

# Reconciling patient access to care

Sadly, the long hot summer is winding down, although the hurricane season continues for yet a few more months. Thoughts of Labor Day and back to school are now firmly in mind. This month, we have several original contributions that directly or indirectly speak to patients of any socio-economic background and their access to health care. One of the major features of the Patient Protection and Affordable Care Act is its potential to insure some of the estimated 35 million Americans who are currently uninsured, without regard to whether or not they have pre-existing conditions. Of course, that will stress our already overburdened health system to provide both care and caregivers. To that end, Renteria and colleagues describe on page 220 the access to care and treatment of locally advanced pancreatic cancer in a socio-economically challenged population. Their analyses reveal that it can be done but it requires, in their words, “intense supportive services,” which highlights how those with poor or little insurance can still have the outcomes similar to those in clinical trials if the system rises to the occasion and makes the extra effort to deliver the appropriate care and treatment. One can only imagine what things will be like when those 35 million have guaranteed insurance-based access to care.

In a similar theme, Cohen and colleagues report on a pilot study of improving access to cancer genetic counseling services. Their “collaborative” approach might help even those centers without board-certified genetic counselors provide appropriate counseling to patients who have had or would like to have genetic testing. Again, this could not be more timely. Increasingly, patients are finding laboratories popping up here and there that offer genetic testing with little explanation or discussion of how to interpret those results. Even the patient’s caregiver, who might have ordered the test or might offer help interpreting the results of these genetic tests, likely has little formal training on how to do educate the patient and interpret the results, which could mean

that the patient ends up being misled and/or misinformed about the implications of the results. Again, imagine the stress on the system if 35 million more potential patients clamor for access to testing and test result interpretation.

Bone metastases are a frequent problem for our patients with advanced cancer. Interestingly, half of the patients who have bony metastases may have no symptoms from them yet they may have skeletal-related events from those asymptomatic metastases. This has led to several national guidelines recommending a bone active agent be given to patients whenever bone metastases are detected to decrease the incidence of the SREs. On page 235, William Gradishar and colleagues review one of the newer agents available to treat and help prevent SREs in patients with solid tumor bony metastases. The bisphosphonates have long been available for this indication and also have value for such patients. Beyond this review of denosumab is the interesting prospect that either or both of these agents might help prevent bony metastases, or even nonbony metastases (see the recent reports of the AZURE trial with zoledronic acid), in patients who do not yet have them. Truly, an interesting concept with ongoing research to help sort this out.



A handwritten signature in black ink, appearing to read "D. H. Henry". The signature is fluid and cursive.

David H. Henry, MD, FACP



To listen to Dr. Henry’s podcast on compensation for community-based oncologists, nab-paclitaxel as a first-line therapy for advanced non-small-cell lung cancer, and continuous imatinib therapy for GIST, scan the accompanying QR code or visit the COMMUNITY ONCOLOGY site at <http://www.oncologypractice.com/communityoncology/home.html> and click on the “Podcast” tab.