

Research Advocacy Network

UpDate

Oncology Research and Treatment News

Breast Cancer: Issue 1

... From the Editor

We are delighted to welcome you to the premier issue of *UpDate: Oncology Research and Treatment News*. This newsletter will provide the community cancer specialist with coverage of the latest developments in cancer clinical research and treatment. Each issue will feature a particular disease condition, clinical problem, or approach to treatment. This inaugural issue focuses on early-stage breast cancer and adjuvant treatment. We are pleased to be able to bring you the results of a few studies reported at ASCO 2004. (See boxes.) Articles begin with a report on recently published studies, which provide further support for the treatment option called aromatase suppression. We include a snapshot of some of the most provocative research relating to treatment with chemotherapy presented at the 2003 San Antonio Breast Cancer Symposium. A review of recent studies helps define the role of anthracyclines in the therapeutic mix. Finally, we include a contribution from Lidia Schapira, MD, from Massachusetts General Hospital and the Harvard Medical School, on ways to improve communication with patients. Dr. Schapira is a recognized authority on the subject, and her thoughts on this most important, but often neglected, facet of medical practice are well worth your consideration.

We welcome and look forward to your feedback on this issue, as well as suggestions and contributions for forthcoming issues. Please write to *UpDate* c/o Research Advocacy Network, 309 East Rand Road, Suite 175, Arlington Heights, IL 60004; phone: 877.276.2187 or e-mail: update@researchadvocacy.org. We hope to hear from you. ■

New Options for Hormonal Treatment

Postmenopausal women with breast cancer who switched to the aromatase inhibitor exemestane after receiving the standard drug tamoxifen were 68% more likely to be disease free after 5 years than were those who continued on tamoxifen, according to results of a study published in the March 11 issue of the *New England Journal of Medicine*. This 32% reduction in risk corresponded to an absolute benefit in disease-free survival of 4.7% at 3 years following randomization (91.5% vs 86.8%, $P = .00005$). Notably, these results

continued on page 2

ASCO 2004: BREAKING NEWS Patients Show Similar Menopausal Symptoms With Tamoxifen and Exemestane

Interim results from the first year of a planned 5-year phase III trial comparing relapse-free survival in postmenopausal women with ER-positive, early breast cancer treated with exemestane or tamoxifen were recently reported at ASCO. The analysis showed no significant differences in the frequency and severity of menopausal symptoms, including vaginal bleeding, mood alterations, impaired word finding, low energy, and hot flashes. Asmar et al observed that vaginal dryness and bone/muscle aches were worse in exemestane patients, while vaginal discharge was more common in the tamoxifen group. Most symptoms were mild or moderate in nature, and many were reported at baseline as well.

Table of Contents



San Antonio Highlights

3



Anthracyclines in Adjuvant Chemotherapy

5



Communication Corner

7

UpDate is published through an unrestricted educational grant from Pfizer Inc.

New Options for Hormonal Treatment

continued from page 1

achieved a level of statistical significance prior to the full completion of the study.

More than 4700 postmenopausal women from the United States, Europe, and South America with hormone receptor–positive breast cancer were enrolled in the phase III, randomized, double-blind trial. All had already completed 2 to 3 years of adjuvant hormone therapy with tamoxifen and were then assigned to receive either exemestane (25 mg daily) or tamoxifen (20 mg daily) for an additional 2 to 3 years.

The investigators found that among the women who switched to exemestane, significantly fewer had recurrences of the disease than those who remained on tamoxifen, including local (33 vs tamoxifen = 44) and distant (101 vs tamoxifen = 161) tumors as well as second primary breast cancer (9 vs tamoxifen = 20, $P = .038$). Similar numbers of women in both groups died, from either breast cancer or other causes.

