# How to measure Quality of Life in Clinical Obesity Care

## The S.Q.O.T. Initiative

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IFSO NAPOLI 2023

# [X] I have no potential conflict of interest to report

# Introduction


Weight loss

Remission of comorbidities

Nutritional deficiencies

Surgical complications

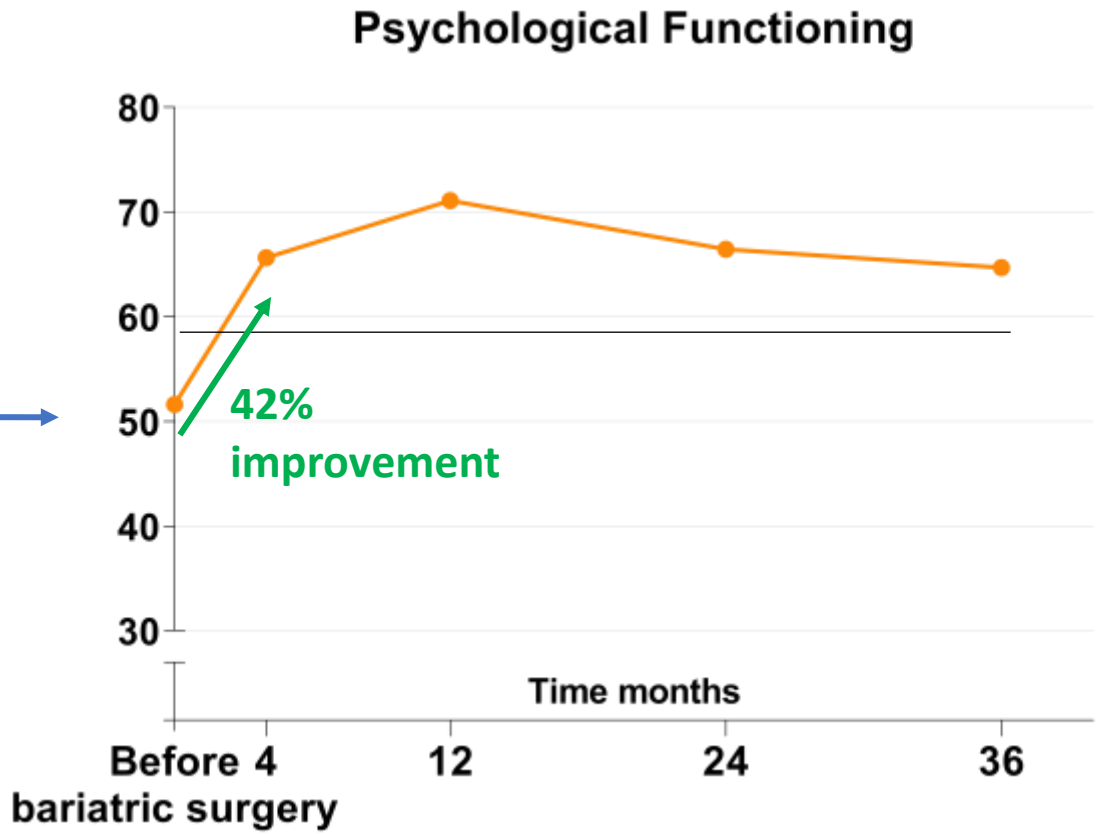
Improved physical function

Alleviation of psycho-social issues

Improved body image

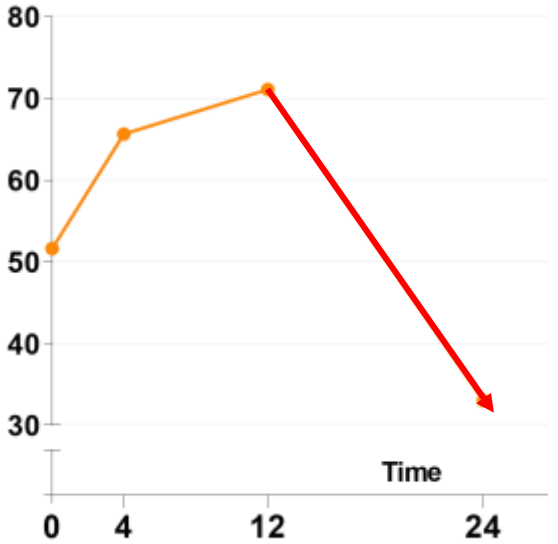
Mitigation of daily challenges associated with obesity

# Patient reported outcome measures

# Benefits of using PROMs

- ✓ Valuable insights into outcomes that truly matter to patients
- ✓ Improved patient-healthcare provider communication
- ✓ Support decision-making when additional interventions are necessary
- ✓ Support the comparative effectiveness of different interventions



# Challenges in quality of life measurement

- Measurement of irrelevant Patient Reported Outcome (PROs) domains
- The use of PROMs with poor measurement properties (reliability and validity)
- The wide variation in PROM use

Standardizing quality of life measures

# Standardizing Quality of Life Measures in Obesity Treatment (S.Q.O.T.)

Goals:

- Standardization of Quality of Life measures in Obesity Treatment

What to measure….

