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The Importance & Power of Physicians Advocating for Themselves

By David Blitzer, MD, and Tomas Diaz, MD

In the past, we as physicians have not done a great job of advocacy, and we have largely been removed from policy discussions. The emergence of physician advocacy is a relatively new phenomenon. During the AIDS crisis, a unified physician voice was largely missing from policy conversations. Since that time, physician advocacy for social change has grown. Physicians have led movements calling for sensible gun control only to be told to "stay in our lane." Physicians have supported broader access to healthcare, defending the ACA against repeated repeal attempts by a government body with minimal healthcare experience."

Despite bearing witness to the consequences of policy decisions, our expertise is dismissed, and our calls for action go unnoticed. With COVID-19, we have begun to find our voice but, as in the past, have lacked the power to push forward important structural changes to address current and future healthcare challenges.

If the current pandemic has taught us anything, it is the importance and power of physicians advocating for ourselves. While we are currently advocating for the supplies and support we need, this is also an opportunity—a call to action—to continue to represent our field, our patients, and our communities. While we enjoy the privilege of caring for others on a daily basis, we must not forget that our profession affords us a class privilege, which we should leverage to promote health equity. There is no doubt that there will always be a need for competent and dedicated clinicians to serve on the frontlines. But, this pandemic has shown that we will also always be in need of effective advocates for our patients and our profession.

If there is a silver lining in all of this, it comes from the affirmation that when we unite and advocate for ourselves and our patients, we can do great things. As the curtain of isolation lifts, we will continue to draw upon this newfound strength, and we hope you, dear reader, will join us.

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ProMisE-ing Predictions for Progression in Endometrial Cancer

Using the Proactive Molecular Risk Classifier for Endometrial Cancer (ProMisE) algorithm to classify patients with endometrial cancer or endometrial intraepithelial neoplasia by molecular subtype can help predict which patients will progress following treatment with the levonorgestrel intrauterine (LNG-IUD) system, according to a retrospective analysis.

The study, led by Alison M. Puechl, MD, of Duke University Medical Center, suggests that patients with endometrial cancer/neoplasia who have an abnormally high copy number of tumor protein 53 (p53) have a shorter time to definitive therapy and/or progression, compared with patients with other molecular subtypes. The findings were to be presented at the Society for Gynecologic Oncology 2020 annual meeting.

"As clinicians, we are aware of the limitations of standard pathologic assessment of endometrial cancers," Tashanna Myers, MD, of Baystate Health, said in a comment on the study. "Histologic subtype and grade are not sufficient as prognostic markers. Additionally, as we seek to offer patients fertility-sparing options, being able to safely provide those options requires as much information as can be obtained from a sampling of the tumor. Historically, we have used grade and radiologic imaging to guide those recommendations. As determined by Dr. Puechl and colleagues, there can be significant heterogeneity in the rates of the progression within this cohort of patients with similar histologic diagnoses."

A Closer Look at the Study

Using immunohistochemistry and single-gene sequencing, patients were classified into one of four molecular subgroups using the ProMisE algorithm: 1) polymerase-ε (POLE) mutated; 2) mismatch repair-deficient (MMR-D); 3) p53 wildtype/POLE wildtype (copy-number low), and 4) p53 abnormal (copy-number high). "These molecular subtypes have been validated extensively, and the application of ProMisE in this cohort of patients is where we should be going as a subspecialty," said Dr. Meyers.

Participants were 48 patients who were treated with the levonorgestrel intrauterine system for medical management of endometrial cancer or endometrial intraepithelial neoplasia from 2013 to 2018 and who had adequate tissue available. Median age was 55.4 years (range 24-91 years), and the median follow-up time was 16.9 months. Overall, 26 of the 48 patients were diagnosed with endometrial intraepithelial neoplasia prior to levonorgestrel intrauterine system treatment. In total, 20 had grade 1 endometrioid endometrial cancer, and two had grade 2 disease. Indications for medical management were fertility preservation in 37.5% and medical comorbid conditions precluding surgery in 62.5%.

Overall, 71% of patients were classified as copy-number low, 12.5% as MMR-D, 8% as copy-number high, and 8% as POLE mutated. One-quarter of patients underwent definitive therapy after attempted medical management. Among these patients, 17% had progressive disease and 8% had stable disease without regression. The patients who progressed and/or underwent definitive treatment comprised 23.5% of the copy-number low group, 33% of the MMR-D group, 50% of the copy-number high group, and 25% of the POLE mutated group.

Considerations

"Patient tumors with endometrioid endometrial cancer/endometrial intraepithelial neoplasia in the copy-number high subgroup demonstrate a shorter time to definitive therapy/progression when managed with levonorgestrel intrauterine system than tumors in other molecular subgroups," concluded the authors. "Molecular classification of endometrial cancer/endometrial intraepithelial neoplasia prior to management with levonorgestrel intrauterine system may predict patients at increased risk of progression or needing definitive therapy."

Dr. Meyers add, "This is an important study, as it further supports the biologic differences when categorizing endometrial intraepithelial neoplasia and endometrial cancer by molecular subtype and correlating that with response rates to the levonorgestrel intrauterine system. As hysterectomy rates decline across the country and patients are seeking fertility-sparing options, understanding those molecular features that place young women at risk for persistent or progressive disease will help to guide treatment decisions."