Side effects with exemestane were mild and included joint pain (5.4%) and diarrhea (4.3%). Tamoxifen was

ASCO 2004: BREAKING NEWS

Exemestane Therapy Increases Bone Remodeling in Postmenopausal Women With Early Breast Cancer

Results of 2 double-blind studies of the effects of exemestane (Aromasin) on bone metabolism indicate that the steroidal aromatase inhibitor induces a marked suppression of estrogen. However, there was an increase in bone remodeling or renewal. The investigators observed no major effects on bone mineral density. A companion analysis conducted by Lonning and colleagues found that women with normal bone density taking exemestane showed no signs of developing osteoporosis effects on the spine, although minor effects on the femoral neck were observed. These early findings are promising; however, longer follow-up is needed to determine the long-term effect of exemestane on bone.

associated with hot flashes (9.0%), vaginal bleeding (5.6%), muscle cramps (4.4%), and blood clots (2.4%). While more fractures were reported in the patients switched to exemestane, the difference was not statistically meaningful. Overall, the incidence of severe toxicity was low in both groups.

The investigators concluded, “These results add to the evidence that the sequential use of aromatase inhibitors and tamoxifen provides additional options for improving adjuvant hor-

mone therapy for postmenopausal women with hormone-responsive primary breast cancer. Our results indicate that 5 years of tamoxifen monotherapy after surgery may not be optimal in these patients and suggest that clinicians should consider switching patients to exemestane between 2 and 3 years after the start of tamoxifen therapy.” Ongoing studies should help clarify the correct sequence of therapy and the effect of aromatase inhibitors on bone metabolism. (See box above.) ■

Adjuvant Hormone Therapy With Letrozole After 5 Years of Tamoxifen Improves Disease-Free Survival in Women With Postmenopausal Early-Stage Breast Cancer

Postmenopausal women with primary breast cancer who received treatment with the aromatase inhibitor letrozole (Femara) after 5 years of tamoxifen had a significantly greater estimated 4-year survival rate than patients given placebo, according to results of a major study published in the November 6, 2003, issue of the *New England Journal of Medicine*. The benefit to women receiv-

ing letrozole was so marked that at the first interim analysis, the data and safety monitoring board terminated the trial.

Nearly 5200 postmenopausal women were enrolled in this phase III, double-blind, placebo-controlled trial. All had hormone receptor–positive disease and had completed 4.5 to 6 years of tamoxifen. The women were randomly assigned to receive either

letrozole (2.5 mg) or placebo orally for 5 years.

After 2.4 years of follow-up, the investigators found there were 207 local or metastatic recurrences of breast cancer or new primary cancers in the contralateral breast: 75 in the letrozole group and 132 in the placebo group. The estimated 4-year disease-free survival rate was 93% for letrozole patients,

compared with 87% for women receiving placebo ($P \leq .001$). While the incidence of hot flashes (47.2% vs 40.5%), arthritis (5.63% vs 3.5%), arthralgia (21.3% vs 16.6%), and myalgia (11.8% vs 9.5%) was greater in the letrozole group, the rate of vaginal bleeding was lower (4.3% vs 6%). New diagnoses of osteoporosis occurred slightly more frequently in the treatment group (5.8% vs 4.5%), although the difference was not significant, and the fracture rate was similar as well. Finally, there was a slight trend toward an increase in overall survival in letrozole patients (96% for letrozole, 94% for placebo, $P = .25$). Overall, few women discontinued the study because of toxic reactions, the investigators noted.

“On the basis of our findings, postmenopausal women with hormone receptor-positive tumors who have completed about 5 years of adjuvant

tamoxifen therapy should be considered for letrozole treatment,” the investigators concluded. “However, these results, which necessitated the discon-

tinuation of the study, leave the optimal duration of treatment undefined and the question of long-term toxicity unanswered.” (See box above.) ■

ASCO 2004: BREAKING NEWS

Quality of Life Maintained in Postmenopausal Women Taking Letrozole

While the NCIC CTG MA.17 trial found that letrozole (Femara) patients were more likely to experience low-grade hot flashes, arthritis, arthralgias, and myalgia, a substudy analysis using the Medical Outcomes Study SF-36 and the Menopause Specific Quality of Life (MENQOL) instruments showed that the aromatase inhibitor did not have a substantial adverse effect on overall quality of life. Although there were small differences in several measures, including SF-36 physical functioning, bodily pain, and vitality domains, and MENQOL vasomotor, physical, and sexual scales, Whelan and colleagues said these findings were consistent with the small number of patients who reported adverse effects during the trial while on letrozole therapy.