- Decide on the key components of QOL (PROs)

How to measure…

- Selection of the preferred patient-reported outcome measure(s) (PROMs) to capture this information

| Domain | PROM(s) available | PROM(s) selected based on face validity | PROM(s) that were selected after the vote[a] |
|---|---|---|---|
| Self-esteem | IWQOL-Lite, IWQOL-Lite CT, PROS, WHO-QOL BREF | IWQOL-Lite, IWQOL-Lite CT | IWQOL-Lite |
| Physical health/ functioning/symptoms | BAROS, BODY-Q, BOSS, BQL-Index, EQ-5D-5L, GIQLI, IWQOL-Lite, IWQOL-Lite CT, M-A QOL QII, OP-scale, PBOT, PROS, QOLOS, SF-36, TRIM, WHO-QOL BREF | BODY-Q, IWQOL-Lite, IWQOL-Lite CT | BODY-Q, IWQOL-Lite, SF-36, |
| Mental/psychological health | BAROS, BODY-Q, BQL-Index, IWQOL-Lite CT, M-A QOL QII, SF-36, TRIM, WHO-QOL BREF | BODY-Q, BQL-Index, IWQOL-Lite CT, SF-36 | BODY-Q |
| Social health | BAROS, BODY-Q, BOSS, BQL-Index, EQ-5D-5L, GIQLI, IWQOL-Lite, IWQOL-Lite CT, M-A QOL QII, OP-Scale, PBOT, PROS, QOLOS, SF-36, TRIM, WHO-QOL BREF | BODY-Q, BOSS, BQL-Index, GIQLI, IWQOL-Lite, OP-Scale, SF-36 | BODY-Q, IWQOL-Lite, OP-Scale |
| Stigma | — | — | — |
| Eating | BODY-Q, BOSS, M-A QOL QII, QOLOS, TRIM | BODY-Q, BOSS, QOLOS | BODY-Q |
| Body image | BODY-Q, QOLOS | BODY-Q, QOLOS | BODY-Q, QOLOS |
| Excess skin | BODY-Q, QOLOS | BODY-Q, QOLOS | BODY-Q, QOLOS |

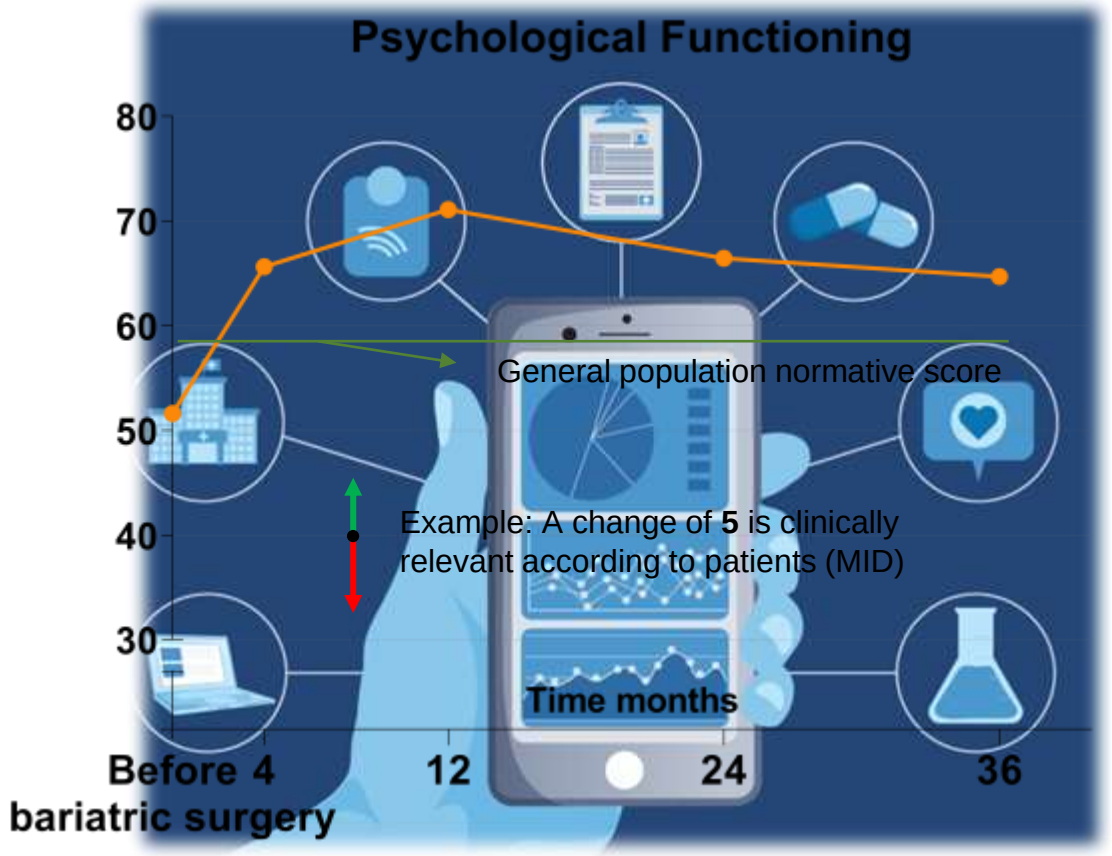
.... >70% "Definitely include"

