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Six-point plan for safer radiotherapy

The American Society for Radiation Oncology (ASTRO) has committed to a six-point patient protection plan intended to improve safety and quality and reduce the chances of medical errors.

The announcement comes in the wake of media reports in the US about serious errors in the delivery of radiation therapy. ASTRO Chair Dr Tim Williams (Boca Raton Community Hospital, Florida, US) said, 'In any area of medicine, and radiation oncology is no exception, even one error is too many. We have been a leader in efforts to improve the culture of radiation safety within our specialty. Any errors, no matter how small, must be reported, understood and used as a tool to further reduce the potential for future errors.'

The ASTRO Board's plan includes:

- Creating a database for reporting linear accelerator- and computed tomography-based medical errors.
- Enhancing the practice accreditation program, and developing modules to address new technologies.
- Expanding educational training programs to include specific courses on quality assurance and safety.
- Developing tools for patients to use in discussions with their radiation oncologist about the safety programs at their centre.
- Further development of ASTRO's connectivity compliance programme to ensure that medical technologies from different manufacturers can safely transfer information.
- Advocating new and expanded federal initiatives.

Split course radiotherapy in NSCLC

A two week break in palliative radiotherapy for patients with advanced non small cell lung cancer significantly reduced patients' symptoms without adversely affecting cancer survival (*Journal of Thoracic Oncology* 2010 *doi:10.1097/JTO.0b013e3181c6eb20*).

In a retrospective analysis, researchers reviewed the medical records of 140 patients. They found that a preplanned two-week break allowed for selection of patients for high-dose palliative radiation, and did not have an adverse effect on survival.

Lead author Dr Su K Metcalfe (University of Rochester, New York, USA) said, 'Balancing symptomatic relief with the side effects of radiotherapy remains a critical element of patient treatment.'

The authors said their finding provides the basis for future large prospective studies evaluating split-course palliative chest radiotherapy against other regimes.

Shorter radiotherapy schedule in breast cancer

A lower overall radiotherapy dose, given in fewer, larger daily doses may be a safe option for women with breast cancer, UK researchers say. They found that hypofractionated regimes did not increase adverse symptoms or result in worse body image compared with the international standard treatment.

They say the results add to the evidence that shorter hypofractionated radiotherapy schedules are equally effective at reducing the risk of further cancer and thus provide better quality for life (*Lancet Oncol 2010 doi:10.1016/S1470-2045(09)-70382-1*).

A total of 2208 women who had received radiotherapy after primary surgery for early-stage breast cancer were recruited from the Standardisation of Breast Radiotherapy Trials (START). They completed quality of life questionnaires and self assessments of body image at intervals for 5 years after treatment.

Adverse change in skin appearance after radiotherapy was the only symptom to differ significantly between the standard and hypofractionated schedules. The researchers said the overall pattern for all adverse effects was similar, with lower or similar rates for the hypofractionated schedules.

An accompanying editorial (*Lancet Oncol 2010 doi:10.1016/S1470-2045(10)-70004-8*) concluded: 'Hopefully the work by this group will inspire both researchers and clinicians to make understanding and assessment of patients' experiences a top priority.'

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doi:10.1016/j.ejca.2010.02.048

Survival benefit after contralateral mastectomy

Contralateral prophylactic mastectomy (CPM) was associated with a small improvement in 5 year survival from breast cancer, US researchers say. The effect was seen mainly in young women with early-stage, oestrogen receptor (ER) negative disease.

Researchers used the Surveillance, Epidemiology, and End Results database to identify 107,106 women with breast cancer who had undergone mastectomy between 1998 and 2003. A subset of 8902 women had also undergone CPM.

CPM was associated with improved disease-specific survival (hazard ratio of death was 0.63). The association was due to a reduction in deaths among women aged 18–49 years with stage I-II ER-negative cancer: 5 year-adjusted breast cancer survival for this group was 88.5% with CPM versus 83.7% without (*J Natl Cancer Inst 2010;* **102***:1–9*).

