Follow up in breast cancer

Quality of life unaffected by general practice follow up

EDITOR,—John Dewar calls for a reappraisal of how women with breast cancer are followed up.[1] We now have compelling evidence that intensive follow up does not improve either quality of life related to health or overall survival.[2,3] In the light of this, Dewar wonders what the effect of routine follow up is on the patient, in terms of both quality of life and cost. He also wonders what the optimum follow up practice should be and calls for as rigorous an assessment of follow up practices as has been applied to screening practices. An important step in that direction was the consensus conference on follow up in breast cancer, which he cites.

Among the papers presented at that conference was one giving the interim results of a randomised controlled trial we recently conducted.[4] This trial evaluated a system of routine follow up that is centred on general practice rather than on specialists, as is the current standard practice. Patients were randomised to routine follow up by their own general practitioner or to continue routine follow up in specialist clinics. We monitored the quality of life of patients in both arms of the trial. At mid-trial there were no differences between the two groups. The fact that two thirds of eligible patients agreed to participate in the trial suggests that patients are willing to consider follow up by their general practitioner as an alternative to hospital follow up if given the choice. In addition, it suggests that a proportion of patients will choose to continue with hospital follow up. This will ensure that a proportion of patients seen in clinics are "fit": Dewar notes that such patients are an important counterbalance to the many seriously ill patients seen in these clinics. We also found that general practitioners were willing to provide follow up: 113 of the 115 general practitioners with patients in the trial agreed to provide follow up care. This is further supported by a separate survey of general practitioners in which 69% selected routine follow up by the general practitioner as their preferred method of follow up.[5]

We embarked on this trial out of concern for the many issues that Dewar raises. We decided to evaluate a system of follow up centred on general practice because we thought that it would address many of these issues and, at the same time, ensure continuity care and support for the patient. We believe that this is the ideal method of shared care: the specialist provides primary treatment, the general practitioner provides continuing care, and the specialist becomes involved again if disease recurs.

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Patients prefer specialist follow up

EDITOR,—We wish to report the "missing data"—namely, patients' views—in the debate on routine follow up in breast cancer.[1] As part of the design process for a multicentre study of hospital follow up versus follow up based in the community we sought patients' views using research methods described by the College of Health.[2] Focus groups of women in remission were drawn both randomly and from the network of cancer support groups established around Mount Vernon Cancer Centre.[3] The focus groups discussed alternatives to the present system of follow up.[4] The patients' view challenges the utilitarian approach of clinicians, and shows differences in the perception of the purpose of routine follow up in the two communities.

The patients expressed their anger and distress about being discharged to their general practitioners for follow up without having the support and specialist services of the hospital available in the community. They challenged the researchers' hypothesis; patients viewed the hospital—its diagnostic tests, specialist physicians, and breast care nurses—as their best defence against a recurrence of their cancer. The hospital was seen as having skill in cancer and understanding the magnitude of cancer in the patients' life. Although there were aspects of the hospital system they did not like—the waiting, the rushed consultations, and the lack of continuity of care—these were seen as the trade off for guarding against a relapse. While there is no evidence that routine follow up improves prognosis or reduces rates of recurrence, this was not the message they had received.

For patients, an acceptable model of community based care would include clinics staffed by someone with specialised knowledge of cancer—for example, a breast care nurse—and a fast track route back to hospital care when this is required; this would overcome the perceived lack of knowledge of their special needs by general practitioners and provide continuity and a specialised intermediate service. Hospital specialists would also have a reduced workload, allowing them to concentrate their care on those who really need it.

While other models may be proposed, at a time when cancer services are primed for reorganisation (precipitated by the Calman report) the views of the patients should not be ignored. Frequently we have found that patients, with their wealth of experiential knowledge, can suggest solutions when clinicians cannot see the wood for the trees.

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Impossible to state which NSAID is safer

EDITOR,—In their article on recent advances in rheumatology Anthony Bradlow and Joel David state that ibuprofen is the safest non-steroidal anti-inflammatory drug when used at conventional doses.[1] However, they present only the risk of serious gastrointestinal adverse events and these for only the seven most commonly prescribed non-steroidal anti-inflammatory drugs.

Data from the Medicines Control Agency show that the incidence of hypersensitivity reactions associated with ibuprofen is similar to that of gastrointestinal reactions (0·5-1 report per 100 000 prescriptions).[2] Both ketoprofen and indomethacin are less likely to provoke hypersensitivity reactions. Spanish data collected in a similar manner show that only 39% of adverse events associated with non-steroidal anti-inflammatory drugs were gastrointestinal.[3] Gastrointestinal adverse reactions are considered to depend on the dose.[4] It is difficult to assess, from data reported voluntarily or observational studies, whether the dose was equivalent between these non-steroidal anti-inflammatory drugs.

For various reasons, different non-steroidal anti-inflammatory drugs are used for different indications. This leads to them being used in different

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