Characterization of the gastroenteropancreatic neuroendocrine tumour patient journey

BACKGROUND

The current management of patients with GEP-NETs varies between institutions, regions and countries

Misdiagnoses and delays in diagnosis are common. 1-3

A survey was conducted to identify knowledge gaps, inefficiencies and unmet needs in the current GEP-NET patient care pathway.

> Inconvenience for the patient?

Costs to the Confidence of the HCP?

Cost to the patient?

METHODS

Interviews were conducted between December 2019 and February 2020 with HCPs and patients from the USA and the EU (France, Italy, Spain, UK).



Moderate or strong Yes expertise in managing patients with GEP-NETs

Provide PRRT for patients with GEP-NETs

TREATMENT

DECISION

MedOncs generally believe that PRRT has higher efficacy

patients with positive SRI and

well-differentiated tumours.

than targeted therapy for

Patient with

confirmed NET

Yes/No Experience with the radiolabelled SSA 177Lu-DOTATATE



Yes Received a diagnosis of GEP-NET

Received at least two different types of prior reatments (including PRRT) for a GEP-NET

Decisions on the use of PRRT

prescribing targeted therapies

More complicated than

Survey questions captured information on multiple patient journey parameters.

Sociodemographic characteristics Clinical characteristics | Initial presentation Referral and consultation | Diagnosis Treatment decisions | Patient eligibility Prescription responsibilities Patient monitoring and follow-up

E.g. availability of tumour

board, understanding

theragnostic approach,

health economic factors

54 **RESULTS** interviews completed patients with **HCPs GEP-NETs**

Key survey insights are described for each of the four main steps of the GEP-NET patient journey.

FOLLOW-UP AND

MONITORING

MedOnc

GI/EC

CONCLUSIONS

Follow-up

Varies according to the

treatment received and

with **GEP-NETs**

the physician's experience

MedOnc remains the

primary point of care

the GI or EC

PRRT

NM manages any

radiation-related side effects

and the patient is referred

back to the MedOnc or

GI/EC for further follow-up

and monitoring.

NET

specialist/ **MDT**

The real-world GEP-NET patient journey is

heterogeneous and complex, with several unmet

needs, inefficiencies and knowledge gaps.

Patients see multiple HCPs, with misdiagnoses being common during the average of 5-7 years

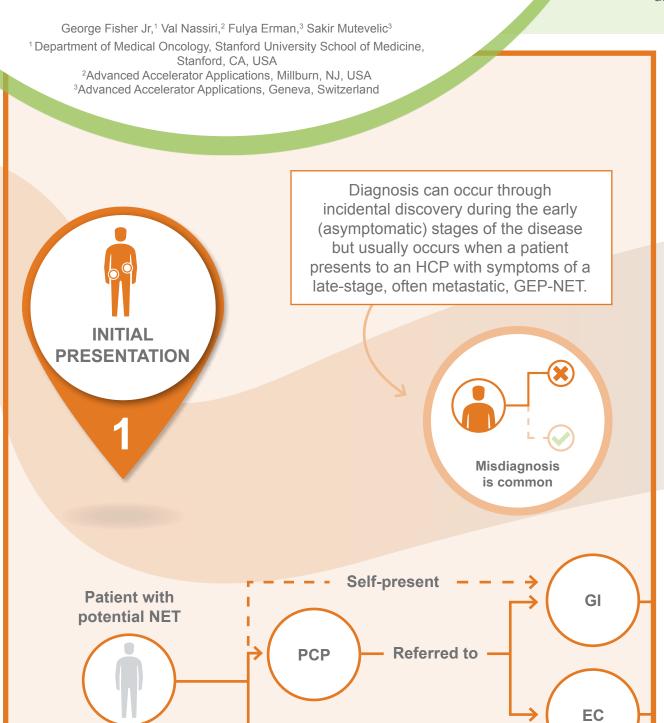
to first diagnosis of GEP-NET.

Differences in decisions on patient management between institutions and regions.

NM physicians are not always involved in the MDT,

but they can help to improve awareness of PRRT.

More commonly



GI/EC

Symptomatic patients are eventually referred to and diagnosed by:

GI or EC depending on the symptom profile

MedOnc

GEP-NET

When a diagnosis is confirmed, the patient may be referred to a NET expert for further testing and treatment.



Community hospitals

Academic centres

DIAGNOSIS

AND STAGING

The NM analyses and reviews the results with the MedOnc, GI or EC.

diagnosis

Assist in

diagnosis



Nurse/

radiation

technician









centres with large **MDT** case volumes may hold a Substantial differences **NET-specific** between practice types and across different institutions and countries in terms Surgeon involvement and dynamics Initial and subsequent treatment Not all MDTs include

MedOnc GI, EC

SSA | Surgical resection Chemotherapy Liver-directed therapy | PRRT

use only and may not be reproduced without permission from ESMO and the authors of this poste

+46737494608 Sweden, Europe

A Plain Language Summary is also available via the QR code.

Visit the web at:

Works collaboratively with the treating physician or MDT

✓ Conducts imaging scan
✓ Determines eligibility for PRRT

Primary treatment decision-makers

✓ Interprets the results ✓ Raises awareness of PRRT

Pathologist

NM physicians

academic

But they are increasingly involved across many institutions

Improved GEP-NET education, along with multidisciplinary collaboration of experts, is key to faster referrals and the best decisions on the most appropriate treatment for individual patients.

A clear pathway can help all patients with GEP-NETs to access a consistent and reliable standard of care, including PRRT.

5–7 years average time to first diagnosis of a GEP-NET

Corresponding author, Sakir Mutevelic: sakir.mutevelic@novartis.com Presented at the ESMO Asia Virtual Congress 2020

Underlying issue(s)

Abbreviations

EC, endocrinologist; GEP-NET, gastroenteropancreatic neuroendocrine tumour; GI, gastroenterologist HCP, healthcare professional; IR, interventional radiologist; Lu, lutetium; MDT, multidisciplinary team; MedOnc, medical oncologist; NET, neuroendocrine tumour; NM, nuclear medicine; PCP, primary care provider; PRRT, peptide receptor radionuclide therapy; SRI, somatostatin receptor imaging; SSA, somatostatin analogue.

Symptoms

Disclosures

Surgeon

GF has served on data safety monitoring boards for Astra Zeneca and Hutchison MediPharma International, and on advisory boards or as a consultant for Merck, Taiho and Pfizer. He has received honoraria from Advanced Accelerator Applications (AAA: a Novartis company) and Ipsen, and has received research support for clinical trials from Genentech/Roche, Aduro Xencor and FortySeven. VN, FE and SM are employees of AAA, which develops and markets treatments for cancer. VN and SM own stock at Novartis. Research was funded by AAA. Under the direction of the authors, Dr Martin Guppy, an employee of Oxford PharmaGenesis, provided writing assistance for this poster with funding from AAA. AAA reviewed the poster for

References

1. Singh S et al. J Glob Oncol. 2016;3:43-53. 2. Wolin EM et al. Pancreas. 2017;46:639-47. 3. Leyden S et al. Int J Cancer. 2020;146:1316–23.

Acknowledgements

The authors thank the participants involved in the survey.

+18324604729 North, Central and South Americas; Caribbean; China +447860024038 UK, Europe & Russia Copies of this poster obtained through QR (Quick Response) and/or text key codes are for personal

Nurse

navigator



186P