Impact of physicians’ characteristics on decision making in elderly acute myeloid leukemia


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SUMMARY/CONCLUSIONS: Over one-half of all newly diagnosed AZA-AML pts met the WHO definition of AML-MRC in central review vs one-third in local review, suggesting potential under-diagnosis of MRC in the community. This difference may also reflect challenges in diagnosing dysplasia. MDS and AML may reflect a continuum of myeloid disease, particularly in this pt population. Pts with AML with MDS-related changes may respond preferentially to AZA. In both the locally (Seeyghe et al. 2014) and centrally identified AML-MRC cohorts, AZA provided a clinically meaningful effect with prolonged OS and improved 1-year survival rates.

P574

IMPACT OF PHYSICIANS’ CHARACTERISTICS ON DECISION MAKING IN ELDERLY ACUTE MYELOID LEUKEMIA (AML) PATIENTS: CAMPAIGN TO IMPROVE DECISIONS

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Background: Outside clinical trials, therapeutic options offered to elderly acute myeloid leukemia (AML) patients (pts) are limited. They can be summarized as an intensive chemotherapy (ICT), low-intensity therapy or best supportive care (BSC) depending on patient- and disease-related prognosis factors. Although scoring systems have been proposed to rationalize this clinical decision-making, there is a strong heterogeneity in clinical practice which is still poorly understood. Indeed, cancer management is highly variable according to the patients’ determinants of care but very few have assessed the influence of physicians’ characteristics and none in AML. In behavioral sciences, attitudes towards risk and ambiguity are crucial psychological traits that may explain medical choices and practices. These characteristics are strongly connected to theoretical models of decision under uncertainty (EU). A last question used two certainty equivalents elicitation (Abdellaoui & al, 2011) and the response to the binary lottery choice questions of the Allais paradox (Kahneman & Tversky, 1979) for identifying respondents conforming to ambiguity averse respondents tend to recommend more ICT (p=0.073).

Aim: The physicians were asked to decide how to treat (ICT, low-intensity therapy or BSC) elderly AML patients presented in clinical vignettes. We present the results for vignette with highest heterogeneity (cf. Figure 1).

Figure 1. Clinical vignette.

Results: Among the 211 physicians who responded to the survey, the median age was 42 years old [inter-quartile range (IQR): 32-52], 54% were male, 72.5% of the physicians were consultants or professor, 70.6% were working in an academic center, 78% were Hematologists, 61% were involved in AML care in their daily practice. Regarding Likert scale of willingness to take risk, median was 5 (IQR 4-7). Regarding the Allais paradox, EU, non-EU and undefined status represented respectively 42.2%, 44.5% and 13.3%. Regarding attitudes towards ambiguity, averse, neutral, seeking and undefined attitudes represented respectively 43.1%, 16.6%, 15.6% and 24.7%. From the clinical vignette we observed that 51.7% choose ICT, 45% favored low-intensity therapy and 3.3% BSC. Using the elicited treatment recommendation in the vignette as the explained variable, a multivariate logit model (N=159) on variables identified from the bivariate analyses highlighted the following trends: the probability of recommending ICT was 60% lower for women compared to men (p=0.012), Risk averse respondents tended to recommend less ICT (p=0.075) as well as EU respondents (p=0.126). Ambiguity averse respondents tend to recommend more ICT (p=0.073).

P575

THE ADDITION OF GEMTUZUMAB OZAGAMICIN (GO) TO INTENSIVE CHEMOTHERAPY SIGNIFICANTLY IMPROVES COMPLETE RESPONSES CR RATES AND OVERALL SURVIVAL IN PATIENTS WITH NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA

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Background: Young patients affected by non APL-Acute Myeloid Leukemia (AML) achieve complete remission (CR) using conventional induction chemotherapy with anthracycline plus cytarabine-based regimens in about 55-70%. The addition of Gemtuzumab Ozagamicin (GO) as third or fourth drug was demonstrated to improve OS, in terms of OS, compared with AZA-AML-001 study (Dombret, Haematologica, 2004). The AZA-AML had a preselection study design, allowing for comparisons of AML cohorts. AZA-AML had a clinical outcome similar to that of AML-MRC in terms of OS if compared with other standard regimens.

Aims: We retrospectively evaluated and compared the efficacy of different induction schedules, in terms of CR rates and OS, administered to two groups of AML patients. Group 1 (n=139) was treated with a GO (MyFLAI or MyAIE schedules); group 2 (n=270) received a non-GO based regimen including or not Fludarabine (FLAI, FLAN, FLAG, 3+7 or DAE).

Methods: From 1997 to 2014, 409 patients with newly diagnosed AML were treated in 3 Italian Institutions. According to karyotype (performed in 392/409 patients), FLT3 (available for 244/409 patients), and NPM1 mutation status (available for 157/409 patients), based on the NCCN-2013 risk stratification criteria, 35.2% of the patients were considered at High Risk (HR) (31.6% and 36.4% in the two groups, respectively) and 76% at low risk (LR) (7.8% and 7.0%, respectively).

Results: The complete remission (CR) rate after induction was 81.4% and 70.4% for Group 1 and 2, respectively (p=0.008). Deaths during induction (DDI), occurring in the first 50 days from 1st line therapy, were 4/139 (2.9%) in Group 1 and 22/270 (8.1%) in Group 2. Patients treated with GO showed a better OS than patients of Group 2; the 5-years OS in the two groups was 54.0% and 34.9%, respectively, and different according to age (54.0% and 34.9% respectively (p<0.001) in patients <60 years, 30.2% and 13.5% respectively (p=0.001) in patients >=60 years). Notably, the analysis on subgroup of HR patients showed a significantly better OS in Group 1 than in Group 2 (p=0.007, 5-year OS 47.7%; 21.0% respectively) and EFS.

Summary/Conclusions: Our conclusion is that adding GO to any induction regimen is an independent and strong predictor of better OS and higher CR rate. Patients with SR and HR AML could therefore benefit from this new approach, especially those treated in AML front line treatment in terms of OS if compared with other standard regimens.

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P576

HOSPITALIZATION FOR TREATMENT-EMERGENT ADVERSE EVENTS (TEAE) IN OLDER (≥65 YEARS) PATIENTS WITH ACUTE MYELOID LEUKEMIA (AML) WITH >30% MARROW BLASTS IN THE PHASE 3 AZA-AML-001 STUDY

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Background: AML treatment (Tx) places an enormous financial burden on both patients and payers. Total direct and indirect cost is the largest cost driver in AML care (Zeidan, Crit Rev Oncol Hematol, 2015) and AML pts report reduced quality of life when in hospital (Sekeris, Leukemia, 2004). The AZA-AML-001 (AZA-AML) study compared azacitidine (AZA) with conventional care regimens (CCR) (chemotherapy) in previously untreated AML. As reported, AZA-AML is associated with lower incidence rates (IRs) of hospitalization and total days in hospital for TEAEs per pt-year (pt-yr) of drug exposure vs the combined CCR arm (Dombret, Blood, 2015). AZA-AML had a preselection study design, allowing for comparisons haematologica | 2016; 101(s1) | 219