Dr. Meyers warns, however, that "this was a single institution retrospective study with small numbers, so it cannot be used to guide clinical care. It challenges us to design prospective studies in endometrial cancer that collect and correlate the molecular subtypes. These algorithms should be used in clinical practice; however, we do not yet have guidance on how to modify care once we obtain these data."

Dr. Meyers recommended that investigators "begin to look at these molecular markers and others (eg, PTEN, PIK3CA, KRAS) in patients choosing fertility-sparing options. However, we should also expand to other subsets of endometrial cancer, such as low-grade tumors with advanced FIGO [Fédération Internationale de Gynécologie et d'Obstétrique] stages and high intermediate risk cancers that may or may not need adjuvant therapy."

33 CHARTS

Telemedicine Fatigue & the Stress of Remote Care

The first thing I heard from my team after starting fulltime telehealth was the exhaustion that seemed to set in at the end of the day. I have noticed this myself. After 8 hours of back-to-back virtual engagement with parents, I found myself with a kind of telemedicine fatigue that's hard to describe.

There are a few potential explanations for this almost consistent report among my colleagues who had transitioned to a full telehealth practice. I'm going to continue to dig deeper into this, but I suspect that it represents a couple of things.

Often, there are inconsistencies in connection, lighting, front-facing lens hygiene, and video quality that require a kind of on-the-fly compensation. And there are the parents who want to hold their phone at arm's length during a 30-minute consult, creating a simulated earthquake experience.

The most obvious potential contributor to this fatigue is the simple stress of transition. Adjusting to a completely different workflow is impossibly challenging, especially for health professionals who have been conducting analog care for most of their career. And on both ends of the encounter is the new "literacy" of engagement by live video connection. For example, the basic error of watching the screen display rather than the seeing-eye camera leads to a classic disconjugate virtual gaze that is subtly jarring and strangely distracting.

But the source of telemedicine fatigue goes beyond professional adjustment and correction of technical glitches.

I've identified that the emotional stress of subtly strained connection is a huge contributor to the exhaustion I feel. A video connection negates the subtleties of connection that are critical to my assessment of a parent and child. Identifying and exploring these subtleties is central to the care of chronically ill children and their families. It feels like I'm working hard to pick up on non-verbal cues that may be difficult to identify or simply out of the frame of view. The simultaneous observation of a mother and child in the same frame presents its own challenges in a home environment. I call this the "drive by" telemedicine assessment, as the child zips in and out of the field of view grabbing toys, running for snacks, etc.

Visit 33charts.com to read the full article.

In Case You Missed It

IBD Not Tied to Female Genital Tract Malignancies

Patients with inflammatory bowel disease (IBD) do not have a higher risk for female genital tract malignancies, according to a study recently published in *Digestive and Liver Disease*. Researchers investigated the risk for female genital tract malignancies, including vulvar and vaginal cancer, among patients with IBD. The analysis was based on data from the Dutch nationwide network and registry of histopathology and cytopathology (1991 to 2015) and patient medical records. The standardized incidence rate for vulvar and vaginal carcinoma among adult female patients with IBD was 1.2, which did not significantly differ from that of the general population. The occurrence of vulvovaginal malignancy did not increase with use of immunosuppressive therapy, nor was there an association with the recurrence rate. Ever-users of immunosuppressive drugs were on average 11 years younger at the time of their gynecological diagnosis. "Although IBD patients are at higher risk of HPV-related cancers, our data do not support intensified screening for vulvar or vaginal malignancies in female IBD patients," the authors write.

Improved Outcomes With Olaparib Plus Bevacizumab Maintenance in Ovarian Cancer

Adding the PARP inhibitor olaparib to bevacizumab maintenance therapy for ovarian cancer among patients who have responded to platinum-taxane chemotherapy improves outcomes regardless of when surgery took place, according to an analysis of the seminal PAOLA-1 data that was to be presented at the Society for Gynecologic Oncology 2020 annual meeting. While sample sizes were too small to confirm benefits among patients with residual disease after surgery, numerical trends favored olaparib. As previously reported, in PAOLA-1 the addition of olaparib to bevacizumab maintenance therapy in patients with ovarian cancer was associated with a longer investigator-assessed progression-free survival (PFS; median 22.1 vs 16.6 months). Among patients who had upfront surgery, median PFS was 29.6 months with olaparib and 18.2 months with placebo (hazard ratio [HR], 0.52). Among those who had interval surgery, results were similar, with a median PFS of 21.4 versus 16.7 months (HR, 0.66). In patients who had upfront surgery and no residual disease, median PFS was 39.3 months with olaparib and 22.1 months with placebo (HR, 0.47). In patients who had interval surgery and no residual disease, median PFS was 22.1 versus 17.7 months (HR, 0.61). PFS was not significantly improved with the addition of olaparib among patients who had residual disease, regardless of whether they had upfront or interval surgery, but numerically still favored olaparib. (HRs, 0.74 and 0.70, respectively).