Clinical reporting in oncological patients

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Abstract

The authors emphasize points of particular importance, essential to record, when making clinical reports on oncological patients. Information must be clear and reproducible concerning criteria for staging, performance status, treatment given, resultant complications. International criteria must be used which allow results to be compared by different investigators.

To use such criteria, even when not undertaking a study protocol treatment program, brings a higher quality to the care given. It is crucial, when identifying familial cancer syndromes, as the follow--up of these cases is different, in comparison to sporadic cases.

Keywords: chemotherapy, clinical process.

Oncological patients represent a very significant percentage of patients admitted to the Medicine Service, and this number is increasing, with forecasts that one in four individuals will develop cancer. Advanced or terminal conditions are prevalent, due to older age groups and low awareness for early diagnosis. Delays in etiological diagnosis are another contributing factor. Three stages can be considered for oncological patients: the phase prior to histological diagnosis; the phase of oncological treatment; and the phase of palliative care.

In the first phase, we point out anamnesis, which will facilitate the rational use of additional diagnostic methods. Family history of cancer, exposure to cancerous agents, and infections are essential (*Table I and II*).

Once the histological diagnosis is obtained, duly documented in its original copy, the therapy is begun. It is important that the interval between the suspected condition, the histological diagnosis and the beginning of the treatment, be short - we suggest 3-4 days. Why? The progress of a tumor can vary considerably, but we would like to point out that in a 1 cm tumor, i.e., a tumor that has become clinically detectable (109 cells), even if the mutation rate is low (let's suppose 10-6), there will be at least one cell clone in the existing cells that will be resistant to cytostatic treatment or radiation.[1] On the other hand, for the normal growth of a Gompertzian tumor,[1] a rapid growth phase will be followed by a plateau phase, in which many of the drugs are not effective. In other words, even if we use effective drugs, they will only affect the proliferating cells, and the cells in the plateau phase will not be affected; thus, a residual tumor mass will remain with its inevitable consequences. The determination of the existing tumor mass in view of the prognostic factors - staging - is essential, but once a staging limit is determined, it is not appropriate to delay the start of treatment until the results of the tests are obtained, because this can take a considerable amount of time, leading to the abovementioned consequences.

The staging method most frequently used (TNM) is a result of the unification of TNM and the UICC system (Union Internationale Contre Le Cancer) in 1987. Successive revisions have enabled this method to be adjusted to the real practice, adopting principles from other specific classification systems, e.g., FIGO

TABLE I

Anamnesis

Family history
Professional exposure
Infections

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TABLE II

Familial cancers

Most of the malignant cancers are of a familial type:

- Most common:
  - Lynch 1
  - Lynch 2
  - Li Fraumeni (sarcomas, germ cell tumors, breast, ovary)
- Most rare:
  - Polyposis of the digestive tract
  - Gardner Type

Men

Be suspicious in case of:

- Young patient
- Right colon tumor
- Family history
- Multiple tumors

TABLE III

Extragonadal germ cell tumors syndrome

- Male below 50 years
- Located in the middle portion (mediastinum, retroperitoneum)
  - multiple pulmonary nodes
  - rapid tumor growth
- Chorionic gonadotropin and alpha-fetoprotein may be high
- Histology of carcinoma

TABLE IV

Treatment regimen

- Type
- Doses
- Frequency
- Secondary effects and toxicity
- Result

(International Federation of Gynecologic Oncology) for gynecologic tumors, or the Dukes' classification for colon tumors. Why is it important to determine the stage of the disease? Staging is said to correspond to a reproducible classification in prognostic groups. Therefore, it should act as a guide when choosing a

TABLE V

Type of treatment

INDUCTION:

Initial treatment in an advanced tumor

PRIMARY (NEOADJUVANT THERAPY):

Initial treatment in a localized tumor for which an alternative therapy is possible

ADJUVANT:

After local treatment of the primary tumor

SALVAGE THERAPY:

When initial cytostatic treatment fails

treatment strategy and, basically, allow the comparison of results for the different groups.[2,3] Staging should be performed initially, and whenever significant clinical changes occur that might result in changes to the therapy. The decision is easier in patients treated under research protocols, as the performance criteria are more clearly defined. Nevertheless, the TNM method is still a fundamentally anatomical classification, although technological advances have enabled the definition of imaging, immunochemical and cytogenetic criteria that will enable future characterization of the prognostic groups.[3] The size of the tumor mass, i.e., the T of the TNM classification, should be determined as precisely as possible, using two reproducible perpendicular diameters. The involvement of the regional lymph nodes (the N of the acronym) is initially clinically determined, with later histological confirmation pN.[3] Metastases are tumors that have spread to locations outside the tissue of origin. A disseminated tumor is, in principle, a tumor for which local treatment is secondary, although there are cases in which a reduction in the original tumor mass is important, e.g., sarcomas. A syndrome has been determined - initial non-defined carcinoma for which, after regular investigation, it is not possible to find a primary tumor. Nowadays, it is believed that it is probably a case of multifocal tumor from the beginning. In a situation of this type, there is no advantage in delaying the start of the treatment to find the primary tumor, particularly if it is a case of germ cell tumor in which a complete response can be obtained with treatment with cisplatin (*Tables III, IV amd V*).

