

Surviving childhood cancer

Sir,

The improvement in survival rates for children and adolescents with cancer discussed by Dr McDowell (vol 63(9), 2002, p. 520) in part reflects more complex and intensive treatment regimens, but also the impact of the national organization of children's cancer trials. This has informed individual therapy. Children have been treated as part of national clinical trials since the launch of the UK Children's Cancer Study Group 50 years ago. Both cancer therapy and supportive care have thus moved forward, increasing survival figures. Continuing national and international collaboration should further this survival advantage and minimize late complications by refining therapy where possible.

Interest is now focused on health outcomes for survivors and well-designed studies must address these issues to inform future treatment strategies and guide appropriate surveillance in long-term follow-up clinics. The Childhood Cancer Survivor Study in North America covers over 20 000 childhood and adolescent cancer survivors to assess both long-term physical and psychosocial morbidity (Robison et al, 2002). A diverse range of sequelae are observed, with endocrine dysfunction being the most common complication reported by Sklar (1999). Infertility and growth hormone insufficiency are examples that lead to significant morbidity, requiring continuing health professional support into adult life.

Perhaps it is more important to ask how survivorship impacts on quality of life in this cohort. Although many childhood cancer survivors demonstrate remarkable resilience as they make the transition to adult life, those with ongoing health problems seem to have the most significant psychological and social difficulties (Zebrack and Chesler, 2002). As the challenges for this population evolve, health professionals must support and inform these potentially vulnerable young adults. The balance between survivorship and

quality of life also needs to be continually addressed as advanced technology informs future clinical trials.

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Robison LL, Mertens AC, Boice JD et al (2002) Study design and cohort characteristics of the Childhood Cancer Survivor Study: a multi-institutional collaborative project. *Med Pediatr Oncol* **38**(4): 229–39

Sklar CA (1999) Overview of the effects of cancer therapies: the nature, scale and breadth of the problem. *Acta Paediatr Suppl* **88**(433): 1–4

Zebrack BJ, Chesler MA (2002) Quality of life in childhood cancer survivors. *Psychooncology* **11**(2): 132–41

Sir,

The improved survival rates for many childhood cancers has resulted in a steady and sustained increase in the number of patients attending for follow-up. Currently these patients are not routinely discharged because there is a need to identify late effects of therapy and, if possible, to intervene and improve the physical or psychological outcome for each individual.

But who should do this? Are we perpetuating 'illness' by bringing them back to the oncology centre indefinitely? Different strategies are being explored and whether review in the primary care setting, continued telephone contact, nurse-led clinics or a new subspecialty clinic would be the way forward needs formal evaluation. Such decisions are being helped by two largely epidemiological studies of survivors of childhood cancer. The Childhood Cancer Survivor Study in the United States identified over 20 000 patients. Questionnaires were sent to the survivors obtaining important information relating to their mental health status and the physical and emotional impact of treatment for childhood cancer. A similar population-based study is currently underway in the UK. Better understanding of the risks these survivors face is vital to establish the areas of greatest need.

However, survival rates have improved because of a better understanding of the disease process and significant changes in the multidisciplinary approach to therapy. For example radiotherapy has been removed from many treatment regimens as it has a profound impact on the

growth of bone and soft tissues and on the brain, particularly in younger children. Intensive chemotherapeutic regimens have therefore been used in some settings. The long-term impact of some of these regimens is not yet known, as the survivors have not reached puberty or been followed for long enough.

The continued evaluation of children currently receiving treatment and an understanding of their views of their quality of life in the long term will remain important over future decades.

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Sir,

Dr McDowell has highlighted many important aspects of this growing area of paediatric oncology. The estimate of 1 in 900 people in the USA, aged between 15 and 44 years, being a survivor of childhood cancer, was made in the early 1990s and is probably a conservative figure. Most of this population need ongoing surveillance, and the late sequelae of intense treatment regimens cannot be ignored when the child outgrows the paediatric model.

In childhood, the paediatric oncologist coordinates follow up and relevant investigations. However, as the patient becomes an adult, where, how often and by whom should they be seen for follow up? They may need access to different adult specialities, and, for example, review in a cardiology clinic will not cover endocrine problems and vice versa. Which clinic will coordinate the overall care of these patients? Many patients only need a routine review on a 1-, 2- or even 5-yearly basis. However, specific clinicians must be trained to deal with all late effects of cancer therapy in childhood and adolescence within an adult setting and oversee the follow up of these patients.

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