In Memoriam of former NRG Oncology Group Chair
Philip J. DiSaia, MD (1937-2018)

The loss of one of our founding NRG Oncology Group Chairs, Philip J. DiSaia, MD, in late September occurred a little more than a year after his retirement from his role with NRG Oncology. NRG Oncology leaders and membership have reflected on the significant impact of his lifetime contributions, not only within the field of gynecologic oncology, but also to oncology research overall. Dr. DiSaia's passion for improving patient outcomes served as a driving force in defining the collaboration that resulted in the formation of NRG Oncology in 2012. The breadth and reach of our organization recently recognized by our grant renewal score in the "exceptional" range, and serves as a testament to the leadership of NRG Oncology.

Dr. DiSaia contributed to the intensive work behind-the-scenes to define how NRG Oncology would function and operate, which has led to our organization’s success today. His leadership has inspired many, and his work in gynecologic oncology has been pioneering. Dr. DiSaia’s decision to have the Gynecologic Oncology Group Foundation participate as a founding member of NRG Oncology set the stage for a highly productive relationship.

Our thoughts are with Phil’s wife, Patti, their four sons and their wives, as well as his grandchildren. His legacy has been detailed here, and NRG Oncology looks forward to celebrating Dr. DiSaia’s legacy at our next Semiannual Meeting in February 2019.

NRG Oncology Study Champions Table

A listing of the NRG Oncology study champions can be found here on the NRG Oncology website. The current version includes:

- **Brain Tumor Trials**: NCCTG N0577 and ECOG-ACRIN EAF151
- **Breast Cancer Trials**: ALLIANCE A011401, ALLIANCE A221505, CCTG MA.39, and SWOG/S1416
- **Gastrointestinal Cancer (colorectal cancer) Trials**: Alliance A021502 and Alliance N1048
- **Genitourinary Cancer Trial**: SWOG S1602
- **Gynecologic Cancer Trials**: ECOG-ACRIN EAE16 and COG AGCT531
- **Head and Neck Cancer Trial**: ECOG-ACRIN EA3163
- **Hematology Oncology Trial**: ALLIANCE A061402
- **Lung Cancer Trial**: SWOG S1400

**NOTE:**
Please remember to credit NRG Oncology and to contact the appointed NRG Oncology Champion with any questions.
Come Celebrate NRG Oncology

March 1, 2019 marks the beginning of our sixth year as NRG Oncology. In honor of our success to date, the February Semiannual Meeting will celebrate our birthday, as well as honor the 50th and 60th anniversaries of our partner foundations, RTOG and NSABP, respectively. As we look ahead to our future and honor our past, the meeting in early February will do both. A special General Session offers a forum to discuss our achievements, honor the legacy of Dr. DiSaia, and share our vision for our future as NRG Oncology. The Welcome Reception on Friday night will include a short program as well. In the spirit of the celebration, NRG Oncology will be waiving the meeting registration fee for NRG Oncology members for the upcoming meeting. Stay tuned for details, meeting registration will open in November. The NRG Oncology Semiannual Meeting is scheduled for February 7-9, 2019 in Phoenix, Arizona.

Send us your Feedback

Our NRG Oncology Communications Committee is always looking for suggestions and feedback on our materials. If you have comments or would like to submit ideas or articles for future newsletters, email us at nrg-broadcasts@nrgoncology.org

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NRG Oncology Trial Highlight

S1418/NRG-BR006 Trial Summary

S1418/BRO06, A randomized phase III trial to evaluate the efficacy and safety of MK-3475 (pembrolizumab) as adjuvant therapy for triple receptor-negative breast cancer with ≥ 1 cm residual invasive cancer or positive lymph nodes (ypN+) after neoadjuvant chemotherapy (NCT02954874)

About this trial:
This study is conducted jointly by SWOG and NRG Oncology clinical trial groups. It is currently open in 405 sites through the NCTN. For active sites please check the clinicaltrials.gov website.

S1418/NRG-BR006 is a randomized Phase III Trial to evaluate the efficacy and safety of pembrolizumab immunotherapy as postoperative adjuvant treatment for triple receptor-negative breast cancer (TNBC) with ≥ 1 cm residual invasive cancer or positive lymph nodes (ypN+) after neoadjuvant chemotherapy.

