



Lessons Not Learned

*Integrated Oncology Consulting Solutions
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Recently, a colleague and friend recommended a book called *The Emperor of All Maladies: A Biography of Cancer* by Siddhartha Mukherjee. This detailed history of progress in the diagnosis and treatment of cancer is scholarly, yet an easy read.

While reading it, I was overwhelmed not only by how much we have learned about cancer and its care, but also by how much we have not.

The treatment of breast cancer is fraught with lessons not learned. In the 1890s, Dr. William Halsted believed, along with other surgeons, that the more aggressive a surgery was for cancer, the greater the chance for cure. While radical mastectomies were the norm, some surgeons believed in an even greater surgery including the breast tissue, chest wall muscles, all lymph nodes one could find (in the axilla, mediastinum and neck) and in one reported case, the removal of three ribs and amputation of the shoulder and collar bone (p.71). This aggressive surgery even carried over into surgery for cervical cancer, where total pelvic exenterations were performed to achieve a cure. However, a review of the data in 1898 by Dr. Halsted revealed that even with this aggressive surgery, 47 percent of women died within three years. In 1907, data revealed that lymph node status was a better indicator of survival than the aggressiveness of the surgery. In spite of his statement that “more surgery does not mean more cures,” radical surgeries were performed routinely until the middle of the last century.

Enter Dr. Bernard Fisher who, in 1967, conducted a study through the National Surgical Adjuvant Breast and Bowel Project (NSABP) that took 10 years to complete. The results, reported in 1981, definitely proved that more radical surgery for breast cancer did not affect survival, recurrence or mortality. More than half a century had passed since the first data revealed the same. Now, radical surgery is rarely performed.

Another example of a lesson not learned for many years was for a rare cancer, choriocarcinoma. Researcher Dr. Min Chiu Li randomized patients to treatment for this disease until no gross disease was evident on radiological studies vs. continuing treatment until the tumor marker (HCG) was normal. Survival was significantly better for those who continued treatment. But his findings, when reported, were scoffed at to the point that he left his position. Now, Dr. Li’s study is considered the first chemotherapy cure for cancer and is a standard (p. 146).

End-of-life care and hospice first came to the U.S. in 1974 with the opening of the first hospice at Yale. Yet today, the average cancer patient is in hospice less than a week when they could benefit from hospice care for up to six months.

Multidisciplinary (or interdisciplinary) cancer care has been discussed for years. As early as 1950, Dr. Sidney Farber stated, “Cancer was a total disease, an illness that gripped a patient not just physically, but psychically, socially and emotionally. Only a multidisciplinary approach would stand any chance of battling this disease.” (p. 133.) His list of caregivers included nurses, social workers, psychiatrists, nutritionists and pharmacists. Yet today, many cancer patients do not have access to these needed services on a regular basis.

Peripheral neuropathy is a serious problem for many cancer patients as a side effect of their chemotherapy treatments. Many options for reducing this troublesome side effect have been tried. When a 2004 study suggested that an IV infusion of calcium and magnesium during chemotherapy would reduce the severity of neuropathy by 50 percent, its use became widespread. This happened even though the study did not compare a placebo group of participants. In spite of the limitation, many oncologists adopted this. However, in 2013 a presentation at the American Society of Clinical Oncology (ASCO) of a randomized study showed no benefit. A new study by oncology nurses investigated the use of cryotherapy—the “icing” of hands and feet—to reduce the toxicity. While a clinical trial is ongoing, the early reports are encouraging that this technique can reduce the effect of the drugs. Recently, I received high dose Taxol and participated in cryotherapy. No peripheral neuropathy occurred. While this is a “study” with one participant, the oncologists and nurses at the center reported that they have seen significant reductions in neuropathy with this treatment. If the study supports this finding, how long will it take for this method to be widely utilized as a nontoxic one for preventing this very troubling side effect?

In patient focus groups facilitated by The Oncology Group staff, one of the top issues addressed is how to deal with the “pile of bills.” Paying for care and knowing costs up front are significant and legitimate concerns for cancer patients. Assistance can be offered prior to the initiation of treatment, which supports not only the patient but the provider. Many programs throughout the U.S recommend and embrace providing financial counseling at the beginning of treatment and in conjunction with any change. However, many centers and offices don’t offer it until the patient has a problem with bills. This only increases anxiety and doesn’t allow a professional to determine whether options are available to assist the patient.

A cancer program medical director and past president of the Association of Community Cancer Centers (ACCC) stated that it takes from 5-15 years for lessons learned from academic center research to translate fully to standards of care across the country. Some reports state that this lag has improved, and the National Cancer Institute (NCI) has taken steps to try to improve it through such initiatives as the National Community Cancer Centers Program (NCCCP).

How do we prevent history from repeating itself? How do we as cancer program leaders assure that the interim between research results to utilization in cancer care settings is shortened? Do you have processes in place for translating the most up-to-date findings into practice?

- When staff goes to meetings, does the program leader (administrative or medical) have a download of best practices to determine what should be implemented? Or is the information not shared?
- When physicians attend national meetings, do you meet with them to determine what changes would improve care? Do you discuss the changes in treatment they will be implementing and the impact on the staff?
- Do you have a research team to review changes in practice each year? Or a Clinical Excellence team to investigate new ideas or research to improve the clinical care you deliver?
- Do you implement supportive care that patients may desire? Do you ask patients what improvements would they like to see put in place?
- Do you have a culture of “if it ain’t broke don’t fix it”? Or “how can we do this better for our patients or staff?”

It's incumbent upon you, as a cancer program leader, to look to the future and implement changes as they occur. There's no clearinghouse that you can review once a year for everything new in cancer care. Change only occurs with research, investigation and implementation of best practices. To be a Best in Class cancer program, you must find ways to actually determine what is best in class and ways to implement changes. In order to be innovative, your organization needs a structure in place that ensures regular reviews of treatment options, clinical care and vital programs such as financial counseling or supportive care.

The Oncology Group's outstanding team of consultants is well-versed and up-to-date in every aspect of cancer programs. We can review your program to help you develop Best in Class practices and operations. To learn more about The Oncology Group, please contact Steve Black, Vice President, at 512.583.8815 or by email at info@theoncologygroup.com.

All page numbers are from the electronic version of:

Mukherjee, S (2010). *The Emperor of All Maladies: A Biography of Cancer*, Simon and Schuster, New York.