

# Challenges in supportive cancer care: perspectives from the Asia Pacific and Middle East

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The Multinational Association of Supportive Care in Cancer defines supportive care in cancer as “the prevention and management of the adverse effects of cancer and its treatment. This includes management of physical and psychological symptoms and side effects across the continuum of the cancer experience from diagnosis through treatment to post-treatment care. Supportive care aims to improve the quality of rehabilitation, secondary cancer prevention, survivorship, and end-of-life care” [1]. Interventions in supportive care includes pharmacological therapy, rehabilitation, and psychosocial support and supportive communication in a multidisciplinary setting. While this approach has gained much headway in developed Western countries, countries in the Asia Pacific and Middle East face a wide variety of challenges that hinder optimal supportive care delivery. To complicate matters, the individual supportive care needs vary from one country to the next due to

differences in culture and available resources [2]. This limits the direct application of Western approaches to the Asia Pacific and Middle East regions [2].

## Challenges in the Asia Pacific and Middle East

On 18 December 2015, a group of 13 oncologists and supportive care specialists convened to discuss challenges in supportive cancer care in the Asia Pacific and Middle East, as well as plans to address these challenges.

Suboptimal treatment of cancer symptoms and treatment toxicities was identified as the first challenge. Studies on various cancers indicate that symptom relief remained a major unmet need among cancer patients in this region [3, 4]. For example, undertreated cancer pain in Asia has a weighted

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mean prevalence of 59.1 %; this is higher than the values of 39.1 and 40.3 % in North America and Europe, respectively [5]. Inadequate symptom control was correlated with poor satisfaction with medical care, as well as delays and modifications in the initially planned tumor-directed therapy [6].

One of the major contributors for the suboptimal treatment of cancer symptoms and treatment toxicities is the relegation of supportive care as secondary to tumor-directed therapy (primary cancer treatment) [7]. On the other hand, the Asia Oncology Summit 2012 resource-stratified guidelines on supportive care encouraged the prioritization of supportive care in resource-poor countries [7]. The undervaluing of supportive care is compounded by the low confidence in using supportive care pharmacological agents, such as opioids, which are still feared to be habit-forming by both physicians and patients.

Availability and access to treatment is also severely limited in the region, as reported by an analysis on the availability and accessibility of opioids for cancer pain treatment in 20 Asian countries [8]. Several essential opioid formulations were not available in Afghanistan, Cambodia, China (rural areas), Bangladesh, Bhutan, Cambodia, Kazakhstan, Laos, and Myanmar. Patients in Bangladesh, Cambodia, Indonesia, Laos, Nepal, and the Philippines also had to pay for opioids at full cost.

The non-registration or delayed registration of supportive care drug is a common hindrance to treatment access. For example, one or more of the following antiemetics for chemotherapy-induced nausea and vomiting (CINV) are not available in many Asia Pacific and Middle East countries either at the time of international guidelines updates, or in selected countries, not at all due to local pharmaceutical industry

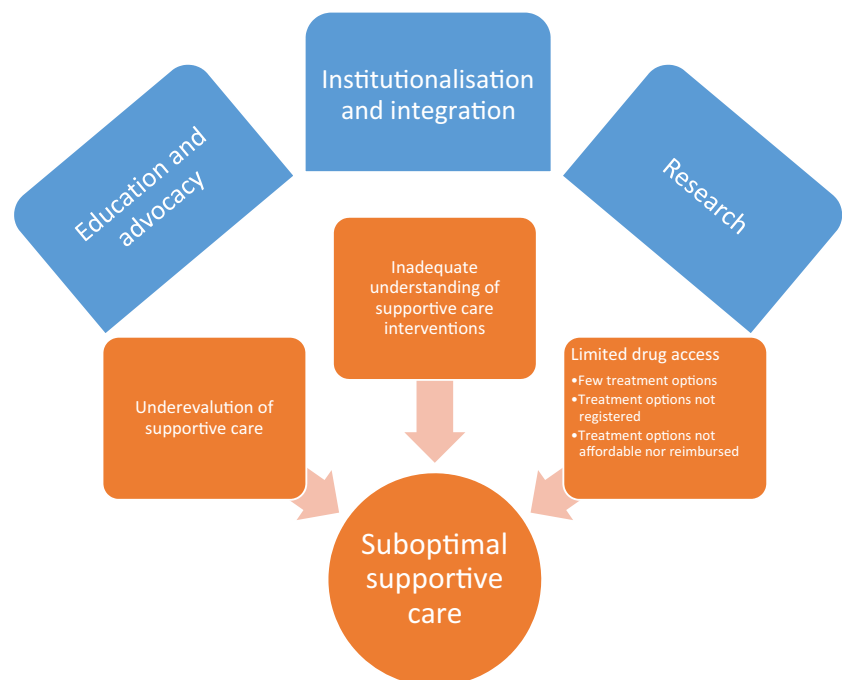
decision not to commercialize: dolasetron, palonosetron, rolapitant, dronabinol, nabilone, prochlorperazine, netupitant, fosaprepitant, and tropisetron. Other obstacles to access may be attributed to local decisions on drug coverage/subsidy protocols either at national or institutional level.

