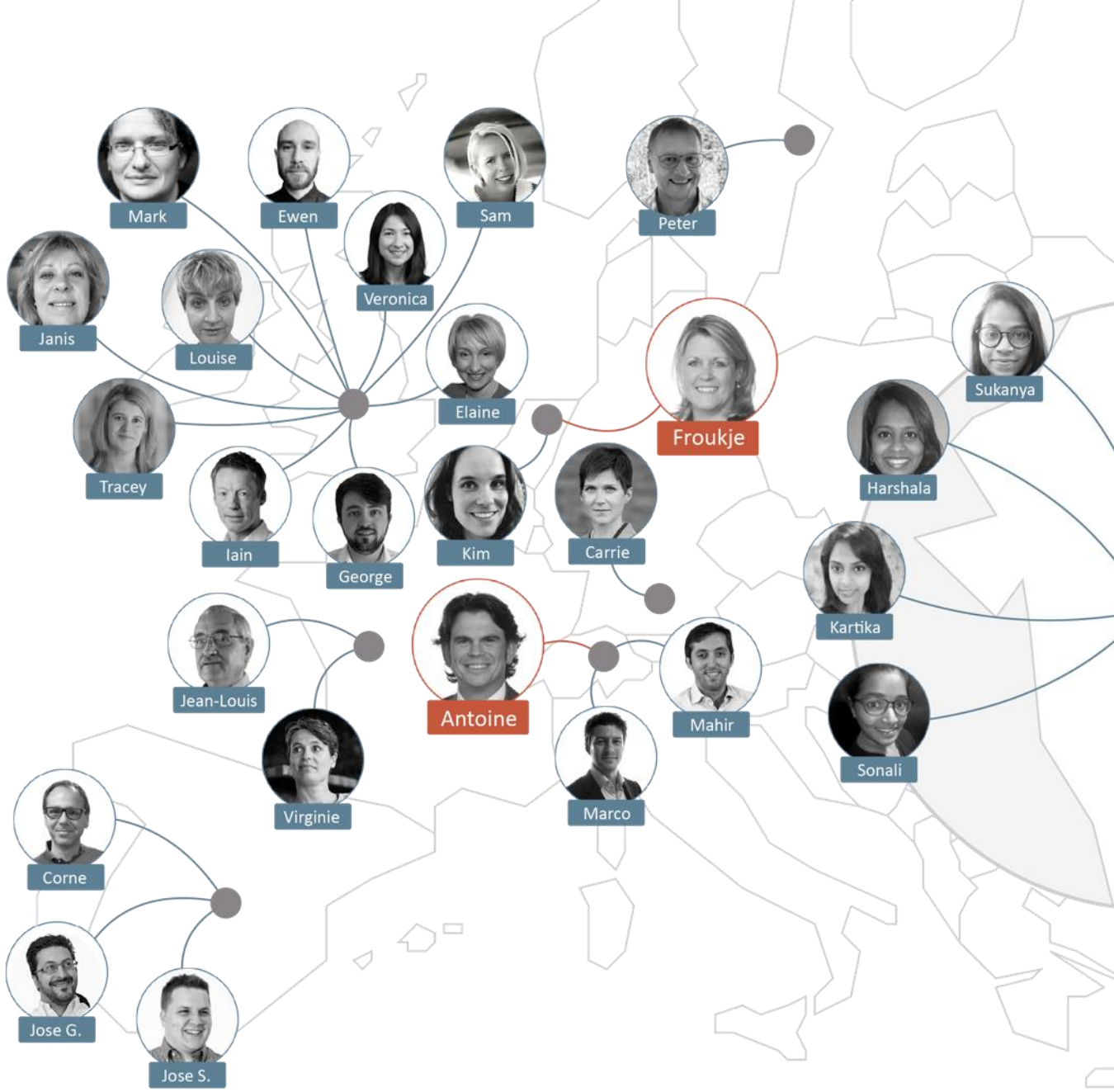
+31 6 2324 3636

froukje.sosef@cor2ed.com

Dr. Antoine Lacombe Pharm D, MBA

+41 79 529 42 79

antoine.lacombe@cor2ed.com



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