San Antonio Highlights: Adjuvant TAC Improves Disease-Free Survival and Overall Survival

Taxane-anthracycline combinations have been shown to be effective agents in the treatment of metastatic breast cancer, prompting researchers to look at the use of these agents in the adjuvant setting. One eagerly watched study, BCIRG 001, compared

TAC (docetaxel, doxorubicin, and cyclophosphamide) with FAC (5-fluorouracil, doxorubicin, and cyclophosphamide) in nearly 1500 women with node-positive breast cancer. The investigators presented 33-month interim results last year at ASCO,

showing a statistically significant improvement in disease-free and overall survival in patients receiving TAC. At San Antonio, Miguel Martin, MD, Medical Oncology Department, Hospital Universitario San Carlos, Madrid, Spain, presented 55-month findings.

In looking at disease-free survival, Dr. Martin indicated that patients in the TAC group (75/50/500 mg/m² q3 wk x 6) reported 172 events, while those receiving FAC (500/50/500 mg/m² q3 wk x 6) had 227. Thus, 80% and 75% of TAC patients were free of disease at 4 and 5 years, respectively, compared with 71% and 68% of those on FAC. For overall survival, there were 91 events on TAC and 130 on FAC, meaning that 89% and 87% of those getting TAC were still alive at 4

About the Research Advocacy Network

The patient advocacy movement has changed the face of research. Patient advocates have provided invaluable input into medical research. The mission of the Research Advocacy Network (RAN) is to develop a network of advocates and researchers who can influence medical research from concept to patient care through education, support, and collaborations. One of the most important aspects of the research process is moving research results into clinical practice. RAN works to accomplish this goal in several ways: Fact Sheets were created to explain the results of the MA.17 trial and the exemestane studies; *Network News*, an e-newsletter, is published monthly and covers a variety of topics, including describing research results and tools for advocates; and this newsletter and its companion for patients and advocates, *Options*.

For more information, visit the RAN Web site at www.researchadvocacy.org

Research Advocacy Network

Advancing Patient-Focused Research

continued on page 4

San Antonio Highlights: Adjuvant TAC Improves Disease-Free Survival and Overall Survival

continued from page 3

and 5 years, respectively, compared with 85% and 81% of those in the FAC cohort. The side effect profile remained unchanged after 55 months: asthenia, febrile neutropenia, and grade 3-4 infections were significantly higher in TAC patients, as was the incidence of congestive heart failure.

The investigators also looked at estrogen and HER2/neu status. They found that hormone-positive TAC patients were 39% less likely to have an event than were those getting FAC; for HER2-negative patients, the diminished risk was 24%. Both differences were statistically significant.

Therefore, Dr. Martin concluded, TAC offers a significant advantage over FAC in disease-free and overall survival in node-positive, early breast cancer patients.

Waiting up to 12 Weeks to Begin Chemotherapy Does Not Affect Survival

When is the best time to initiate adjuvant chemotherapy after breast cancer surgery? Caroline Lohrisch, MD, and colleagues from the British Columbia Cancer Agency in Vancouver, Canada, retrospectively examined the institution's breast cancer and pharmacy databases to determine whether the time from surgery to the onset of adjuvant treatment influenced patient outcomes.

In the analysis, 2594 patients were divided into 4 groups, based upon the time at which treatment was begun after surgery: 0-4 weeks (n = 993), >4-8 weeks (n = 1272), >8-12 weeks (n = 217), and >12-24 weeks (n = 112). Prognostic factors such as estrogen-receptor status, lymphatic or venous invasion, tumor grade, and age of diagnosis generally were similar across the groups, although group 1 (0-4 weeks)

had a significantly higher proportion of patients with positive nodes. The 5-year relapse-free (RFS) and overall survival (OS) rates were comparable between the first 3 groups: RFS = 74%, 79%, and 82%, and OS = 84%, 85%, and 89%. However, those patients whose adjuvant treatment began more than 3 months after surgery fared significantly worse: their RFS was 69% and their OS was 78%. As a consequence, Dr. Lohrisch reported that this study provides "reassurance" that there is little difference in beginning adjuvant chemotherapy up to 12 weeks after initial surgery. However, delaying more than 12 weeks may lead to higher relapse rates and poorer overall survival. Thus, physicians can reassure patients that waiting to gather more information, getting a second opinion, making arrangements for work or family needs during treatment, or just taking some time will not affect their survival.

