What Is Proper Cancer Care in the Era of Managed Care?

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The excellent article by Monaco and Goldschmidt summarizes potential pitfalls that must be confronted and avoided as we balance the cost and allocation of health-care resources with the state-of-the-art cancer care that we as a society have come to expect. As a clinician and researcher who is devoting most of my professional efforts to prostate cancer, I would like to put Monaco and Goldschmidt's article in the context of the most common cancer now affecting American men.[1] Although these are my personal opinions, they are based on a number of recent practice guidelines, as will be noted.

Early Diagnosis of Prostate Cancer
I believe that managed-care organizations should provide services for the early diagnosis of prostate cancer. The American Urological Association (AUA), American College of Radiology, and American Cancer Society all recommend an annual prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) for men starting at age 50.[2,3] For men with a family history and African-American males, who are at higher risk, testing should start at age 40.[4]

Because no study has yet proven that these early detection strategies improve prostate cancer-specific mortality,[5] some managed-care organizations have refused to pay for PSA testing when used for screening. With studies now showing that cancers detected by screening are more often organ-confined[6] and that the prostate cancer death rate has decreased in the PSA era (1991 to 1995),[7] in my opinion there are fewer arguments for refusing coverage. Furthermore, studies by our group[8,9] and others[10] show a tumor size, stage, and survival disparity for African-American men. Thus, even if managed-care organizations feel justified in rejecting coverage for detection services for the majority of men, I feel that they should cover testing for high-risk groups.

Managed-care systems also should be encouraged to further our knowledge in this area. Through their systems, they could prospectively assess the costs and benefits of screening and study various fine-tuning strategies for PSA testing, such as age- and race-specific reference ranges,[4] the value of longitudinal testing,[11] and new free/complexed PSA assays.[12]

Treatment of End-Stage Prostate Cancer

Both the AUA[13] and the National Comprehensive Cancer Network (NCCN)[14] have published guidelines for the management of prostate cancer. These guidelines are obviously works-in-progress, as new research data will serve to modify the recommendations over time. At present, all authorities seem to agree that radical prostatectomy and external-beam radiation therapy are the accepted treatment options for carefully selected men with localized prostate cancer and a life expectancy of 10 years or more. In addition, expectant or watchful-waiting is an accepted option for men with low-grade, low-stage tumors who have a limited anticipated life expectancy due to other diseases. Treatment options for localized disease that are more controversial include prostate seed radiation (brachytherapy) and cryotherapy (percutaneous freezing of the prostate).[15] Because 15 years may be needed to assess reliable prostate cancer outcomes data with the new treatments, practitioners are faced with a dilemma with respect to these options. While the newer modalities may provide potentially curative treatment with less expense and lower morbidity, studies on their long-term efficacy are not yet available.

Although patient advocacy groups and many providers have been enthusiastic supporters of the newer therapies, many managed-care organizations have refused coverage because they consider
these treatments unproven and therefore experimental or investigational. While the AUA guidelines suggest that brachytherapy may be considered a standard option for localized disease,[13] the NCCN guidelines still consider it investigational.[14] Regarding cryotherapy, the NCCN deems it experimental and the AUA recently (August 1996) revised its policy statement as follows: Cryosurgical treatment of the prostate is one of the methods of management of adenocarcinoma of the prostate. The long-term curative efficacy of this treatment modality has not been established. When used, appropriate disclosure of facts regarding all other treatments for prostate cancer should be made to the patient.

I am keeping an open mind about these newer treatments for localized prostate cancer. For the patient's sake, I hope that they are effective over the long term, and I include these treatments when I counsel my patients about their options. On the other hand, I can honestly empathize with the managed-care organizations that refuse to cover these procedures because of sparse long-term outcomes data. Certainly, as part of a well-designed institutional review board clinical trial to further test these therapies, managed-care coverage has an opportunity to advance our knowledge of localized prostate cancer.

Management of Advanced Prostate Cancer
Advanced prostate cancer includes locally advanced disease (traditional stage C or T3) and metastatic disease (traditional D1 or any T, N1, M0 [lymph node metastases] and D2 or any T, any N, M1 [distant metastases]). The mainstay of treatment for advanced disease has been and continues to be hormonal therapy, or treatment to lower testicular and/or adrenal androgens. Also, a short course of hormonal medications given prior to definitive local radiation for stage C prostate cancer, called neoadjuvant hormonal therapy, has been proven effective in intermediate (5-year) follow-up and is becoming a more standard treatment.[16]

Hormonal therapy for metastatic disease is standard, but the method of hormonal therapy may become more controversial under managed care. Two options are available for hormonal therapy: orchiectomy (castration) or injections of luteinizing hormone-releasing hormone (LHRH) agents. Of the two options, orchiectomy is generally the least expensive. Despite the higher cost of monthly or quarterly injections of LHRH agents, most patients, when given a choice, would rather take injections than have their testicles removed.

In their quest to cut costs, I hope that managed-care organizations do not mandate that prostate cancer survivors undergo orchiectomy. On the other hand, the cost to society of these expensive medications is not trivial. Intermittent hormonal therapy is a new approach that appears promising, which mandates the reversible LHRH agents. This may make the argument between orchiectomy and LHRH agents less relevant.

In addition to testicular androgen suppression, adrenal androgen suppression using oral antiandrogens has been a common practice over the last decade.[17] Some, but not all, randomized trials have shown a survival benefit of antiandrogen therapy, and meta-analysis has shown a modest benefit.[18] Although not as expensive as LHRH injections, antiandrogens do add cost to a managed-care budget. My hope is that antiandrogens and LHRH agents continue to be covered by managed care and that patients and doctors be allowed to choose these treatments if they so desire.

Treatment of Hormone-Refractory Prostate Cancer
Hormone-refractory prostate cancer is frustrating for both patients and providers. We have no "magic bullets," and the final stage of disease may be painful and depressing if not managed properly. Managed care must continue to provide good palliative care for bone pain and late-stage morbidity. Most important, this is the stage for which clinical trials testing new treatments are urgently needed. Managed-care organizations should be encouraged to support such trials, as well as trials of future innovative therapies.

References:


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