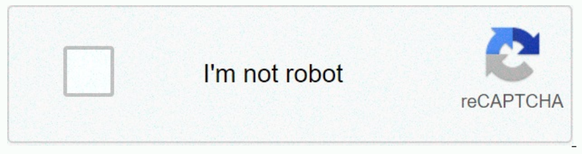

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Karnofsky performance scale prognosis

L. Ferrucci, ... J.M. Guralnik, at the Encyclopedia of Gerontology (Second Edition), the 2007Carnophome Score is a simple and quick method for assessing patient performance in ADLs, which is mainly used in medical oncology. The assessment was useful not only for following the course of the disease, but also for obtaining prognostic information. Patients with the highest (best) Carnofsky rates at the time of diagnosis of the tumor have the best survival and quality of life throughout the disease. Counting is subjectively assigned by a healthcare professional on the following hierarchical scale: 100=normal, no signs of disease; 90=able to perform normal activity only with minor symptoms; 80=normal activity with effort, some symptoms; 70=able to take care of yourself but unable to do normal activities; 60=requires random care, care for most needs; 50=requires considerable assistance; 40=disabled, requires special assistance; 30=hard disabled; 20=very ill, requires active supportive treatment; 10=Moribund. You can assign intermediate or even decimal points. The instrument is named after David A. Karnofsky, who described the scale in 1949.Sheldon Kwok, ... Edward Chow, in Supportive Oncology, 2011Clinical Survival Predictions (CPS) influence medical decisions and assist in planning supportive care and resource allocation26 They are critical for patients and their families, allowing them to use the time they have left. Clinicians are required to predict the survival of patients to be considered for phase 1 clinical trials, and for hospice referral27 Despite the consensus that end-of-life care should be supportive and aimed at treating symptoms,28.29 few patients die at home, a desirable place of death.30 less than 20% receive hospice care,31, and most die in acute care hospitals.30.32 One possible explanation for these findings is the inaccuracy of CPS.3,7,15,16U 2001 Chow, etc.3 conducted a systematic review to examine the accuracy of CPS in terminally ill cancer patients. They identified 12 studies conducted between 1980 and 1999, 9 of which showed that survival scores tended to be inaccurate in an optimistic direction; however, methods of obtaining CPS and identifying errors in CPS ranged from study to study. However, Chow and others. expressed concern about the use of CPS alone to predict survival, in that inaccurate survival predictions often lead to inadequate provision and choice of palliative care. A Weeks et al.25 study in 1998 found that patients with overly optimistic prognosis scores were much more likely to be asked for very aggressive, but useless, prolonged therapy over palliative care that focuses on relieving pain and discomfort. The results of these studies demonstrate the need for an accurate predictive model in palliative conditions that not only relies on CPS but takes into account other clinical symptoms such as performance and weight An updated systematic review was conducted by Glare et al.1 in 2003 to examine the accuracy of CPS in terminally ill cancer patients. This review identified eight evaluable studies between 1972 and 2000 that provided 1,563 individual predictions of dyads survival. The median CPS among these studies was found to be 42 days old, and median actual survival (AS) was 29 days, demonstrating the overly optimistic nature of the CPS. Glare and partners also determined that the longer the CPS, the greater the variability in real survival, with any CPS exceeding 6 months without having the predictable value for actual survival. The authors, however, found that converting the journal CPS was significantly correlated with the conversion of the journal AS in eight studies, suggesting that despite its limitations, the CPS was still one of the best predictors of survival, and that clinicians can still feel when things start to go wrong. A similar conclusion was drawn in a previous system review of Vigano et al. in 2000.34War theory, which has been documented in connection with the survival forecast, is an effect of the horizon, analogy with meteorology, in which short-term predictions tend to be more accurate than long-term forecasts.3,34.35 The horizon effect seen in the forecast indicates that CPS is more accurate when short-term predictions , for example, to