Novel Multi-Gene PT-PCR Assay Predicts Recurrence in Certain Breast Cancer Patients

Treatment planning for node-negative, estrogen receptor-positive breast cancer patients is based on standard prognostic factors that are limited in their predictive power (eg, tumor size and patient age) or are not reproducible (tumor grade). Thus, clinicians have long sought a more precise and reproducible means to quantify the risk of a distant recurrence. Soonmyung Paik and colleagues from the National Surgical Adjuvant Breast and Bowel Project (NSABP) group in Pittsburgh, Pa, and Genomic Health in Redwood City, Calif, used a new multi-gene RT-PCR assay, which is done on paraffin blocks of tissue, to analyze tumor sam-

ples from patients enrolled in the NSABP B-14 trial. They identified a 21-gene panel that appeared to predict the likelihood of disease recurrence in these patients. At San Antonio, the team presented results of a prospective validation study of the panel in 668 women assigned to the tamoxifen arm of the NSABP B-14 study.

Patients were divided into 3 risk groups (low, intermediate, and high) based on their recurrence score (RS), a predictive figure determined from results of the gene-panel analysis. Those in the low-RS group (51% of patients) had a 10-year recurrence rate of 6.8%, while patients in the intermediate cohort (22%) had a rate of 14.3% and those in the high-RS group (27%) reported a 30.5% rate of recurrence. The difference between the low and high groups was highly statistically significant ($P < .00001$), the investigators said. They added that the gene panel-derived RS was also successful in predicting distant recurrence-free survival and overall survival. As a result, the researchers concluded that the RS "provides accuracy and precision in predicting the likelihood of distant recurrence" and exceeds standard measures such as age, tumor size, and grade in either prognostic power or reproducibility. The test, which is now available, has been validated only on newly diagnosed patients with node-negative, estrogen-positive disease who will be treated with tamoxifen.

Survival Following Mastectomy and Chemotherapy: The African-American Experience

Is race predictive of outcome in women with breast cancer? Wendy A. Woodward, MD, and a team of researchers

from M.D. Anderson Cancer sought to shed light on this question by studying whether Caucasian (CA), African-American (AA), and Hispanic (HI) women enrolled in prospective clinical trials with mastectomy and doxorubicin-based chemotherapy had different rates of distant metastasis and OS. The investigators looked at 2 independent patient cohorts, who received radical surgery and either adjuvant ($n = 1456$) or neoadjuvant ($n = 684$) doxorubicin-based chemotherapy. The findings were striking.

In the adjuvant cohort (1142 CA, 186 HI, 128 AA), African-American women had larger primary tumors and

later-stage tumors than the other 2 groups. They also had a higher rate of estrogen receptor (ER)-negative disease. As a consequence, their 10-year OS was significantly poorer (52%) than Caucasian or Hispanic patients (62% for both CA and HI).

Similar results were reported in the neoadjuvant population (448 CA, 114 HI, 122 AA). African-Americans had higher rates of ER-negative disease, and their illness had progressed to a more advanced clinical stage. Their 10-year OS also was significantly worse (40%), compared with either Caucasians (50%) or Hispanics (56%).

In assessing these data, Dr. Wood-

ward suggested that while Hispanic and Caucasian women shared similar biological tumor features, African-Americans appeared to have more aggressive disease and worse outcomes. Race was an independent predictor of survival in both data sets. She called for further studies to identify the sociodemographic and biological factors that account for this disparity in outcomes. Doctors and patients should take this information into consideration when making treatment decisions. In addition, it is especially important for physicians to encourage all African-American women to participate in screening programs. ■

New Approaches, New Findings in Breast Cancer: Anthracyclines in Adjuvant Chemotherapy

Well established among the most active class of chemotherapeutic compounds, anthracyclines now serve as a mainstay in adjuvant regimens. Epirubicin, the 4' epimer of doxorubicin, has been shown to provide comparable efficacy and reduced toxicity, compared with doxorubicin, and thus has become the focus of much current clinical research looking into the optimal chemotherapeutic cocktail.

