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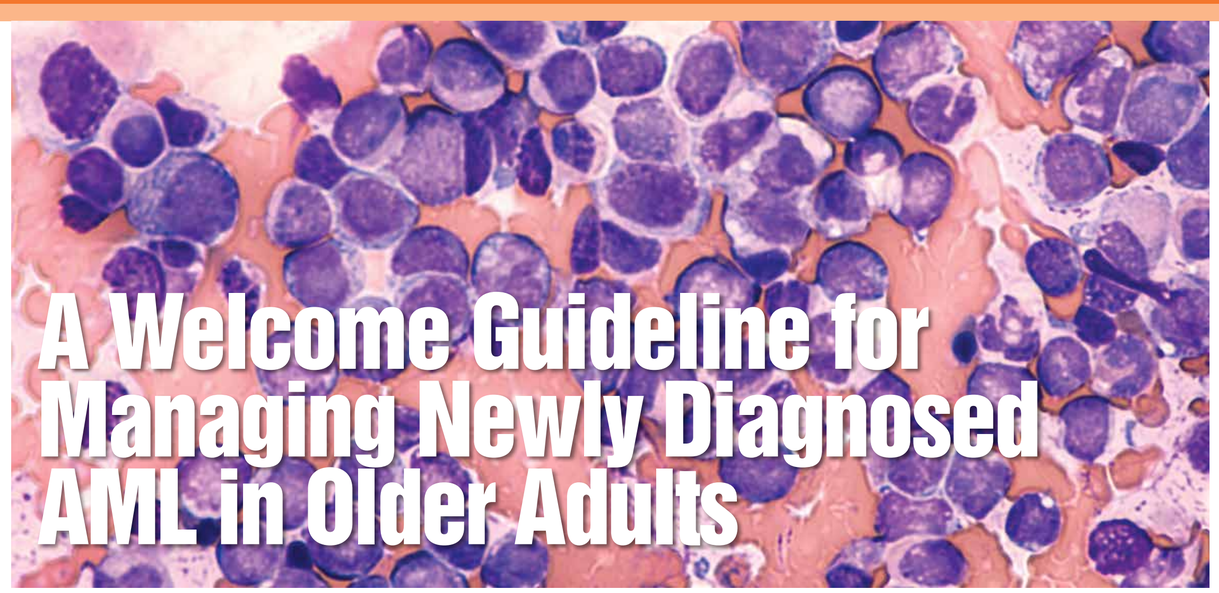

A Welcome Guideline for Managing Newly Diagnosed AML in Older Adults

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Acute myeloid leukemia (AML) generally develops in patients who fall into the "baby boomer" category, a group that is increasingly living longer than ever before. "The treatment of older adults with AML is extraordinarily complex because of the spectrum of treatments and varying patient care goals," explains Mikkael A. Sekeres, MD, MS. "The intensity of treatment can range from supportive or palliative care to cytotoxic chemotherapy that necessitates a 4-to-6-week hospitalization. Patient care should focus on the goals of therapy and other factors, such as comorbidities and a balance of safety and efficacy, that go in to treatment decisions."

New Guidelines

The American Society of Hematology (ASH) recently published guidelines for treating newly diagnosed AML in older adults. Developed in partnership with the McMaster GRADE Centre and published in *Blood Advances*, the guidelines offer recommendations for this vulnerable population based on systematic reviews of all available evidence (Table). They are intended to help with critical care decision making, including if and how to proceed with cancer treatment and the need for blood transfusions for those in hospice care.

"While guidelines for AML have been published by other groups, these recommendations are the first to keep the goals of care for patients front and center," says Dr. Sekeres, who chaired the ASH guideline panel. "They guide healthcare providers and patients through the many decisions that must be made about treatment in real time, from diagnosis until treatment is complete." He adds that the guidelines are one of the few to be developed through a rigorous process of vetting the evidence underlying the recommendations.

According to Dr. Sekeres, the ASH panel was comprised of experts in leukemia, geriatric oncology, guideline development, epidemiology, frailty, and quality of life, representing a wide range of considerations in older adults with AML. "We initially identified about 20 questions that we felt were important to answer but winnowed these to the six most critical questions to guide treatment recommendations," he says. "This included determining if an older adult with AML should be treated at all while also considering the different intensities of initial and subsequent therapies and palliative care or hospice considerations."

Important Guidance

If deemed appropriate based on a patient's treatment plan, the ASH guidelines recommend chemotherapy or other treatments over supportive care. They also recommend more intensive over less intensive treatment when tolerable. Of note, the guidelines also describe the clinical benefit of palliative red blood cell (RBC) transfusions for those who are no longer receiving therapy for leukemia, including those in hospice care.

