

Communication: Key to Addressing Toxicity and Recurrence Risks

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Immuno-oncology (IO) has radically altered the patient care paradigm. One of the most important changes attributed to IO is improvement in outcomes and lengthening of survival. This good news comes with multiple challenges, not least of which is

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the need for new and better communication and coordination among multiple specialties over time. IO requires providers to adapt to more multidirectional, dynamic relationships to optimize patient care. Management of potential toxicities of IO is involving specialties that have not historically had much of a role in oncology. This includes gastroenterologists to help manage colitis or enteritis, endocrinologists to treat hypophysitis or hypothyroidism, dermatologists to care for dermatitis, and many others. Late events, including responses, recurrences, and toxicities, are also more common now, often occurring months after the start of treatment or even later. For patients with metastatic solid tumors, these long timelines are a fairly new development.

What can we do to proactively address this paradigm shift? First, we must open more lines of communication so that we can provide more updates with each follow-up visit, meet more requests for help in unfamiliar clinical situations, and support shared problem-solving. Here, despite continued shortcomings, electronic medical records can help with messaging and forwarding reports. But often, there is no replacement for a direct conversation about a patient or a tumor-board presentation.

Second, we must engage and educate our patients. Since patients undergoing immunotherapy often don't "look like" cancer

patients, their history of cancer therapy may not be obvious to a physician who is seeing them for an "unrelated" symptom. For example, severe diarrhea requires a substantially different work-up in the Emergency Department in a patient who has received checkpoint blockade. Well-informed, prepared patients can provide information about their diagnosis and treatment to non-oncology physicians on the front lines—whether through treatment education they have received or even by presenting an IO wallet card to the clinician. In larger practice settings, creating an oncology "toxicity team" can establish a single, broadly available resource for non-oncology physicians to reach out to for guidance and information in evaluating an IO patient.

Finally, as patients move from active therapy to post-treatment survivorship and long-term follow-up, we must clearly identify which member of the patient's care team will be primarily responsible for their care. As more patients enjoy long-term, durable responses, their medical home will likely revert to their primary care physician. Although when and how this transition occurs will vary, good communication among all parties is key to ensuring that everyone is on the same page as it is happening.

There is much we do not yet know about the optimal strategies for caring for immuno-oncology patients, including those who do very well over the long term. One thing is certain: Things will continue to change, and ongoing communication will be essential to success.



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