the end of a patient's life than long-term survival forecasts of a few months or longer. A systematic review of glare et al.1 supports the concept of horizon effect for CPS, but other studies have come to contradictory conclusions.36–39 Other trends observed include improved prediction with repeated assessments, as well as with physician experience3.8; In addition, a decrease in accuracy is noted with stronger doctor-patient relationships.40Research showed that CPS and Carnof performance status* (KPS) were closely related (r=0.61), suggesting clinicians take into account the patient's state of performance when making survival predictions.8.41 This demonstrates the need for more research on the topic to better understand the rationale for CPS. In addition to the complexity of forming an accurate CPS, forecasting requires clinicians to perform an additional, perhaps even more difficult task: communicating the prognosis to their patients. Lamont and Christakis27 divided the forecast into two separate categories: predictions and lashings. Prediction is a survival assessment determined by practices; forevitation involves the transmission of this prognosis to the patient. Their study shows that doctors not only make overly optimistic mistakes in predicting patient predictions, but they make equally big optimistic mistakes in foreviting their predictions to patients. The potential reason for this mistake in the forelorn is the desire of clinicians to provide hope42 The need for hope and optimism is an ideal supported by both doctors and patients. However, there is a fine line between hope and creation of unrealistic expectations and perhaps encouraging useless treatments13Past studies have focused on investigating patient preferences to predict cancer survival in an advanced setting. Most patients wished for detailed information about their disease, but preferred to negotiate the format, scope and timing of receiving information from their caregivers.43–45 Patients with higher rates of depression were more likely to want to know the shortest time to live without treatment, but patients with lower rates of depression preferred never to discuss the expected survival43 Patients who were expected to live longer were more likely to discuss the prognosis at the first consultation. but patients with children preferred to discuss prognosis later or never.43 Regardless of patients' desire to know how long they have to live, studies have shown infrequant communication of predictive information between doctors and patients.47.48 Concern states in the literature on whether patients fully understand the information they are provided.18 ,49 Obviously, communicating predictive information is challenging for both patients and clinicians, and it's getting harder as the news deteriorates.42A a study by Butow et al.13 in 2002 identified seven topics related to the disclosure of predictive information to patients with metastatic disease: 1.Connection within caring, trusting, long-term relationships. Open and repeated negotiations on patient preferences for information.3 A clear, simple representation of the forecast where we wished.4 Strategies for ensuring patient understanding.5 Encouraging hope and a sense of control.6 The consistency of communication within the multidisciplinary team7.Communicating with and caring for other family members whose needs may differ from the patient's needs, which is an predictive prognosis for an advanced cancer patient, is challenging, and clinicians should remember that each patient is unique and has specific needs and benefits that can change during their disease50As a result of the difficulties faced, and general which lead clinicians to both predict and persevere patient prognosis, increased focus has been on identifying survival predictors that could assist clinicians in their prognostication scores for similar patients51 The main benefits of CPS as a predictive tool is its flexibility and accessibility8, but additional studies in clinical psychology have shown that statistical methods tend to surpass CPS in the prognosis of survival and other human behaviors52 In their systematic review Maltoni, etc.9 recommended that CPS should be used in conjunction with other predictor or evaluations to improve survival forecasts.R. Soffietti, ... R. Ore, in the Directory of Clinical Neurology, 2012A the number