Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/heart-matters/reduce-cv-risk-adult-survivor-childhood-cancer/67139/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Reducing Cardiovascular Risk in Adult Survivors of Childhood Cancer

Announcer:
Welcome to *Heart Matters* on ReachMD. On this episode, Dr. Stephanie Dixon will share opportunities for cardiovascular risk prevention in adult survivors of childhood cancer. She's a pediatric oncologist and an Assistant Member in the Division of Cancer Survivorship in the Department of Oncology at St. Jude Children's Research Hospital. Here's Dr. Dixon now.

Dr. Dixon:
I think there's a couple different opportunities for prevention. One is improved screening. So that can just be basic screening for traditional cardiovascular risk factors that might not be done in a 20- or 25-year-old as routinely as we might like them done. And so that should begin at the time of diagnosis, but certainly when they enter cancer survivorship. We should be looking for overweight, obesity, high blood pressure, and in certain survivors at risk, high cholesterol and diabetes even well before general population screening might kick in, like maybe in their 20s.

But we should also think about screening in terms of what additional screening tools we can use. So for whom may an echocardiogram for surveillance be of benefit? In the childhood cancer survivor literature, anyone who's exposed to moderate- or high-risk cardiotoxic therapies is indicated to have an echocardiogram every two or five years for life depending on the level of risk, and that's beginning, at the latest, at five years from diagnosis.

And so for us, it's part of our routine assessment to say, "How much anthracycline and how much chest-directed radiation did this survivor receive? Based on that, are they indicated for an echocardiogram, and how often?" And if that echo is normal, they continue on the normal screening pathway. But if there's any abnormalities, we may send them to a cardiologist or a cardio-oncologist, or we may adjust our frequency of screening and say, "Hey, there was a little bit of a dip in one of these measures of interest, but not big enough to be a true level of dysfunction. But we need to check in again in a year instead of in five years."

I think the other piece that we don't know is when to use some of the risk-enhancing tools that are commonly used in the general population, say a coronary artery calcium score for a survivor who doesn't meet general population criteria for intermediate risk for atherosclerotic disease, but we know from their treatment exposures, they're actually quite high risk for atherosclerotic disease. So can we use some of these population-based tools to re-risk stratify? That evidence is still emerging, but I think it's on a patient-to-patient basis something that we as providers should be thinking about.

If you're seeing a survivor who, say, had a high treatment exposure risk for developing future heart failure and they then develop both high blood pressure and diabetes, you need to manage both of those, but you're going to start somewhere. You're probably going to manage both of them, but you might be more aggressive about one or the other based on how bad their blood pressure is or what the level of their hemoglobin A1C is. I don't think we have enough survivor-specific data for us to say, "Clearly, the blood pressure is the bigger problem," or "The diabetes is the bigger problem." They're all interacting with each other to compound risk in the survivor, and so you can't ignore one while managing the other.

But there might be factors at play where you say, "Hey, actually, I can get what I need to treat this patient who is uninsured, who maybe doesn't have access to medications, for four dollars for a 90-day supply for their blood pressure management." And so for that patient, you prioritize one thing, and for a different patient, you might make a different choice because they are differently resourced.

A lot of times, these survivors have risks for late complications that require screening that isn't just cardiovascular. So for example, we see a lot of survivors of Hodgkin lymphoma who received chest-directed radiation to their whole mediastinum or very large chest fields, which puts you at risk of not just cardiac disease but also secondary breast cancer. And so now we may say, "Well, we need to

recommend screening for both of those, and so you need both your breast MRI and mammography annually alternating and your echocardiogram every two years." And the survivor may say, "Well, that's going to cost this much. Which one do I pick?" And so then we have to have a real-life discussion about how we start to balance these risks and the potential benefits of the testing.

Announcer:
That was Dr. Stephanie Dixon sharing her perspective on opportunities for cardiovascular risk prevention in adult survivors of childhood cancer. To access this and other episodes in this series, visit *Heart Matters* on ReachMD.com, where you can be part of the knowledge. Thanks for listening!