

An interview with Jennifer T. Tam-McDevitt, PharmD, PhD, Director of Scientific Development, and Stuart Lichtman, MD, Scientific Advisory Board Member, Geriatric Oncology Consortium

Too many trials, not enough patients

By Cori Vanchieri

They're on a mission to open more clinical trials to older patients. But first, Jennifer T. Tam-McDevitt, PharmD, PhD, and Stuart Lichtman, MD, both members of the Geriatric Oncology Consortium (GOC), want you to know that there may be too many trials to fill. From September to November 2005, Drs. Tam-McDevitt and Lichtman combed ClinicalTrials.gov for active trials in breast, lung, or prostate cancers. They added up the number of patients needed to complete those studies and presented their results at the 2006 an-



Jennifer T. Tam-McDevitt, PharmD, PhD

nual meeting of the American Society of Clinical Oncology (ASCO). Dr. Tam-McDevitt, GOC's director of scientific development, hopes to spark discussions about prioritization of the trials under way. Dr. Li-

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chtman is an oncologist at Memorial Sloan-Kettering Cancer Center in Commack, New York.

Community Oncology: Your study indicates that demand for patients in clinical trials has outpaced supply. How bad is it?

Dr. Tam-McDevitt: Certainly for some tumor types such as breast cancer, more than 150,000 patients—which is more than half of all new cases—would be required to complete the studies listed in ClinicalTrials.gov. For lung cancer and prostate cancer trials, more than 26,000 and 52,000 patients, respectively, would be needed. We didn't get a chance to look at all tumor types, but our feeling is that the percentages are similar for other cancers as well. That becomes significant when you start looking at most literature, which says that fewer than 10% of adult cancer patients are participating in clinical trials. The participation rate for patients age 70 and older is even lower.

Are all studies slowed down by this lack of patients?

Dr. Tam-McDevitt: We don't want to say across the board that everything is running slowly. I know there are studies that have exceeded their timeline. But on the flipside, especially for smaller trials involving tumor types that may have many active studies because a lot of drugs are in the pipeline, we see a competition for patients.

Why do you say that it is an "ethical responsibility" for the medical community

to ensure sufficient patient enrollment in clinical trials?

Dr. Tam-McDevitt: Obviously, cancer is a disease for which everybody is looking for a cure. We're ethically bound to conduct trials to learn how to manage and treat patients. We need to know what is safe and effective for the patient. We will never arrive at those answers if we don't enroll



Stuart Lichtman, MD

patients in clinical trials and conduct them more efficiently.

Another study presented at ASCO, by Robert Comis, suggests that 40% of patients who learned about a clinical trial from their doctor ended up enrolling or trying to. Does this put the problem squarely in the laps of physicians?

Dr. Lichtman: Yes, it's very doctor driven. The Cancer and Leukemia Group B [CALGB] did a good study a few years ago led by Margaret Keme-

ny and others about barriers to clinical trials. Older patients were offered a trial less often than were younger patients at the same stage of disease. Importantly, the older patients were just as likely as the younger ones to participate once they were offered a trial.

Dr. Tam-McDevitt, you suggest that the most important trials have to be prioritized in order to get done. How do you see that happening?

Dr. Tam-McDevitt: Prioritization can occur on many levels. There's the physician level, which tends to be most upfront. Doctors will look at trials they have and will decide which one is most relevant scientifically. And they'll more aggressively put patients on it. But maybe we need to go beyond that, to a higher level involving investigators, the National Institutes of Health, the US Food and Drug Administration, and patient groups.

In addition, there might be a better way to design clinical trials, which haven't changed much over the years. From our study, more than 50% of trials are phase II. Very often, a lot of them never go beyond those data. Is there a more efficient way of doing phase II trials so that we find out earlier whether it makes sense to move to phase III or see whether it's a dud sooner rather than later? In this way we wouldn't be waiting until a drug trial enrolls 60–80 patients, who could have gone on another trial. I don't know if anyone has an answer. But we need more open dialogue.

