

Childhood Cancer Survivors Lack Follow-Up Care

BY DAMIAN McNAMARA

ORLANDO — Fewer than half of childhood cancer survivors who are deemed to be at high risk of secondary breast, colon, and skin malignancies follow cancer-screening and surveillance recommendations as adults, according to a new analysis of the large, longitudinal Childhood Cancer Survivors Study.

Skin cancer is the most common radiation-associated second malignancy in survivors, but just 26.7% of 4,833 survivors at high risk had ever had a complete skin exam, said Dr. Paul Nathan, an oncologist at the Hospital for Sick Children in Toronto.

High-risk survivors were the least compliant with colonoscopy recommendations: Only 11.5% of 794 survivors who were considered vulnerable for colorectal cancer had a colonoscopy during the 5 years before they were surveyed, Dr. Nathan reported at the annual meeting of the American Society of Clinical Oncology.

Women at high risk for breast cancer were more compliant with recommendations, he added; even so, only 46.3% of 521 in this group had a mammogram performed during the 2 years before they were asked about screening.

Most of the 8,318 survivors surveyed in this phase of the National Cancer Institute-funded study were in the care of family physicians. About 12.5% had been seen at a cancer center or within a long-term follow-up program in the previous 2 years. Another 12% reported no medical care during this time. The remaining patients were “predominantly seen by their primary care physician in their community,” he said.

Cancer survivors and their primary care physicians need to be more vigilant, Dr. Nathan said. Individual primary care physicians may have only a few childhood cancer survivors in their practice, he said, but they should be made aware

of these patients’ special requirements.

“There is broad consensus that survivors of childhood cancer need regular surveillance and screening in the hope that if we pick up these cancers early, we can change the mortality [and morbidity],” Dr. Nathan said.

Study discussant Dr. Charles L. Bennett, professor of geriatrics, economics, and oncology at Northwestern University, Chicago, was unsure whether survivorship care was the responsibility of oncologists or primary care providers but suggested it is most likely a shared responsibility.

This study is important because “surveillance is essential, yet empirical data are lacking,” Dr. Bennett said, adding that “these are real issues. These are lifelong concerns.”

With a 5-year survival rate of 80% for pediatric cancers, most patients survive long term (J. Clin. Oncol. 2009;27:2308-18). Dr. Nathan estimated that about 9% of 325,000 survivors of childhood cancer who are alive in the United States will develop a new malignancy within 30 years of their original diagnosis. In addition, secondary malignancies are the leading cause of death among survivors who live at least 20 years beyond initial diagnosis.

The Childhood Cancer Survivors Study enrolled 20,602 people who were initially diagnosed with cancer in 1970-1986 and had survived at least 5 years. Of these original participants, 3,305 had been lost to follow-up and 1,541 had died by the time of the 2003 follow-up survey, on which the new study is based. Another 3,197 declined to participate in the survey and 990 were excluded from the analysis (among them, 960 survivors who had already developed a secondary malignan-

cy). The average age of survivors interviewed was 31.2 years. A matched group of 2,661 siblings and 8,318 population controls was also assessed.

The study’s primary aim was to determine adherence to the Children’s Oncology Group’s guidelines for following survivors of childhood cancers. Survivors were considered at high risk for the following:

► Skin cancer, if they were exposed to any radiation during childhood. An annual skin examination of treated areas is recommended. (“We know the rate of

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DR. NATHAN

the breast during childhood. Mammography is recommended every 1-2 years beginning at age 25 years, or 8 years after the initial cancer diagnosis for these patients.

► Colorectal cancer, if they received 30 Gy or more of radiation to the abdomen, pelvis, or spine. Screening colonoscopy is recommended every 5 years starting at age 35 years.

In a secondary analysis, the researchers compared survivors who were not at high risk of secondary cancers with matched controls from the National Health Interview Survey of the general population to determine adherence to U.S. Preventive Services Task Force cancer screening guidelines for breast, colon, and cervical cancer.

