



BC Hydro Foundation and industry, was designed to investigate the short-term effects of osteoporosis risk assessment on patient behaviour. Over the long term, the study was intended to relate any fractures that occurred to the results of the initial calcaneal ultrasonography and historical risk factors. The trial was considered particularly relevant in BC, where the provincial government has restricted the number of densitometry-testing sites to the 7 that existed in 1994.

The study sought to recruit 10 000 volunteers. Participants were to undergo osteoporosis risk assessment and receive advice on diet and lifestyle modification to reduce their risk of fracture. The risk assessment involved a questionnaire, and participants were informed of historical risk factors along with the results of calcaneal ultrasonography. No drugs or other diagnostic tests were discussed or recommended, and follow-up was by mailed questionnaire. In 10 months 6500 participants were recruited, and the response was universally positive.

In November 1996 a provincial agency, the BC Office of Health Technology Assessment, held a closed meeting to discuss its review of bone densitometry, a report that has never been made public. The office did not request any representation from or information about the BC study. In discussing the study, the office argued that bone densitometry (by dual-energy x-ray absorptiometry [DXA] or ultrasonography) was not a valid tool for risk assessment. In December 1996 and January 1997 a series of newspaper articles stated that fractures are a normal consequence of aging and that risk assessment is therefore unnecessary. Fearful of controversy, hospital administrators decided not to support further recruitment to the trial, although follow-up would be continued. BC residents have since expressed disappointment that their needs for information are not being met.

Over the past year many study participants have asked why people took issue with researching the outcome of osteoporosis risk assessment that promoted good diet, exercise and better lifestyle habits. They have asked whether the calcaneal ultrasound technology was inappropriate. With the passage of a year, we have seen European, US and Canadian osteoporosis societies endorse multifactorial risk assessment, including bone mass measurement (which can be done by calcaneal ultrasonography) — exactly the same process that was done in the BC study. The Food and Drug Administration has now approved the first calcaneal ultrasound instrument for use in the US. At a recent consensus meeting, the Osteoporosis Society of Canada endorsed the use of this instrument in settings such as those arranged for the BC Study of Osteoporosis Risk. Time has answered a lot of the questions raised by opponents of osteoporosis risk assessment.

What we now need are data from studies such as this one to guide us in implementing multifactorial osteoporosis risk assessment for improving patients' behaviour. Only through pioneering initiatives such as this one will we be able to stand up for our patients' right to acquire the personal health information they need to make important decisions about their future.

David Kendler, MD

Assistant Professor of Medicine
University of British Columbia
Vancouver, BC

Follow-up after endometrial cancer

As radiation oncologists at the BC Cancer Agency, we frequently see patients with endometrial cancer — 221 in 1996 alone. As such, we eagerly read the article “Costs and benefits of routine follow-up after curative treatment for endometrial can-

cer” (*CMAJ* 1997;157[7]:879-86), by Dr. Olu O. Agboola and colleagues.

We congratulate the authors on a clearly written paper, but we also have a few concerns that were not addressed there.

When considering follow-up, physicians should give thought to the goals of such follow-up and the selection of an appropriate population. The risk of recurrence and the chance of potential curative treatment depend on the tumour and individual patient factors. Treatment recommendations are therefore based on these factors. For example, grade and stage are significant prognostic factors in endometrial cancer and can be used to predict recurrence. The risk of pelvic recurrence is affected by whether or not the patient has received adjuvant treatment. Karnofsky performance status is also a factor in patients with recurrent disease.

If treatment recommendations depend on these factors, then it seems reasonable that follow-up should also, to some extent, be based on the same factors, as well as those related to fiscal responsibility.

In the cohort of patients described by Agboola and colleagues, 62% of recurrent lesions were at distant sites. Such lesions are conventionally thought to be incurable, so their early detection has little effect on overall survival. In contrast, isolated local recurrence is thought to be treatable, and in the *CMAJ* study most local recurrent cases were picked up during routine follow-up. From this perspective, routine follow-up with pelvic examination was important.

Follow-up is also important for assessing the toxic effects of treatment. Many times we are not only assessing disease status but also the morbidity associated with radiation therapy, surgery or chemotherapy. Knowledge of toxic effects and survival is important for critical assessment of current treatment policies and consideration of newer treatment regimens.



We believe that follow-up is an important part of oncologic clinical care and that tailoring follow-up regimens allows us to optimize our resources. What is evident from the article by Agboola and colleagues is that the cost of detecting a treatable recurrence and preventing another cancer death is considerable.

Christina Aquino-Parsons, MD

Peter Lim, MD

Radiation Oncologists
BC Cancer Agency
Vancouver Cancer Centre
Vancouver, BC

This article adds to the growing number of publications assessing the value of routine follow-up in cancer care. Such work is of interest to centres such as the Toronto-Sunnybrook Regional Cancer Centre (TSRCC). In 1993-94 the TSRCC logged 38 930 nontreatment follow-up visits and saw 4045 new patients. Compared with Ontario's 7 other regional cancer centres, the TSRCC's ratio of follow-up visits to new patient visits is low (10:1; the ratios elsewhere range from 12:1 to 23:1). In general, follow-up visits represent an expensive and time-consuming portion of clinical activity at cancer centres. Health care services face increasing demands on limited resources and are under pressure to continue to improve patient care while realizing substantial cost efficiencies. In cancer care, clinicians and managers must critically examine the traditional systems and processes involved in investigation, treatment and follow-up.

