
Carmustine implants and temozolomide for the treatment of newly diagnosed high grade gliomas.

Patient Evidence: Written Submission to NICE: June 2005

I represent a charity that supports patients with cancer and their carers. I have spoken to several patients and their relatives specifically for their experience relating to carmustine implants, temozolomide and treatments presently offered. The majority of patients were newly diagnosed with glioblastoma multiforme or Grade III glioma when chemotherapy was offered to them though some are now a year or so beyond diagnosis.

Living with a brain tumour

“Since the day I was diagnosed I’ve been getting better and now the only options are that I stay the same or things get worse again.”

All the quotes in this section are from the diary of a 34 year old patient with a glioblastoma following completion of radical radiotherapy and adjuvant procarbazine, CCNU, and vincristine chemotherapy (PCV). This was prior to the release of the concomitant and adjuvant data on temozolomide. This quote reflects the futility of his situation. His choice at the time was to do as much as he could to prevent the tumour returning. He is finding an uncertain future increasingly hard to cope with because the stronger he feels recovering from the side effects of treatment the closer he feels to the tumour recurring. He has no physical problems caused by the tumour, but for him psychological impact is reaching a crescendo because the security of actively doing something about the tumour has gone.

For everyone I have spoken to the problems from their brain tumour can easily be separated by them into physical and psychological categories. Living with and fighting against a time bomb.

Many of the patients who fit the criteria for adjuvant treatments deem their quality of life to be reasonable. Their symptoms include minor memory problems, fits, and focal neurological deficits but many return to work, some before or during treatment. Psychologically this can create an acceptance problem because they have difficulty believing they have a life limiting disease.

It is not possible for treatment to improve an already good performance status so any treatment they have can only negatively impact on their quality of life short term. It forces them to come to hospital, may create difficulties with employers, has implications for insurance, driving issues, conception concerns, the knock on effects are many disregarding the physical side effects of treatment. It is sometimes difficult to remain positive when they feel well and face the potential side effects of any treatment to gain them months of life.

“As much as I try to keep positive about it, every one of the four times a day I take some tablets I’m reminded that I have a tumour that may well kill me. On a day to day basis it’s a bit like knowing when you drive that there’s a chance you might crash, you’re aware of it but it doesn’t stop you.”

There are many manifestations of a brain tumour; personality change, hemi paresis, and communication problems are among the commonest I see. There are patients who are not fit enough to receive adjuvant treatment if any at all. Frequently, expressive and receptive dysphasia makes communication difficult and informed consent merely an unattainably ideal. The burden of decision has to shift to the relatives and professionals involved in their care. Guidelines can help relieve this burden.

Guilt is a huge emotion which concerns associates of a patient with a brain tumour as well as the patient themselves. The need but inability to do more for the loved one, feeling responsible and making decisions that impact on so many people for example not to mention the change in roles and lifestyle all add to the feeling of guilt.

“It’s not fair that I have a tumour, the people who love me never did anything to deserve this pain and sometimes I just want to tear out what’s left of my hair in desperation of the injustice of it all.”

Many patients but in particular relatives find that being involved does help relieve some of the guilt. The internet has assisted this and frequently articles are brought to clinic. People are more aware about what is or is not available and are generally more proactive in their approach to their treatment.

There are many issues for individuals living with a brain tumour that need to be addressed: their quality of life, their prognosis, being taken seriously, being involved in decisions and supported so they can live their lives are a few.

Carmustine Implants

I have only met one patient who has received carmustine implants. The overriding concern of the team looking after him was the lack of time for breaking bad news. There was little time to prepare the patient and his wife for an unconfirmed malignant tumour, its limited prognosis and the potential effect of the implant. Obviously for informed consent the real possibility of the best and worse case scenario needs to be explained and all this before a diagnosis has been confirmed introducing even more maybes to an already uncertain scenario. This is possibly not so much of an issue in the recurrent setting where the patient is probably more informed and aware of the implications of their brain tumour, having experienced it already. In this one case the patient was very stoical in his approach to life, was very accepting of the information and pleased to be offered the treatment. This patient is currently undergoing concomitant radiotherapy and

temozolomide following insertion of the carmustine implant. He is continuing to work full time during his treatment.

Temozolomide

All the patients I spoke to had been offered chemotherapy. In patients that had received both PCV and temozolomide at different stages of their treatment, there was a preference towards temozolomide above other chemotherapies for a number of reasons.

1. Ease of use. Tablet form was preferred in all the patients over a combination of oral and IV medication
2. One simple hospital attendance every 4 weeks was expressed as an advantage over a protracted stay waiting for the vincristine. In the case of concomitant use there was no additional hospital attendance and weekly blood tests were not mentioned to me as a problem.
3. The fact that the drug was newer was appealing.
4. The side effect profile was smaller that of PCV simply because it is one drug and not three.
5. Anyone who had searched the internet was interested in temozolomide with one exception. A 36 year old who wanted quality of life and felt that chemotherapy in addition to radiotherapy would cost him too much quality time in the short term.

The reasons for declining temozolomide in the newly diagnosed patients were that of declining chemotherapy in general

1. The impact of side effects on quality of life.
2. The low statistic for improving survival.
3. Wanting minimum medical intervention.

One patient, who searched the internet prior to the 2004 ASCO meeting where the Stupp paper was presented, was adamant that he received temozolomide in the adjuvant setting. He said that on balance it was the best and although not a cure wanted to live as long as possible. He felt that he had not been given the full picture of available treatment and although not recommended by NICE (of which he was aware) he was determined to receive the drug. They paid for the drug and received 5 of the 6 planned courses of adjuvant temozolomide. It was stopped due to increasing tiredness.

Tiredness appears to be an issue for patients prescribed concomitant radiotherapy and temozolomide. To my knowledge no one in the centre I work in has stopped the treatment because of it but on balance although hard to predict it was felt that a few patients do have a generally more difficult time. The additional impact on any aspect of their life is not dramatically affected with concomitant use. Patient experiences of adjuvant chemotherapy (albeit PCV) are of considerably more difficulty. People have mentioned virtually every area of their lives being affected. The treatment time is longer and an overriding frustration of patients is that the clock does not start ticking for the return of their driving licences until treatment is complete. Again so many of the patients are well at the start of treatment that it is difficult for them to quantify any improvements.

People have reported that they are able to ease the side effects of Temozolomide themselves without medical intervention. This is a more common occurrence than with PCV. For example a patient who was vomiting on the first cycle of temozolomide simply took the tablets over the period of an hour which negated the need for any anti emetics whatsoever.

What matters most?

The range of what actually matters most to the patients and relatives I spoke to varied from the huge area of quality of life that they could define for themselves to wanting to live whatever the cost. Lots of short term goals were mentioned, significant events and dates. The majority of drivers craved their licences back and the loss of independence and reliance on family centred on this. Some wanted to be involved in the detail of treatment and felt that they didn't want to be 'short changed' because they had a poor prognosis. But the overriding feeling that came from everyone I spoke to was what mattered most was hope.