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How Can a Multidisciplinary Team Optimize Management of G/GEJ Cancer–Related Symptom Burden?

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Janjigian:
Hello. My name is Dr. Janjigian. I'm a Medical Oncologist and Chief of GI Oncology Team at MSKCC in New York, and I also lead our multidisciplinary team in management of patients with gastric and gastroesophageal adenocarcinoma. So I wanted to give you our pearls and how we approach this disease in our DMT, and how symptom burden and other factors really help us understand what the patient needs will be.

So the typical way that these patients with gastric and gastroesophageal junction adenocarcinoma present in the clinic is with weight loss and dysphasia. And often, you know, these symptoms are relatively quick in onset. The data suggests that the tumors have been, you know, relatively rapid growing, and the symptoms quickly develop within 8 months of diagnosis. So anemia is also one of the symptoms that present, especially if the patient is on anticoagulation, sometimes also with obstruction, both gastric outlet obstruction or esophageal obstruction. The fistulization and hemorrhage is rare, but do occur, particularly for squamous cell cancers, because they can be more proximal.

So how do we approach these patients? These patients sometimes present from their surgical oncology group, but most commonly, they come in straight to see medical oncologists, as they find us for our clinical trials and programs. And the big question is always, what is the stage of the cancer? How can we help the patient in that moment? What are the cancer-related symptoms that we can alleviate and get the patient stronger?

Nutritional support is the number one factor that drives outcome and ability to tolerate chemotherapy. So to get nutritional information as quickly as possible and start to encourage patients to eat small, frequent meals and assess the patients for need of a feeding tube is critical. In most of our cases, both in early stage and even stage IV disease, we do not recommend prophylactic placement of feeding tubes. Often when once you start the therapy, the treatment shrinks the tumor and the patient starts to eat, but meeting with a nutritionist is important.

We know that supportive care and supportive management of cancer-related symptoms by specialized nursing and physicians is the most important thing to prolong patient survival. Why is that? It’s because we are able to then give them more aggressive and more on time and targeted in terms of schedule treatment, so there's no schedule breaks or interruptions. So we try to navigate these factors as we're getting the patient stronger.

Systemic disease control is our first priority, so we maximize the system-wise approach, which is usually treatment with intravenous chemotherapy and also targeted therapy, depending on the biomarker testing. Check out our biomarker module, because we talk a little bit – in a lot in depth about that.

So it takes a nursing champion and a physician champion to help navigate all these options within our disease management team, and we discuss these cases with a surgeons, medical oncologists, radiation oncologist. And we typically use one systemic approach, which is chemotherapy and immunotherapy or targeted agents such as HER2 or PD-L1 targeting agents and claudin inhibitors. And then one localized disease approach. Typically multimodality therapy with chemoradiation and then surgery have been falling by the wayside. So really, surgery and/or systemic therapy has been the mainstay. We occasionally use radiation therapy, again, in a bleeding patient or severely obstructed patient to help control the symptoms, if the surgery is not a good option or will not be an option in the future.

So forming this coalition, a physician to help our patients, together with also nurse navigators, social workers, and also, you know, patient advocates and financial advocates is really how we get patients on treatment and better very quickly at Memorial Sloan Kettering and other tertiary cancer centers. And it's important to try to do that at every clinical setting.

So chemotherapy side effects can cause myelosuppression, nausea, vomiting, diarrhea, and peripheral neuropathy, and we need to monitor those. Immune-related adverse events are important to monitor. And then with claudin inhibitors, particularly as they enter practice, prolonging the infusion and referring the patient for palliative care, for strong pain control and nausea control, if all else fails, is important. And we have suggestions for nausea protocols for claudin inhibitors, and the antiemetic protocols with ASCO, so that'll be important to follow. For HER2-targeted agents, it has not been as big of an issue, but we need to follow for interstitial lung disease for trastuzumab deruxtecan type drugs, and cardiac function.

So the number one recipe for success is communication and letting the patient know what their immune and other adverse events could be so they can report them to you, and of course, breaking down barriers and improving communication within DMT. So thank you so much for your attention.

Announcer:
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