They found that these survivors were more likely to undergo recommended mammography (67%, vs. 58% of controls), were more compliant with Pap smear recommendations (82% vs. 70%), and had a comparable—albeit low—rate

of recommended colonoscopy (24% in both groups).

Predictors of adherence to the skin examination were care at a cancer center (RR, 1.55) and the survivor’s having a treatment summary (RR, 1.30). Being a nonwhite patient was associated with a lower likelihood of adherence to the skin examination guideline (RR, 0.63), he reported.

Significant predictors of adherence to mammography were older age at interview (RR, 1.09) and care at a cancer center (RR, 1.70).

Older age at the time of the interview was the only significant predictor of colonoscopy adherence (RR, 1.08).

The investigation was limited by the fact that the cancer diagnoses occurred from 1970 to 1986 “and clearly therapy has changed,” Dr. Nathan said. Investigators are recruiting another 20,000 adult survivors who were treated as children between 1987 and 1999 to ask similar questions of a more contemporary cohort.

The new study population also will include more minorities. About 89% of survivors in the current study are white non-Hispanics.

As survivors of childhood cancer live longer, increasing attention is being paid to the long-term effects of therapy. A key question is whether changes at the time of therapy administration will have an impact on these downstream adverse effects. A consortium of institutions is planning intervention studies to address such questions and to see whether using innovative methods to educate patients about their follow-up needs will make a difference, Dr. Nathan added.

Dr. Nathan reported having no relevant conflicts of interests to disclose. ■

► To view a video interview of Dr. Nathan, go to www.youtube.com/watch?v=aF7c1xCGpAY&feature=channel_page.



Consistency Is Key to Securing High-Quality Mohs Photos

BY ALICIA AULT

AUSTIN, TEX. — Getting good, consistent pre- and postoperative photos of Mohs procedures is crucial to documenting a reconstructive procedure and sharing those procedures and outcomes with colleagues.

Dr. Juan-Carlos Martinez of the Mayo Clinic in Jacksonville, Fla., shared tips on getting the best pictures at the annual meeting of the American College of Mohs Surgery. “Mohs surgeons make a living out of striving for perfection,” he said, adding that “photographs can and should reflect those same qualities,” including being meticulous, thoughtful, and consistent.

Consistency, especially, is key. Ideally, the only difference between the preoperative and postoperative photos should be the surgical intervention, said Dr. Martinez.

The standard for photography is to have a dedicated studio, but this is an expensive undertaking. Although photographs might not turn out as well without such a studio, the advent of digital photography has simplified image acquisition and management, making it much easier to obtain high-quality, reproducible pho-

tographs, he said. There are some simple tools that can make this task easier: a felt-covered foam board for a background and a digital camera with at least 7 megapixels of resolution. The felt board can be purchased online or made from materials obtained at a local hardware store. The camera can be a digital single lens reflex (SLR) or a point-and-shoot model.

The same camera should always be used. It’s also important to always use flash to maintain consistent lighting.

To frame the photos and keep up the consistency, use anatomic landmarks. The patient should always be sitting upright, in front of the felt board, looking straight ahead. A neutral expression is best, since smiles are hard to reproduce on a consistent basis. Gently closed eyes can help avoid the distraction of inconsistent sideways glances, said Dr. Martinez.

Some cameras have a viewfinder grid, which allows

better framing. Dr. Martinez uses a horizontal line across the pupils to ensure there is symmetric framing for the frontal, oblique, and base views. For an oblique view, he uses the same horizontal line across the pupils and another across the peak of the nasal tip. This locks the head in the transverse and sagittal planes. For a lateral image, he employs a single horizontal line from the lateral canthus to the top of the auricular helix and a vertical line from the brow to the chin. The goal is to ensure that no aspect of the contralateral brow is in view.

The base view is preferred by professional photographers, said Dr. Martinez, noting that it’s nicknamed the “view of shame” because it will highlight the slightest tip or alar distortion resulting from a reconstruction. It is useful for any tumor on or near the nose. Any nasal reconstructive paper or presentation should include this view.

Dr. Martinez reported no conflicts. ■

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