# Core set of PROMs for clinical obesity care

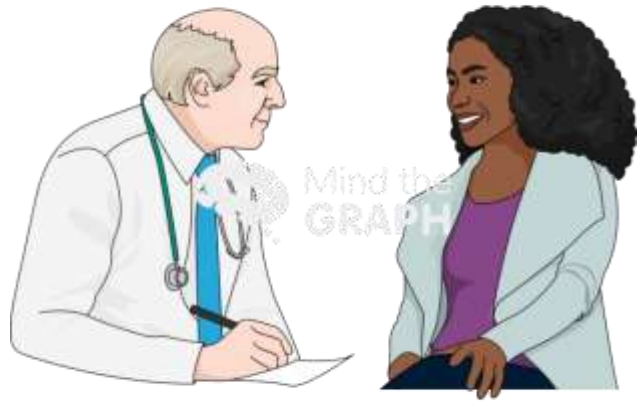
| PRO | Clinical practice |
|---|---|
| Self-esteem | IWQOL-Lite |
| Physical functioning | BODY-Q |
| Physical symptoms | BODY-Q |
| Psychological health | BODY-Q |
| Social health | BODY-Q |
| Stigma | - |
| Eating | BODY-Q |
| Body image | BODY-Q |
| Excess Skin | QOLOS |

# Examples of using PROMs in clinical practice

- Normative scores
- Minimal clinically important difference



# Conclusion



- To measure the outcomes that truly matter to patients, it is essential **to measure** quality of life in clinical obesity care and **to provide feedback** to the patient

- A core outcome set of PROs and PROMs for clinical practice is now available, incorporating the opinions of patients and experts

# Sponsors

- None of the members of the organizing committee (C.V., V.M., B.W., I.J., R.L. and P.D.) and none of the participants received payment for their participation.

- Travel expenses and the hotel overnight for the face-to- face meetings of the S.Q.O.T. were supported by Medtronic, Johnson & Johnson, Philips Vital Health, Novo Nordisk, Goodlife, Castor, Fitforme and Bart Torensma.

# Questions?

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VOLUME 34 · NUMBER 6 · FEBRUARY 20, 2016

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

# Symptom Monitoring With Patient-Reported Outcomes During Routine Cancer Treatment: A Randomized Controlled Trial

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See accompanying editorial on page 527

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Published online ahead of print at www.jco.org on December 7, 2015.

Supported by the National Cancer Institute and a grant from the Society of Memorial Sloan Kettering.

The National Cancer Institute and the Steps for Breath Fund of Memorial Sloan Kettering Cancer Center did not play any role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; or decision to submit the manuscript for publication.

Authors' disclosures of potential conflicts of interest are found in the article online at www.jco.org. Author contributions are found at the end of this article.

## ABSTRACT

**Purpose**

There is growing interest to enhance symptom monitoring during routine cancer care using patient-reported outcomes, but evidence of impact on clinical outcomes is limited.

**Methods**

We randomly assigned patients receiving routine outpatient chemotherapy for advanced solid tumors at Memorial Sloan Kettering Cancer Center to report 12 common symptoms via tablet computers or to receive usual care consisting of symptom monitoring at the discretion of clinicians. Those with home computers received weekly e-mail prompts to report between visits. Treating physicians received symptom printouts at visits, and nurses received e-mail alerts when participants reported severe or worsening symptoms. The primary outcome was change in health-related quality of life (HRQL) at 6 months compared with baseline, measured by the EuroQol EQ-5D Index. Secondary endpoints included emergency room (ER) visits, hospitalizations, and survival.