In the case of oral mucositis (OM), there is a dearth of proven therapies. Despite this huge gap in treatment options, research on breakthrough OM treatments are lacking, which also hinders the development of strong evidence-based guidelines. Because of this, physicians are limited to the prevention of OM, with some success. In Hong Kong, patients are encouraged to see a dentist and a dietitian before initiating tumor-directed therapy. In Japan, health insurance covers the cost of oral examination and care before chemotherapy is initiated. After chemotherapy, there is a follow-up by the dentist. However, when OM eventually develops, physicians and patients are left with few options, and many patients turn to traditional or alternative therapies instead.

Limitations in treatment access and suboptimal treatment have led to the popular use of complementary medicine throughout the region. These include traditional Chinese medicine (TCM) and other herbal medicines, which either lack support from clinical trials, or carry potential for drug interactions with cancer treatments. One survey reported that 58 % of oncology practitioners in the Middle East have patients that use herbal medicines [8]. Reports in East Asia and Southeast Asia have indicated that up to 85 % of cancer patients use TCM or herbal medicines.

Lastly, there is the issue of cost and reimbursement. The health care financing structures in the Asia Pacific and Middle East vary widely. Many developing nations remain out-of-

**Fig. 1** Causes of suboptimal supportive care in Asia Pacific and Middle East with conceptual framework to address them



pocket markets, while in others, CINV drugs, OM therapies, and other supportive care medications are not reimbursed.

### Meeting the challenges in supportive cancer care

Addressing these challenges requires the concerted effort of various sectors. A conceptual framework is presented in Fig. 1.

All throughout the Asia Pacific and Middle East, more physicians should be encouraged to specialize in supportive care. Medical education should emphasize the crucial role of supportive cancer care in improving patient quality of life and treatment satisfaction. Medical education efforts should include programs to dispel the misconceptions about supportive care and medications, especially around opioid use. Educational programs should also reach patients and their relatives or caregivers so that supportive cancer care becomes a priority for them as well.

Supportive care practitioners and their parent organizations (e.g., oncology, pain, or palliative care medical associations) should also advocate for the reduction or removal of restrictions in opioid prescription. Medical associations may also strengthen guidance and processes for the integration of supportive care in oncology services.

Pharmaceutical companies should be encouraged to register supportive care agents in developing countries. Industry and academia may also work together in research that could fast-track drug discovery, development, and commercialization. Clinical trials and pharmacoeconomic studies to demonstrate the cost-effectiveness of treatments would also facilitate drug reimbursement and the development of evidence-based guidelines. In terms of prioritization, there should be focus on areas with wide unmet needs, such as CINV and OM.

Finally, countries in the Asia Pacific and Middle East should self-organize and develop country-specific action plans to address the unique challenges faced by their supportive care practitioners.

The points outlined here are based on experts' opinions and should be considered against other scientific evidence. Furthermore, greater representation of the Middle East is recommended to provide a more comprehensive perspective of supportive care challenges in this region. Well-designed studies are recommended to establish the challenges in supportive care in the Asia Pacific and Middle East, and collaborative meetings may be conducted to establish actions to address the gaps in care.

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