

# Cancer survivorship: a challenge for primary care physicians

It is very good news that people with cancer are living longer. The proportion of the population who are cancer survivors is on a steady increase with approximately 9.8 million cancer survivors in the US<sup>1</sup> and an estimated 2.5% of the Canadian population.<sup>2</sup> The most common prevalent cancers are breast, prostate and colorectal cancer. Taking all cancer types, two-thirds of individuals diagnosed today will survive at least beyond 5 years and be long-term survivors. If one considers breast and prostate cancer, over 80% will be long-term survivors.<sup>1</sup> Approximately two-thirds of cancer survivors are over the age of 65. For a GP, as many as one in every six adults over the age of 65 years in their practice is likely to be a survivor of adult cancer.<sup>3</sup> A survey of cancer survivors in the US has identified a range of physical, psychosocial and economic needs that are unmet, such as management of symptoms related to the primary treatment, depression, fear of recurrence, and problems related to employment and health insurance.<sup>4</sup> The healthcare needs of the growing numbers of long-term cancer survivors is viewed as a challenge for cancer care specialists. It is a happy challenge that cancer care is no longer focused exclusively on treatment and palliation, and must now also consider how best to manage survivorship. In my view, however, this challenge rests squarely with GPs.

An important aspect of the medical management of cancer survivors is cancer-specific follow-up care. Follow-up care consists of periodic routine visits and tests towards the broad goals of detecting recurrence, monitoring late effects of treatment, screening for related new primary cancers and providing psychosocial support. The frequency of visits and the types of tests vary according to the type of cancer. The growing research literature on cancer follow-up care has challenged some of the basic tenets on the value of routine

visits and tests for detecting recurrence, as exemplified by current guidelines on breast<sup>5</sup> and colorectal cancer,<sup>6</sup> which recommend very few routine tests (for example, only mammograms are recommended for breast cancer) and focus on history taking and physical examination. Also challenged is the long-held tradition of providing routine follow-up care in cancer specialist clinics. It has now been shown in two randomised controlled trials — one conducted in the UK and one in Canada — that primary care-based follow-up of breast cancer patients is a safe alternative to specialist follow-up as measured by a range of outcomes, such as delay in diagnosing recurrence, the rate of recurrence-related serious clinical events, health-related quality of life and patient satisfaction.<sup>7-9</sup> While these two trials studied breast cancer patients the findings can be arguably viewed as proof of principle for the other most prevalent cancers. Previous research has suggested that family physicians wish to be more involved in the ongoing care of their patients with cancer.<sup>10</sup> These two trials have shown that not only are GPs willing to assume primary responsibility for follow-up care, but that they can do so with outcomes similar to specialist care.

For survivors of childhood cancers, some have recommend follow-up for life in specialist clinics. Whether this is sensible or feasible is questionable both from the perspective of resource implications and from the perspective of a child growing to adulthood with the associated changes in healthcare needs and location of care. Moreover, paediatric oncology clinics do not have the skills to manage the range and changing healthcare needs of survivors of childhood cancer throughout their lifespan: it is GPs who are experts in this form of care. Fragmenting care is not in the best interests of the patient. When discharged, almost all patients are discharged to the care of their family

physician,<sup>3</sup> and survivors of childhood cancer ranked primary care physicians as the most practical source of long-term medical care.<sup>11</sup>

Comprehensiveness of care is one of the important potential benefits for cancer survivors of primary care-based follow-up. Most cancer survivors require not just surveillance for the index cancer, but general medical and preventive care. Two studies that examined this question found that patients followed solely by a primary care physician were more likely to receive general medical and preventive care, but less likely to receive cancer specific surveillance such as colonoscopy and mammography.<sup>12,13</sup> This finding may be due to ambiguity as to which healthcare practitioner is primarily responsible for aspects of the patient's care, and can potentially be addressed by a clear allocation of responsibility for follow-up to the GP. For the patient, both forms of care are important and neither should be neglected. It can be argued, however, that for long-term survivors of breast, colorectal and prostate cancer the greater health threat lies with other comorbid conditions than with the index cancer.

Central to the discussion about the family physician's role in cancer follow-up care is the views of patients. There is a growing body of research exploring cancer survivors' views and preferences on several aspects of follow-up care. This research is exemplified by a recent report that the majority of breast cancer patients prefer routine tests and periodic routine visits for 10 years or longer by specialists.<sup>14</sup> That is, patients prefer a pattern of follow-up care that reflects the practice they are accustomed to rather than evidence of what is effective.<sup>14</sup> This points to the need to inform patients frankly of the evidence on cancer follow-up so that they can make informed choices about their care. In trials of breast cancer follow-up, transfer of care to the primary care physician was acceptable to

the majority of patients<sup>7,8</sup> and patient satisfaction was better.<sup>9</sup> The transfer of follow-up care to the patient's GP for breast or colorectal cancer is now accepted practice in many cancer centres in Canada. This experience shows greater acceptability to patients than was previously assumed.

The possibility of devolution of long-term follow-up care to the primary care setting poses important challenges for GPs and cancer specialists alike. These challenges are akin to the dissemination and uptake of new knowledge that faces us in all areas of medicine.<sup>15</sup> In the two breast cancer follow-up trials<sup>7,8</sup> primary care physicians provided follow-up care with the aid of a simple guideline. While guidelines are an important tool<sup>16</sup> they are not always sufficient.<sup>15</sup> Many studies have shown that adherence to guidelines by GPs can be suboptimal. Mechanisms to improve adherence to guidelines is a hotly researched area of medicine.<sup>15</sup> This research points to the multiple factors that influence adherence to guidelines such as the credibility of the guideline producer, potential barriers and supports within the practice environment and — above all — factors unique to the specific patient. Primary care physicians will vary their adherence to a guideline recommendation according to factors unique to the specific patient.<sup>16</sup> This points to the importance of engaging cancer survivors as active participants in their long-term care.

GPs have stated that they wish to be more involved in the care of their patients with cancer. With the growing prevalence of cancer survivors in the population, the opportunity — and the challenge — are upon us now.

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