PS2283

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Patient-physician Communication Regarding TKI-related Adverse Events and Their Impact on Quality of Life in CML – Insights from Patient and Physician Surveys in the US

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KEY FINDINGS & CONCLUSIONS

- Gaps in communication exist between patients with CML in the US and physicians concerning TKI-related AEs and their effects on QoL, where perceptions in the timing of discussions differed; the gaps found were equally important in patients receiving first or second TKI, with patients receiving second TKI more likely to refrain from discussing AEs
- From the patient's perspective, AEs also played a significant role in treatment change decisions
- To empower patients in treatment decisions for better quality of care, patients' perception throughout treatment needs to be recognized, and continuous support, such as ongoing patient education and proactive monitoring of AEs by physicians, should be offered to minimize gaps in communication and improve patient satisfaction

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BACKGROUND & OBJECTIVES

- Tyrosine kinase inhibitor (TKIs) used to treat chronic myeloid leukemia (CML) have well-documented adverse events (AEs) and intolerance profiles[1]
- Nonetheless, limited information is available on how patients with CML and physicians discuss TKI-related AEs and their impact on quality of life (QoL)[2]
- This study aimed to assess patient and physician perspectives on communication about the management of CML and potential gaps regarding AEs and their impact on QoL and TKI switching

METHODS

- Cross-sectional online surveys were conducted from June to December 2024 in:
  1) Adults with CML treated with first or second ATP-competitive TKI (i.e., imatinib, dasatinib, nilotinib, bosutinib, ponatinib) for ≥ 3 months
  2) Hematologists or oncologists with experience treating CML in US clinical practice
- Surveys collected self-reported information on patient and physician characteristics, as well as communication about AEs and impact of AEs on QoL and treatment switch, including:
  - Frequency and timing of discussions
  - Who initiated and reasons for delaying or avoiding discussions
  - Patient satisfaction about the communication
- Analyses were descriptive and conducted separately for patients and physicians
- This study was exempt by the Pearl Institutional Review Board (IRB) under 45 CFR 46.104(d)(2)

RESULTS

Communication Gap 1: When did the discussion occur?

While most patients and physicians reported discussing AEs and impact on QoL, perceptions differed on timing of the discussion

- While most physicians (93%) reported discussing AEs at diagnosis (64% during subsequent medical visits), most patients reported having discussions later at subsequent medical visits (73%) as well as at diagnosis (69%)
- In addition, 5% of physicians reported they did not discuss potential AEs and 17% did not discuss the impact of TKI-related AEs on QoL with their patients
- In general, physicians who did not discuss the impact of AEs on QoL preferred to focus on efficacy of TKIs or severe AEs, while some indicated they do not consider the topic
- 41% of physicians reported AEs of any severity were all discussed in the same way; 59% said the discussion differed depending on the severity

Communication Gap 2: Who initiated the discussion?

Patients and physicians have different views on who initiates the discussion about AEs

- Almost half of patients (45%, n=118) report initiating to better understand their symptoms and experience, whereas most physicians (85%, n=121) report initiating the discussion about AEs because it is their role as their physician to ask and monitor for AEs of the medication
- Top reasons for patients initiating (out of 118 patients who usually initiates discussion): "I am, in general, proactive, and involved in my care" (61%); "I seek help and solutions to manage the AEs" (60%), and "I want to know if what I experience is normal and I ask questions" (59%)
- Top reasons for physicians initiating (out of 121 physicians who usually initiates the discussion): "It is my role, as their physician, to ask them about it" (88%), "I do that as part of the regular monitoring visit" (86%), "Patients are uncertain if what they experience is an AE" (78%)

Patient and Physician Characteristics

A total of 271 patients **(Figure 1)** and 150 physicians **(Figure 2)** participated in the study

