

CORRESPONDENCE

Guideline-Compatible Treatment of Breast Cancer Patients – The Status Quo in Schleswig-Holstein

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Language is the Source of All Misunderstandings

As a radiation oncologist I was horrified to hear that in Schleswig-Holstein, more than 35%—rather than 10%—of patients with breast cancer receive radiotherapy to the axilla. The indication for classic axillary radiotherapy—level I to II; level III is optional—is narrowly defined at the tumor center in Munich (1). It is an option as alternative to axillary dissection in selected cases (2)—after axillary dissection it is justifiable only in case of high risk of local recurrence.

It is possible that the authors are unfamiliar with target volume concepts in breast cancer.

The lymphatic drainage is not defined as a target volume after breast conserving surgery and axillary dissection in patients with N0 status. However, for technical reasons it is regularly inevitable that the ventro-caudal axillary region is included. In patients with pN+ status, if particular conditions are met (1), the adjacent paraclavicular lymphatic drainage should be treated with radiation. For this target volume, parts of the craniomedial axillary drainage area are included, but the operated parts of the axilla (levels I and II) are not subject to radiotherapy.

The authors raised the question of axillary radiation. If they meant therapy of the paraclavicular lymphatic drainage areas then the question was formulated incorrectly because the complete axilla is not included in this target volume. If the question had included each partial concomitant treatment of the axilla, almost all patients might have responded "yes".

As radiation oncologists we are dependent on the trust and benevolence of our referrers more than other physicians are. We could not afford to give inadequate care or, to be exact, the wrong care to 25% of our patients. I therefore seriously doubt the hypothesis of inadequate care.

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Is the Care Provided Really Adequate?

The question of whether the healthcare provision for patients with breast cancer meets the standard is worth while. I am a gynecologist with a psycho-oncological subspecialism, and I find it baffling that this question seems to have been studied only in the context of surgery/chemotherapy/radiotherapy, whereas the problem of psychological advice and care were not taken into consideration at all.

The guidelines state that psycho-oncological measures should be integrated into the basic concept, and that all patients should be informed at an early stage and as a rule about psycho-oncological measures during acute treatment and also during aftercare. High grade evidence supports these recommendations.

It would be possible to convert these prescriptions, in analogy to other evidence based recommendations, into reference ranges and to question patients accordingly. Why was this not done, and why was this central research area not touched?

I fear that the results might be depressing. After more than 20 years' experience I would state with confidence that the physical treatment may meet a high standard but that the women are often left alone with the shock of their illness and dealing with it. Psychosomatic care from the beginning still does not seem to be important enough for hospitals to particularly pay attention what the S3 guideline has to say on the subject. Psycho-oncological care during aftercare benefits very few women; applications to obtain it are laborious, and it is not available as an adjuvant routine measure like chemotherapy or hormone therapy.

While it is satisfying that the concept of guideline conform treatment has been mostly implemented, the question remains of how do authors base their findings on an idea of "adequate" care provision if they don't question this area which is so crucial for the quality of life?

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In Reply:

The OVIS study was a population based study and investigated 1927 patients with breast cancer from Schleswig-Holstein by means of a questionnaire about their medical care, with an emphasis on diagnostics and therapy. Additionally, psycho-oncological measures were taken into consideration in the initial and second survey—some 1.5 and 3.5 years after the diagnosis.

Our results for these areas are consistent with those of Dr Schumann: only 20% of patients had used psychological or psychotherapeutic help in dealing with their illness. In addition to professional psycho-oncological help, patients were also questioned about "low level

advice", such as regional cancer advice centers, self help groups). 36% of patients reported knowledge about self help groups and 6% reported membership of those. Cancer advice centers were known to about half of the women. With regard to areas that need improvement in caring for cancer patients, 36% evaluated "psychological care" as in need of optimization (unpublished results).

In spite of this, the patients reported a high quality of life 1.5 or 3.5 years after their diagnosis. Their global assessment of their quality of life was higher at a clinically relevant level than that of a comparable general population. However, breast cancer patients described impairments in role functioning as well as emotional and social functioning. Other symptoms included fatigue, dyspnea, and insomnia and were reported by cancer patients 1.5 years and 3.5 years after the diagnosis. (1)

We have nothing to add to Dr. Stadler's comments on the radiological therapy for breast cancer. The described complex clinical contexts are not always easy for patients to follow. Patient surveys may reach their limitations in these settings. An overestimate of the rate of radiation after axillary dissection is entirely possible if only patients are questioned. On the other hand, we were able to arrange a questioning of the treating doctors for a partial cohort of the patients. Even the physicians reported axil-

lary radiotherapy or radiotherapy of the parasternal lymphatic drainage pathways for 30% of patients.

Such a result should prompt a closer look in practice (comparable original article...[the indicator radiotherapy after axillary dissection should be checked]). Inadequacies in care to the extent described seem unlikely to us if not totally out of the question.

We did not claim to have delivered a conclusive evaluation of oncological care; we merely provided an orientation. We think that patient surveys are an effective procedure to evaluate oncological care, at least for as long as Germany does not have wide ranging and cross sectoral clinical cancer registration system.

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Conflict of interest statement

The authors of the letters and of the reply declare that no conflict of interest exists according to the guidelines of the International Committee of Medical Journal Editors.