of factors (age, Carnophotic state of execution (CPS), primary/systemic tumor activity, neurocognive function, brain count primary tumor type and initial tumor diagnosis time) are of prognostic importance in patients with brain metastases (Gaspar, etc., 1997; Lagerward, etc., 1999). Of these, the CPS constantly found itself the main determining factor of survival. On the basis of the most powerful factors developed predictive indicators, able to distinguish between subgroups of patients with different prognosis. Three-level prognostic categorization based on recursive section analysis (RPA classes I, II and III) were obtained from 1,200 patients in the Radiotherapy Oncology Group (RTOG) database who received whole brain radiotherapy (WBRT) (Gaspar et al., 1997, 2000; Agbola et al., 1998; Chidel et al., 2000) (Table 49.1). Another prognostic index was developed for patients undergoing stereo-ectactic radioelectrony (SRS), the Radiovaluation Points Index (SIR), which takes into account not only the age, CPS and status of systemic diseases, but also the number of lesions and the largest volume of lesions (Weltman et al., 2000). A new prognostic index, the Grade Prognostic Assessment (GPA), was recently proposed, derived from an analysis of rtog's updated database of 1960 patients (Sperduto et al., 2008). This new index, which takes into account the number of brain metastases, in addition to age, CPS and extracranial metastases, seems as predictive as RPA, being less subjective and more quantitative. Table 49.1. Three-tiered prognostic categorization based on recursive section analysis (RPA)RPA classCriteriaMedian survival (months)IKarnofsky Performance Status ≥ 707.1Age < 65 Years Controlled Primary TumorNeed Systemic MetastasiaCarnophotic Performance Status ≥ 70 and at Least One of the Following:4.2Prognosis ≥ 65 YearsNext Directing primary tumorPresentation of systemic metastasesIIKarnofsky Performance Status < 702.3Prognosis is no different between patients with a known and unknown primary tumor (Merchut, 1989; Nguyen et al., 1998). Anne C. Regier, Kurt Posinger, at Facharzt Hämatologie Onkologie, 2007Patientenbezogene Faktoren:▪Schlechter AZ (z.B. Karnofsky Performance Indicator Background < 70%; A4).▪Begleiterkrankungen, die eine intense Überwachung erfordern, z.B. Diab. No, no, no, Bei Notwendigkeit der Steroidgabe, Herzinsuffiesenz bay großer Volumenbelastung, Niereninsuffizienz bei nephrotoxischen Substanzen.▪Unzureichende Einsicht in the death of Gephageren Einer Chemotherapy, z.B. bei psychiatry Erkranzingen, Demenz, etc. ▪Oziale Grunde, z.B. keine onkologische Betreuung in Wohnortnähe möglich. 3-▪ in the 1990s, intensivierte Protokolle.▪Lange Infusionszeiten (Ausnahme: 5-Fluorouracil-Dauerinfusionen).▪Notwendigkeit der Anlage eines ZVK.▪Ungewöhnlich-a starkusgeprägte Toxizitäten bei vorangegangenen Therapien, z.B. Hyperemesis.Dawit G. Eregavi, ... David Schiff, in the Clinical Neurology Handbook, 2012Patents with two or three brain metastases, good performance status (CPS 70 or more) and controlled systemic disease the proposed surgery, rather, such patients are usually managed by WBRT or SRS. For patients treated with MLRs, the question arises whether to add WBRT. Aoyama et al. (2006) conducted a randomized controlled trial of 132 patients with brain metastases of 1 to 4, each with a diameter of less than 3 cm. Patients were randomly assigned to receive SRS alone or WBRT plus SRS. The 1-year tumor recurrence rate is 76.4% for SRS alone and only 46.8% for WBRT plus SRS. In addition, brain thring treatment required less frequently in the WBRT plus SRS group than only for SRS. Most patients with more than 3 brain metastases receive WBRT alone to a dose of 25-35 Gy in 10 to 15 fractions. Bedded patients should consider withholding radiotherapy and limiting therapy with supportive care. Obit Kaidar-Man, ... Timothy Zagar, in Abeloff Clinical Oncology (Sixth Edition), 2020Modern factors are associated with poor prognosis of neoplastic meningitis. These include CPS estimates of less than 60 to 70, multiple and severe neurological deficits, cumbersome or large CNS disease, encephalopathy, and a large systemic disease with multiple treatment options.125,128,130,132,133,135,136 Other factors suggested to link to poor prognosis include blocking the flow of CSF. parenchymal metastases, ages over 55-60, high CSB lactate, and