Why is this trial important?
The prognosis of patients with TNBC who have extensive residual cancer after neoadjuvant chemotherapy is poor. The risk of distant recurrence can be as high as 40-50% within the first 3-5 years and metastatic recurrences are uniformly fatal.
Pembrolizumab, an anti-PD1 antibody, that mobilizes the patient's own immune system to fight cancer, has shown promising results in the early phase trials in breast cancer. The goal of S1418/NRG-BR006 is to test if pembrolizumab could reduce the risk of recurrence, and improve invasive disease-free survival, in TNBC. We assess the efficacy of pembrolizumab in the entire patient population and also separately in the PD-L1 positive patient subset.

Who is eligible?
Patients diagnosed with stage I-III TNBC, or weakly ER or PR positive (≤ 5% IHC positive) cancer who received preoperative chemotherapy and have and residual invasive cancer in the breast or in the lymph nodes. The residual disease in the breast must be ≥ 1 cm in greatest dimension if the lymph nodes are negative; if any lymph node contains cancer after the preoperative chemotherapy a patient is eligible regardless of the size of the residual cancer in the breast. Patients may receive postoperative adjuvant chemotherapy with 6-8 cycles of capecitabine or other agents at the discretion of the treating physician before enrolling in the study.

Frequently asked questions (FAQ) about this trial:

Is central path review required for S1418/NRG-BR006?
NO. Patients are enrolled based on local pathology results. Central PD-L1 assessment on the residual cancer tissue is mandatory but both PD-L1 positive and-negative patients are eligible.

Can a patient enroll if he or she is receiving postoperative (adjuvant) capecitabine (Xeloda)?
Yes, absolutely, but if adjuvant chemotherapy is administered, currently it must be completed before starting pembrolizumab. An amendment has been submitted to allow concurrent administration of adjuvant capecitabine and pembrolizumab.

Can a patient enroll if he or she is currently receiving radiotherapy?
Yes, patients can enroll and start treatment on the study before, during, or after radiation therapy. We recommend enrollment before radiation therapy is started because patients randomized to pembrolizumab could receive XRT concurrent with pembrolizumab and this may augment the efficacy of both treatment modalities.

How do you sequence radiotherapy and pembrolizumab in this study?
They can be given concurrently or pembrolizumab can be given after radiotherapy, if the patient has already completed XRT before enrolling onto S1418/NRG-BR006.

Are BRCA1/2 mutation carriers eligible for S1418/NRG-BR006? Yes.
NRG Oncology at ASTRO

Plenary Sessions

Radiation/cisplatin combination established as standard of care for HPV-related head and neck cancer

Combinations of radiation and chemotherapy drugs have been shown to cure HPV-related head and neck cancer with a high success rate. The new phase III NRG-RTOG 1016 trial has now determined that cisplatin chemotherapy, combined with radiation therapy, produces the best results and should be considered the standard of care. Read the press release

Combined therapy including pelvic lymph node radiation provides significant benefit for prostate cancer patients

The first report of the large, international NRG-RTOG 0534 clinical trial shows that, for men who show signs of prostate cancer after surgical removal of their prostates, extending radiation therapy to the pelvic lymph nodes combined with adding short-term hormone therapy to standard treatment can extend the amount of time before their cancer spreads. Read the press release

Radiation therapy outcomes better for African-American prostate cancer patients than Caucasian patients

While popular beliefs and population data suggest that African-American men are at higher risk of dying from prostate cancer than Caucasian men, a new analysis of genetic data from a large prospective registry and clinical data from several randomized RTOG trials indicates that African-American patients may have comparatively higher cure rates when treated with radiation therapy. Read the press release

Clinical Trials Presentation

Radiation therapy cuts low risk of recurrence by nearly three-fourths for patients with “good risk” breast cancer

A subset of patients with low-risk breast cancer is highly unlikely to see cancer return following breast conservation surgery but can lower that risk even further with radiation therapy, finds a new long-term report of NRG-RTOG 9804. Read the press release

Best of ASTRO 2018

SBRT Considered Safe Treatment Option for Patients with Multiple (2-4) Metastases

