1. **Avoid cytotoxic chemotherapy in patients with advanced cancer who are unlikely to benefit from chemotherapy (ECOG performance status 3 or 4) and continue to focus on symptom relief and palliative care.**

For some patients with advanced cancer, chemotherapy is no longer effective. Symptom relief and palliative care should become the primary modes of care. The Eastern Cooperative Oncology Group (ECOG) performance status is a valid predictor of poor survival, reduced response, and worsened toxicity from chemotherapy. Patients with advanced solid tumours, with an ECOG performance status of 3 or 4, generally exhibit a poor response to chemotherapy. There are well known exceptions to this. These are generally patients with untreated highly chemo-sensitive malignancies, and who have recently declined from a good performance status.

2. **Do not perform routine cancer screening, or surveillance for a new primary cancer, in the majority of patients with metastatic disease.**

For patients with metastatic cancer (particularly but not restricted to those with life expectancy of less than five years), screening for new primary cancers is of little value and may even cause harm. Reductions in mortality due to earlier detection and management of cancer due to various forms of screening (e.g. breast, colorectal, and prostate) typically take approximately ten years to accrue. Also, patients who have suspected cancers detected after screening may need to undergo further tests (such as prostate biopsies) and treatments. Patients with metastatic disease are more susceptible to complications arising from such tests and treatments given that they are already in frail health.

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Avoid tests (biomarkers and imaging) for recurrent cancer in previously treated asymptomatic patients unless there is evidence that early detection of recurrence can improve survival or quality of life; including avoiding surveillance testing (biomarkers) or imaging (PET, CT and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.

Some biomarker and imaging tests are effective in staging cancers. For instance, flourodeoxyglucose (FDG) PETs are most effective at staging NSCLC (non-small-cell lung cancer), restaging HL (Hodgkin lymphoma), staging/restaging colorectal cancer, and detection of SPN (solitary pulmonary nodule). However, the clinical impacts of these tests for surveillance of asymptomatic patients are unclear, particularly in cases where early detection of recurrence is unlikely to improve clinical outcomes.

Moreover, despite more recent evidence that PET-CT scanning and serial measurement of serum tumour markers can be helpful for some asymptomatic patients by leading to appropriate treatment modifications, there are alternatives to these intensive approaches for detecting recurrence (e.g. surveillance mammography and clinical breast examination in the case of breast cancer).

Do not perform serum tumour marker tests except to evaluate or monitor a cancer known to produce these markers.

In patients with non-specific symptoms, testing for a panel of tumour markers to try and diagnose an underlying cancer is not supported by evidence given the low sensitivity and specificity of these tests. An exception is in cases of suspected, strong underlying predisposition of specific cancers, in which case testing may prove a useful adjunct or in specific contexts where biomarkers may be useful such as CA-125 for suspected ovarian cancer and the use of PSA to detect prostate cancer in men with lower urinary tract symptoms (LUTS).

The appropriate use of tumour biomarker testing is otherwise to monitor the progress of specific cancers under treatment or to detect changes in cancer activity or a secondary or recurring cancer.

Do not routinely offer pharmacological venous thromboembolism (VTE) prophylaxis to ambulatory outpatients who are undergoing oncological treatment.

Patients receiving oncological treatment are at higher risk of thromboembolic disease and hence may require anticoagulant treatment. While there is some evidence that some of these treatments significantly reduce the risk of venous thromboembolic (VTE) events, this benefit must be weighed against the risk of haemorrhagic complications. Pharmacological VTE prophylaxis should not, therefore, be routinely offered to ambulant oncology patients. Exceptions may apply to high-risk cases, such as patients with multiple myeloma receiving antiangiogenesis agents, with chemotherapy and/or dexamethasone.
SUPPORTING EVIDENCE


NICE Guidance, Venous thromboembolism: reducing the risk for patients in hospital, last updated 2015.

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HOW THIS LIST WAS MADE

An *Evolve* working group of MOGA members was established and compiled an initial list of 79 potentially low-value tests, treatments, and other clinical practices in medical oncology, drawing on the results of a desktop review and clinical experience. Anonymised email feedback on the list was collated and analysed and the initial list was reduced to 64 items. These were divided into seven categories, ranging from ‘Diagnosis and staging’ to ‘Therapy’. An online survey allowed members of the working group to anonymously choose the top six or the top three from each category (depending on the number in the category). From this, a list of the top-28 items was then presented to the MOGA Executive Committee. Following anonymised email feedback, this list was further reduced to 24 items. Each member of the Committee was invited to nominate their top-12 of these. Responses were consolidated and a list of 11 items compiled, which served as the basis of a final online survey, to which the entire MOGA membership was invited to respond. Respondents assigned a score of 1 to 5 for each item based on their level of agreement with each. Scores for each item were averaged and the top-5 list produced.

Current as at: May 2019

About Choosing Wisely Australia
Choosing Wisely Australia® is enabling clinicians, consumers and healthcare stakeholders to start important conversations about tests, treatments and procedures where evidence shows they provide no benefit and in some cases, lead to harm. This initiative is being led by Australia’s medical colleges, societies and associations and is facilitated by NPS MedicineWise.

About the Medical Oncology Group of Australia (MOGA)
The Medical Oncology Group of Australia (MOGA) is the peak representative body for medical oncologists in Australia. The Association works closely with Government, health organisations, affiliated international associations and societies, industry, consumer advocacy groups and learned colleges throughout Australia to improve and develop the profession of medical oncology and the management of cancer nationwide.

About NPS MedicineWise
Independent, not-for-profit and evidence-based, NPS MedicineWise enables better decisions about medicines, medical tests and other health technologies. Visit [nps.org.au](http://nps.org.au)

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