Figure 1: Participating Patient Characteristics

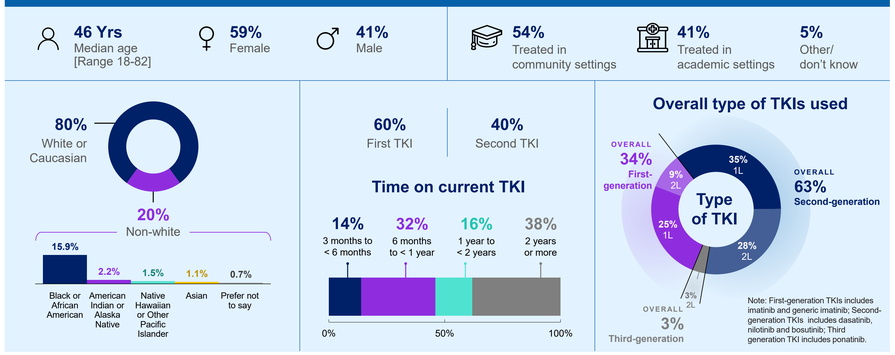


Figure 2 : Participating Physician Characteristics

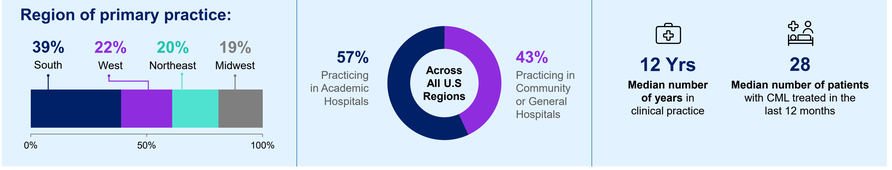
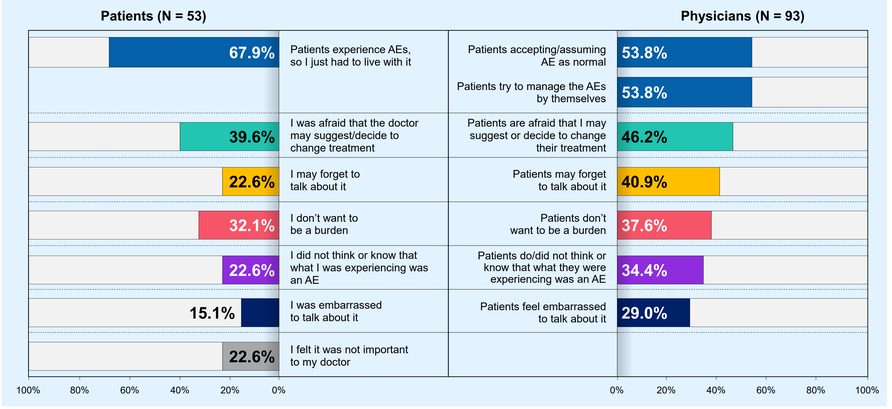


Figure 4: Reasons patients with CML delay or refrain from discussing AEs and impact of AEs on QoL with their physicians – Patient and physician perspectives



Communication Gap 3: Why did patients switch treatment?

Patients reported switching treatments due to AEs/intolerance, whereas physicians also considered lack of efficacy as the primary reason for treatment switch

- Discussion on treatment switch was typically suggested or initiated by physicians
- For patients treated with a second TKI (N=109), primary reasons for switching TKIs were often related to AEs and intolerance (most common reasons [non-exclusive]: 49% experienced AEs that could not be managed; 38% due to test results being not as good as they should have been; 36% had one or multiple serious AEs)
- On average, physicians reported a lack of efficacy (resistance or suboptimal response) as the primary reason for switching TKIs in two-thirds (63%), followed by intolerance to TKIs in one-third (36%) of their patients

Communication Gap 4: How satisfied are patients about the discussion?

One-third of patients did not report being satisfied with the discussion they had with their physician about AEs (32%; Figure 3a) and impact on QoL (28%; Figure 3b)

Figure 3a

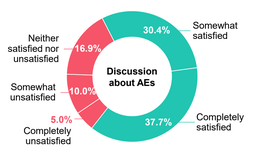
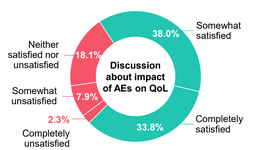


Figure 3b



- Around one fifth of patients reported delaying/refraining from talking to their physician about AEs (20% of 271 patients) or their impact on QoL (16% of 216 patients), mainly because they assume they just have to live with AEs **(Figure 4)**
- Patients on their second TKI were more likely to delay telling their physician about AEs and to endorse the response "patients experience AEs, so I just have to live with it"
- More than half of physicians (65%) believed their patients delayed/decided against telling them about AEs, mainly because they accept AEs are normal or try to deal with it by themselves
- Potential treatment change was also reported as a key stress factor (by 40% of patients; 46% of physicians), discouraging discussions about AEs

LIMITATIONS

- Diagnosis confirmation by a medical professional or through medical charts was not required for patient eligibility
- Patients with more severe disease, males, and older patients may be under-represented; findings may not be generalizable to the overall population of patients with CML and physicians treating CML in the US

REFERENCES

1. Bixby D & Talpaz M. *Hematology Am Soc Hematol Educ Program*. 2009; 461–476. **2.** Jadhav K, et al. *Value in Health*. 2023;26(6), S400.