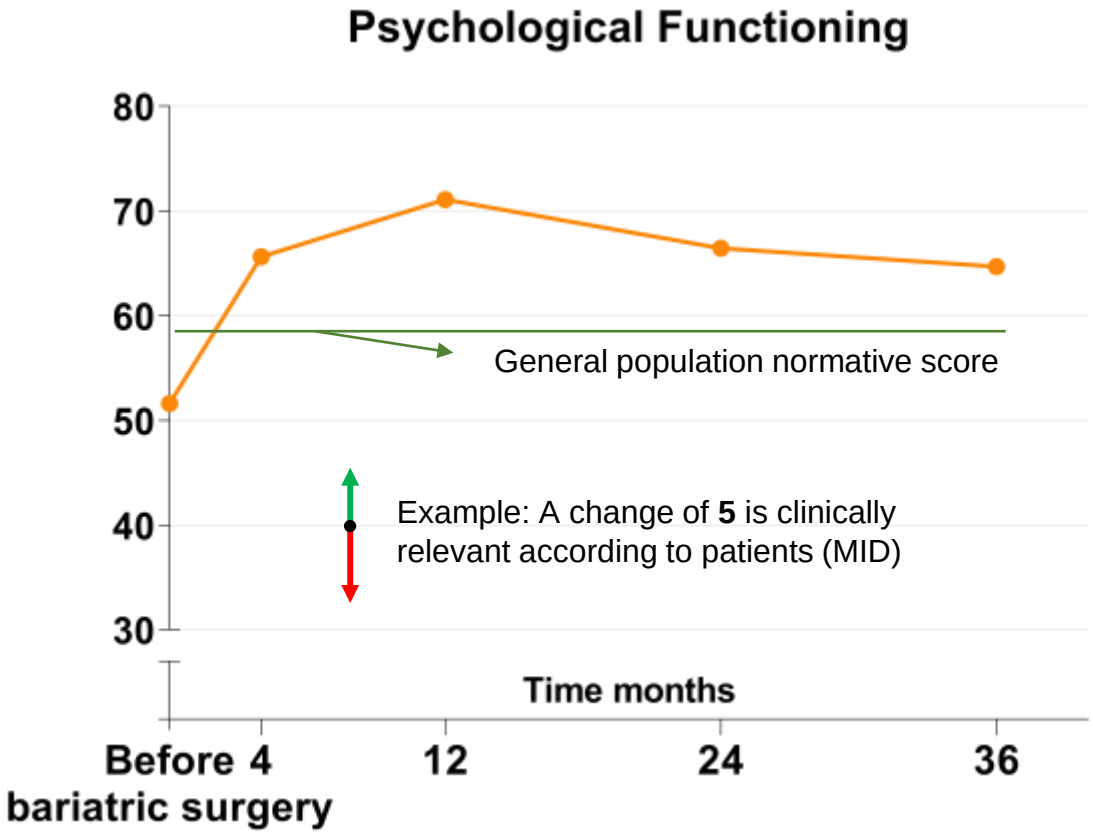
**Results**

Among 766 patients allocated, HRQL improved among more participants in the intervention group than usual care (34% *v* 18%) and worsened among fewer (38% *v* 53%; $P < .001$). Overall, mean HRQL declined by less in the intervention group than usual care (1.4- *v* 7.1-point drop; $P < .001$). Patients receiving intervention were less frequently admitted to the ER (34% *v* 41%; $P = .02$) or hospitalized (45% *v* 49%; $P = .08$) and remained on chemotherapy longer (mean, 8.2 *v* 6.3 months; $P = .002$). Although 75% of the intervention group was alive at 1 year, 69% with usual care survived the year ($P = .05$), with differences also seen in quality-adjusted survival (mean of 8.7 *v.* 8.0 months; $P = .004$). Benefits were greater for participants lacking prior computer experience. Most patients receiving intervention (63%) reported severe symptoms during the study. Nurses frequently initiated clinical actions in response to e-mail alerts.

**Conclusion**

Clinical benefits were associated with symptom self-reporting during cancer care.

*J Clin Oncol 34:557-565.* 


Psychological Functioning
80
70
60
50
40
30
General population normative score
Example: A change of 5 is clinically relevant according to patients (MID)
Time months
Before 4 bariatric surgery
12
24
36