Cancer follow up: time for review

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The regular review of patients who have received treatment in the past is a tradition in all branches of medicine. Long-term follow up is especially common in patients who have had cancer and indeed some clinicians believe that such patients should be seen on a regular basis in a hospital clinic for the rest of their lives. But now that more patients are surviving for longer periods, the time to examine this practice is long overdue. There is considerable variation in follow-up routines throughout the country and yet no variations in mortality, the final yardstick by which all cancer treatment policies must be assessed. So clearly, some follow-up visits are unnecessary; the question is, which ones?

There are several logical arguments for reviewing cancer patients regularly. First, to detect at the earliest possible stage recurrences that may be asymptomatic or causing minimal discomfort. Appropriate therapy can be instituted while the size of the recurrent cancer is small, and the prospects of a cure are greatest. If no disease is found the patient can be reassured, thus allaying the fear that often surrounds this disease. Secondly, a check can be made on treatment-induced problems such as skin changes after radiotherapy or infertility after chemotherapy.

Thirdly, the results of treatment, both good and bad, will become apparent to the clinician and those training in the management of cancer patients, thus optimizing treatment regimens. Finally, follow up provides an opportunity to gather precise statistics on the natural history of cancer and on the comparative efficacy of different treatments throughout the world. Do the vast clinics seen at most centres fulfil these roles adequately?

Unfortunately, there is little evidence in the literature to suggest that regular follow up improves survival for patients with one of the common solid tumours. By the time a recurrence is detected, even using the most sensitive screening procedure, it is unlikely to be curable by current therapies. The exceptions are a few rare tumours, such as testicular cancer, where the combination of precise tumour markers and effective salvage therapy coexist. It has yet to be shown for tumours of the lung, breast and colon that a recurrence detected in the clinic carries a better prognosis than one detected at a symptomatic stage by the patient. Studies to examine this aspect of cancer care would be welcome indeed. For the patient, follow up is a mixed blessing. Some welcome the opportunity to express their hopes and fears and to meet those involved in what may have been the most emotionally traumatic time of their life. Other patients may regard the whole exercise as a waste of their valuable time or, perhaps worse, a reminder that they are still at risk.

The detection of treatment-related problems is important. Fortunately, most of these occur early, either during or shortly after radiotherapy or chemotherapy. The late complications are often irreversible but are important in influencing management. Many of these problems could be overcome by a full and repeated explanation of treatment and its consequences. Time spent on such counselling may well be a better investment than a cursory interview at a follow-up visit. The opportunity is often lost by the sheer weight of the numbers attending the clinic.

The role of the clinic as a teaching exercise for junior staff is often exaggerated. Seeing a different set of patients who are mostly well in a rushed atmosphere is not likely to be of much educational value and the staff often regard it as a chore. As a statistic gathering procedure clinics are perhaps at their least cost-effective. We live in a high-technology age with interfacing computers silently transmitting information concerning our daily lives. It is decidedly 'low-tech' to expect an octagenarian with lung cancer to get up on a winter's morning at 08.00 hours, be driven 30 miles to a hospital, wait for two hours to be seen by a junior registrar for five minutes and then be driven home in time for tea. The patient and his general practitioner between them are best able to sort out whether such visits are really necessary. The concept that follow-up clinics provide valuable information for research is clearly untenable. Rarely is there time to collect the detailed information required by a rigorous clinical study and for this purpose, it is far better to follow a small cohort of patients meticulously than many poorly.

Annual follow-up visits are the most questionable. The number of patients found to have a treatable problem is tiny. Far more recurrences are detected in between appointments, resulting in the patient consulting earlier than expected. Even the reassurance that can be given on annual visits must be outweighed by those patients who delay seeking advice for new symptoms on the grounds that they have an appointment in some months time.

At a time when scarce resources are becoming scarcer it is appropriate to examine the effectiveness of our traditional practices. The initial treatment of cancer has been repeatedly demonstrated to be the most important and it is here we must spend the most time and effort. Regular review should be restricted to those patients where the likelihood of recurrence of cancer is high and where the early detection of disease can lead to effective salvage. A critical evaluation of long-term follow-up for patients with common tumours is urgently needed. If the burden of excessive routine visits could be lifted, then extra time would be available for counselling to encourage rapid self-referral back to hospital if problems develop. More time could then be spent with those patients with active problems while those who were well could forget they had ever had cancer.

References

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