There is little evidence that follow-up of asymptomatic cancer patients influences survival or quality of life.¹ This is not surprising, since for the majority of cancers there is no curative treatment for relapse or progression. Effective therapy for relapse is rare.

Some of the reasons why physicians consider follow-up useful for

cancer patients include evaluation of response to treatment, early detection and treatment of recurrence, monitoring of late effects of therapy, patient rehabilitation and psychological support, family and patient risk counselling, early detection of second malignant lesions, medical education for health professionals, research and investigation of new treatment for cancer relapse. It is unclear to what extent patients share these views or what follow-up services they want and from whom they prefer to receive those services.

Patients worry about recurrence and about missing symptoms of new cancer.² About 1 in 5 report anxiety associated with follow-up visits, especially during the first post-treatment year or if the cancer is not in complete remission. Several authors have stressed the importance of follow-up involving cancer centre and community-based physicians.³⁻⁵

One of the challenges facing regional cancer centres is to provide a cost-effective community cancer care network to satisfy the changing needs of patients and to meet the educational and research requirements of multidisciplinary health care providers. Differences of opinion about the roles of various caregivers in the follow-up of patients with cancer suggest that changes to current practice will have to be carefully introduced in consultation with family physicians, specialists and patients.

It seems inevitable that changes are needed in the traditional system of cancer follow-up. Objectives must be articulated and the respective roles of institutions and other caregivers clarified. Patients at the TSRCC are quite clear that what they value most about follow-up is the sense that they are being looked after within a humane, caring system and that current and future follow-up policies give them ready access to expertise if and when they need it. Any improvement in the effectiveness and efficacy of

follow-up care should, at a minimum, seek to preserve and enhance those characteristics.

C.E. Danjoux, MD

B. Doan, PhD

N. Hurst, RN

P. Chart, MD

C. Tan, CCHRA(A)

D. Russell, MIR

Toronto-Sunnybrook Regional Cancer Centre
North York, Ont.

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Evidence-based medicine, the medical profession's new mantra, has the noble aim of taking precious medical resources away from procedures with no proven benefit. The study by Agboola and colleagues is therefore of great interest. I suspect that future studies will show that, for most malignant lesions, routine tests for detecting occult metastatic disease fail to improve survival or reduce morbidity. Eliminating such tests would clearly be desirable.

The next foreseeable step would be to transfer routine follow-up care from the expensive oncologist to either a family doctor or a trained nurse specialist. Studies to evaluate the feasibility and efficacy of such a practice are already under way. The most obvious objection to this concept is that patients' quality of care might be affected in ways that cannot necessarily be measured by conventional outcomes, including "quality of life." But there are several important,



though less obvious, reasons to maintain specialist follow-up.

Many patients with potentially curable cancer present with unusual case scenarios for which evidence-based medicine will never provide management guidelines. The specialist must then rely on his or her slowly acquired professional experience and judgement. Without the opportunity to provide long-term follow-up for many patients and to manage chronic treatment-related complications, such experience and judgement will never be acquired.

When patients do experience a relapse, the oncologist must choose from a variety of *equivalent* management options. The most appropriate choice for that patient can only be made if one understands the patient's premorbid personality, lifestyle and social support structure (or lack thereof). Such knowledge cannot be acquired during a single consultation at the time of relapse.

Finally, I would like to argue that those of us who must spend most of

our day breaking devastating news or attempting to palliate progressive disease symptoms need well follow-up patients, our *successes*, to give us the emotional strength to do the more difficult part of our work.

Ellen Warner, MD, MSc
Division of Medical Oncology
Toronto-Sunnybrook Regional Cancer
Centre
North York, Ont.

[One of the authors responds:]

The purpose of our study was not to discount the experience and judgement that oncologists bring to the follow-up care of cancer patients but to highlight the fact that if improved survival is the endpoint of such follow-up practice, it is not achieving its purpose.

Of the cancers that recur after curative treatment, few are treatable and in most cases the survival of the patient or the control of the cancer depends to a greater extent on the bi-

ology of the tumour than on the intervention.

The assumption that the quality of life or care of asymptomatic patients is better for those followed at a cancer centre than for those cared for by their family physician has not been proven by randomized clinical studies. For example, a significant proportion of these patients experience increased anxiety in anticipation of their visits to the cancer clinics, which could have a negative impact on their quality of life.

The results of our study on endometrial cancer should not be applied to all cancer types, but the current practice of intense, lengthy follow-up of patients who have undergone curative treatment and whose disease has a good prognosis needs to be reviewed.

Olu Agboola, MB, BS
Head
Department of Radiation Oncology
Ottawa Regional Cancer Centre
Ottawa, Ont.

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