

Reflections on the follow-up of long-term cancer survivors in Spain



Reflexiones sobre el seguimiento de largos supervivientes de cáncer en España

Dear editor:

We read with great interest the article titled *Health status and health resource use among long-term survivors of breast, colorectal and prostate cancer*, published in a recent issue of *Gaceta Sanitaria*¹. We would like to highlight the analogy of their results to those of our experience in long-term survivors of breast cancer². Although ours is a more limited survey, we detected similar morbidities, comparable treatment-related sequelae, good quality of life having equivalent scores in both studies, and high satisfaction with both care levels. Furthermore, our study shows that survivors do not perceive follow-up in primary care as a problem.

Regarding the use of health resources, our study compared the follow-up of long-term survivors of breast cancer in the hospital or in primary care. However, similarities in this matter can also be found between both studies. Despite the fact that survivors continued hospital reviews, in the Ferro *et al.* study, they visited the general practitioner for care of cancer-related morbidity. We would want to emphasize that when analyzing the use of health care resources, it is found that cancer patients need many requirements in the first level of care regardless of their clinical condition (on active treatment or survivors)³.

Catalonian study analyzes the use of health care services, the type of current medication, and complementary therapies. Using this information, an approximation of measurement and analysis of costs could have been conducted. The redundant and inadequate follow-up of cancer survivors creates a problem of health care resources, quality of care, and results in unnecessary costs to the health system.

Now it is not time to look for a model to deal with the growing snowball of the cancer survivors. It is time for action and in Spain, with an adequately developed level of primary care, it seems logical for the primary care doctor to be responsible for the routine follow-up of patients who have been treated for cancer but always with the option of renewing hospital care when and if necessary. To achieve this, channels of rapid communication without barriers between levels of care, should be set up. Although as in many aspects of cancer survivors care, scientific evidence is still too insufficient, the development of survivorship care plans⁴ should become the norm. We disagree to establish differences in the follow-up intensity, type or place depending on the risk of relapse. Common

solid tumors in adult such as breast, prostate or lung will not get a clear benefit of early diagnosis of metastatic disease. Palliative treatment of metastatic disease in asymptomatic phase is not the goal. Results are not improved with intensified diagnostic procedures or focusing the follow-up in the hospital rather than in primary care. Proceeding in this way is source of overdiagnosis and overtreatment. Probably in the case of colorectal cancer, the survivorship care plan should include screening for early metastatic disease, or new primary colorectal cancer, or precancerous lesions, because curative treatment is possible. However, this should not exclude the role of primary care in the follow-up, in coordination with hospital care.

Authors' contributions

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Conflicts of interests

None.

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