Reaching the Underserved Through the Media

BY GINA SHAW
Contributing Writer

NEW YORK — When Elmer E. Huerta, M.D., left his oncology practice in Peru to come to the Washington, D.C., area in 1987, "I thought I was going to the heavens," he recalls.

In Peru, 85% of breast and cervical cancers are found at stage III or IV, he told physicians at a cancer symposium.

But when he arrived in the United States, Dr. Huerta found pockets of poverty and lack of access, where people were horribly underserved and where diagnosis of disease came much too late, just as it did in Peru. He treated women with breasts horribly swollen and disfigured by tumors, who hadn't sought care until their symptoms were overwhelming, and their cancers so far advanced that they were almost untreatable.

"I saw women who could not bring themselves to do breast self-exams, because their mothers and grandmothers told them never to touch their breasts," Dr. Huerta said at the symposium, which was sponsored by New York University and the Lynne Cohen Foundation for Ovarian Cancer Research.

Dr. Huerta realized that cultural barriers—as well as unfamiliarity with the health care system, a lack of insurance coverage, and linguistic isolation—were keeping many Hispanic men and women in the United States from seeking preventive health care.

Many would go to the doctor only when they were sick, which meant that diseases that could have been caught and treated early were being diagnosed in late, deadly stages.

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The answer came through television and radio. He asked a patient with an advanced case of cervical cancer why she had not had a Pap smear before, and she responded, "What's that?" Seeking to lighten the mood during the same visit, he asked her what she thought of the goings-on on a popular soap opera appearing on a Spanish-language television network. She was instantly engaged, telling him what she thought the characters would do next.

So, "I thought, why can't we sell health like we sell shoes—through the media?"

In 1989, Dr. Huerta created his first radio program, "Cuidando Su Salud [Taking Care of Your Health]," selling not pills, potions, and products, but prevention.

The show has run daily ever since, and now Dr. Huerta has added a weekly, nationally syndicated call-in talk show and a local live television program to his roster. Together, the programs are estimated to reach 90% of Hispanics in the United States.

In 1993, a Montgomery County, Md., health clinic learned about the power of Dr. Huerta's message. In an average quarter, the clinic saw perhaps 20 Hispanic women for mammograms and Pap smears.

During the first quarter of 1993, for example, 23 Hispanic women came to the clinic. But in the following 3 months, that number skyrocketed to 118—more than 5 times as many Hispanic patients as the clinic had seen in any quarter. "How did you hear about us?" they asked this flood of new patients. "The doctor on the radio," the women would reply, noting that he talks all the time about mammograms and Pap smears and refers them to the clinic.

Dr. Huerta also convinced his listeners to participate in clinical trials, which have struggled with low rates of accrual in the Spanish-speaking community. When he promoted one National Institutes of Health–sponsored trial on the radio, 325 of his listeners signed up, compared with no Hispanic participants in the previous month.

Each day, he broadcasts clear, easy to understand information on topics ranging from how clinical trials work, to why men should examine their testicles regularly just as women should examine their breasts, to the importance of wearing seat belts.

Once people got the message about preventive care and screening, they were left to seek affordable care. This is one reason Dr. Huerta founded the Cancer Preventorium more than a decade ago at the Washington (D.C.) Hospital Center.

The Preventorium is an affordable clinic where low-income people can go for screening tests and get referrals for treatment. It's the opposite of the sanatoriums that sprang up in the early part of the 20th century, which hosted people with long-term illnesses such as tuberculosis, he said.

You don't go to the Preventorium if you're sick, he tells his audience: You go there because you're well and want to stay that way.

Three weeks after its opening, the Preventorium had appointments booked through the end of the year. Patients pay $64 for a visit, and the collection rate is almost 100%. "Even poor people will pay if you give them something of value," he said.

To date, the Preventorium has seen more than 15,000 patients. Most are recent immigrants who have been convinced by Dr. Huerta's broadcasts that prevention and early detection of illness are essential.

Dr. Huerta said he believes that using the media to sell a disease prevention and health promotion message and providing preventive care and screening in an affordable, one-stop setting could work with almost any underserved group.

