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The surgeon and surgical procedures as prognostic factor

H. Burns. *Department of Public Health, Greater Glasgow Health Board, Scotland*

Intuitively, one would expect that surgeons dealing with a large volume of patients with a particular cancer would deal with them more proficiently. The literature, however, is inconclusive. In the case of oesophageal cancer, operative mortality appears to be inversely related to surgical workload while no such relationship exists with gastric cancer. Some data from 1984 suggests higher in-hospital mortality amongst colorectal cancer cases operated on in hospitals treating low volumes. Subsequent studies have failed to confirm this. Data from centres treating breast cancer, testicular teratoma and ovarian cancer suggest that a major determinant of long-term survival is the use of multi-disciplinary teams to manage these cancers in an integrated fashion.

Individual surgical competence is probably a less important determinant of long-term survival in cancer patients than the overall organisation of care.

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The nursing perspective of good quality symptom management

E.W.C. Ambaum. *University Hospital Utrecht, Department of Internal Medicine, B2W, P.O. Box 85500, 3508 GA Utrecht, The Netherlands*

Problems resulting from cancer or its treatment effect patients daily activities. While different individuals may develop the same symptoms, the cause of and the persons response to those symptoms may vary. Management of the symptoms experience merits high priority for both the cancer patient and for the nurse caring for the patient. Appropiate management of symptoms promotes higher quality of life, preventing needles suffering and distress.

In broad outlines nursing symptom management consists of 3 phases. First of all consensus has to be found on the matter of definitions; what is symptom experience, – distress and – occurrence. Second part is the assessment phase. Reliable and valid measurement tools need to be developed in order to measure the symptom experience in an appropiate and accurate way. The third part is the intervention or treatment phase. The medical profession has a long tradition of research in finding the best treatment options. Nursing research has a relatively young tradition in the area of nursing care, interventions and treatment options. The domain of nursing research should be the domain of symptom management due to cancer or cancer treatment. However, the challenge lies in the fact of a multidisciplinarily approach on a scientifically bases, for our mutual concern:

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Does poor management of side effects compromise treatment outcome? An oncologists view

P. Harper. *Dept. of Medical Oncology, Guy's & St Thomas' Hospital, London, UK*

The fear of cancer chemotherapy has lessened as the treatment of its toxicities and side effects become more regularized and established. For the patient who has cancer, the hope of a treatment response is a very powerful motivator to take treatment whether or not it is offered with palliative or curative intent. This was well shown in the questionnaire of Slevin et al where patients, cancer nurses, radiotherapy oncologists and medical oncologists were asked whether or not they would accept treatment of differing toxicity for a potentially marginal benefit. It is not surprising that the patients would accept quite considerable difficulties for the hope of a response.

There have been considerable improvements in the amelioration of nausea and vomiting with the introduction of the HT3 antagonist, the avoidance of neutropenic sepsis by the use of growth factors, the use of scalp cooling to prevent alopecia in some combination treatments, the use of infusional chemotherapy, and most recently the possible prevention of cardiomyopathy of the anthracyclines. The ability to control the side effects of standard treatments has led to, in some cases, an increase in the intensity of treatment and further toxicities are then encountered. Whether such an increase in intensity is reflected in a better outcome will be discussed. Patient selection has a profound effect both on treatment outcome and on perceived toxicity.

The overall 'package' of support that can now be offered has substantially increased the treatment options and will hopefully improve outcome.

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The special problem of elderly cancer patients

S. Monfardini. *Istituto Nazionale Tumori, Napoli, Italia*

Selected elderly patients with good PS and adequate organ function can, in general, be entered in the ongoing combination chemotherapy trials for adults since in those patients usually no excess toxicity is observed. However when treatment is scheduled, older adults differ in terms of willingness to "trade" survival for current quality of life. For unselected elderly patient to be treated in the clinical practice in the general population the problem of prevention of excessive toxicity is more complex because of the possible presence of several age-related conditions not compromised in elderly patients with good PS. Comorbidity, mental status and disability, should be clinically considered not only because they interplay with patients, families and physician's attitudes, but because they can influence directly the choice of treatment.

1) *Comorbidity.* Several studies have shown that frequently the elderly present with several co-existing pathologies. For example, it has been reported that among individuals aged 65–74, the mean number of chronic disease is 4–6. Over 50% of elderly have chronic arthritis, 33% backache, 32% visual deficit, 28% exertional dyspnoea, etc. Preliminary observations on cancer patients also confirm the co-existence of other diseases in elderly cancer patients. Anyone who has dealt with elderly cancer patients knows that comorbidity may play an important role in preventing the administration of aggressive chemotherapy or at least in modifying treatment plans, for example in patients with cardiac deficit or impairment of renal and hepatic function. For patients needing surgery and, to a lesser extent radiotherapy, in the presence of comorbidity, necessary modification of treatment plans may already be pre-determined, but the same is not entirely true fo chemotherapy. Well-defined exclusion criteria are, of course, provided for cardiac, renal and hepatic function for patients entering clinical trials, but no firm rules are available for the treatment of older patients presenting with other non-neoplastic associated conditions to be treated out of clinical studies.

2) *Mental status.* It is obvious that the conservation of cognitive function or its deterioration may play an important role in the decision of the type of treatment plan, its application and follow-up. The same applies to the presence and degree, or absence, of depressive symptoms which frequently accompany old age.

3) *Functional status.* The ability to care for oneself is a factor to be considered in planning antineoplastic treatment of an older person. Measurement of the ability, not only in performing the basic activities of daily living (bathing, dressing, feeding, etc.), but also the instrumental activities of daily living (ability in telephoning, shopping, money handling, taking drugs, etc.) is considered by geriatricians as an important index for their choice of therapy and may represent, in older patients, an instrument more useful than the Performance Status. Nevertheless, little information is available comparing PS with instruments of measurement of the activities of daily living.

In conclusion if the above mentioned variables are not carefully considered before starting of treatment a good prevention of excessive side effects cannot be achieved with the consequence of treatment discontinuation and poor treatment outcome.

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Cancer treatment and fertility preservation

L.O. Delbeke, U.R. Punjabi, D. De Neubourg, K. Peeters. *Division for Reproductive Medicine, University Hospital Antwerp, Belgium*

Introduction: Children or young individuals undergoing cancer treatment have few, if any, chances for preserving their fertility due to unavoidable medical or surgical ablation of reproductive organs.

Methods: Medical prevention of gamete destruction in the gonads, nor surgical techniques or led covering have been proven effective. Assisted reproductive techniques such as sperm sampling and cryopreservation, or pretreatment IVF with embryo-storage are only feasable in adult men or couples, but not in children or unmarried individuals. Cryopreservation of testicular or ovarian tissue and subsequent grafting after complete remission, or in vitro maturation of individual cryopreserved gonadal cells and subsequent fertilization by ICSI can be offered as fertility preservation.

Results: In men 70% fertilization rates were obtained after ICSI with testicular spermatozoa cultured in vitro. In animal studies, the survival rate for primordial follicles or egg producing areas is 50–70% after cryo-thawing.

Conclusion: Preservation of fertility is preferable above infertility treatment. Close colaboration between Oncology and Reproductive Divisions, offering cryopreservation of gametes or gonadal tissue should be possible before starting treatment in young individuals who want to preserve their fertility.