Interventional Oncology: The Fourth Leg of the Cancer Treatment Stool

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I recently had the opportunity to read some of the proceedings from the 2014 Society of Interventional Radiology (SIR) Annual Scientific Meeting and thought that the excitement surrounding the nascent field of interventional oncology is palpable. As a practicing medical oncologist who manages the often complex needs of patients with gastrointestinal malignancies, I have experienced first-hand the rapid expansion of diagnostic and therapeutic options provided for these patients by our interventional radiology colleagues. In 2014, interventional oncology has indeed evolved to be the “fourth leg of the cancer treatment stool,” or table, as it were. Welcome to the table!

My own oncology practice, which principally includes patients with hepatocellular carcinoma (HCC), is a testament to integration of the panoply of interventional radiology procedures into state-of-the-art cancer treatment. Without the support and services of superb interventional radiologists, it is simply not possible to adequately care for patients with complicated HCC. In early 2011, my colleague Marcelo Guimaraes, MD, proposed that we create a joint hepatobiliary clinic. During this weekly combined interventional radiology–gastrointestinal oncology clinic, we concurrently evaluate and manage patients with HCC, cholangiocarcinoma, metastatic colorectal cancer, and neuroendocrine tumors. The goal of this clinic is to ensure close coordination of patient care, consistent incorporation of the best medical evidence into treatment decisions, and access to clinical trials when appropriate.

As I was reading about the SIR meeting, several words, phrases, and themes resonated with me: team, multidisciplinary, evidence-based, collaboration, tumor board, coordination of preprocedure and postprocedure care, clinical trial. These concepts are the sine qua non of state of the art, multidisciplinary cancer care that patients expect and deserve.

I personally welcome and celebrate the emergence of interventional oncology as a specialty with a full seat at the cancer care table. But I respectfully ask that my interventional radiology and interventional oncology colleagues listen, observe, learn, and embrace the lexicon of how we as oncologists converse with our patients over the arc of their cancer journey.

Because I am a medical oncologist, I can only speak from the perspective of a medical oncologist, although I regularly share patient care responsibilities with radiation and surgical oncology colleagues. In oncology, we enjoy longitudinal relationships with patients—hopefully for many years, but often not. Medical oncologists are commonly the first cancer specialists that patients visit, and we are often the last one they see. Patients ask us very direct questions: “Will my cancer return?” “How long will I live?” “Will this cancer take my life?” “Is one treatment option better than another?” “What are the benefits and side effects of the treatment options?” “Will I be alive and well enough to celebrate my daughter’s wedding next spring?”

Patients often ask these us these questions not once, but many times. They ask these questions when they have forgotten the answers from previous discussions, when they are seeking an answer different from what they’ve already heard, when they are at a decision point in their journey, and if their cancer has recurred or progressed. In every such conversation with patients and family members, the concept of the level of evidence that supports our recommending a particular treatment, its side effects, and attendant quality of life, is central to the words we can offer when it is difficult to find the right words.
We can encourage a positive outlook and support spiritual beliefs, but patients want facts to weigh in their decision-making. When the best possible evidence of benefit does not exist or is weak or conjectural, then oncologists are left with a void in our conversation and our relationship with patients that cannot be filled with empty promises.

In my view, a “seat at the table” for interventional oncology comes with the obligation to expend the time, effort, and resources to consistently conduct prospective, controlled, adequately-powered research studies that demonstrate the benefits and risks of interventional oncology-proffered treatments to a degree of certainty expected of new chemotherapy drugs. Our patients, your patients, deserve nothing less.