

Outpatient follow-up appointments for patients having curative treatment for cancer of the head and neck: are the current arrangements in need of change?

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Abstract

Although there are recommendations, there is little evidence about the rationale for the frequency and duration of review appointments for patients with cancer of the head and neck. We have recorded the pattern of follow-up in a tertiary cancer centre and its association with survival and recurrent disease. We used clinical letters and a prospectively maintained database to obtain details on 297 patients who were treated curatively for squamous cell carcinoma (SCC) of the oral cavity between 2005 and 2008. Mean (SD) age was 63 (12) years and 58% (n = 171) were male. Most patients were seen about 6 times in year one, 3 times in year 2, twice in year 3, twice in year 4, once or twice in year 5, and once yearly beyond year 5. Fewer clinics were scheduled for and attended by patients over 75 years of age, those with overall clinical grades 0-1, and those treated by operation alone in contrast to those who also had adjuvant radiotherapy. Patients were usually seen about 15 times over the 5 years. Taking into account the stage of the tumour and overall mortality, the number and timing of follow-up visits is adequate for the needs of patients with stage II-IV disease. Those with stage I disease may be considered for discharge after the third year if they are told about the risk factors, and signs and symptoms of recurrent disease, and surveillance in primary care.

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Introduction

After diagnosis and treatment for cancer of the head and neck, patients are normally followed up in outpatient clinics, but there is no consensus about the number of appointments, the

extent of the consultation, or the type of any investigations used.¹⁻³ Consequently clinicians across the world use different guidelines and protocols to follow up their patients. Manikantan et al⁴ suggested that no particular surveillance programme can detect recurrence or improve the patients' quality of life more efficiently than another. A common review protocol includes monthly examinations during the first year, 2-monthly examinations during the second year, 3-monthly in the third, 4-monthly in the fourth, and 6-monthly in the fifth.^{5,6} Therapeutic strategies vary, and different regimens have been proposed by the British Association of Head

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Table 1
Clinic attendance, cancellation and non-attendance by year from primary diagnosis. Data are number (%).

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
Patients (starting year)	292	247	213	195	135	68	32
Clinics scheduled	1986	953	623	488	237	75	26
Clinics attended	1746 (88)	722 (76)	470 (75)	342 (70)	170 (72)	56 (75)	18 (69)
Hospital cancelled	102 (5)	104 (11)	65 (10)	69 (14)	32 (14)	9 (12)	4 (15)
Patient cancelled	94 (5)	84 (9)	63 (10)	46 (9)	20 (8)	3 (4)	2 (8)
Patient did not attend	44 (2)	43 (5)	25 (4)	28 (6)	14 (6)	6 (8)	2 (8)
Not known	-	-	-	3 (1)	1 (<1)	1 (1)	-
Total follow-up (months)*	3318.2	2717.6	2422.0	2024.7	1204.2	581.1	172.3
Months/ clinic scheduled	1.7	2.9	3.9	4.2	5.1	7.8	6.6
Months/clinic attended	1.9	3.8	5.2	5.9	7.1	10.4	9.6
Clinics scheduled/year	7.2	4.2	3.1	2.9	2.4	1.6	1.81
Clinics attended/year	6.3	3.2	2.3	2.0	1.7	1.2	1.3

* Combined total for all patients starting that year: either 12 months to end of year, or months to loss to follow-up at 1-3-12, or to date of death.

and Neck Oncologists, the National Comprehensive Cancer Network, the Dutch Head and Neck Oncology Cooperative Group, the American Society for Head and Neck Surgery, and the Society of Head and Neck Surgeons.⁷ In the UK it is not clear whether any units have based the frequency of review on the risk of recurrence, and most units follow a specific protocol.⁵ We know from a previous study that, despite the best intentions, patients were seen less often than expected, and one in 5 attended half, or less than half, as often as intended in the first year.⁶

Health services have tried to implement systems to help patients manage their condition. UK examples include the Choose and Book service, implemented in 2004, and the Expert Patient Programme, established in 2006.^{8,9} Various initiatives have been introduced to encourage patients to attend appointments, or to avoid appointments not being filled - for example, overbooking, introducing fines for missed appointments, and sending alerts and reminders. While these may help to reduce the number of missed appointments, they do not make the scheduling of appointments more responsive to patients' needs.¹⁰ Pressures on capacity, and demand in the NHS can lead to appointments being cancelled and patients being dissatisfied. We recorded the pattern of follow-up for review of patients with oral cancer at Liverpool University Hospital, a tertiary cancer centre, and looked for potential associations and links with variables such as recurrence and mortality. To do this we had to find out how many consultations took place, and how often each patient was seen during the year. We have used data on appointments not attended or cancelled and the reasons why, and based on survival and recurrence, we will be able to stratify the frequency of review according to risk.

Methods

Using a computerised database, we identified patients with primary oral squamous cell carcinoma (SCC) who presented to the unit between January 2005 and December 2008. Data on attendance at clinics were followed up to 1 March 2012,

and deaths were tracked through the Office for National Statistics to 1 January 2014, which ensured a follow-up of at least 5 years for all patients. Details on outpatient appointments were obtained from clinical letters and included clinic dates, special investigations, admissions after primary operation, dates of discharge, and evidence of recurrent disease.

Statistical methods

For each year after diagnosis the number of clinics scheduled and the number of appointments attended were expressed as a fraction of the total number of months of available follow-up and multiplied by 12 to give the number of clinics/12-month period.

The total follow-up in months for each patient comprised each whole year survived, plus the number of months to death or to 1 March 2012, whichever came first. The chi square or Fisher's exact test was used as appropriate to test for associations of clinical or demographic data with mortality and recurrence. Otherwise the analysis is descriptive and observational of trends over time.

Results

A total of 297 patients diagnosed with SCC of the oral cavity between 2005 and 2008 were treated with curative intent. Five patients were excluded as no clinical letters and outpatient appointment details could be found after diagnosis, so 292 patients were included.

Mean (SD) age was 63 (12) years and 57% (n = 167) were male. Tumour sites were anterior two-thirds of the tongue (n = 112, 38%), floor of the mouth (n = 86, 29%), buccal (n = 48, 16%), lower gum (n = 26, 9%), and other oral sites (n = 20, 7%). The clinical T stage was advanced T3-4 in 90/290 (31%), 60/291 (21%) had invaded nodes, and 119/290 (41%) had an overall clinical stage of 3-4. Primary treatment was operation alone (n = 180, 62%), operation and adjuvant radiotherapy (n = 90, 31%), and chemoradiotherapy alone

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