Patient Perspectives on Adjuvant Therapy in Renal Cell Carcinoma

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Background and Rational

- Sunitinib recently was approved as adjuvant therapy (AT) for renal cell carcinoma (RCC) in patients at high risk of recurrence
- Previously, no approved AT therapy existed for RCC patients and standard of care was surgery followed by surveillance
- Significant controversy exists about the approval of sunitinib as AT due to conflicting data from multiple trials
- Frequent discussions on AT have focused on the question of overall survival (OS) benefit for sunitinib, pending maturation of the trial data
- Missing from the discussion is how patients perceive AT and drivers that will influence their decision-making process.
- The purpose of this study was to assess the understanding and value of specific adjuvant outcome measures in patients with RCC

Methods

- The patient survey was designed together by the European Association of Urology (EAU) Renal Cell Carcinoma Guidelines Panel and the Kidney Cancer Research Alliance (KCCure), a U.S. based non-profit patient advocacy organization
- The survey on patient perspectives on adjuvant therapy was conducted on surveymonkey.com and was promoted via kccure.org, through on-line communities including Facebook and smartpatients.com
- No data on adjuvant trial results were included
- No education on adjuvant or medical endpoints were provided
- Approximately 800 patients between April 1st and June 15th, 2017 addressed online
- n = 450 patients with RCC responded

Statistical Analysis

- Calculations were done with SPSS statistics 25.0 (IBM Corp., Armonk, New York, USA).
- Medians were calculated with a confidence interval (CI) of 95% and an alpha of 0.05
- Significance was calculated using Kruskal-Wallis test with a significance level of 0.05.

Questions on SurveyMonkey

1. What is your gender?
2. What is your age?
3. Are you White, Hispanic or Latino, Black or African-American, Asian/Pacific Islander, American Indian or Native American, or some other race?
4. Give the date you were diagnosed with kidney cancer
5. What stage was your disease at diagnosis?
6. Did you have surgery for the primary tumor in your kidney?
7. If you weren't stage 4 at diagnosis, has your disease recurred?
8. Since your diagnosis, rate your anxiety related to concerns that your cancer will come back (1-10)?
9. Are you on systemic therapy (drug therapy) for metastatic renal cell carcinoma?
10. If taking a drug for one year following surgery could help prevent or delay cancer from recurring, would you:
    - ✓ not use it
    - ✓ use it, if there was moderate toxicity
    - ✓ use it, only if there was no toxicity
    - ✓ use it, no matter what toxicity level
    - ✓ use it, only if it prolongs survival
    - ✓ don´t know, more information needed
    - ✓ other
11. If you were able to get treatment to prevent recurrence of your kidney cancer, what would be important for you?
    - ✓ insurance coverage
    - ✓ toxicity of the drug
    - ✓ increased time to recurrence of cancer
    - ✓ better surveillance
    - ✓ physicians recommendation
    - ✓ available data on efficacy
    - ✓ longer survival

Results

Median age was 55.6 years (17-82 years). 56.4% of the patients were female. 73.6% underwent nephrectomy, 22.0% had a partial nephrectomy 76.4% of the patients had clear cell RCC. 39.1% had recurrence of RCC 35.3% were receiving systemic therapy for metastatic RCC 63.1% of patients would use AT if it prolonged OS 60.1% if AT prolonged disease free survival (DFS), 42.7% if AT demonstrated acceptable toxicity, and 36.7% if guaranteed insurance coverage and efficacy.

Experience with systemic therapy was correlated with a wish for a prolonged OS ($p < 0.0001$). Patients with a history of systemic therapy rely on the physician's recommendation in contrast to patients without a history of systemic therapy ($p < 0.0001$). The recurrence status, age, initial stage and type of surgery had no influence on the patients´ decisions. 28.0% of the patients would need more information prior to their decision, 24.2% would only take AT with a proven OS benefit, 16.9% would use AT if there was moderate toxicity, 13.6% would use AT independent of the associated toxicity level, 8.2% would only use AT without any toxicity. 3.8% of the patients would not use AT. Patients on systemic therapy had a significant higher acceptance of toxicity ($p < 0.0001$).

Results (cont.)

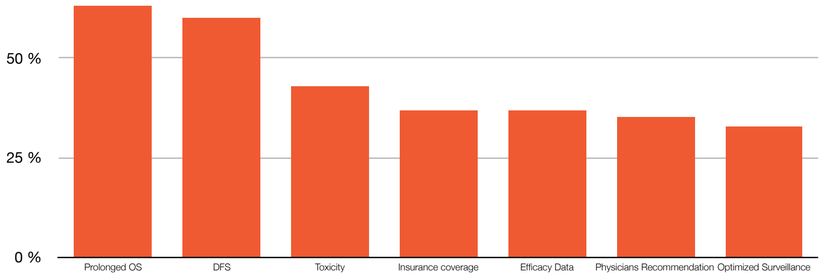
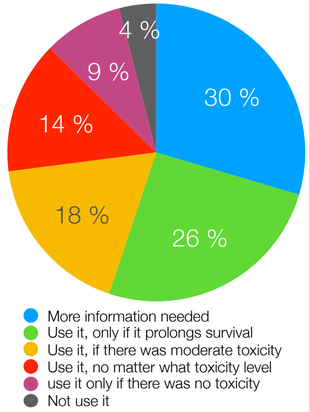


Fig.1: Reasons for patients willing to take an adjuvant drug

Stage of disease had little impact on patient responses to the questions. Patients were willing to accept toxicity even if their risk of recurrence was low. Though, almost 30% of patients want to have more information on AT, the majority would still be willing to take a drug to delay or prevent disease recurrence regardless of toxicity. Patients who already had or are still treated with systemic therapy had a significantly higher acceptance of toxicity than patients who had no experience with systemic treatment. On the other hand, patients who had systemic therapy were more likely to ask for an OS benefit and a physician's recommendation ($p<0.0001$).

Fig.2: Answers Question 11



Conclusions

- Patients are willing to use AT
- OS and DFS benefits are not differentiated by patients
- Toxicity is not a main driver of decision making

These data provide an important perspective on patient perceptions of AT, and emphasize the need for patient education on harms and benefits of AT

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