Caring for Breast Cancer Survivors

A recent report from the American Cancer Society estimates that 13.7 million cancer survivors are currently living in the United States and that 21% of these—about 2.9 million women—are breast cancer survivors.¹ The number of breast cancer survivors is projected to grow at a rate of about 80,000 per year; by 2022, we will have more than 3.78 million breast cancer survivors. How are we going to care for this rapidly growing population of patients with specific and compelling health care needs? This challenge is exacerbated by the countervailing trend of a shortage of oncologists relative to the treatment demands of an aging population.²

A consensus has been emerging that we need a new care model for breast cancer survivors. Oncologists are busily engaged in caring for patients with “active” cancer evaluation and treatment needs, and current reimbursement models tend to provide greater revenues for those services than for follow-up care. However, breast cancer survivors have well-defined surveillance needs, including history-taking, examination, and breast imaging. A variety of health care providers, including primary care providers, nurses, nurse practitioners, and physician assistants, could probably offer and coordinate the long-term care or medical surveillance of these women. Indeed, in many countries, the prevailing model is that the care for cancer survivors revolves back to general practitioners at some point. A variety of pilot and feasibility studies in the United States have suggested that similar models could work here and would be readily accepted by cancer survivors, especially if guarantees are in place for rapid contact with the oncologists should clinical circumstances warrant. These observations have led many institutions to begin exploring ways of following up cancer survivors without direct management by the original oncologists.

I have been thinking about these challenges in light of 2 particular events: the annual San Antonio Breast Cancer Symposium and the run of busy end-of-the-year clinics.

The results of the ATLAS study were presented at San Antonio. This study addressed the question of extended course tamoxifen treatment beyond 5 years. The data suggest that longer durations of endocrine therapy with tamoxifen may benefit women, particularly premenopausal women, though there are trade-offs with respect to both common and rare side effects. Leaving aside the particulars of the ATLAS trial, what struck me is that many medical discoveries in recent years have direct bearing on the treatment plans for breast cancer survivors. These include data on switching endocrine therapies between years 2 and 3 after diagnosis; use of extended adjuvant endocrine therapy with aromatase inhibitors; introduction of adjuvant trastuzumab and its relevance to women in the first year after diagnosis; improvements in management of specific treatment-related side effects, such as osteoporosis, and genitourinary health; insights into dietary and lifestyle changes that might affect breast cancer recurrence and quality of life in survivors; characterization of links between hereditary breast cancers and certain histological subtypes; and now data on longer use of tamoxifen.

The central clinical observation is that hormone-receptor positive breast cancers have a long arc of treatment and care. Because of the “deep time” realization of this disease³ and the long course of therapy, most breast cancer “survivors” are really patients involved in active treatment. Their medical management needs must be redefined in real time.

The practical consequence is that women who would conventionally be considered survivors have benefited from regular, ongoing input regarding optimal oncologic care or management of treatment-based symptoms from their oncology team. In the past 2 weeks alone, I have had dozens of clinical encounters, phone conversations, and...
email exchanges regarding duration of tamoxifen therapy or reinitiation of tamoxifen therapy, all with women who are 4 or more years away from the diagnosis.

This is not to say that well trained, non-oncologist providers could not have tackled these questions. It is to point out that for breast cancer survivors—especially those with the most common form of breast cancer—ongoing guidance from cancer specialists has been the norm, not the exception, over the past decade.

The personal side of doctoring must also be considered. Oncologists help people deal as best they can with serious illness and, hopefully, see them through their cancer diagnosis and treatment successfully. Ours is a discipline in which too many patients will succumb to the disease or struggle to find effective treatments. There are rewards in being actively involved in the care of patients with advanced cancer, and the emotional bonds between patients and doctors in such circumstances are intense and gratifying. But there are also joys from the simpler pleasures of having patients do well—friendships that blossom and flourish, and appreciation of the span of time that help heals the wounds of cancer. As a busy clinician, I find professional fulfillment and comfort in the mixture of patients that I encounter on a daily basis. A typical clinic session includes patients who are newly diagnosed and embarking on treatment; patients receiving regular, sustained therapy; patients who need reassessment or have new needs that must be explored; and patients doing well. This is a mixture that is intellectually engaging and balanced both in emotional and scheduling demands. As an oncologist, I would not want all the patients who are “fine” to be siphoned out of my practice. They may have occasion to benefit from my insights or new scientific data, and I have much to gain from seeing them thrive. I hope that whatever models we explore for survivorship care allow for oncologists to nurture doctor-patient relationships for the long haul.

References