The 65th ASH Annual Meeting Abstracts

ORAL ABSTRACTS

905.OUTCOMES RESEARCH-LYMPHOID MALIGNANCIES

Quality of Life and Global Response Score in Cutaneous T-Cell Lymphoma

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Background: Cutaneous T-cell lymphoma (CTCL) encompasses a heterogenous group of conditions that are typically incurable and managed as chronic, life-long diseases. Clinically, CTCL is associated with pruritus, and skin lesions that can cause pain and cosmetic discomfort, resulting in reduced health-related quality of life (HRQoL) for patients. As these patients often receive life-long therapy, any proposed therapy should maximize therapeutic safety and efficacy as well as patient HRQoL. Improvement in HRQoL may provide an indication to continue therapy, even for patients with partial response.

Clinical trial response assessments for CTCL utilize a global response score, which includes skin, nodal and blood assessments (Olsen et al, JCO 2011). Dermatology-specific instruments, such as Skindex-29 (Chren 2012, Dermatol Clin 30), and oncology-specific instruments such as the Functional Assessment of Cancer Therapy - General (FACT-G) (Cella et al, JCO 1993), have been used to assess quality of life in this population. Disease entity, stage, age, sex, education, and treatment regimen are related to the extent of HRQOL impairment in patients with CTCL (Porkert et al, EJC 2018). Correlation between clinical response and HRQoL response has been reported in other cancers, such as renal cell carcinoma (Grimm Oncol Ther 2017) and other dermatologic conditions such as psoriasis (Acta Derm Venereol 2017), but has not been reported in CTCL. We evaluated changes in HRQoL in relation to the global response score in CTCL.

Methods: Global response data, as well as Skindex-29 and FACT-G scores, were obtained from the phase III MAVORIC study (Kim et al, Lancet Oncol 2018). Patients with stage IB-IVB mycosis fungoides or Sézary syndrome were prospectively enrolled. Global response score was assessed every 8 weeks. Skindex-29 and FACT-G questionnaires were administered every 8 weeks. Patients with at least a baseline value for Skindex-29 or FACT-G score, at least one subsequent visit with both Skindex-29 or FACT-G value, and an overall response value were included. Changes in scores were calculated from baseline to the first visit with best overall response. A higher score in Skindex-29 indicated worse HRQoL. A higher score on FACT-G indicated improvement in HRQoL. Wilcoxon rank-sum test was performed. Correlation was calculated by Pearson coefficient.

Results: 324 patients were evaluable for total Skindex-29 analysis. First visit with best overall response for patients with PD/SD occurred at a median of 1.26 cycles (IQR; 1.26, 14.26); 5.98 cycles (IQR; 1.26, 48.98) for PR; and 10.98 cycles (IQR; 3.98, 36.98) for CR. Patients with CR/PR as best response (n=121) had median change in Skindex-29 of -16 (IQR; -31, -8) and patients with SD/PD as best response rate had median change in Skindex-29 of -4 (IQR; -12, 3) (p <0.001) (Table 1). 333 patients were evaluable for total FACT-G analysis. Patients with CR/PR as best response rate had median change in FACT-G of 6 (IQR; -2, 16) and patients with SD/PD as best response rate had median change in FACT-G of 2 (IQR; -6, 8) (p <0.001) (Table 1). Skindex-29 correlates with global response score overall and across all domains. FACT-G correlates with global response score overall and across all domains, with the exception of social well-being. There was a moderate reverse correlation between change in total Skindex-29 and change in total FACT-G score (R=-0.61, p<0.001) (Figure 1).

Conclusion: HRQoL as measured by the Skindex-29 and FACT-G correlate with complete or partial response to therapy in the global response score in patients with CTCL. There is moderate correlation between skin-specific quality of life and general quality of life in this population. Further exploration of factors affecting social well-being in patients with CTCL is warranted. Incorporation of QOL scales in global response score criteria should be considered.