Results from the NRG-BR001 indicate that utilizing SBRT is safe as treatment for patients with 2 metastases in close proximity or 3-4 metastases regardless of proximity, in the following anatomic locations: peripheral lung, central lung, abdomen/pelvic, bone/osseous, spinal/paraspinal, cervical and liver. Read the press release

PROs on NRG-RTOG 0232 Indicate Brachytherapy Alone is the Superior Treatment for Men with Intermediate Risk Prostate Cancer

Patient-Reported Outcomes (PROs) from the NRG Oncology trial RTOG 0232 comparing a combined
treatment of external beam therapy and brachytherapy (EBT+B) to transperineal interstitial permanent brachytherapy (B) alone for men with intermediate risk prostate cancer indicate a significantly different clinician and patient-reported late toxicity profile between arms despite similarities in progression-free survival results. Read the press release

Short-Term ADT with RT Improves Survival Over RT Alone for up to 10 Years Among Men with Early Stage Prostate Cancer

The long-term follow up of the NRG Oncology trial RTOG 9408 studying the addition of short-term androgen-deprivation therapy (ADT) to radiotherapy (RT) for men with early, localized prostate adenocarcinoma, indicated that RT combined with ADT is superior to RT alone for overall survival (OS) up to 10.4 years following treatment. However, when researchers assessed these results up to 18 years, the benefits of adding ADT to RT dissipated. Read the press release

Late-Breaking Presentation

Avoiding the Hippocampus During Whole-Brain Radiotherapy Prevents Cognitive Side Effects

Whole-brain radiotherapy can be delivered more safely to patients with brain metastases by avoiding the hippocampus according to the randomized phase III NRG-CC001 trial. Read the press release

Oral Presentations

First Study to Identify the Impact of MGMT Gene Expression on OS for Patients with Anaplastic Glioma Tumors

Analysis of the NRG Oncology trial RTOG 9813 revealed for the first time that elevated MGMT gene expression is independently associated with worse overall survival for patients with anaplastic grade III gliomas. Read the press release

Data Supports Interaction of Pretreatment Immune Inflammatory State of Patient Outcomes following Radiotherapy in High Risk Prostate Cancer Trial

Data from a validation study of NRG-RTOG 0521 suggests that, while there is no association between an elevated level of C-reactive protein (CRP) and disease-free survival (DFS); higher levels of pretreatment interleukin 10 (IL-10) were linked to lower rates of DFS. Read the press release

The role of heart-related dose-volume metrics on OS on NRG-RTOG 0617

Researchers investigated the potential role of heart substructures in a dose-volume histogram (DVH) model for overall survival (OS) after radiotherapy (RT) for stage III Non-Small Cell Lung Cancer. Results support efforts to avoid heart irradiation using planning and delivery techniques such as intensity-modulated image-guided radiotherapy.
NRG Oncology Trial Highlight: NRG-GI002

Amendment and Reactivation
A Phase II Clinical Trial Platform of Sensitization Utilizing Total Neoadjuvant Therapy (TNT) in Rectal Cancer

Overview:
NRG-GI002 is designed to evaluate if the addition of either the experimental drug veliparib or pembrolizumab to the usual chemotherapy and radiotherapy treatment can improve neoadjuvant rectal cancer (NAR) scores for patients with rectal cancer. The NAR score is based on the degree of downstaging noted between the initial clinical and final pathologic stages. Adenocarcinoma of the rectum is typically treated with neoadjuvant chemotherapy and radiotherapy followed by surgery then adjuvant chemotherapy. NRG-GI002 utilizes a “total neoadjuvant therapy” (TNT) approach to treatment that includes upfront use of combination chemotherapy [regimens that include 5-fluorouracil, leucovorin, and oxaliplatin (i.e., FOLFOX)] followed by chemoradiotherapy, then surgery. Researchers on NRG-GI002 will be comparing neoadjuvant FOLFOX followed by radiotherapy with capecitabine alone (chemoRT) to two additional experimental arms. Experimental Arm 2 patients will receive FOLFOX followed by a chemoRT treatment of capecitabine with veliparib. Experimental Arm 3 patients will receive FOLFOX followed by a chemoRT treatment of capecitabine with pembrolizumab. All three treatment arms will be followed by surgery at 8-12 weeks following the chemoRT. Secondary endpoints include the evaluation of overall survival, disease-free survival, rates of pathologic complete response, sphincter preservation and correlative molecular analyses.