New Combinations

Several recent studies have helped clarify our understanding of epirubicin's role as a core component in adjuvant regimens. One important question has been whether the addition of the compound to the classic cyclophosphamide, methotrexate, and fluorouracil (cCMF) combination is more effective than and comparably as safe as CMF alone in the treatment of early breast cancer. Reporting at the 2003 "Best of ASCO" meeting, Poole et al presented results of a nearly 2400-patient joint efficacy analysis of the NEAT (National Epiru-

bicin Adjuvant Trial) and SCTBG BR 9601 (Scottish Breast Cancer Group) trials. The NEAT trial compared epirubicin ($100 \text{ mg/m}^2 \times 4$ cycles) followed by cCMF ($\times 4$ cycles) with classic CMF ($\times 6$ cycles), while the SCTBG used the same epirubicin regimen and followed it with an IV dose-modified 3-weekly CMF ($750:50:600 \times 4$ cycles) and compared it with an IV 3-weekly CMF ($\times 8$ cycles). Prognostic characteristics were balanced across treatments: 72% were node-positive, 59% were less than 50 years old, 58% had grade 3 tumors, 57% of those were greater than 2 cm, 32% were estrogen receptor-negative, and 50% were positive. The investigators reported that there was a highly significant advantage in favor of epirubicin plus CMF for both relapse-free survival (HR 0.70, 95% CI 0.58-0.85, $P = .0003$) and overall survival (HR 0.64, 95% CI 0.51-0.81, $P = .0001$), even when adjusting for trial and prognostic factors. The regimen also was well tolerated and was able to reach optimal dose intensities.

Long-term Findings

Are there long-term benefits to be gained from combining epirubicin plus cyclophosphamide and fluorouracil (CEF), compared with classic CMF (cCMF)? Ten-year data from the National Cancer Institute of Canada Clinical Trial Group MA.5 trial found that a significant improvement in disease-free survival (DFS) and overall survival (OS) seen after 5 years in CEF patients was maintained through a decade of monitoring. The trial followed more than 700 perimenopausal women with axillary node-positive breast cancer. Those receiving CEF (cyclophosphamide 75 mg/m^2 on days 1-14, epirubicin 60 mg/m^2 on days 1 and 8, fluorouracil 500 mg/m^2 on days 1 and 8) showed a 10-year DFS of 52% and OS of 62%, compared with women in the cCMF (cyclophosphamide 100 mg/m^2 on days 1-14, methotrexate 40 mg/m^2 on days 1 and 8, and fluorouracil 600 mg/m^2 on days 1 and 8)

continued on page 6

New Approaches, New Findings in Breast Cancer: Anthracyclines in Adjuvant Chemotherapy

continued from page 5

cohort, whose corresponding survival rates were 45% and 58%, respectively. CEF also was well tolerated: the rate of leukemia remained unchanged after 10 years of therapy (5 patients in the CEF cohort), while the rate of congestive heart failure was slightly higher, but “acceptable,” in the CEF group: 4 cases in CEF patients versus 1 in the cCMF subjects. These findings show that the established benefit of the CEF regimen is sustained out to 10 years, the investigators said.

Dose-Dense Treatment and Survival

Although still controversial, dose-dense approaches to chemotherapy, in which the interval between successive treatment doses is reduced, are increasingly

being offered to cancer patients as a therapeutic option. Investigators from the Cancer and Leukemia Group B (CALGB) recently reported results of a trial using dose-dense doxorubicin (A),

paclitaxel (T), and cyclophosphamide (ATC) as postoperative adjuvant therapy in women with node-positive primary breast cancer. The trial sought to answer 2 questions: is there a benefit from dose-dense therapy, and is sequential better than combination chemotherapy? The 2000 women in the trial were randomized into 1 of 4 groups. After 3 years of follow-up, Citron and colleagues carried out a safety analysis required in the protocol. They found that 315 patients had either relapsed or died, compared with the expected rate of 515. Even with this lower-than-anticipated event rate, dose-dense treatment significantly improved DFS and OS. In fact, the 4-year DFS was 82% for the dose-dense arms (II and IV) and 75% for the others. There was no difference in survival between the concurrent and sequential schedules, nor was there any interaction between density and sequence. Surprisingly, severe neutropenia was less frequent in patients who received dose-dense treatment. While the increased cost of dose-dense strategies remains a factor due to the use of supportive therapies, this approach will continue to be attractive to many physicians and patients.