high CSB protein-to-albumin ratio,128, and primary tumor chistology. Breast cancer has been linked to better survival compared to patients with lung cancer or melanoma.125,128,130,132,133,135,136Mamoon your Rashid,... Sarfraz Ahmad, violating pancreatic cancer tolerance, does not match chemotherapy, 2019Meta-analysis conducted earlier showed that patients with poor performance status (KPS 60-80, ECOG PS2) are going to benefit less from combination chemotherapy. A subgroup analysis of the MPACT study found that 40% of the population with CPS of 70-80 (equivalent to approximately ECOG PS 1-2) still benefited from a combination of gemcytabin/nab-pacitaxel (HR0.61) [21], although this approach is a little aggressive and can be tested with caution in borderline patients while maintaining a low threshold for termination if toxicity develops Similarly, the PA3 study included patients with ECOG PS 2, consisting of 20% of the study cohort [74], and HR 0.61 in the gemcytabin/erlotinib subgroup, indicating that this combination may be considered. Monotherapy with gemcytabin is the recommended approach in the main portion of patients in this group. A standard dosage schedule of 3 weeks per/1 week off is an initial approach for these patients, which typically changes 2 weeks per/1 week off or even an alternative week schedule that allows a patient's recovery between treatments. For patients who opt out of the option of intravenous chemotherapy, fluoropimidine monotherapy may be an acceptable choice. C-1 combines potassium, tagafur and The gemcytabin and C-1 (GEST) trial was a three-armed trial that evaluated 834 chemotherapeutic naïve patients with locally progressive or metastases of pancreatic carcinoma and was randomly singled out in hemcytabin monotherapy, S-1 monotherapy and hemcitabine plus a combination of S-1. The S-1 was found to be unfriendly to hemcytabin with OS of 9.7 vs. 8.8 months (HR0.96, P < 0.001 for noninferiority). These results are suggested using C-1 monotherapy as an alternative in areas where there is C-1. Capecitabine, an oral 5-FU prodrug, could possibly be used as an alternative in areas where the presence of S-1 is a problem. Although there is no phase II supporting this strategy, the non-randomized PHASE II trial evaluated 42 patients with untreated metastases and showed a response rate of 9.5% and OPZ of 24% with capecitabine [85]. Kavitha J . For example, CPS 50 or higher has been shown to correlate with patient survival from 50 to 90 days. CPS of 30 to 40 correlates with median survival from 8 to 50 days, and CPS 10 to 20 correlates with survival from 7 to 16 days.5–9 This data is extracted primarily from studies of patients with advanced malignant disease who are no longer candidates for anti-cancer therapy and cannot be applied to patients with early-stage disease who is still receiving anti-carcass therapy. Treatment of patients relative to their condition is based on studies that demonstrate correlation between efficacy and response to treatment, survival, and quality of life.10–13 For example, In patients with non-dyssnolite lung cancer, cytotoxic therapy is not effective and may increase toxicity in patients with ECOG 2 or more.10,14,15 effectiveness in patients with other solid tumors.16–18 Similarly in patients with leukemia and lymphoma, poor efficacy excludes aggressive therapy such as stem cell transplantation.19–23 Further evidence of the importance of efficacy is available from data collected in geriatric patient populations. Older adults with good work status have treatment outcomes, similar to those of younger colleagues23–25 Some rare diseases are considered exquisitely chemo sensitive (e.g., small cell lung cancer, Berkitt lymphoma), and in these patients poor performance may be reversed by appropriate cytotoxic therapy.26–29 It should be noted that most of the data that correlates the state of treatment response effectiveness are based on standard cytotoxic chemotherapy. The scope of treatment has changed dramatically and now includes immune modators, biological therapy (targeted therapy) and hormonal therapy. The data on the state of performance and these treatments are far from clear and continue to evolve. For example, patients with non-dyflitis-cell lung cancer a mutation in the epidermal growth factor receptor (EGFR) may benefit from treatment with erlotinib or gefitinib (EGFR