		Overall[1]	PD/SD[1]	CR/PR[1]	p-value[2]
Total Skindex-29	N	324	203	121	
	Change	-8 (-19, 0)	-4 (-12, 3)	-16 (-31, -8)	<0.001
Skindex-29 emotional	N	323	203	120	
	Change	-8 (-20, 2)	-4 (-12, 5)	-18 (-31, -5)	<0.001
Skindex-29 functional	N	323	204	119	
	Change	-7 (-17, 2)	-2 (-12, 4)	-15 (-26, -2)	<0.001
Skindex-29 symptoms	N	324	203	121	
	Change	-11 (-25, 0)	-7 (-14, 4)	-25 (-39, -11)	<0.001
Total FACT-G	N	333	205	128	
	Change	3 (-4, 11)	2 (-6, 8)	6 (-2, 16)	<0.001
FACT-G functional	N	335	207	128	
	Change	1.0 (-2.0, 4.0)	0.0 (-2.0, 3.0)	2.0 (-1.0, 6.0)	<0.001
FACT-G emotional	N	336	207	129	
	Change	1.0 (-1.0, 3.7)	1.0 (-1.0, 3.0)	2.0 (0.0, 5.0)	0.003
FACT-G physical	N	337	208	129	
	Change	1.0 (-2.0, 3.0)	0.0 (-3.0, 2.0)	2.0 (0.0, 5.0)	<0.001
FACT-G social	N	338	209	129	
	Change	0.0 (-2.0, 3.0)	0.0 (-2.0, 3.0)	0.0 (-2.0, 3.0)	0.7

[1]n; Median (IQR)
[2]Wilcoxon rank sum test

Table 1: Skindex-29 correlates with global response score overall and across domains. FACT-G correlates with global response score overall and across domains, except for social well-being.
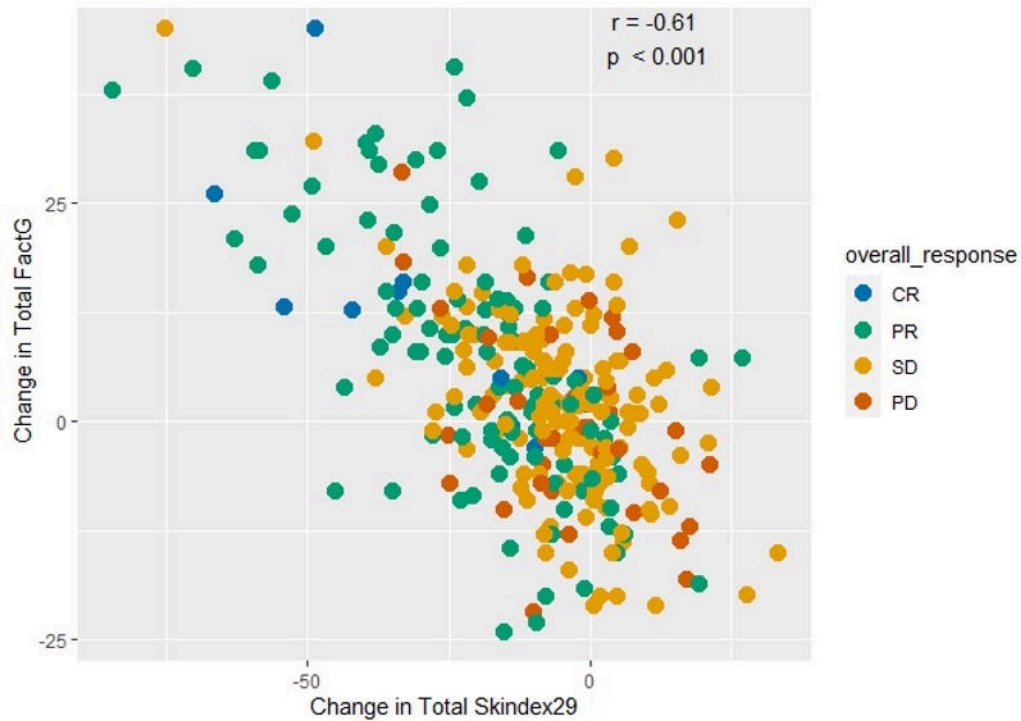

Figure 1: There is a moderate correlation between improvement in quality of life (increased FACT-G score) and improvement in skin-specific quality of life (lower Skindex-29 score).

Figure 1

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