Group I	Group II	Group III	Group IV
Sequential	Sequential	Concurrent	Concurrent
A x 4	A x 4	AC x 4	AC x 4
T x 4	T x 4	T x 4	T x 4
C x 4	C x 4	Q 3/weeks	with filgrastim
Q 3/weeks	with filgrastim		Q 2/weeks
	Q 2/weeks		

A = doxorubicin; T = paclitaxel; C = cyclophosphamide

ASCO 2004: BREAKING NEWS

Dose-Dense Sequential Chemotherapy With ETC Improves Survival, Compared With a Conventional Dosing Regimen: German AGO Trial

Findings from the multicenter phase III German AGO trial comparing a 3-course, dose-dense/dose intense regimen of epirubicin (150 mg/m²), paclitaxel (225 mg/m²), and cyclophosphamide (2500 mg/m²) every 2 weeks with 4 courses of conventionally dosed chemotherapy comprising epirubicin/cyclophosphamide (90/600 mg/m²) followed by 4 courses of paclitaxel (175 mg/m²) every 3 weeks suggest that the dose-dense protocol significantly improves both disease-free and overall survival in high-risk breast cancer patients. Mobus and colleagues reported that after 28 months, dose-dense/dose intense sequential chemotherapy reduced the risk of relapse by 36% ($P = .0009$). Both regimens were fairly well tolerated, although dose-dense patients reported a higher rate of hematological toxicities and hospitalizations for febrile neutropenia, despite the administration of adjunctive G-CSF. Based on these results, the investigators concluded that dose-dense sequential chemotherapy might be a treatment option for high-risk (4+ positive nodes) breast cancer patients in the near future. However, this interesting study cannot answer the question, Was it the increased dose of the drugs given in the ETC arm or the fact that they were given every 2 weeks instead of every 3 weeks that resulted in the improved results?

Does Age Matter?

Recent research shows that older women with early-stage breast cancer are less likely than younger women to receive adjuvant chemotherapy. A number of explanations have been offered for this finding, including diminishing life expectancy and treatment utility, greater comorbidities, and age bias. To try to help determine whether adjuvant regimens are beneficial to this population, researchers from the CALGB cooperative group analyzed data from nearly 6500 breast

cancer patients enrolled in 4 of their trials. The patients, who were node-positive, received a variety of different doses and schedules of adjuvant treatments, some of which were deemed to be quite high at the time. More than half of the women were less than 50 years of age; 38% were 51–64 years, 8% were 65–70 years, and 2% were over age 70. The multivariate analysis showed that smaller tumor size and fewer positive lymph nodes and high-versus-low doses of chemotherapy were significantly related to longer

relapse-free survival. Age was not. Thus, even though older women in these trials had more advanced disease, they showed similar dose-related benefits in reducing cancer-related relapse from adjuvant chemotherapy to those seen in younger women. Interestingly, in looking at these data, the investigators found that as half of all new breast cancer diagnoses are in the women above age 65, older patients were greatly underrepresented in these, and likely many other, clinical trials. ■

Communication Corner: One Size Doesn't Fit All

In medicine, a well-conceived treatment plan is essential to producing a good outcome. The same is true when it comes to communicating with patients. Successful communicators will tell you that the secret is to have a strategy for communication, the ultimate objective of which is to enable both the physician and the patient to reach a satisfactory level of comfort and mutual respect. This positive dynamic is critical if the therapeutic relationship is to flower.

Effective communication in a clinical setting is not a product of spontaneous combustion. Physicians must not stumble into a consultation without a plan. Prepare in advance to negotiate with the patient an outline of what is to be accomplished during the consult. Both should agree on the agenda and the time frame for discussion, as well as on the goals of the session and the follow-up. Few things are more frustrating for both physicians and patients than the introduction of new issues or concerns just before the consult is over. It is imperative that patients and physicians begin each exchange knowing exactly what is going to happen at the end.