mutation inhibitor) regardless of performance status. A Japanese study found that patients with poor performance status still benefit from treatments targeting this specific mutation. Poor performance status was identified as an ecog score of 3 or 4 in all comers; assessment from 2 to 4 in patients over 70 years; or in patients over 80 with any performance condition, but with symptoms30 however, by contrast, the study conducted in North America was less definitive and showed only a nonstatic tendency to benefit in survival for a similar population of patients. These patients had an ECOG 2 or 3 efficacy condition (see Table 50-1) and were considered unfit for chemotherapy. In addition, survival was fairly limited (3 months in both groups).31 In patients with renal carcinoma, interleiquin-2 may be an effective therapy for those with renal carcinoma. who has a good efficacy condition but has a substantial risk of treatment-related mortality in patients with poor performance status.32–36 Interestingly, an alternative class of drugs for renal cell carcinoma, mammalian target rapamine, seems to be more effective in patients with poor risk factors , one of which is poor performance status.37.38Hormon-based therapy can be quite effective in patients with hormone-sensitive prostate or breast cancer. Hormone therapy may be considered even in patients with poor performance (e.g., ECOG more than 2, or KPS score less than 40).39–41 The main issues to consider in an unsuitable group of poor performance conditions are cardiovascular and bone-related side effects (i.e., osteopenia, osteoporosis) hormone manipulation.42–44 In addition, less dangerous but debilitating effects of arthralgia and joint pain may affect the quality of life of this patient. The benefits and burdens of therapy should be carefully weighed in light of the patient's goals and values. This is the joint in which cooperation between palliative care and oncology becomes critical. Nora A. Janjan, ... Christopher H. Crane, in Radiation Oncology (Ninth Edition), 2010Quality-of-life measurements can enhance predictive information derived from Carnofsky's performance score and the extent of the disease and help with survival prognosis. Physical symptoms such as pain, dry mouth, constipation, change of taste, lack of appetite and energy, Bloating, nausea, vomiting, weight loss, drowsiness or dizziness, affect poor prognosis.38 In one study, 208 patients with terminal cancer (median survival duration, 15 weeks), shorter survival time was independently associated with the following factors: primary tumor area (pulmonary bowel cancer against gastrointestinal cancer) , presence of liver metastasis , weight loss over 8 kg for previous months, as well as clinical evaluation through treatment of survival duration less than 2 months.45 Laboratory assessments including serum albumin levels of less than 35 g/L, lymphocyte count less than 1 ×109/L, and lactate dehydrogenase levels over 618 U/L were also associated with poor prognosis. Once these independent factors were factored into the analysis, other factors, such as performance status, symptoms other than nausea and vomiting, tumor load and socioeconomic characteristics, did not affect on their own the prognosis.45Kyle M. Walsh, ... Margaret R. Vrensh, in the Clinical Neurology Handbook, 2016Education is consistently associated with improved gliom prognosis: younger age, higher score of carnophoma efficacy scale (although this is an intermediate endpoint), a greater degree of resection and the ability to complete resection, lower necrosis, lower tumor preoperative magnetic resonance imaging, decreased residual disease volume, lower tumor preoperative and postoperative size, and tumor location (splenium infiltration, basal ganggia, thalamus, or midbraine is associated with worse survival) (Lacroix et al., 2001; Jeremic, etc., 2003; Lutterbach, etc., 2003; Chang and Barker, 2005; Jan, etc., 2009; Christensen, etc., 2011). In addition to these patient and tumor characteristics, a number of prognostic biomarkers have been identified, some of which have been incorporated into molecular subgroups previously discussed (Eckel-Passow et al., 2015). A recent study identified an inedisting genetic variant in SSBP2 that was associated with improved survival among similarly treated patients with glioblastoma (Xiao et al., 2012). In addition, the