

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/project-oncology/supporting-patients-urothelial-carcinoma-treatment/67086/>

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Supporting Patients Throughout Urothelial Carcinoma Treatment

Announcer:

Welcome to *Project Oncology* on ReachMD. Today, we'll learn about strategies for managing treatment-related toxicities in urothelial carcinoma with Dr. Petros Grivas. He's a board-certified medical oncologist and researcher at Fred Hutch Cancer Center. He's also a Professor and the Medical Director of Local Regional Outreach and the International Program at the University of Washington. Here's Dr. Grivas now.

Dr. Grivas:

Palliative care is important in managing side effects, and I always applaud the efforts by the palliative care teams across cancer centers to help us treat patients by providing the best supportive care.

Sometimes, pharmacologic intervention or non-pharmacologic interventions can be important. For example—I will take the example of peripheral neuropathy—preemptive and proactive dose adjustments of enfortumab vedotin, platinum, or taxane can be helpful to try to mitigate and, as much as possible, reduce the risk of peripheral neuropathy. Or sometimes, pharmacologic interventions like duloxetine, gabapentin, or pregabalin in some cases can be of consideration. Of course, non-pharmacologic interventions like physical therapy, cancer rehab, massage therapy, and mechanical devices could help with neuropathy, including assisting devices to prevent falls. All of those are relevant.

This is an example. Of course, there are many other toxicities that can happen with different drugs, and I think it's important to take into account the totality of the data, timing, severity, appearance, and type, and put it together with the patient's overall clinical status to make the determination of, should we hold off the dose? Should we dose reduce? Should we permanently discontinue treatment? All of those are relevant in order to maximize the patient's outcomes, both in terms of optimum treatment exposure and optimizing cancer control, but at the same time, keeping in mind toxicity and the impact in quality of life.

And that's why I think it's important, at least in clinical trials, to measure patient-reported outcomes, which are very relevant in that discussion. It's very important to hear the patient's wishes, objectives, goals, and priorities. I think we need to have the time to discuss with the patient and caregivers what is important for them: what is most important for them, and what is less important for them. Of course, there may be multiple considerations, like longer survival, quality of life, patient-reported outcomes.

I think we need to have this discussion upfront with the patient in a thoughtful and compassionate manner in order to better understand what these goals are. For example, if you have a curative-intent therapy in a localized bladder cancer setting, this may be a different scenario compared to a more advanced metastatic setting, when you have goals more for prolonging life and palliation.

So I think the patient goals and priorities are important, and better understanding of those can help inform the discussion about management of toxicities, decisions that should be informed, and shared decision-making about treatment. Again, going back, should we reduce the dose of a drug, hold off temporarily, or permanently discontinue? All of those factors, including the patient voice, are very important. And that requires a detailed discussion with the patient and a better understanding of their goals and priorities.

Announcer:

You just heard Dr. Petros Grivas talking about how patient priorities can guide toxicity management in urothelial carcinoma care. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!