Amendment:
Recent amendments to NRG-GI002 included the addition of the third study arm utilizing pembrolizumab, clarifications to eligibility and ineligibility criteria, and added time points for blood collections in the optional collection of specimens for biobanking section. NRG Oncology also issued a consent form Addendum 1 and 2 on informing currently enrolled patients of new information. This trial recently reactivated. Of note, the second study arm testing the addition of veliparib to TNT has successfully completed enrollment.

More Information:
Protocol documents are located on the CTSU website.

See a listing of all of our studies on NRG Oncology's protocol table.
When I graduated in 1988 with a Master of Science in microbiology, I was certain I didn’t want to work in a lab, but I was unsure of which career path to pursue. When several members of my family – my dad, grandfather, mom, aunt, and sister – were diagnosed with various cancers, I became interested in working in oncology research and took a job as a research specialist. Little did I know that first research position would be the beginning of a 32-year career.

As we all know, working in research has its ups and downs. Many of the studies I’ve coordinated were negative studies, but others did improve survival, quality of life and/or disease-free intervals. I was also a part-time microbiology professor and therefore, always strived to impart knowledge to others, in the unique field of National Cancer Institute studies. I became a certified clinical research coordinator (CCRC) in 1997. Shortly thereafter, I took a job in a startup pharmaceutical company. Two years later, I left industry research and returned to clinical practice, as I missed patient interaction. In 2007 I became the Chair of the Radiation Therapy Oncology Group (RTOG) Research Associates Committee and helped guide new coordinators and support the group’s research. I continue this effort as a Co-Chair of the Protocol Support Committee in NRG Oncology, and as co-facilitator of the protocol review committee.

Research has changed a lot over the years, and as a seasoned coordinator, I believe it is my duty to share my passion and knowledge to help other researchers continue improving the lives of patients who participate in trials. These patients are heroes who often participate wholly altruistically.

My expertise is in brain tumors and radiation oncology. My principal investigator (PI), David Brachman, MD, and I were the highest enrollers on nearly every brain tumor trial in RTOG, and continued this trend with NRG Oncology. These studies provided a deepening understanding of brain tumor genetics and have resulted in modestly improved outcomes.

In 2011 driven by our shared passion to improve the lives of patients with brain tumors, Dr. Brachman, three other physicians and I began creating a process for treating recurrent brain tumors with implantable radiation therapy. After many long nights and weekends, our invention, GammaTileTM Therapy, received FDA approval on July 6th, 2018 for the treatment of recurrent intracranial neoplasms. Data from an IRB-approved trial is very encouraging and affirms that GammaTile offers an effective and less burdensome therapy for these patients.

Earlier this year, I underwent my first FDA audit of a study I facilitated. I been through many standard NCI three year audits and audit preps as a high enroller, but this was the first non-oncology study I had ever facilitated (a device study for treating COPD). The PI and I were essentially responsible for the entire study. I was thrilled to have our program pass the audit with no deficiencies.

Looking back over my 32-year career, much has changed, but one thing remains the same: we have an incredible opportunity to advance research and work to improve the lives of the heroes who enroll in clinical trials. When I work with seasoned researchers, as well as those who are new to the field, I always encourage them to not be afraid to learn new things and voice ideas. Every resulting positive change in the life of a patient or their family, makes this career truly rewarding and most worthwhile.
NRG Oncology Health Disparities Committee Column

Now Accepting Applications for Health Disparities Committee Research Vice Chair
Deadline: November 20, 2018

NRG Oncology initially formed its Health Disparities Committee to support accrual of underrepresented groups in our research. The Health Disparities Committee will continue this important work but will also transform into a protocol generating committee beginning in the summer of 2019. In addition to the leadership provided by Chair, Dr. Kate Yeager, we are seeking a new vice chair. We are looking for a researcher with an active program of funded research with expertise in health disparities and clinical trials. Top candidates will be invited to present at the next NRG Oncology meeting in February 2019.