TABLE VI

Assessment of functional capacity

Performance status

0 - Normal

1 - Symptomatic, but still eligible for outpatient treatment

2 - Bed-ridden for less than 50% of the time

3 - Bed-ridden for more than 50% of the time, but capable of walking

4 - Bed-ridden all the time

5 - Deceased

TABLE VIi

Concept of dose intensity

- Dose intensity is the amount of drug administered per unit of time, i.e., mg/ m2/week (mg/m2=40x mg/kg)
- Relative dose intensity is the amount of a determined drug administered per week in relation to the standard dose intensity of the same drug.
- In a combined treatment, it corresponds to a tenth of the ratio between the dose intensity averages of the drugs of the study treatment and the average intensities of the standard dose (if there is no drug in the study treatment, its intensity is 0)

In some cases, a 20% decrease in dose intensity may be translated into a 50% decrease in cure rate.

The assessment of functional capacity of patients, – performance status – is important for the prognosis; one of the most commonly used assessment systems is shown in *Table VI*. Criteria such as quality of life and disease-free period have increasingly been taken into account, in addition to survival.[3]

It is important to point out that failure to take dose intensity into account (*Table VII*) contributes to the poor results that have been observed. Neglecting this concept results in delays to treatment without a valid clinical reason, which is common in our institutions, which close on the weekends, reducing the doses actually administered and affecting the results. Although increasing the dose has no universal validity (it has been proven in combined therapy for breast and ovary cancer), at least in the sense that an increase in the dose will always correspond to increased response, we should bear in mind that reducing the dose of one or more drugs of a cytostatic treatment

Response criteria (who)

COMPLETE RESPONSE (CR):
Complete cure of the disease, determined in two assessments with intervals of > 4 weeks; in case of bone lesions - disappearance on X-Ray or scintigraphy for at least 4 weeks.

PARTIAL RESPONSE (PR):
Decrease > 50% in two assessments with intervals of 4 > weeks; the measurement can be:
Bi-dimensional
- in case of a single lesion; a 50% decrease in the tumor area (multiplication of the largest diameter by the largest perpendicular diameter).
- in case of multiple lesions; a 50% decrease in the sum of the products of the perpendicular diameters of the multiple lesions.
One-dimensional
- a 50% reduction in the largest dimension of the tumor.
Non-measurable tumor
- an estimated 50% reduction, for at least 4 weeks.

NO RESPONSE (NR)
If the tumor is reduced by less than 50%, or if no increase is observed in one or more measurable lesions for at least 4 weeks (or for at least 8 weeks in the case of bone lesions).

MINIMUM RESPONSE (MR)
25% < MINIMUM > 50%.

STABLE DISEASE (SD)
Reduction ± 25%.

PROGRESSION (P)
An increase greater than 25% in one or more lesion, or the appearance of new lesions; in the case of bone lesions, it is important to observe an increase in the size of the existing lesions (instead of the development of compression fractures or their consolidation).

OVERALL RESPONSE (OR)
Local progression indicates progression of the disease, despite objective response in other sites; if the local complete response and partial responses have added values greater than NR, the overall response will be PR; if no changes are observed in the overall disease, but if there is a complete or partial response in measurable sites, the overall response will be PR.

RESPONSE DURATION AND SURVIVAL
These are expressed in days, weeks or months, and are calculated from the beginning of the antitumor treatment (in the case of complete response, it is considered from the time the response was observed).

could decrease the possibility of response, a reduction is not directly proportional to the decrease in the dose. Another aspect that will be clarified in the future is the importance of chronotherapy, but this topic is beyond the scope of our subject. Regarding the phase of palliative care, it should be prepared during the period of active treatment, creating a connection with the bodies that will support the patient in the most intense stage of the disease.

In conclusion, the clinical information on oncological patients brings aspects that should be clearly defined, so that even if patients are not being treated under a research protocol, it would still be possible to assess the results, which is the only way to improve clinical performance. We consider that the use of these principles would be easier if each institution had, for each type of tumor, a staging classification and follow-up form that would make the clinical work easier.[4]

We took into account the aspects considered indispensable for the assessment of the quality of the oncological process.

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