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## On two fronts in cancer care: politics and treatment

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I've just returned from chairing the second annual Community Oncology Conference, held in Washington, DC. Once again, it was a tremendously successful meeting. All came away with new ideas to help their practices.

We heard in no uncertain terms that today, reimbursement in medical oncology has reached the breaking point. Not only are the full reductions of the Medicare Modernization Act of 2003 reaching fruition—with no prior-year transitional payments or demonstration projects—private payers are beginning to model their payment systems after Medicare. The net effect is to severely limit community oncology practices from delivering the full range of services that define comprehensive, patient-centered care. As anticipated, satellite offices have closed, patients are being redirected to the hospital, and some physicians are considering not accepting new Medicare patients.

But our efforts at grass-roots advocacy are paying off. A new bill, HR 1190, The Community Cancer Care Preservation Act of 2007, was just introduced into the House of Representatives by bipartisan cosponsors Rep. Artur Davis (D-AL) and Rep. Jim Ramstad (R-MN). This bill seeks to address the inequities of the current reimbursement system by fairly adjusting the calculation of average selling price, creating new payment codes for treatment planning, and restoring appropriate payment for cancer drug administration. Help make this bill a legislative reality by contacting your local representatives and asking them to co-sponsor HR 1190.

Another major theme of the meeting was the rich and growing number of options available for patients with breast cancer, lymphoma, kidney cancer, colon cancer, and lung cancer. Over the past few years alone, new agents, including targeted treatments, have led to meaningful improvement in survival in every one of these diseases. This issue of *Community Oncology* focuses on both the benefits

and side effects of some of these new agents.

Our Community Translations section beginning on page 121 presents a summary of the clinical trial evidence supporting the use of panitumumab (Vectibix), a new fully human monoclonal antibody directed against the EGF receptor. In our Nursing Management section on page 157, Judy Hetherington and colleagues put into perspective such targeted drugs, discussing the most common class-specific toxicity—follicular rash. They outline practical approaches for treating this common, bothersome, and at times debilitating side effect.

On page 137, Dr. Priya Vishnubhotla offers an excellent review in Cases in Community Oncology of the latest data for primary therapy in multiple myeloma. A related article in our Adverse Events Alert department addresses toxicities of thalidomide (Thalomid) and lenalidomide (Revlimid; see page 147). As always, Ms. Angelotta and Dr. Charles Bennett bring vital information to our attention.

Don't miss Drs. Policarpo and Henry's comprehensive and cogent analysis on page 129 of the use of epoetin alfa in chemotherapy-induced anemia, a topic of great importance to every medical oncologist. Intriguing, too, is the report by Drs. Curtis and Northfelt on the experience of the Mayo Clinic Arizona in fielding second opinions in hematology/oncology (see page 151). They question the cost-effectiveness of second opinions and their worth to patients, asking: Who really benefits from second opinions? How do we assess patient comprehension and satisfaction? Do outcomes differ from primary providers and larger centers? I think we need a series of health services research studies to answer these questions. Let us know what you think.



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