

# Fostering the Pediatrician-Oncologist Partnership

BY DEEANNA FRANKLIN  
Associate Editor

BALTIMORE — From the outside, pediatric oncology treatment may look like a puzzling maze for patients, their families, and even primary care providers.

“One question that tends to come up is, ‘How exactly is that black box of pediatric oncology organized?’ From the pediatrician’s perspective, often it’s hard to know who are the best people to get in touch with to get the best information,” said Dr. Patrick Brown, of the pediatric oncology department at Johns Hopkins University, Baltimore.



Each patient is assigned a primary team of oncologists who have longitudinal responsibility for the patient’s care. “These providers are your primary point of contact. You should be hearing from either the attending or the fellow while the patient is being treated, and you should know how to get in touch with one or both of these individuals,” he said.

As with all good relationships, communication is a two-way street, and Dr. Brown suggested pediatricians initially try to refer patients to a medical center that can offer a multidisciplinary approach. While it’s not necessary that a center

be a transplant center, he urged physicians “to find a place that’s a member of a clinical trials network for children with cancer. It’s been documented over the years that children with cancer who are treated within the context of clinical trials have better outcomes.”

The pediatrician plays a key role in communicating many of the elements of the diagnosis, prognosis, and treatment plan to the child, parents, and any siblings and—most importantly—offers them emotional support. The pediatrician also provides essential background information on the patient to the oncology team.

Dr. Brown stressed it is the job of the oncologist to “open lines of communication with the pediatrician early and sustain them.

“We recognize the diagnosis of cancer is almost always the unexpected result of a series of rational diagnostic procedures, and that true cases where cues have been missed that cause a delay in diagnosis and negatively impact prognosis are exceedingly rare,” he said. While it often seems to parents that something should have been picked up earlier, “we do everything we can to dissuade them of that notion, because in the vast majority of cases that is not true. I think it’s our job to help the parents understand that and to help you understand that.”

During treatment the oncology team takes responsibility for all medical issues, including primary care issues, but they may ask a pediatrician for assistance with blood work, referrals, and urgent care matters, especially for patients who live far from the cancer treatment center or for patients who are in “lower-intensity phases of therapy or on maintenance therapy,” he noted. In turn, oncologists should update pediatricians on all major events, such as complications or relapses.

After a patient is treated, the pediatrician should be given a comprehensive treatment summary by the oncologist. “It should not be something that’s done over the telephone. This should be a document in your hand that you can refer to and put in your patient’s chart,” said Dr. Brown. This document should contain information on the location of the cancer, its stage, and any relapses. It should include information on chemotherapy and radiation treatments (“you should know where and at what dose”), surgeries and the extent of resection, bone marrow

transplants (autologous or allogeneic), any investigational treatments used, complications, and adverse reactions or allergies.

“It’s very important to know what chemotherapy agents patients have received,” he said.

For example, anthracycline carries a risk for cardiac toxicity, while use of high or low doses of methotrexate or cytarabine should be noted because the particular doses of these agents significantly affect the risk of certain long-term complications.

The oncologist should detail the risk of relapse and the risk of secondary malignancies. Relapse and the timing of relapse are very disease specific. “If a patient comes back to you after having received treatment for Burkitt’s lymphoma and they’re a year out from completion of therapy, the chances are excellent that they’re not going to relapse ... compared with a patient with a low-grade brain tumor, for example, where it is actually relatively common for the duration of remission prior to relapse to be fairly extended,” Dr. Brown said.

The pediatrician should be involved in any major changes in the goals of care, specifically a switch to end-of-life and palliative care, and of course should be immediately notified of a patient’s death. “It’s at that point that I think the pediatrician should be reinvested in a significant way,” he said. This provides further emotional support for the family, reinforces the therapeutic relationship, and assists in psychosocial screening. The pediatrician’s involvement at this stage also is often particularly helpful for surviving siblings. ■

## Ark. Childhood Obesity Prevention Law Reaps Some Benefits

BY MICHELE G. SULLIVAN  
Mid-Atlantic Bureau

SAN FRANCISCO — The first state effort to address childhood obesity through changes in public schools has met with some success, according to researchers who spoke at the annual meeting of the Society of Behavioral Medicine.

Arkansas Act 1220 passed into law in 2003, said James Raczynski, Ph.D. The product of a “remarkable confluence of political, private, and institutional support,” the law requires schools to monitor every student’s weight annually, remove vending machines from elementary schools, and disclose all vending contracts. It also mandates the creation of state and local advisory committees to examine nutrition and physical activity programs in schools and to advise legislators on future childhood health policies.

Concerns about the number of obese and overweight children in Arkansas spurred legislators,

physicians, and communities to work together on the law, said Dr. Raczynski of the University of Arkansas, Little Rock: 36% of children in the state are either overweight or at risk for being overweight.

Initially, he said, public support for every aspect of the legislation was very high. Concerns arose during the first year, however. “The biggest issue was parental worry about the annual body mass index [BMI] measurement,” he said. “Parents feared that having their child identified as overweight or at risk would stigmatize the child.”

Although spearheaded by a small group of vocal parents, the debate became heated and garnered lots of publicity, he said.

Physicians also expressed concern. The law requires schools to send home letters about the annual BMI measurement; parents whose children were identified as overweight or at risk are advised to take the letter and the child to a physician. “We heard from some physicians that they were concerned they’d be over-

whelmed with visits from worried parents,” Dr. Raczynski said.

He and his colleagues presented information from a 1-year evaluation of the law, which included interviews with parents, children, and physicians and visits to schools. Baseline data from spring 2004—when the law went into effect—were compared with data collected during 2005.

The annual BMI measurements appear to be having a positive impact on parents, said Delia West, Ph.D. After the school BMI screening, parents were significantly better at accurately identifying whether their child was overweight, said Dr. West of the University of Arkansas.

The baseline survey asked parents of children in kindergarten through grade 10 to assess their child’s weight status. The follow-up survey asked the same after the child had brought an annual BMI report from school. Before the BMI screen, only 40% of parents accurately identified their child as

overweight or at risk of becoming overweight. After the screen, that number increased to 50%.

Black parents and parents of children younger than 12 years were most likely to improve. Before the screen, only 35% of parents with young overweight children correctly identified their

**The law requires schools to monitor every student’s weight annually, remove vending machines from elementary schools, and disclose all vending.**

weight status. After the screen, that number rose to 65%. Black parents also improved their identification of overweight children, increasing from 30% correct before the BMI screen to 44% correct after the screen.

The change is important because family identification of weight problems can be the foundation of behavior change, Dr. West said. “Parents who identify their child as overweight may be more likely to institute or support

appropriate health behaviors.”

The parental concern of an increase in stigmatization of overweight children was not an issue, said Nadia Siddiqui of the University of Arkansas. Data from the baseline and 1-year follow-up surveys found no increase in weight-based teasing among any age group after the annual BMI measurement was instituted.

Physicians’ concerns about being overwhelmed with unnecessarily worried parents were unfounded as well, said Jada Walker, also of the university. More than half of the 481 physicians surveyed (57%) reported that at least one family had brought in a BMI report to discuss. “They were not as overwhelmed as some had feared, and they also reported being very supportive of the legislation,” Ms. Walker said.

However, added Dr. Raczynski, it is somewhat worrisome that only 57% of physicians had dealt with a BMI concern prompted by the act. “We’d like to see more letters going to physicians.” ■