And 87.5% of former cancer patients saw their provider every 6 months for follow-up of congestive heart failure compared with 94.1% of healthy control subjects ($P < 0.001$). Among patients with chronic obstructive pulmonary disease, 90.6% of cancer survivors saw a provider every 6 months as recommended compared with 93.3% of control subjects ($P < 0.001$).

Preventive care, too, fell short for the cancer survivors. Fewer of them received influenza vaccinations (53.2% versus 55.4% of control subjects; $P < 0.001$), cholesterol screening (36.5% versus 39.4%; $P < 0.001$), and eye examinations (47.4% versus 50.6%; $P < 0.001$).

The type of doctor visited seemed to make a difference in the level of care provided. Patients who visited only an oncologist fared worst in terms of overall care (management of comorbid conditions, preventive care, and acute care). Those who saw only a primary care doctor fared somewhat better, while patients who saw both types of providers had the best overall care. In terms of cancer screening, however, oncologists performed better than primary care physicians.

Earle attributes the gaps in care to poor communication both between doctor and patient and between different physicians.

In some cases, he said, cancer survivors lose touch with their primary care doctor and other specialists they may have had before their cancer diagnosis, because other conditions do seem less important by comparison. And some patients may not draw distinctions between physicians, not realizing that an oncologist may not offer the same services as a primary care provider.

“I think it’s important for [cancer survivors] to keep in touch with their primary care doctor,” said Earle. “Ask if the doctor is comfortable doing cancer screenings, and if not, they should keep in touch with their oncologist.”

Physicians, too, should do more to be sure patients are getting the full spectrum of care they need, Earle said.

“The main thing for us oncologists is to make sure patients have a primary care doctor looking into other issues,” he said, noting that in a large survey by the American Society of Clinical Oncology, an overwhelming majority of oncologists indicated they did not want to provide primary as well as cancer care (Journal of Clinical Oncology 1996;14:2,612–2,621). Conversely, primary care doctors should know whether the cancer survivors they care for also expect them to do cancer-related follow ups.

POST-LUMPECTOMY RADIATION NOT NECESSARY FOR ALL ELDERLY WOMEN

Some older women with early-stage breast cancer may be able to safely skip radiotherapy after lumpectomy, according to a recent study in the New England Journal of Medicine (2004; 351:971–977).

“If a patient does not need to have radiation therapy, her quality of life can improve significantly,” said lead author Kevin Hughes, MD, of Massachusetts General Hospital in Boston, in a prepared statement. “By showing that radiation therapy has very little impact on outcome for these patients, we can help each woman and her physician decide on the right treatment.”

Hughes and colleagues studied 636 women aged 70 or older with clinical Stage I (T1N0M0), estrogen-receptor-positive breast cancer treated by lumpectomy. After surgery, 317 women were randomized to receive radiotherapy and tamoxifen, while 319 were given only tamoxifen.

The only significant difference between the two groups after a median 5 years of follow up was that fewer women who received radiation therapy in addition to tamoxifen had local or regional recurrences. There were two (1%) local or regional recurrences among women in the tamoxifen plus radiotherapy group as compared with 16 (4%) such recurrences among women who received only tamoxifen.
Although the 3% absolute risk difference was statistically significant \((P < 0.001)\), it may not be clinically significant, Hughes noted. “The local recurrence risk in both groups was extremely low, and women who have not had radiation have the option of another lumpectomy if they do have recurrence in the same breast,” he said. “Once a patient has had radiation, however, she must have a mastectomy if her tumor recurs.” In fact, the time to mastectomy analysis did not find a significant difference between the two groups. The 5-year probabilities of undergoing mastectomy because of a recurrence were 1% in the group that received radiation and 2% in the tamoxifen-only group.

The 5-year probabilities of distant recurrence were statistically indistinguishable in the women treated with and without radiotherapy (2% and 1%, respectively). There were no differences in 5-year breast cancer-specific survival (94% for both groups) or in overall survival. Three women in each group died of breast cancer. Among the groups treated with or without radiotherapy, there were 51 and 50 deaths, respectively, from other causes.

In an editorial accompanying this article, Ian Smith, MD, and Gillian Ross, PhD, of the Institute of Cancer Research and Breast Unit of London’s Royal Marsden Hospital, point out that these results are qualitatively similar to those of a Canadian study that included younger women (aged 50 and older) published in the same issue of the *New England Journal of Medicine* and of previous trials such as the National Surgical Adjuvant Breast and Bowel Project’s B-06 study. The clear conclusion of this body of evidence is that for women with early breast cancer, radiotherapy reduces the risk of local recurrence but has no impact on distant recurrence or death. The important new information from this latest study is that for women aged 70 and older, the risk of local recurrence is much smaller than that faced by younger women, that the difference in that risk between women who undergo radiotherapy and those who don’t is small (3%), and that most local recurrences in women who did not initially have radiotherapy can still be successfully treated without mastectomy.

“There are clear advantages in identifying ... women who do not require radiotherapy after lumpectomy and tamoxifen,” Smith and Ross wrote. For one thing, they noted, radiation therapy still has the potential to damage the heart, even though modern techniques have made the treatments safer than ever. And in the Hughes study, women who had radiation in addition to tamoxifen reported worse breast pain, swelling, and cosmetic outcomes in the first few years of follow-up compared with women who took only tamoxifen. After about 4 years though, these effects were similar in both groups. The time, inconvenience, and expense of daily radiotherapy are also issues for some women.

For some women, the chance to bypass these side effects may well be worth a small increase in the chance of a relapse, Smith and Ross wrote. Elderly women already have a low risk of recurrence because their breast cancers tend to be less aggressive. And, Smith and Ross noted, it might be possible to reduce the risk of relapse even further by adding aromatase inhibitors to treatment. Studies of younger women have shown that these newer drugs can lower the risk of breast cancer recurrence even more when given after a course of tamoxifen.

Moreover, elderly women also are more prone to have other illnesses that are more likely to be deadly before breast cancer would be. Hughes and colleagues observed that 94% of deaths in their study were from causes other than breast cancer.

“In the long run, each woman and her physician should choose a treatment plan by weighing the slightly increased local recurrence risk against the virtually certain costs of radiation—the patient’s time, adverse effects, and financial cost,” Hughes said.