Individuals with interest in the position should send their resumé along with a cover letter outlining their interest in this position no later than November 20, 2018.

Please send any material or questions regarding this position to Martha Duncan at DuncanM@NRGOncology.org

Dr. Zafar Speaks on Intervening on the Financial Toxicity of Cancer Care
A Look Back to the NRG Oncology Summer Meeting

On July 13, 2018, the NRG Oncology Health Disparities Committee (HDC) at the Semiannual Meeting hosted Dr. Yousuf Zafar, Associate Professor of Medicine and Public Policy, Duke Cancer Institute to discuss Intervening on the Financial Toxicity of Cancer Care. According to the Centers for Disease Control and Prevention, one in three Americans experience financial burden as a result of medical care. The burden is greater for cancer patients, who pay more out-of-pocket for care than those with other chronic illnesses. Indeed, 13% of non-elderly cancer patients spend at least 20% of their income on out-of-pocket expenses. Fifty percent of Medicare beneficiaries with cancer pay at least 10% of their income towards cancer treatment-related out-of-pocket costs. In other words, half of elderly cancer patients are underinsured.

There were over 80 attendees at this breakfast workshop which was extremely well received and generated much discussion. Approximately 34% of the attendees identified as PIs, 15% Clinical Research Associates, 6% Program Coordinators, 19% Nurses, and the remaining attendees split between auditors, program directors, administrators, data managers, regulatory, and pharmaceutical personnel.

Dr. Zafar started a thought provoking discussion of the financial burden of cancer treatment on patients and its impact on outcomes. We know that financial problems are the strongest predictors of quality of life when compared to other factors including age, race, education, insurance status, and family income. Other interesting findings Dr Zafar mentioned include that 13% of non-elderly cancer patients spend at least 20% of their income on out-of-pocket expenses; as patients’ out of pocket expenses related to cancer care are greater than $53/month, the likelihood of non-adherence approaches 70%. He also discussed ways providers can encourage patients to discuss financial costs and interventions to reduce financial toxicity.

Dr. Zafar’s lecture, which was videotaped can be accessed on the NRG Oncology website. Click on Cultural Competency & Health Disparities Resources then Cultural Competency Workshops.

NRG Oncology Health Disparities Committee (HDC)
The HDC was formed to assist clinical investigators increase enrollment of diverse populations to NRG Oncology clinical trials. The HDC helps investigators and research staff identify and overcome barriers to enrollment of underrepresented populations in specific NRG Oncology Clinical Trials.

Continued on next page
Dr. Zafar Speaks on Intervening on the Financial Toxicity of Cancer Care (cont’d)

If you would like assistance with diversity recruitment during concept and protocol development phases or if you would like suggestions to improve diversity accrual, more information about the HDC, and access to health disparity training, resources, and contact information, please refer to the HDC section on the NRG Oncology website.

NRG Oncology Publications Corner

Recent Publication Highlights

Lymphedema symptoms and limb measurement changes in breast cancer survivors treated with neoadjuvant chemotherapy and axillary dissection: Results of ACOSOG Z1071 (Alliance) substudy

Read more on PubMed.gov


Germline genome-wide association studies in women receiving neoadjuvant chemotherapy with or without bevacizumab (NSABP B-40)

Read more on PubMed.gov


NRG Oncology Publications Policy & Guidelines v.03-06-2018 now available on NRGOncoology.org
NRG Oncology Protocol Support Committee Column

The Multi-factorial Dimensions of Adherence to Oral Oncolytics (Part 1)

Cancer treatment has evolved to include widespread use of oral oncolytics (OCs). Oral oncolytics are drugs with explicit anti-tumour activity achieved through blocking cell signal transduction; they include cytotoxic agents and targeted therapies (Esper 2013).

Over 50 oral oncolytics are currently approved; more than 20 new therapies were approved in the last 10 years (Moody and Jackowski 2010) and this will increase because 25-30% of cancer therapies in development are oral oncolytics (Weingart et al 2008). OCs offer the advantages of fewer clinic visits and procedures; however, taking medications at home confers immense personal responsibility on the patient to take their therapy safely and correctly (Tipton 2015).

