The Times Have Certainly Changed in Radiation Oncology

by Dale Fuller, M.D., F.A.C.R.

The other day I was handed some statistics relating to a radiation oncology department with which I am familiar. The data, carefully kept, cover a period of 13 years (1990 to 2002) and reveal a 37 percent drop in the number of patients started on radiation treatment (from a high of 681 to a low of 428).

In 1990 the data show that nearly 21 percent (141 out of 681) of the patients started in radiation treatment were established patients, having received one or more prior courses of therapy. By 2002 the number of established patients starting on radiation treatment had dropped to only 9.5 percent (41 out of 428).

In 1990 nearly 40 percent of patients (264 out of 681) received radiation treatment for palliation of symptoms. By 2002 only slightly more than 27 percent of patients (118 out of 428) continued to receive radiation treatment to palliate symptoms of cancer.

What caused the 37 percent drop in patients receiving radiation treatment? I believe the overall decline in numbers is relatively easy to explain when you consider four industry trends: 1) increased competition in the marketplace, 2) changes in the medical and radiation oncology professions, 3) the rising cost of radiation therapies, and 4) advances in pharmaceutical management.

Increased competition in the marketplace. For the radiation oncology department whose records I had just reviewed, the start-up of seven new radiation treatment facilities in the region helped reduce its market share. Patients who used to come to the center for treatment now had the choice of being treated at a center closer to their home. A fiercely competitive market and the advent of freestanding radiation centers have caused radiation programs across the country to experience similar drops in patient numbers.

Changes in the medical and radiation oncology professions. In the past decade, the medical oncologist assumed the lead consultant role, particularly in the minds of referring physicians and surgeons whose patients were diagnosed with cancer. This change was profound for the radiation oncologist, who began seeing fewer patients. Instead, the medical oncologist began making decisions about whether a patient with cancer would benefit from irradiation (either in lieu of or in conjunction with medical management) and calling in the radiation oncologist for fewer and fewer patient consults.

Although radiation oncologists now look to the patient's primary care physician or medical oncologist for continuing patient oversight, follow-up by a radiation oncologist offers patients a number of benefits. The radiation oncologist can assess the patient's response to the delivered treatment and watch for the onset of early and late side effects to the radiation dose. When detected early enough, problems related to treatment volume can be resolved quickly and effectively in almost all instances, especially when the treating physicians know what to look for. An experienced radiation oncologist can reduce instances where new metastatic disease is mistakenly attributed to side effects of radiation treatment. Such timely recognition and intervention offer the patient the best chance of returning to active life.

High cost of radiation therapies. The past decade has also seen the cost of radiation treatment skyrocket, in part because of newer, more expensive treatment equipment. In my experience, the higher technical charge for radiation treatment has served as a disincentive for referral of patients for irradiation, particularly for patients in funding-constrained programs such as hospice.

It is well known that irradiation can be effective in the management of many skin cancers. Unfortunately, the cost of this therapy has limited its ability to compete with dermatology and plastic surgery procedures, even though these therapies offer patients varying degrees of success. Practitioners outside of the oncology field have not received training on the benefits that irradiation can have for patients with skin cancer, and they aren't likely to gain such information during their practice years.

Advances in pharmaceutical management. While pharmaceutical management of painful metastases sometimes obviates the need for the patient to be transported to and from the radiation treatment center, it is not always the answer. Patients still experience side effects to the drugs and, in some instances, must also deal with incomplete or inadequate pain relief.

While the trend is clearly moving away from the use of irradiation for palliation and towards pharmaceutical management of pain symptoms, my experience and the experience of other senior radiation oncologists is that irradiation remains a valid treatment option for palliative care. Radiation treatment can be very effective in reducing pain, often for extended periods of time. Within certain dose limits, irradiation may even be repeated if symptoms recur. Patients receiving irradiation remain functional without the side effects of strong narcotics.

The time has come to remind both patients and practitioners alike that the radiation oncologist is an integral part of the multidisciplinary cancer team. A radiation oncologist providing direct patient care brings invaluable expertise to the table.

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