This model could save thousands of lives and millions of dollars in health care costs by enabling physicians to treat patients at an earlier stage, he added. ■

Aggressive Tx for Ovarian Ca in Elderly Doesn't Raise Morbidity

BY SHERRY BOSCHERT
San Francisco Bureau

RANCHO MIRAGE, CALIF. — Aggressive surgery for epithelial ovarian cancer did not increase mortality or morbidity, compared with less aggressive surgery in patients over age 65 or with medical comorbidities, a review of 140 cases found.

Some surgeons are hesitant to pursue cytoreductive surgery in these kinds of patients as aggressively as they might in patients with fewer surgical risk factors because of previous data showing poorer survival rates in older women.

Federal data show that older patients with cancer are less likely to be treated surgically.

In the current study, only the amount of ovarian tumor removed was associated with survival, Sameer Sharma, M.D., said at the annual meeting of the Society of Gynecologic Surgeons.

Surgery reduced the tumor to less than 1 cm in diameter (considered "optimal debulking") in 88% of patients. Patients with optimal debulking survived a median of 52 months, compared with 26 months for patients with more tumor left after surgery, said Dr. Sharma of the Roswell Park Cancer Institute, Buffalo, N.Y.

There appears to be no significant difference in survival based on age alone, which contradicts previous findings, Dr. Sharma reported.

There were no significant differences in survival or in the rate of complications during or after surgery among the 24% of patients who underwent standard debulking surgery, the 57% who had radical debulking surgery, or the 19% who underwent supraradical debulking surgery.

Patients with comorbid medical conditions tolerated the radical procedures without an increase in postoperative complications.

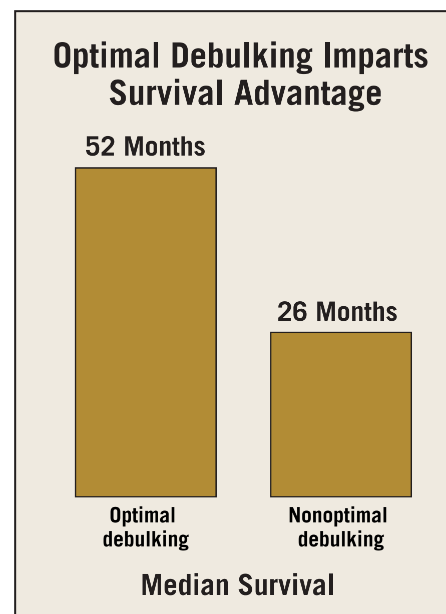
Older patients and those with comorbidities were just as likely to undergo extensive cytoreduction as less aggressive surgery.

Patients who underwent the more radical procedures, however, were more likely to need a blood transfusion, "which is probably due to underlying cardiovascular disease," Dr. Sharma said.

Forty-five percent of patients were aged 65 years or older, and 49% of the total cohort had major medical comorbidity, most commonly cardiovascular disease.

A majority of patients had multiple surgical risk factors, such as advanced age plus medical comorbidities.

Despite this, "we were able to achieve highly respectable optimal cytoreductive rates, with 60% of patients having less than 0.5 cm of residual disease after surgery," he added.



The study clearly shows that older women with ovarian cancer can tolerate aggressive surgery, which leads to better survival rates, Dr. Donald Gallup said in formal commentary that was given after Dr. Sharma's presentation.

"This study is important for those gynecologists who operate on the elderly with comorbidities, whether the patient has cancer or other female conditions that require major operative intervention," said Dr. Gallup of Savannah, Ga.

The median age of patients in the study was 63 years. They remained hospitalized after surgery for a mean of 8 days, mainly for reasons related to bowel function, Dr. Sharma said.

Follow-up lasted a median of 30 months.

Overall, 24% of patients required transfusion within 30 days after surgery, and 18% had other postoperative complications, mostly problems related to infection or the ileus. Two patients required reoperation. There was one perioperative death in a patient with liver failure from multiple liver metastases.

Age and medical comorbidities should not preclude patients from receiving "maximal surgical effort. Optimal cytoreduction continues to be a critical factor in survival," Dr. Sharma said.

In the United States, 48% of ovarian epithelial cancer is diagnosed in women older than 65 years. It is the leading cause of death from gynecologic cancers. In 2004, of the 26,000 U.S. women diagnosed, 16,000 will ultimately die of the disease, he said. ■