Patients have identified education and support as critical to adherence (Esper 2013, Schneider, Adams, Gosselin 2014, Tipton 2015, Speolstra, Sansoucie 2015). It is a misnomer that adherence is driven solely by patient behaviors; adherence is multi-factorial.

In 2003 the WHO classified factors in adherence into five interdependent dimensions:

Health care team (HCT) and systematic factors:
Nurses spend an average of 3.3 hours with patients initiating IV chemotherapy (deRaad et al 2010); patients are a captive audience permitting time for education. Oral oncolytic education is not afforded the same gravitas. Nurses educate patients and manage toxicities of oral therapies by phone and email often without formal policies in place (Kav et al 2008, Rittenburg 2012).

Electronic medical records (EMRs) permit prescriptions to be sent to mail order speciality pharmacies creating a system barrier as medication delivery to patients’ homes cannot be tracked (Weingart et al 2008); early or late arrival of medications may be unknown. Medications delivered early have caused patient confusion resulting in unintentional overadherence (Speolstra et al 2013). Conversely, late arrival of medications from cumbersome dispensing produces underadherence (Schneider, Hess and Gosselin 2011).

The Institute for Safe Medication Practices (2014) reported a case in which temozolomide was changed to lomustine: three cycles of lomustine were dispensed via the mail; familiar with taking different doses of temozolomide the patient unintentionally took all three cycles precipitating an early death from severe myelosuppression; deficits in follow up process was identified as one of several system flaws.

Communication with Patient About Oral Agents in Clinical Trials

The physician, pharmacist, and/or nurse should:

1. Review all current medications (prescribed and over-the-counter) with patient to check for potential drug interactions. Instruct patient to notify physician before taking any new medication.

2. Review potential side effects and what to report to physician/study team

3. Review medication dose, schedule, and what to do if a dose is missed.

4. Review storage and safe handling. Patients should not crush tablets or open capsules.

5. Review any monitoring requirements such as taking BP.


7. Follow-up with patient within the first week to assess whether the patient is taking the medication correctly and what side effects she/he may be experiencing.

8. Remind patient to keep pill diary and to bring medication with them to their study visits.

Continued on next page
**Patient factors:**
Patients perceive oral oncolytics as having less toxicities than IV chemotherapy (Weingart et al 2008); this is quickly dispelled when neuropathies, plantar-palmar erythrodysthesia, mucusitis, acneform rash, diarrhea or hypertension start to disrupt daily life (Esper 2013, Kavookjian, Wittayanukorn 2015). Complex factors such as health beliefs, knowledge, literacy, fear of disease recurrence, motivation for self efficacy, cognitive function, language and cultural barriers all effect adherence (WHO 2003, Boucher et al 2015, Irwin and Johnson 2015).

Schneider, Adams, Gosselin (2014) randomised patients to standard education or customised teaching/coaching by phone. Comparing patients’ self reports of adherence with pharmacy refills records, the intervention arm adherence rates were superior to the control arm. Despite the intervention, prescriptions refills rates for patients on study were just 65-68%.

**Condition related:**
The highest risk factor for cancer is age. Cancer incidence is 1 in 78 people over 70 years in the US (American Cancer Society 2014). In elderly patients, poor eyesight, arthritis, hearing loss or declining memory complicates adherence. Doubts about medication effectiveness, pre-existing depression and/or anxiety disorders are known to negatively impact adherence (WHO 2003, Weingart et al 2008, Irwin and Johnson 2015).

**Therapy Related:**
Simply feeling unwell hinders adherence. Speolstra et al (2015) reported a patient stopped oral therapy for 3 weeks because she did not want to experience toxicities on holidays. This begs the question if the patient was not on a clinical trial, would this be known? Adherence rates are higher with study supervision and monitoring (Schneider, Adams, Gosselin 2014). Patients provided with ongoing education about drug schedules, drug and food interactions, safe handling are more successful in adherence; importantly, patients are comforted knowing they can speak with a nurse. (Adhmad et al 2014, Marin et al 2014, Kavookjian and Wittayanukorn 2015, Griffiths and Pascoe 2013).