"One recommendation that may seem intuitive is that older adults with AML should be offered some chemotherapy over none, if it aligns with patient goals of care," Dr. Sekeres says. "As incredible as it may seem, about 50% of older adults with AML in the United States are never offered any chemotherapy. Another recommendation that is particularly important is that patients in palliative care or hospice should receive RBC transfusions to improve quality of life. This should be considered standard supportive care rather than an extraordinary measure. Many hospices will not allow patients to receive any RBC transfusions, but the ASH guidelines clearly state that such practices are wrong and inappropriate."

Weighing Risks & Benefits

The guidelines note that discussions between patients and physicians are instrumental to personalizing treatment plans in AML. They recommend collaboration to establish patient goals and wishes, paying attention to factors like side effects and risks of chemotherapy and time in the hospital. These issues must be weighed against potential benefits like remission and extended life. Such efforts can ensure that patients make appropriate treatment decisions that are consistent with their goals.

Clinicians are encouraged to visit www.hematology.org/AML/guidelines to access the complete guidelines and find more information and resources. In the meantime, Dr. Sekeres says additional research is necessary to further inform healthcare providers on the most appropriate strategies for treating newly diagnosed AML in older adults. "We need more rigorous clinical trials to compare less and more intensive treatment approaches," he says. "We also need to define the value and precise duration of post-remission treatment in older adults with AML."

Table Summarizing Key Recommendations for Older Adults With Newly Diagnosed AML

	Recommendation	Strength of Recommendation
1	For those who are candidates for such therapy, the ASH guideline panel recommends offering antileukemic therapy over best supportive care	Strong
2	For those considered candidates for intensive antileukemic therapy, the ASH guideline panel suggests intensive antileukemic therapy over less intensive antileukemic therapy	Conditional
3	For those who achieve remission after at least a single cycle of intensive antileukemic therapy and who are not candidates for allo-HSCT, the ASH guideline panel suggests post-remission therapy over no additional therapy	Conditional
4a	For those considered appropriate for antileukemic therapy but not for intensive antileukemic therapy, the ASH guideline panel suggests using either of the options when choosing between hypomethylating-agent monotherapy and low-dose-cytarabine monotherapy	Conditional
4b	For those considered appropriate for antileukemic therapy but not for intensive antileukemic therapy, the ASH guideline panel suggests using monotherapy with one of these drugs over a combination of one of these drugs with other agents	Conditional
5	For those who achieve a response after receiving less-intensive therapy, the ASH guideline panel suggests continuing therapy indefinitely until progression or unacceptable toxicity over stopping therapy	Conditional
6	For those who are no longer receiving antileukemic therapy, the ASH guideline panel suggests having RBC transfusions be available over not having transfusions be available	Conditional

Abbreviations: allo-HSCT; allogeneic hematopoietic stem cell transplantation; AML, acute myeloid leukemia; ASH, American Society of Hematology; RBC, red blood cell.

Source: Adapted from: Sekeres MA, et al. *Blood Adv.* 2020;4(15):3528-3549.

Q&A WITH DR. MEDLAW

Professional Vs. Ordinary Negligence

A patient fell off my examining table. She had felt a bit woozy when I was removing her sutures, so I stopped to give her a breather and stepped out to take a phone call. When I came back, she was on the floor, shaken and upset but not hurt other than a large bruise. She is suing me pro se; I guess she was not able to get a lawyer because she did not have serious damages. She is claiming that I was negligent for leaving her alone. In my state, malpractice claims first require a doctor to attest that the case has merit. My patient did not do this. Can I get the case dismissed?

Not every negligence case against a doctor, or based on an event in a doctor's office, is a malpractice action. Malpractice is professional negligence, a tort that can only occur in the setting of the practice of a profession, in this case medicine. Doctors can, however, also be subject to claims of ordinary negligence.

Claims of ordinary negligence raise issues within the common knowledge and experience of anyone who might sit on a jury or of any judge who might hear the case in a bench trial. Claims of medical negligence raise questions involving medical judgment beyond the common knowledge and experience of non-physicians.

She is probably suing for ordinary negligence, precisely because it is an easier claim to bring. She would say it is within anyone's knowledge that a woozy person on an elevated table without side guards is at risk of falling and should not be left alone.

However, what would be ordinary negligence if it happened in another setting will, if it is part and parcel of the rendering of medical diagnosis or treatment, be legally viewed under the scope of malpractice, because the professional obligation to act non-negligently extends to all aspects of the care, including a safe physical setting. The test is whether the negligent act occurred in the rendering of services for which the healthcare provider is licensed. This is separate from the duty to the patient as just a visitor to the office who is owed a duty of care against dangerous conditions on the premises the doctor controls, just as is everyone else.

