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Add your voice to the community dialogue

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Thrombocytopenia is a familiar problem to most medical oncologists giving chemotherapy, but is it just a numbers game or is it a clinical problem? On page 357, Dr. Douglas Pugmire reports on a retrospective analysis of clinically significant thrombocytopenia in a heavily pretreated gynecologic oncology population. Thirty-six percent of patients in this analysis had thrombocytopenia; 52% of chemotherapeutic cycles were complicated by thrombocytopenia. Dose reductions and delays in chemotherapy and/or the need for platelet transfusions were a significant problem. Dr. Pugmire's analysis found that interleukin-11 (rhIL-11) enhanced thrombopoiesis significantly in patients whose platelet counts were a problem, allowing more frequent adherence to dose intensity and schedule in subsequent cycles for patients trying for cure or significant palliation.

This month, the Community Translations section on page 348 addresses another important issue in gynecologic cancers: Is intraperitoneal chemotherapy with cisplatin the new standard of care in optimally debulked ovarian cancer patients? A clinical alert issued by the National Cancer Institute in January 2006 seemed to suggest that this was the case, but is it? The study by Armstrong et al from GOG 172 demonstrated a significant relapse and overall survival benefit for patients receiving intraperitoneal chemotherapy with a cisplatin-containing regimen compared with an all-IV cisplatin-containing regimen. However, there was significant toxicity in patients receiving IP chemotherapy. Drs. Robert Ozols and Maurie Markman provide us with an interesting point/counterpoint discussion of this study and whether or not it should be applied to optimally debulked ovarian cancer patients in the community setting.

As part of our ongoing series "Implementing Clinical Trials," Dr. Lori Minasian gives a brief and timely update on how to take part in NCI-sponsored trials (see page 393). It's one of our major roles as community oncologists.

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Most patients with breast cancer have no identifiable, genetic predisposition to cancer; their breast cancer appears sporadically. However, women with a strong family history of breast cancer or those identified as carrying the BRCA1 or BRCA2 mutation face a much greater risk of future cancers and this can affect their surgical decisions now. Should they consider prophylactic bilateral mastectomy? The emotional upset of having breast cancer is difficult enough, but it can be compounded by the additional anxiety of considering bilateral mastectomy. But is bilateral mastectomy a full-proof way to prevent future breast cancer? Unfortunately, it is not. As Drs. Kristine Calhoun and Benjamin Anderson write in *Controversies in Patient Management* (see page 379), breast cancer can still recur after prophylactic surgery since it's impossible to remove every breast cancer cell. Their article reviews the data to help assess the risk of future malignancies and the risk reduction of prophylactic bilateral mastectomy. Interestingly, they examine the utility of the Gail model to help predict future breast cancer in high-risk women, pointing out its shortcomings, which fail to consider history of ovarian cancer, paternal breast cancer history, or age of onset.

Who among us doesn't flinch when someone in our practice says, "you need to talk to a lawyer." In this month's Ask Your Lawyer column (see page 375), Lee Doty, Esq., describes the best way to work with legal counsel. For a medical practice to function normally, several fundamentals should be in place, and Ms. Doty outlines five essential ones:

Structure refers to professional incorporation. There are several possibilities with different tax consequences. The S corporation is the simplest



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and most popular.

Employees are something we cannot live without and sometimes have difficulty living with! Managing our personnel is time consuming and sometimes tedious, but an employee manual can reduce a lot of the headaches by providing a template for most every situation an employee in your practice may encounter. Absenteeism and lateness are perhaps the most vexing issues and should always be addressed in this manual.

Revenues are the next most important issue and refer to the income the practice realizes from the patient's insurance payor. While some physicians in certain areas may not have much negotiating power because of a single large payor, legal advice may assist in maximizing the revenues from the payor agreement, especially with such sticky items as timely payment and penalties for tardiness.

Contracts and leases are another important legal matter, which counsel can and should address in advising any practice. The payment you make to rent your office space is the most important here, and details of the rental agreement should always be reviewed by counsel and revisited on a regular basis.

Compliance with the rules of the documentation and legal game is essential. Each of us in practice should have a compliance plan since Federal regulation (remember the Stark Law) requires us to know the law. If your practice is ever audited, the best defense is to have an updated compliance plan ready to go and available for review.

Our Washington Update this month on page 397 highlights a very interesting bill currently before Congress: The Health Insurance Marketplace Modernization and Affordability Act of 2006. Healthcare insurance is currently regulated at the state level, but this bill seeks to put a Federal regulation in place that would require a minimum health insurance set of standards for all states.

On page 389, our Technology column explores a new way of communicating with patients: You spend an hour with a patient and family discussing

a new cancer diagnosis and give your office number and e-mail address for them to contact if further questions arise. A few phone calls follow over the next few days to clarify a few issues and the patient's therapeutic plan is set in motion. But then, your computer lights up as e-mails begin to come in from this same patient, other family members, and even well-meaning friends who suggest other therapies and Web sites you should visit before treatment begins. In our practice, that has not yet become a huge problem, but e-mail is gaining in popularity between clinicians and patients. There is some risk of patients abusing e-mail, and of course, even privacy concerns. Jo Cavallo and John Fried explore these issues.

Finally, I want to point out a thought-provoking piece by Dr. Alva Weir on faith and medicine (see page 372). Religious faith is very important to some patients and may even enter into the exam room as we discuss their concerns. But where do you draw the line? Should a physician go so far as to pray with a patient? Can addressing religious issues make us even more effective healers? Don't miss reading our Practice Survival column this month.

I encourage you to add your voice to *Community Oncology*. For more information on submitting articles, go to www.CommunityOncology.net, where you'll find our Author Guide with a "mission statement" for each section as well as details on submitting manuscripts. We welcome your comments and questions at our Web site where you can also find and search back issues. Make it your own: *Community Oncology* is truly your forum for quality care, practice management, and community research.



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