**Socio-economic:**
Almost 50% of oncology patients are Medicare recipients; Medicare patients relinquish adherence to oral oncolytics twice as often as patients with private insurance. Taking more than 5 prescribed medications has been correlated with a 26-50% higher incidence of stopping therapy than for patients without concurrent prescriptions (Community Oncology Alliance [COA] 2010). Out-of-pocket health care expenses average $5,118 for elderly patients, representing a 12.7% annual expenditure and a 43% increase since 2002 (U.S. DHHS 2015).

Financial burden is not unique to elderly patients, the working poor, unemployed and disabled people will all experience financial distress. Oral oncolytics are placed in the highest tier of drug costs; some with prices tags of $5,000 or more monthly (COA 2010). Knowledge of patient assistance programs has become a part of nurses’ expanding roles.

The 2003 WHO report “Adherence to Long Term Therapy: Evidence for Action” identified the following:

- Medication adherence is a worldwide problem of “striking magnitude”.
- Low adherence results in poorer health outcomes with increased healthcare costs.
- Increasing adherence will safeguard patients.
- Adherence is a significant modifier in healthcare performance.
- Improving adherence may prove more beneficial to patient outcomes than newer treatments.

Patient education to ensure safe dosing, early toxicity recognition, and knowledge of when to contact the oncology team is essential (Moody, Jakowski 2010). As long as these new challenges in care remain unaddressed patient safety is compromised (Rudnitzki and McMahon 2015). The consequences of poor adherence to oral oncolytics are pervasive. Providing optimal patient therapeutic education serves to increase adherence rates and promote overall health in cancer survivorship. Healthcare today demands better patient outcomes; an educated patient can foster safer care with consequent impact for improved patient outcomes.

A list the references for this article can be found on the PDF version here.
NRG Oncology Member News

Dr. Ganz receives 2018 ACCC Clinical Research Award

Patricia A. Ganz, MD, co-chair of NRG Oncology’s Patient Centered Outcomes Research Committee, a member of the NRG Oncology NCORP Steering Committee and of the NRG Oncology Breast Cancer Committee, is the recipient of the 2018 Clinical Research Award from the Association of Community Cancer Centers (ACCC). The ACCC Clinical Research Award recognizes individuals whose research has significantly and positively impacted the oncology patient, family, or community. Dr. Ganz was honored for her achievements in cancer research during the ACCC’s 35th National Oncology Conference held October 17-19 in Phoenix, AZ. Dr. Ganz is a distinguished professor at the UCLA Fielding School of Public Health and David Geffen School of Medicine, and is Director of Cancer Prevention and Control Research at the UCLA Jonsson Comprehensive Cancer Center in Los Angeles. Read more

Dr. Markham appointed hematology-oncology interim chief at UF Health

Merry-Jennifer Markham, MD, has been named interim chief of the division of hematology & oncology at the University of Florida Health, effective September 1, 2018. Dr. Markham is a current member of the NRG Oncology Communications Committee and of the NRG Oncology Ovarian Cancer Subcommittee. Our congratulations to Dr. Markham on her appointment!

Dr. Bruner appointed as Senior Vice President of Research at Emory University

Deborah W. Bruner, RN, PhD, FAAN, NRG Oncology’s National Cancer Institute’s (NCI) National Community Oncology Research Program (NCORP) grant contact primary investigator, was appointed as Senior Vice President of Research for Emory University. Dr. Bruner’s new role will take effect on October 1, 2018 and she will be responsible for cultivating talented and engaged scholars and developing best practices for education, training, and guidance for research conduct and administration at Emory University. Congratulations to Dr. Bruner! Read more

Dr. Levine appointed NRG Oncology NCORP Representative on the NCI CPSC

Douglas A. Levine, MD, Director of Gynecologic Oncology and Head of the Gynecology Research Laboratory at the Perlmutter Cancer Center, New York University (NYU) Langone Medical Center was appointed as an NRG Oncology National Cancer Institute (NCI) National Community Oncology Research Program (NCORP) Representative on the NCI Cancer Prevention Steering Committee (CPSC). Congratulations, Dr. Levine!