In your case, the patient was already in the midst of her appointment and was woozy because you were removing her sutures, bringing it fully into the ambit of medical care, which would then include maintaining her safety on the high table. You can, therefore, move to have the case dismissed. She would have to bring a new case for malpractice—or, since you actually were negligent in leaving her alone while woozy on the table but she was not seriously harmed, you can offer a reasonable settlement.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.

MEDPAGE TODAY'S KevinMD.com

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Culture: Why the US Will Experience 500,000 COVID-19 Deaths

By Robert Pearl, MD

With its "acceptable" death rate and surprisingly high rate of asymptomatic transmission, COVID-19 presents an unsolvable problem in a nation known for the words "give me liberty or give me death." The reality is that we know what to do. We just won't do it. Americans lack the cultural commitment to doing what is necessary to slow the spread of this particular virus. Given our national culture, the United States will continue to experience consistently high rates of cases and deaths until a safe and effective vaccine is broadly administered. And that time is a long way off. In a recent interview, the CEO of Moderna, a leading vaccine developer, told the *Financial Times* he doesn't expect to have approval until the Spring of 2021.

CDC Director Robert Redfield said it would take 6-9 months to get the American public vaccinated once a vaccine is approved. That takes us into the fourth quarter of 2021 at the earliest. And, according to Dr. Anthony Fauci, the chances of a first-round coronavirus vaccine being highly effective are "not great," which means nationwide viral control won't happen until even later. By that time, the math indicates the US death toll will reach half a million. Assuming the current count of 720 deaths a day in October holds steady and projected timelines for a vaccine prove correct, anywhere from 260,000 to 320,000 more people will die over the next 12 to 15 months.

I hope I'm wrong. And I'd be remiss not to recognize that almost anything can occur, including a miraculous medical discovery or a helpful viral mutation. But hoping for a "Hail Mary" solution isn't a viable strategy. The one thing we can say with full confidence is that there won't be any meaningful changes in American culture over the next year and a half. And as a result, the death toll from the current coronavirus will rise far longer and to far higher than most Americans recognize or are willing to acknowledge.

Robert Pearl, MD, is a plastic surgeon and author of Mistreated: Why We Think We're Getting Good Health Care–And Why We're Usually Wrong. *He can be reached on Twitter @RobertPearlMD.*

In Case You Missed It

Relationship Explored Between Physical Activity and Lymphoma

High levels of physical activity may lower the risk for developing lymphoma, according to a review/meta-analysis published in *BMC Cancer.* Researchers conducted a systematic literature review/meta-analysis to examine the association between physical activity and incident lymphoma. Eighteen studies (nine cohort, nine case-control) were included in the final analysis. The researchers found that for all lymphoma, comparing the highest with the lowest activity categories showed physical activity was protective (relative risk [RR], 0.89; 95% confidence interval [CI], 0.81 to 0.98). In a sensitivity analysis, the effect persisted in case-control studies (RR, 0.82; 95% CI, 0.71 to 0.96) but not in cohort studies (RR, 0.95; 95% CI, 0.84 to 1.07). A subgroup analysis showed some protective effect of physical activity for non-Hodgkin lymphoma (RR, 0.92; 95% CI, 0.84 to 1.00) but not for Hodgkin lymphoma (RR, 0.72; 95% CI, 0.50 to 1.04). A protective effect was demonstrated in a dose-response analysis, with a 1% reduction in risk per three metabolic equivalent of task (MET) hours/week (RR, 0.99; 95% CI, 0.98 to 1.00; P = 0.034). "Dose response analysis supports these conclusions, with a linear decrease in incidence seen with increasing recreational physical activity," the authors write.

Factors Associated With Suicide in Leukemia Identified

Male sex, older age at diagnosis, White race, and having acute myeloid leukemia are risk factors associated with suicide among patients with leukemia, according to a study published in *Cancer Medicine.* Study investigators analyzed data from 142,386 patients with leukemia from the Surveillance, Epidemiology, and End Results database (from 1975 to 2017) to identify potential risk factors associated with suicide. During an observation period of 95,397 person-years, the researchers found that 191 of the patients committed suicide. For leukemia patients, the suicide rate was 26.41 per 100,000 person-years, and the standardized mortality rate was 2.16. In univariate and multivariate analyses, higher risk for suicide was associated with male sex (hazard ratio [HR], 4.41), older age at diagnosis (60 to 69, 70 to 79, and ≥80 years versus ≤39 years; HRs, 2.60, 2.84, and 2.94, respectively), White versus Black race (HR, 6.80), acute myeloid leukemia and unspecified and other specified leukemia versus lymphocytic leukemia (HRs, 1.59 and 2.72), and living in a small versus large city (HR, 2.10). A protective factor for suicide was non-Hispanic Black versus Hispanic race (HR, 0.06). "Medical workers can use our research results to screen leukemia patients with a higher risk of suicide and apply targeted preventive measures to them," the authors write.