Good Listening Is Crucial

It may seem paradoxical, but in talking with patients, the most important thing a physician can do is listen. (It also can be one of the hardest things a physician can do: research shows that doctors interrupt patients after 18–23 seconds.) Solicit the patient's agenda so you can help her prioritize her concerns and determine together how best to allocate time for discussion. Remember as well that each patient brings a different temperament, worldview and personal history into the doctor's office, and these can shape her perception of health, disease, and treatment options. A patient may find a review of disease staging or treatment options either helpful or overwhelming. In medicine unlike in fashion, one size does not fit all. Listen carefully, and read her body language. If a patient is unable to absorb the presented information or keeps asking questions that go around in circles, be attuned to the dynamic. More information at this time will not be helpful. Save it for a later date and take the time instead to explore her present concerns.

Once again, how you communicate is as important as what you say. Patients

read your body language and speech as carefully as you do theirs. Thus, it helps to look engaged and show enthusiasm. Patients must know that you are interested in knowing them as a person and, if the setting is appropriate, that you are enthusiastic about treatment, for it instills in them a sense of hope and forms the foundation for a solid partnership. To this end, use clear and simple language whenever possible and avoid jargon. The use of written information aids such as brochures, pamphlets, and reviews can be quite helpful in amplifying and clarifying key issues in diagnosis, natural history, prognosis, and treatment, and much good information is readily available from a variety of sources, including the Internet.

Keep to the Structure

Every physician knows there is a well-defined organizational structure shaping the consultative process, a format with a clear beginning, middle, and end. However, most patients are unaware of the rationale for such structural scaffolding and may thus

continued on page 8

Communication Corner: One Size Doesn't Fit All

continued from page 7

wonder why, for example, their surgeon and oncologist ask the same questions. To this end, it may be beneficial to explain how the process of information gathering works in clinical medicine: very specific data must be gleaned for reports that must be filed with the treatment team and the referring physician. Although certain questions may appear to be either unnecessary or redundant, in fact they are not. Each physician needs to flesh out details directly in his/her own manner. Cancer patients are often relieved to peer behind the curtain to learn why consultations flow as they do, that a history must be taken and an examination made before discussion of treatment (usually a patient's primary concern) can begin. Despite what patients might think, there are very

good reasons for going over the same things twice.

Patients also should know that they too have a role to play in making the clinical dialogue flow smoothly. Consulting with a physician also requires some preparation on their part, including the listing of key questions and concerns. This can be easier said than done. Many newly diagnosed breast cancer patients go into overload from the impact of the finding. To help women navigate this emotional tide, physicians should suggest that it might be beneficial to record the consultation or bring along a family member or trusted friend to listen or help take notes. Finally, at the end of each session, patients should ask their physicians to clarify their recommendations, making sure they understand all

of the ramifications. They also should ascertain what the follow-up will be and how to reach the physician.

Good communication is a dynamic two-way street. For the process to work effectively, patients and physicians need to be both flexible and clear about their concerns. By using joint decision making to create a structured plan that will raise and answer essential questions in a predictable manner, patients and physicians can readily meet their objectives while maximizing their use of the dearest of all medical resources — time. ■

Lidia Schapira, MD

*Attending physician at the
Massachusetts General Hospital and
assistant clinical professor of
medicine at Harvard Medical School*

UpDate

Oncology Research and Treatment News

Editorial Advisory Board**George W. Sledge, MD**

Professor of Medicine & Pathology
Ballve-Lantero Professor of Oncology
Indiana University School of Medicine
Indianapolis, IN

Joyce O'Shaughnessy, MD

Co-chair, Breast Cancer Research
Baylor-Sammons Cancer Center
Dallas, TX

Edith A. Perez, MD

Professor of Medicine, Mayo Medical School
Director, Clinical Investigations, and Director
of Breast Cancer Program
Division of Hematology/Oncology
Mayo Clinic
Jacksonville, FL

**Co-founders
Research Advocacy Network****Judy Perotti****Mary Lou Smith****Elda Railey****Research Advocacy Network**

309 East Rand Road
Suite 175
Arlington Heights, IL 60004

