



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.

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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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3-5</sup>

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.

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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.

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**[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.

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