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LETTERS TO THE EDITOR

Social Workers' Role Is Crucial

As a licensed clinical social worker with a background in oncology, I was greatly disappointed with the lack of any reference to psychosocial concerns in the Spring 1990 *Oncology Issues*. In an otherwise excellent compilation of articles, comments, and expositions, there was essentially nothing documenting the crucial role the oncology social worker can assume to supplement and complement the cancer center's care of patients.

I am assuming the ACCC is aware of new legislation that will permit psychosocial counseling reimbursement by Medicare as of July 1990. This certainly offers an opportunity to broaden the range and scope of social workers' contributions to cancer care. Your own organization's standards clearly spell out the expectations of a social worker in an oncology setting.

As you are also likely aware, there is a very strong and viable National Association of Oncology Social Workers which could, and likely will be able to, assist in filling the "Leadership Gap" referred to in the "From the Editor" column.

While kudos are to be extended to Oncology Issues for an excellent issue, it should also be admonished for the oversight of an important and crucial dimension of "Cancer Care in the 1990s."

—Lance Sams, LCSW, Social Service Department, Mease Health Care, Dunedin, FL.

IN THE NEWS

NIH PANEL FOCUSES ON EARLY-STAGE BREAST CANCER

Breast conservation treatment is "an appropriate method of primary therapy for the majority of women with stage I and II breast cancer," according to a recent consensus statement developed by members of an NIH panel. The panel concluded that breast conservation followed by radiation therapy is "preferable" to mastectomy "because it provides survival equivalent to total mastectomy, and it also preserves the breast."

However, at a press conference, William Wood, M.D., Chairman of the NIH Consensus Development Panel and Chief of Surgical Oncology, Massachusetts General Hospital, Boston, admitted that, at present, "breast preservation is used in a minority of women in this country"—a fact that he attributed to "variables in implementation." However, the consensus statement "doesn't mean that conservation should be employed in the majority of women," Wood said, noting that "many women elect to have a mastectomy" rather than breast conservation and radiation therapy.

As far as adjuvant systemic therapy is concerned, Wood said it is the Panel's hope that the consensus statement will help to decrease adjuvant therapy for women at a low risk of recurrence and, alternately, increase adjuvant therapy for women who are at high risk. The Panel's major recommendations were as follows:

- The recommended technique for breast conservation includes local excision of the primary tumor with clear margins, level I-II axillary node dissection, and breast irradiation to 4,500–5,000 cGy, with or without a boost.
- The many unanswered questions in the adjuvant systemic treatment of node negative breast cancer make it imperative that all patients who are candidates for clinical trials be offered the opportunity to participate.
- The rate of local and distant relapse following local therapy for node negative breast cancer is decreased by both combination cytotoxic chemotherapy and by tamoxifen. The decision to use adjuvant treatment should follow a thorough discussion with the patient regarding the likely risk of relapse without adjuvant therapy, the expected reduction in risk with adjuvant therapy, toxicities of therapy, and the impact on quality of life.
- While all node negative patients have some risk for recurrence, patients with tumors less than or equal to one centimeter have an excellent prognosis and do not require adjuvant systemic therapy outside of clinical trials.
- Future research should focus on refining existing prognostic factors, developing risk factor profile systems with sufficient accuracy and reproducibility to allow identification of subgroups, improving systemic chemotherapy regimens, and gathering further data concerning tamoxifen.

AMA REVOKES RCTS

The AMA has scratched its plan to establish a registered care technician (RCT) category in health care. In AMA committee discussions, it was reported that, to date, not a single hospital or nursing home had agreed to sponsor an RCT training program because of intense opposition from nurses.

PRUDENTIAL TO EXPAND IQ NETWORK

The Prudential Insurance Company of America plans to expand its "Institutes of Quality" (IQ) program to include a network of hospitals that perform autologous bone marrow transplants. The intent of the program, which was initiated in July 1988, is to guide beneficiaries to select major institutions for high-tech medical procedures. Prudential believes the program will improve health outcomes and help to control costs.

To date, Prudential has established IQ networks for centers specializing in one or more major organ transplants (heart, kidney, and liver) and in allogeneic bone marrow transplants. The company uses quality criteria to identify hospitals for possible inclusion in the networks (i.e., organ transplant programs must be at least two years old, have physicians with special training and extensive experience in transplants, perform a minimum number of transplants annually, and meet patient survival rate standards). Prudential further narrows its selections based on geographic considerations (i.e., proximity