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Treating HIV-Related Malignancies

One-third of all AIDS cases in Chicago are in Illinois Masonic's service area, according to David Lyter, M.D., M.P.H., an oncologist/hematologist with more than twelve years' experience working with HIV-positive patients. Since the beginning of the AIDS epidemic, Illinois Masonic has provided primary and hospitalized care for people with HIV infection and opened

Illinois Masonic Medical Center (IMMC) in Chicago, Ill., has been providing quality health care for more than seventy years. The Medical Center operates eleven full-service medical practices and is the primary teaching affiliate of Rush University and Rush Presbyterian St. Luke's Medical Center. IMMC employs more than 3,300 people to serve approximately 260,000 outpatients and 20,000 inpatients each year.

VITAL STATISTICS

- Total system-wide bed size: 507
- Dedicated cancer unit beds: 15
- New analytic cancer patients seen each year: 561
- Current number of patients on NCI-approved protocols: 132
- Managed care penetration in Illinois: 20 percent

PATIENT SUPPORT SERVICES

- IMMC Community Health Education offers a range of classes, including smoking cessation, cancer prevention, and nutrition information.
- The Cancer Center operates a free breast cancer risk assessment line.
- The hospital provides an annual prostate cancer screening day, and a four-part breast screening program is offered twice a month.
- The AIDS and cancer programs provide an oncology psychologist, an art therapist, a nutritionist, social workers, on-call pastoral care, and a dedicated team of volunteers.

the city's first AIDS inpatient unit in 1985. "Our center's top priority is to develop a more comprehensive program that provides a high standard of care and also offers research-oriented protocols," said Lyter, who heads the AIDS Malignancy and Blood Disorder Program at Illinois Masonic Medical Center in Chicago.

Illinois Masonic is affiliated with the AIDS Clinical Trials Group (ACTG) through Northwestern and Rush Universities. Within the ACTG and the Eastern Cooperative Oncology Group (ECOG) there are treatment protocols for cancer patients with HIV infection. Patients with HIV infection are placed onto protocols for the five main HIV-related malignancies—Kaposi's sarcoma, primary central nervous system lymphoma, non-Hodgkin's lymphoma, Hodgkin's disease, and cervical cancer.

"We're in the process of understanding the natural history of malignancy and its response to therapy in the setting of HIV as compared to the general population," Lyter explained.

AIDS-related malignancies comprise 10 percent of Illinois Masonic's new cancer patients, and this number will grow, said Lyter. "Patients with HIV are living longer as we become better at prophylaxing against or treating infections. As patients live longer, they develop complications we cannot prophylax against, especially malignancies and hematological disorders."

HIV AND CANCER: THE WHOLE PICTURE

To treat cancer in a patient with HIV infection, the oncologist must have a good understanding of primary HIV care issues, including antiretroviral drugs, prophylaxis, opportunistic infections, and quality of life issues. Lyter's background in HIV primary care helps him judge when chemotherapy is appropriate and how it fits into the prognosis.

"Our program is unique in that we have someone trained specifically in AIDS malignancies who can treat the patient while looking at the whole picture," explained Laura Fullem, R.N., M.S.N., administrative director.

The complications of AIDS make HIV-related malignancies more difficult to treat and follow. An HIV-infected patient has a much greater risk of developing a complication such as pneumocystis carinii pneumonia during chemotherapy. In many cases the physician must postpone chemotherapy while the infection is treated. During that time there is the risk that the cancer will grow out of control.

"Increased complications, hospitalizations, and multiple medications are factors that also drive up the costs of treating patients," said Fullem. "You have to consider not only the cancer but also the complications that AIDS presents."

For example, marrow suppression often occurs in AIDS malignancy patients as a result of AZT, chemotherapy, and other supportive medications. "While patients are receiving chemotherapy, many must also start on growth factors for either neutropenia or anemia," Fullem explained. In some cases Illinois Masonic receives medications for the patient directly from the pharmaceutical companies through research trials or reimbursement programs.

Addressing quality of life issues may increase the complexity of decisions about treatment options, depending on the patient's stage of HIV and cancer as well as the type of cancer. Aggressive treatment may benefit a patient in the early stages of HIV infection who has lymphoma, but it may be less appropriate in patients with end-stage HIV disease. Early stage Kaposi's sarcoma may initially allow a "wait and see" or localized approach, but will require more aggressive therapy with time.

Fullem credits the oncology nurses for assisting with cost containment. "We strive to manage the patients as outpatients as much as possible. Doing so depends on education and efficient triaging by the nurses and their ability to identify complications as early as possible," said Fullem.

HIV-infected patients with malignancies are often admitted into the HIV unit, where nurses from the oncology unit administer chemotherapy. Eventually nurses on the HIV unit will be trained to provide chemotherapy. Patients go to the HIV unit where they can receive greater support for their AIDS-related needs.

Illinois Masonic Cancer Center has a grant from the Chicago Department of Public Health to educate and screen women with cervical cancer or dysplasia for HIV infection. Women with cervical dysplasia and HIV often have similar histories and risk factors. In addition, an HIV-infected woman is immunosuppressed, placing her at even greater risk of developing cervical cancer or dysplasia. With early detection and proper management, HIV-positive patients should have as much chance for cure of cervical cancer as other patients.

Successfully treating cancer in HIV-positive patients can be frustrating because the HIV infection remains even if the cancer may be gone. Research, however, offers reason for hope. Studying the relationship between immunosuppression and cancer contributes to increased knowledge of both cancer and AIDS. ■