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Comment

Radiation oncology should be a partner to medical oncology in end-of-life care

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The end-of-life management of cancer patients has traditionally been managed almost exclusively by Medical Oncology; however, Radiation Oncology has begun to take a more active role in the past decade. A recent study examining the Medical Oncology perspective on the role of Radiation Oncologists in end-of-life care provides an interesting perspective on this issue.[1] Unfortunately, previously reported stereotypes of Radiation Oncology interest in patients post-treatment persist in this analysis, including the questionable narrative that Radiation Oncologists subject terminally ill patients to unnecessary treatments.[1–3]

While lacking the systemic therapy knowledge of our Medical Oncology colleagues, Radiation Oncologists have unique expertise in diagnostic imaging and clinical evaluation of symptoms associated with anatomically-based lesions. Furthermore, as a procedure-based specialty, Radiation Oncologists share with our Surgical Oncology colleagues the responsibility accompanying the short and long-term consequences of our therapeutic interventions; such responsibility goes far beyond being mere technicians. In centers with multidisciplinary tumor boards/clinics where Radiation Oncology, Surgical Oncology, and Medical Oncology work collaboratively to optimize patient care, the role of the Radiation Oncologist as a clinician in the first place and as a deliverer of radiation therapy (RT) in the second place becomes obvious.

Several centers have a multi-year track record of intimately involving Radiation Oncology with hospitalized cancer patient care in the palliative setting, with follow-up protocols facilitating expedient RT for symptomatic metastatic disease.[4–6] In the outpatient setting, programs such as PRADO (Palliative Radiation Oncology) allow for rapid evaluation of new-onset symptoms with advanced imaging, allowing for timely and expedient palliative RT initiation,[6] but also provide a balanced continuity of care for these patients, as metastatic disease by definition implies multi-focal progression and thoughtful re-evaluation and re-treatment is paramount to maintaining quality of life at the end of life. Furthermore, dramatic improvements in systemic therapy have resulted in patients living longer and thus needing more durable control of their symptomatic lesions and greater attention paid to potential long-term side-effects. The alternative for these patients, in the absence of palliative RT, is additional narcotic pain medication, which is less efficacious and far more addictive than RT.

As Gross et al. note, there is already evidence of existing Medical Oncology support for increased Radiation Oncology role in end-of-life care for patients with malignancies of the central nervous system, head and neck, and prostate.[1] It would behoove Radiation Oncology as a specialty to build on this support to become more involved in end-of-life care, optimally in a multidisciplinary fashion.[7] Radiation oncologists with their unique sets of clinical skills and highly effective palliative treatment modality are poised to become the leaders of palliative care for oncology patients in a not so distant future, as long as there is desire and appropriate training.

Furthermore, we would argue that just as death with dignity decisions allowed in some states require patient communication with several physicians (in Oregon, at least three separate physicians), end-of-life care and decision-making should be optimally made in a multidisciplinary setting with several physicians – certainly the Medical Oncologist's expertise in systemic therapy options, as well as the Radiation Oncologist's guidance regarding the feasibility of controlling symptoms and/or disease progression (this is particularly pertinent given the recent reports of radiation therapy improving survival in the oligometastatic setting).[8,9] We would argue that a third important component of this process should be a spiritual care provider who can provide an important insight into the patient's goals at the end of life; such goals can differ dramatically between patients and may not be adequately appreciated by clinicians.

Author contribution

Study concept and design: McClelland.

Acquisition, analysis, or interpretation of data: McClelland, Mitin.

Drafting of the manuscript: McClelland.

Critical revision of the manuscript for important intellectual content: McClelland, Mitin.

Administrative, technical, or material support: McClelland, Mitin.

Study supervision: McClelland, Mitin.

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Conflict of interest

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