So there's the issue of which trials get done, but you're also concerned about studies that exclude older patients.

Dr. Lichtman: Physicians wonder whether their older patients can really tolerate it. For some drugs studied, investigators want patients with normal kidney and liver function. They don't want to see any prior cardiac disease. These exclusions rule

out many older patients.

Dr. Tam-McDevitt: Investigators want to run their studies in the ideal population. They will choose a population for which the regimen will work best. I understand that when a drug has not been approved for use, obviously you want to make sure safety is the first priority in a clinical trial. But soon after, we need to start asking: How do we know that this particular regimen, which works in a trial where the average age is 50, applies to my 70-year-old patient?

So how do we address this concern?

Dr. Tam-McDevitt: That's been the mission of the Geriatric Oncology Consortium. To better involve the population of older patients, we want to figure out how to design clinical trials that don't compromise safety but broaden the number of patients included. The other very important part is geriatric assessment. Can we enroll older

The Cancer Trials Support Unit (CTSU)

A NATIONAL CANCER INSTITUTE-supported program, CTSU provides clinicians across the United States and Canada with access to phase III cancer treatment trials. The goals of CTSU are to:

- Provide a wide choice of clinical trial options to the largest possible number of investigators
- Involve a larger number of treating institutions in the clinical trials process
- Increase enrollment to cancer clinical trials
- Streamline or eliminate redundant processes and procedures
- Provide all necessary support services to make working with the CTSU a positive experience

For more information, visit www.ctsuo.org.

patients with comorbidities, such as decreased kidney and liver function? Will they be able to do fairly well? CALGB and others are also looking at this issue.

Dr. Lichtman: Martine Extermann [at the H. Lee Moffitt Cancer Center and Research Institution] had an idea that I think would work. Let's say patients have comorbidities or have impaired functional status. We could start at a low dose and escalate the dose based on their functioning. That's a reasonable thing to try. And that would be a small study, like a phase I/II study. Bottom line: The doctors in practice have to have studies available. The Cancer Trials Support Unit [CTSU] might help with this. It offers access to trials for doctors who don't belong to a cooperative group. [For more information on CTSU, see the box at left.]

Dr. Lichtman, you've been treating elderly cancer patients for a long time. How have they changed? Are they better informed? More or less optimistic? Are their expectations different than in the past?

Dr. Lichtman: Medically speaking, older patients are in better condition. They're not as decrepit anymore since we're treating conditions such as osteoporosis and heart disease. If you're not hunched over, or weakened by heart disease, you're a better functioning person and you're potentially eligible for cancer therapy.

In terms of expectations, I see the independent old people who want to function and do things, such as my 79-year-old patient with melanoma. I also see the older lady whose family brings her in and she may or may not know what's going on. But her kids have nine pages of printouts and want to know why I'm not giving her a particular drug. In either case, people still have trouble putting all the information into the context of their disease and understanding eligibility criteria for trials.

What will it take to boost clinical trial participation above these long-standing, low rates?

Dr. Lichtman: There are many factors that affect the enrollment of patients into clinical trials and will need to be addressed. To get past the current 5%–10% recruitment rate, perhaps we need a celebrity to promote our cause. Or we could go the European route: If you want the drug, you may have to go on trial. But that will never happen in the US.

My preference would be that the government or insurance would pay carte blanche to treat patients with

certain diseases, particularly relative refractory disease for first- and second-line therapies, and the treatment would have to be on a trial.

Dr. Tam-McDevitt: Financial incentives may help with some of the big trials. For example, one trial involving chronic myeloid leukemia is enrolling older cancer patients. The cancer trial will provide up to 5 years of medication. For Medicare patients in the “donut hole,” that free drug may be a motivator.

What else would help more oncologists enroll

patients in studies?

Dr. Lichtman: Most community oncologists are smart and motivated. I don't think they'd mind putting people on trial. I honestly think it's an infrastructure issue and a matter of time. One suggestion is a traveling study nurse who can support the doctors who want to get their patients on trial but don't want to or can't join a group. We just need a grant.

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