Routine follow up of breast cancer in primary care

Follow up by non-specialists should not be encouraged

EDITOR,—While I welcome new initiatives in the management of breast cancer, I believe that the study by Eva Grunfeld and colleagues must be interpreted with caution.¹ The authors report no delay in the diagnosis of recurrent breast cancer or reduction in the quality of life of patients randomised to follow up by their general practitioner, but their conclusions must be questioned. The data on recurrence are based on a short follow up (18 months) and small numbers (10 women followed up by their general practitioner, 16 followed up in hospital), and the comparisons of quality of life are flawed. Women randomised to follow up by their general practitioner knew that they were under special surveillance, which is different from being "discharged" from hospital. A third of women declined to enter the trial even under these circumstances.

Guidelines drawn up by the breast surgeons' group of the British Association of Surgical Oncology recommend that a breast clinic sees a minimum of 50 cancers a year, rising to 100-150 to be cost effective,² and this view is endorsed by the senate of the royal surgical colleges. Grunfeld and colleagues' study seems to lend support to the development of double standards, encouraging follow up by non-specialists, who individually will see less than one recurrence every six years (from their figures). This is surprising, because the detection of recurrence is often difficult, particularly after breast conservation and

when metastases present with more generalised symptoms such as hypercalcaemia, lymphangitis, and retroperitoneal disease. Claims for compensation for delay in the diagnosis of breast cancer are second only to those arising from the birth of neurologically impaired infants in the United States,³ and litigation in this field is increasing in Britain. A policy that endorses double standards would be difficult to defend in court and might place well intended general practitioners in the firing line.

Common sense must prevail at a time when the Department of Health (which funded this study) seems intent on a wholesale shift of health provision towards primary care. Patients deserve more consideration than this, with the need for surveillance being decided by personal prognosis⁴ rather than political expediency.

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- 1 Grunfeld E, Mant D, Yudkin P, Adewuyi-Dalton R, Cole D, Stewart J, *et al*. Routine follow up of breast cancer in primary care: randomised trial. *BMJ* 1996;313:665-9. (14 September.)
- 2 Guidelines for Surgeons in the management of symptomatic breast disease in the United Kingdom. *Eur J Surg Oncol* 1995;21(suppl A):1-13.
- 3 Physician Insurers Association of America. *Breast cancer study*. Washington, DC: PIAA, 1995.
- 4 Galea MH, Blamey RW, Elston CE, Ellis IO. The Nottingham prognostic index in primary breast cancer. *Breast Cancer Research and Treatment* 1992;22:207-19.

Study of open access centre for patients with breast cancer is planned

EDITOR,—Routine follow up of patients with breast cancer is believed to serve two main purposes: to provide early detection of loco-regional recurrence and new primary tumours and psychosocial support for the patient. Since it does not, at present, translate into improved survival, early detection of distant metastatic disease is not a priority.^{1 2}

The clinical trial reported by Eva Grunfeld and colleagues suggests that the two main aims of follow up in breast cancer may be achieved as well by general practitioners as by specialists.³ Perhaps more interesting is the finding that most (69%) recurrences (distant, regional, and local) were discovered by patients themselves. We recently investigated the mode of presentation of locoregional recurrence of breast cancer. We reviewed the charts of all 579 patients with stage I-III breast cancer seen in 1982 at our institution, who were treated by mastectomy (367 cases), lumpectomy alone (53 cases), or lumpectomy plus radiotherapy (159 cases).

Between 1982 and 1996 only 13 patients were lost to follow up. Locoregional recurrence was diagnosed in 184 patients. Recurrent disease was first detected by the patient in 79 cases. Recurrences were also detected at routine mammography (13 cases) and at visits to doctors other than an oncologist (40 cases). In 18 cases the method of detection was unknown. Only 34 locoregional recurrences were detected at routine visits to the oncology clinic. Although patients may see hospital based follow up as "their best defence against recurrence of their cancer,"⁴ the belief that routine follow up at an oncology clinic is an efficient method of

detecting recurrence is illusory. It is also questionable whether a busy ambulatory care clinic is the ideal environment in which to provide the emotional support needed by patients with breast cancer.

Given the limitations of routine follow up, we plan to establish a breast cancer resource centre at our institution. It will be staffed by an advanced practice nurse, and patients will be able to attend it whenever they have concerns relating to breast cancer. We will carry out a study to measure the use that patients make of this facility as well as a controlled, prospective evaluation of the influence it has on survival, time to detection of recurrence, quality of life, and cost effectiveness. Certainly, our observations suggest that, given sufficient education and support, patients with breast cancer are well placed to take greater responsibility for their care than is currently the norm.

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- 1 GIVIO Investigators. Impact of follow-up testing on survival and health related quality of life in breast cancer patients: a multicenter randomized controlled trial. *JAMA* 1994; 271:1587-92.
- 2 Del Turco R, Palli D, Cariddi A, Ciarto A, Pacini P, Distant V. Intensive diagnostic follow-up after treatment of primary breast cancer. *JAMA* 1994;271:1593.
- 3 Grunfeld E, Mant D, Yudkin P, Adewuyi-Dalton R, Cole D, Stewart J, *et al*. Routine follow up of breast cancer in primary care: randomised trial. *BMJ* 1996;313:665-9. (14 September.)
- 4 Maher J, Bradburn J, Adewuyi-Dalton R. Follow up in breast cancer. *BMJ* 1995;311:54.

More use should be made of specialist nurses

EDITOR,—Eva Grunfeld and colleagues' randomised trial in patients with breast cancer compared community follow up by general practitioners with follow up in a hospital oncology clinic.¹ This is an important contribution to our understanding of selected consequences arising from competing surveillance regimens after treatment for operable breast cancer. The rising incidence of breast cancer imposes increasing costs, borne by individuals, the health sector, and society. The end points of the authors' trial were clinical (the time to diagnosis of recurrence and quality of life related to health). These did not differ between the two arms of the trial. The trial did not, however, include any parallel or integrated economic evaluation, which might have identified the more cost effective mode of follow up.

Having a suitably trained clinical nurse specialist to undertake clinical follow up in conjunction with doctors may provide an alternative model. With the increasing trend for patients with breast cancer to be managed in specialist centres as a result of the Calman proposals,² we expect that the follow up of patients will remain hospital based rather than become community based. There is growing evidence that the involvement of specialist breast care nurses is beneficial during primary treatment.³ Recently, Hammond *et al* described an innovative scheme

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