Lead author Dr Isabelle Bedrosian (University of Texas MD Anderson Cancer Center, USA) said that growing numbers of breast cancer patients are opting for CPM. 'Across the breast cancer community, studies have shown that the utilisation of the procedure is skyrocketing.

'Until now, we've counselled these patients on a very important, personal decision in a vacuum. With our study, our goal was to understand the implications of the surgery and who may benefit.'

Although a causal relationship between survival and CPM was not proven in this study, the researchers said they expect that the survival benefit will increase with longer follow-up.

'Our research found that breast cancer patients over the age of 60 can be reassured that they will not benefit from CPM,' Bedrosian said. Among other populations of women – such as those aged between 50 and 60; or among young women with early stage, ER-positive breast cancer who receive tamoxifen for only 5 years – the findings about CPM are less clear.

'For some additional breast cancer patients, CPM may very well be a medically-appropriate option,' she said.

Pain relief 'is a human rights issue'

Over-zealous regulations are restricting the availability and accessibility of opioid drugs and depriving many cancer patients of adequate pain relief, a pan European study has found.

Researchers say that restricting access to pain relief through formulary deficiencies and regulatory barriers is a breach of patients' human rights and they conclude: 'There is an ethical and public health imperative to address these issues.'

The study, conducted by ESMO and the European Association for Palliative Care, included data from 21 Eastern European and 20 Western European countries.

Access to pain relief was good in some countries, particularly in Western Europe, but in Lithuania, Tajikistan, Belarus, Albania, Georgia and Ukraine, some essential opioid medicines were completely unavailable.

'While most governments allow physicians to prescribe opioids for patients, regulations vary among nations and in many countries, regulations to reduce substance abuse and to restrict the diversion of medicinal opioids into illicit markets unduly interfere with medical availability for the relief of pain. This is the basis for the internationally recognized public health problem of overregulation,' the researchers write (*Annals of Oncology 2010; 21: 615–626*).

Both the World Health Organization (WHO) and the International Narcotics Control Board (INCB) recommend that opioids should be available for cancer patients and that physicians should be able to prescribe opioids according to the individual needs of each patient.

According to the researchers, regulations which contravene WHO and INCB recommendations include: requirements for special patient permits; limiting the authority of some physicians to prescribe; imposing dose limits; limiting the duration of prescriptions to, for example, 7 days' supply; restrictions on opioid dispensing; increasing bureaucratic burdens through the use of complex or poorly accessible prescription forms or complex reporting requirements; and intimidating health care providers and pharmacists by imposing legal sanctions.

One of the authors, Dr Nathan Cherny (Shaare Zedek Medical Center, Jerusalem, Israel) said: 'This is an issue of cancer patients' human rights, and it's not only a legal imperative, but a moral imperative for the WHO and individual European countries to address the findings of our report. At present, cancer patients in a number of countries are suffering unnecessarily as a result of the under-treatment of their pain.'

An editorial in Palliative Medicine was published to coincide with the study (*Palliative Medicine 2010 doi: 10.1177/0269216309360103*). The authors state that a review of the actual laws and regulations needs to precede reform of national policies to identify the excessively restrictive provisions that can be removed: 'In this way, the consensus need to reform national policy will be based on evidence.'

'IT'S A LEGAL AND MORAL IMPERATIVE FOR THE WHO AND EUROPEAN COUNTRIES TO ADDRESS THESE FINDINGS'

Implementation of any reforms – which may be the hardest step – is vital. 'It would be false to state that the inadequate treatment of cancer pain is due entirely to regulatory restrictions,' they write.

'We know from experience that policy change alone does not bring about increased access. We need to address the low priority of pain with health care, inadequate education, exaggerated fear of opioids and addiction, and problems in the supply chain for medications.'

A global pain relief initiative limited to cancer pain risks inadvertently increasing disparities in pain treatment for those suffering from pain related to AIDS and other conditions; broad collaboration will be necessary. The editorial suggests that the International Union Against Cancer (UICC)'s goal of exacting change by 2020 could be achieved 'but it will require appropriate resources, leadership from individuals and their continental and national palliative care associations, and cooperation from government agencies responsible for drug regulation, cancer and HIV/AIDS,' it concludes.