rs55705857 variant of 8q24 is associated with longer progression-free survival in patients with oligodendrogliomy receiving radio and chemotherapy (Cairncross et al., 2014). Further studies are examining an inherited variation on survival after diagnosis of gliom. Recent efforts to identify prognostic factors have focused on molecular tumor markers and serological factors. Glioblastoma was the first cancer systematically analyzed by the Cancer Genome Atlas Research Network (2008). Further studies have shown that glioblastomas can be grouped into four subtypes according to gene expression profiles (Verhaak et al., 2010). Most glioblastomas are classified in a classic subtypage, possessing characteristic amplifications of EGFR. The mesenchyma subtyp reflects some resemblance to classic glioblastomas, but with frequent hemizygotic removal of NF1. The neural subtyp is the most poorly defined and may partly be associated with a pattern of contamination with insipable tissues (BRENNAN, etc., 2013). The prone subtyp showed clear amplification and mutation of PDGFRA and point mutations in IDH1/IDH2 (Brennan, etc., 2013). Patients with prone subtype tumors tend to have IDH mutations and hypermetlation through the genome, as well as experience patients in other expression groups (Brennan, etc., 2013). The most established marker of favorable prognosis in patients with glioma is the IDH1 or IDH2 mutation present in 70% to 80% lower-grade glioma and glioblastoma preceding lower grade glioma (called secondary glioblastoma) (Jan, etc., 2009; Ohaki and Kleihoues, 2013). Further studies have found a strong link between the SDUG mutation and genoomous gliom cytosine-phosphate-guanin island methylator phenotyp (Noushmehr, etc., 2010; Moore, etc., 2013). G-CIMP is more common among lower-grade gliomes, strongly associated with a prone expression regimen, and has better patient outcomes (Age, etc., 2009; Noushmehr, etc., 2010; Christensen, etc., 2011; Brennan, etc., 2013). Methylation of the MGMT gene promoter is a positive predictor for glioblastoma, especially in chemotherapy with alkyrizing drugs such as temozolomide (Esteller et al., 2000; Hegi et al., 2005; Chen et al., 2013). The effect of MGMT methylation on survival in patients with grades II-III glioms remains unresolved (Sadones et al., 2009; van den Bent et al., 2011). Simultaneous loss of chromosom 1p and 19q is strongly associated with oligodendroglial tumor morphology and improved patient survival (SMITH, etc., 2000). The vast majority of tumors with 1p/19q joint removal have IDH mutations, and often carry gene mutations in FUBP1 (on the 1p chromosome) and CIC (on the 19q chromosome) (Labussiere et al., 2010). These tumors rarely have EGFR amplifications common in primary glioblastomas or TP53 and ATRX mutations common in secondary glioblastomas and lower-grade astrocytoms (Jiao, etc., 2012; Kannan, etc., 2012; Liu, etc., 2012). Significant overlap among joint removal of 1p/19q, IDH mutation, G-CIMP phenotyp, and MGMT methylation makes it difficult to assess the independent prognostic role of these changes. Recent studies also indicate that telomere-lengthening mechanism glioma (telomerase vs. ALT) may correlate with the patient's prognosis, but further studies are needed to characterize these relationships (Jiao, etc., 2012; Liu, etc., 2012; Kilela, etc., 2013). Increased IL-6, a cytokine that may contribute to glioblastoma, has been associated with decreased survival of glioblastoma (Tchirkov et al., 2007). Higher levels of circulation CCL22, a chimokin derived from macrophages, are associated with longer survival times in patients with glioblastoma (Zhou, etc., 2015). Analyses of atopia, IgE, and additional cytokines on gliom prognosis may help us better understand the complex nature of the immunological response to gliomagenesis, including secreted tumor-specific factors and host immune responses. Such studies can also have important implications for gliom immunotherapy. An additional link between brain tumors and the immune system is the need for malignant cells to evade presumably using mechanisms similar to foreign tissue growth mechanisms. Future studies should also include studying T-cell activity, such as regulating T cells that have been associated with taking tissue graft, as well as prognosis of brain tumors (Fecci et al., 2006; Yong et al., 2007). 2007).