

T5P-FIVE

RECOMMENDATIONS on low-value practices

Better care. **Better** decision-making. **Better** use of resources.

The Medical Oncology Group of Australia (MOGA) is the peak representative body for medical oncologists in Australia. The Association works closely with Government, health organisations, affiliated international associations and societies, industry, consumer advocacy groups and learned colleges throughout Australia to improve and develop the profession of medical oncology and the management of cancer nationwide.

1

Avoid cytotoxic chemotherapy in patients with advanced cancer who are unlikely to benefit from chemotherapy (ECOG performance status three or four) and continue to focus on symptom relief and palliative care

2

Do not perform routine cancer screening, or surveillance for a new primary cancer, in the majority of patients with metastatic disease

3

Avoid tests (biomarkers and imaging) for recurrent cancer in previously treated asymptomatic patients unless there is evidence that early detection of recurrence can improve survival or quality of life; including avoiding surveillance testing (biomarkers) or imaging (PET, CT and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent

4

Do not perform serum tumour marker tests except to evaluate or monitor a cancer known to produce these markers

5

Do not routinely offer pharmacological venous thromboembolism (VTE) prophylaxis to ambulatory outpatients who are undergoing oncological treatment



1

Avoid cytotoxic chemotherapy in patients with advanced cancer who are unlikely to benefit from chemotherapy (ECOG performance status three or four) and continue to focus on symptom relief and palliative care

For some patients with advanced cancer, chemotherapy is no longer effective. Symptom relief and palliative care should become the primary modes of care. The Eastern Cooperative Oncology Group (ECOG) performance status is a valid predictor of poor survival, reduced response, and worsened toxicity from chemotherapy. Patients with advanced solid tumours, with an ECOG performance status of three or four, generally exhibit a poor response to chemotherapy. There are well known exceptions to this. These are generally patients with untreated highly chemo-sensitive malignancies, and who have recently declined from a good performance status.



2

Do not perform routine cancer screening, or surveillance for a new primary cancer, in the majority of patients with metastatic disease.

For patients with metastatic cancer (particularly but not restricted to those with life expectancy of less than five years), screening for new primary cancers is of little value and may even cause harm.

Reductions in mortality due to earlier detection and management of cancer due to various forms of screening (e.g. breast, colorectal, and prostate) typically take approximately ten years to accrue. Also, patients who have suspected cancers detected after screening may need to undergo further tests (such as prostate biopsies) and treatments. Patients with metastatic disease are more susceptible to complications arising from such tests and treatments given that they are already in frail health.



3

Avoid tests (biomarkers and imaging) for recurrent cancer in previously treated asymptomatic patients unless there is evidence that early detection of recurrence can improve survival or quality of life; including avoiding surveillance testing (biomarkers) or imaging (PET, CT and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.

Some biomarker and imaging tests are effective in staging cancers. For instance, flourodeoxyglucose (FDG) PETs are most effective at staging NSCLC (non-small-cell lung cancer), restaging HL (Hodgkin lymphoma), staging/restaging colorectal cancer, and detection of SPN (solitary pulmonary nodule). However, the clinical impacts of these tests for surveillance of asymptomatic patients are unclear, particularly in cases where early detection of recurrence is unlikely to improve clinical outcomes.

Moreover, despite more recent evidence that PET-CT scanning and serial measurement of serum tumour markers can be helpful for some asymptomatic patients by leading to appropriate treatment modifications, there are alternatives to these intensive approaches for detecting recurrence (e.g. surveillance mammography and clinical breast examination in the case of breast cancer).

4

Do not perform serum tumour marker tests except to evaluate or monitor a cancer known to produce these markers.

In patients with non-specific symptoms, testing for a panel of tumour markers to try and diagnose an underlying cancer is not supported by evidence given the low sensitivity and specificity of these tests. An exception is in cases of suspected, strong underlying predisposition of specific cancers, in which case testing may prove a useful adjunct or in specific contexts where biomarkers may be useful such as CA-125 for suspected ovarian cancer and the use of PSA to detect prostate cancer in men with lower urinary tract symptoms (LUTS).

The appropriate use of tumour biomarker testing is otherwise to monitor the progress of specific cancers under treatment or to detect changes in cancer activity or a secondary or recurring cancer.

5 Do not routinely offer pharmacological venous thromboembolism (VTE) prophylaxis to ambulatory outpatients who are undergoing oncological treatment

Patients receiving oncological treatment are at higher risk of thromboembolic disease and hence may require anticoagulant treatment. While there is some evidence that some of these treatments significantly reduce the risk of venous thromboembolic (VTE) events, this benefit must be weighed against the risk of haemorrhagic complications. Pharmacological VTE prophylaxis should not, therefore, be routinely offered to ambulant oncology patients. Exceptions may apply to high-risk cases, such as patients with multiple myeloma receiving antiangiogenesis agents, with chemotherapy and/or dexamethasone.

 For the list of references supporting these recommendations and further information on the development process, see evolve.edu.au/recommendations/moga.
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WHAT IS EVOLVE?

As part of a global movement, Evolve is a flagship initiative led by physicians, specialties and the Royal Australasian College of Physicians (RACP) to drive high-value, high-quality care in Australia and New Zealand.

Evolve aims to reduce low-value care by supporting physicians to:

- be leaders in changing clinical behaviour for better patient care
- make better decisions, and
- make better use of resources.

Evolve works with specialties to identify their 'Top-Five' clinical practices that, in particular circumstances, may be overused, provide little or no benefit, or cause unnecessary harm. Evolve 'Top-Five' recommendations on low-value practices

are developed through a rigorous, peer-reviewed process; led by clinical experts, informed by evidence and guided by consultation.

Evolve enables physicians to:

- safely and responsibly phase out low-value tests, treatments and procedures, where appropriate
- enhance the safety and quality of healthcare
- provide high-value care to patients based on evidence and expertise, and
- influence the best use of health resources, reducing wasted expenditure and the carbon footprint of the healthcare system.

Evolve is a founding member of Choosing Wisely Australia® and Choosing Wisely New Zealand, with all Evolve 'Top-Five' recommendations part of the Choosing Wisely campaign.