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Editorial

The Top Five in Oncology: Where Do We Go From Here?

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In 2009, Howard Brody posted an ethical and moral challenge to the medical community.[1] He proposed:

> that each specialty society commit itself immediately to appointing a blue-ribbon study panel to report, as soon as possible, that specialty's "Top Five" list. The panels should include members with special expertise in clinical epidemiology, biostatistics, health policy, and evidence-based appraisal. The Top Five list would consist of 5 diagnostic tests or treatments that are very commonly ordered by members of that specialty, that are among the most expensive services provided, and that have been shown by the currently available evidence not to provide any meaningful benefit to at least some major categories of patients for whom they are commonly ordered. In short, the Top Five list would be a prescription for how, within that specialty, the most money could be saved most quickly without depriving any patient of meaningful medical benefit.

In response to that challenge, ASCO has now published its top 5 "do not" list for oncology[2]:

1. No cancer-directed therapy for patients with solid tumors with the following characteristics: low performance status (3 or 4), no benefit experienced from previous evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anticancer treatment.
2. No PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.
3. No PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.
4. No surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic patients who have been treated for breast cancer with curative intent.
5. No white cell–stimulating factors for primary prevention of febrile neutropenia for patients with less than 20% risk for this complication.

If the ancient adage, "First, do no harm" is still sacred, then the next line would be "Second, do no things that are unnecessary." ASCO has honored both the letter and spirit of the top 5 challenge in identifying 5 areas of unnecessary treatment or investigation that are not likely to help cancer patients feel better, do better, or live longer. These are common sense suggestions, supported by robust data and expert opinion, which will allow clinicians and patients to avoid common unneeded steps in cancer care. The imprimatur of ASCO should bring both a healthy respect for these recommendations and some serious attention to their importance.

How much money the implementation of these recommendations might actually save is unclear. We know very little about the true prevalence of these interventions or their true cost. Surely, however, eliminating unnecessary testing and treatment is an easy thing to endorse as a cost-saving strategy, and one that will not in any way diminish outcomes for patients with cancer.

In fact, the only real shock about the oncology top 5 list is its lack of shock value—nothing here is new at all. Each listed item has been well documented and codified in detailed guidelines from NCCN and ASCO for years. In fact, the ASCO top 5 article clearly references the appropriate ASCO and NCCN Guidelines as part of the assembled documentation. Further, writers have already urged adoption of these same oncology practices to "bend the cost curve in cancer care."[3] Indeed, an

editorial in the *New England Journal of Medicine* in 2011 advised, nearly verbatim, the precise "do not" recommendations that ASCO made.[3] This seems akin to asking Moses to identify his top list of good behaviors and then remembering that he already distributed the "10 Commandments" quite some time ago.

The question is, "why is no one paying attention to them?" If these instructions reflect practices that are both common and acknowledged to be wasteful, then we have done a woeful job of helping clinicians, patients, and third-party payors understand how to effectively use the guidelines that have for years proscribed them. There is no question that bringing attention to the top 5 oncology items is a critical step towards minimizing ineffective testing and treatment. But the need to publicize and reiterate these suggestions is principally a reflection of how inadequate the current education about and compliance efforts for guideline-based care are.

So, the first challenge is determining how to invigorate public and clinical awareness of the available guidelines and make them stick. The second challenge is creating recommendations 6 through 10, which actually affect treatment decisions. By design, the top 5 were to be relatively low-lying fruit, for which consensus would be easy and cost-savings obvious. That's the right place to start. Those determining the next 5, however, should look more directly at the heart of what drives expensive cancer care. That means articulating the various costs across the spectrum, from diagnosis through treatment, for interventions that have some but not much value and determining which are worthwhile and which are not. I suspect that the second 5 will be much more challenging to articulate than the first 5.

References

1. Brody H. Medicine's ethical responsibility for health care reform: the top five list. N Engl J Med 2010;362:283–285.
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3. Smith TJ, Hillner BE. Bending the cost curve in cancer care. N Engl J Med 2011;364:2060–2065.

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