

RESEARCH HIGHLIGHTS

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Breast Cancer Treatment Outcome Is Unaffected by Marital Status

During the October 2005 annual meeting of the American Society for Therapeutic Radiology and Oncology held in Denver, CO, researchers reported that marital status had no significant effect on relapse-free survival. Results were reported from a study involving 2,143 women with early-stage breast cancer treated with lumpectomy and radiation from 1984–2003. The women were divided into one of four groups reflecting their marital status: married (63%), single (10%), divorced (10%), and widowed (18%). Age, rather than marital status, was found to have a significant effect on relapse-free survival. Women aged 40–70 had better survival rates. Physical and biochemical status were important, whereas social status was not found to be a significant factor. Women with HER2-positive sensitivity have worse prognoses and may benefit from more aggressive treatment strategies, such as tamoxifen.

Hayes, S., Freedman, G.M., Li, T., Ross, E., Anderson, P., & Andre, K. (2005). An analysis of outcome based on marital status in early stage breast cancer patients undergoing breast conservation therapy. *International Journal of Radiation Oncology, Biology, Physics*, 63(Suppl. 1), S433–S434.

Single Men With Metastatic Prostate Cancer Are Not Likely to Seek Retreatment

The Radiation Therapy Oncology Group at Fox Chase Cancer Center in Philadelphia, PA, found that single men with metastatic prostate cancer were less likely to receive retreatment with radiation therapy for bone pain than their married counterparts. In an attempt to evaluate outcomes based on marital status, data were analyzed from men and women with symptomatic bone metastasis resulting from either prostate or breast cancer. Patients were randomly selected to receive either 10 radiation treatments of 30 Gy each or a single dose of 8 Gy. Researchers reported that women lived longer than men (11.8 months versus 7.8 months) regardless of the treatment protocol. Married men, and

all women in the study who received 8 Gy, sought retreatment more readily than single men. All patients who received 10 treatments of 30 Gy were significantly less likely to return for retreatment. A tendency for single men not to receive retreatment also was realized. Researchers perceived the difference in retreatment rates likely resulted from single men having less social support. Developing strategies such as nurse follow-up and patient navigators to help them through the health-care system was recommended. Knowing that single male patients are unlikely to return, the investigators also recommended that a more aggressive first treatment be given.

Konski, A.A., DeSilvio, M., Hartsell, W., Watkins-Bruner, D., Coyne, J., Scarantino, C., et al. (2005). Continuing evidence for poorer treatment outcomes for single male patients: Re-treatment data from RTOG 97-14. *International Journal of Radiation Oncology, Biology, Physics*, 63(Suppl. 1), S192.

Colonoscopy Often Is Inaccurate in Localizing Colorectal Cancer

According to a report in the October issue of the *Archives of Surgery*, colonoscopy is very sensitive in detecting colorectal cancer but often fails to correctly localize the malignancy. The sensitivity of the colonoscopy procedure in detecting colon cancer is reported to be 85%–95%, but the accuracy in localizing tumors is unclear. Researchers reported that precise tumor localization is important for preoperative planning. Researchers investigated the accuracy of localizing tumors by analyzing data from 314 patients having surgical resection for colorectal cancer from 2000–2003. The location of the tumor was identified incorrectly in 49 (21%) of the patients. In 27 cases, a different operation from the one initially planned was needed. An alternative to the surgical approach was required in 10 additional cases.

The researchers determined that having a previous colorectal procedure increased the odds of inaccurate localization more than fourfold. The study also showed that the accuracy rate for localization was higher if the colonoscopy was performed by a surgeon

rather than another physician. The data suggest that surgery may be unnecessarily prolonged, excessive amounts of bowel may be resected, trocars may be placed inappropriately, or the lesion may be missed altogether if colonoscopy is the only method used for tumor localization.

Piscatelli, N., Hyman, N., & Osler, T. (2005). Localizing colorectal cancer by colonoscopy. *Archives of Surgery*, 140, 932–935.

Recurrence Rate Is Not Increased by Delaying Surgery Following Prostate Biopsy

To allow postbiopsy inflammation to resolve, surgeons generally wait at least two months after a prostate biopsy before performing surgery. Investigators tested the safety of the practice by examining nearly 4,000 consecutive patients who had a radical prostatectomy within one year following the diagnosis of prostate cancer. The time between biopsy and prostatectomy did not predict biochemical recurrence when evaluated by multivariate analysis, as either a continuous variable or a dichotomous variable divided at three months. To further evaluate, researchers performed additional reviews using patients considered at high risk for biochemical recurrence. For those reviews as well, researchers determined that the time between biopsy and radical prostatectomy did not predict biochemical recurrence after surgery. The researchers reported that most men do not delay surgery longer than six months if they are considering immediate treatment, but some men opt for active surveillance and delay treatment for months or years. Studies continue to follow these patients to determine whether their decision to wait influences their outcomes.

The importance of taking the time to obtain the information needed to make a well-informed decision about what patients need

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