MORE THAN HALF OF CANCER PATIENTS DIE IN HOSPITALS DESPITE SURVEY RESULTS INDICATING A WISH TO DIE AT HOME

By A. Robert Kagan, MD, FACRO

Note: The views expressed in the following editorial are not necessarily those of the American College of Radiation Oncology.

Ethicists, physicians, and end-of-life philosophers have voiced the opinion time and time again that the best place to end life with dignity, given that support systems are in place, is at home. In fact, two-thirds of surveyed people have stated that they would like to die at home. But fewer than half do, and, by 2013, the proportion is likely to have been reduced to one in ten.

According to the Dartmouth Atlas, a project that studies variations in medical care across the United States, the possibility of dying peacefully at home with loved ones nearby is becoming increasingly remote for patients with terminal cancer.

"On average, patients would much prefer to receive care that allows them the highest quality of life in their last weeks and months and care that allows them whenever possible to be at home and with their families," reported John Goodman, MD, a co-author of the Dartmouth Atlas.

The bottom line: Patients are not getting the care they want. Their wishes are overlooked, and a medical center’s established practice protocols are carried out instead. Physical and emotional stress on the patient increases, and the patient’s family is at higher risk of anxiety and a prolonged period of grief. And, many times, the aggressive care does continue on page 3

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ACRO 22ND ANNUAL MEETING TO BE HELD IN FORT MYERS, FLORIDA

ACRO 2012, the Annual Meeting of the American College of Radiation Oncology, will be held from Thursday, February 23, to Saturday, February 25, at the Sanibel Harbour Marriott Resort on Florida’s Gulf Coast near Fort Myers.

Conference highlights will include clinically oriented sessions providing the radiation oncologist with up-to-date management for their patients. Concentrated sessions will focus on breast, lower gastrointestinal, and prostate cancers. In addition, featured speakers, a pre-conference workshop on contouring, a Women in Radiation Oncology forum, a resident-focused symposium, oral-paper and poster sessions, and a 55-booth scientific exhibition will make up the three-day program.

Come enjoy the Florida sunshine and attend a meeting dedicated to your professional and economic success in radiation oncology. Highlights of the ACRO Annual Meeting program can be found on page 9 of this issue of the ACRO Bulletin.

Sincerely,

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Please note: To obtain a room at the Sanibel Harbour Resort at the discounted rate of $209 per night, please go to http://acro.org/Events-Education/travel.cfm. Also, the Southwestern Florida International Airport is 20 miles from the resort. ACRO has arranged a rental-car deal with Hertz. Rental-car booking can also be done through this website.
not prolong life. Therefore, it is not surprising that a study funded by the Robert Wood Johnson Foundation found that many patients would prefer conservative end-of-life care.

The report goes on to suggest an absence of planning when it comes to dealing with fatal cancer. But the chances of patients spending final days at home can vary widely from region to region. Manhattan has the most cancer deaths in the hospital (46.7%) while Mason City, Iowa, has the least (7%).

Treatment Should Respect Patient Desires

The American Society of Clinical Oncology (ASCO) supports hospice care for dying cancer patients, which can ease pain and allow patients to spend their last days at home. But, notes Douglas Blayney, MD, the immediate past president of the ASCO, many patients resist admitting that no cure is possible, and cancer specialists have never been good at telling patients directly that they will die soon.

Nevertheless, research has shown that patients live a little longer on average if lifesaving measures are discontinued and medication is given only for pain relief.

Dr Blayney suggests that oncologists re-focus their care for the dying. Physicians should not take a defeatist attitude and conclude that nothing can be done. Instead, treatment should reflect respect for patient wishes, which may mean alleviating symptoms and making the patient as comfortable as possible during the final days.

Dr Kagan is the Editor of the ACRO Bulletin and past-president of ACRO. Reactions or responses to this article can be sent to Dr Kagan at the Department of Radiation Oncology; Kaiser Permanente Medical Group; 4950 Sunset Blvd; Los Angeles, CA 90027.

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Economics Resources Available for Download

The ACRO Economics Committee has prepared and published the following documents as a membership benefit. To access these documents, go to the ACRO website (acro.org) and click on the following links:

- Applying for eRx Hardship Exemption
- Maintenance of Certification
- Medicare Denial of Claims Because of Edits

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ACRO Bulletin

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Under this proposal, physicians would have been required to obtain approval from radiology benefit managers (RBMs) before ordering certain imaging services. However, evidence is unclear whether RBMs significantly reduce unnecessary utilization of imaging services. Private plans that employ RBMs have reported drops in use of imaging services immediately after implementing a prior authorization approach but increases in use as physicians adapt to the new approval procedures. In many cases, the growth of spending returned to its previous pace.

MedPAC has recommended a limited prior authorization program for practitioners who order substantially more imaging services than their peers. This proposal was included in Representative Cantor’s slides on debt-ceiling and deficit-reduction options. Medicare has never used prior authorization with respect to physician services, so instituting this policy would have been an unprecedented departure from current practice for physicians and beneficiaries alike. An argument for prior authorization is that there has been a steady and significant increase in imaging services and reduction in use of advanced imaging services that are of little or no clinical benefit would lower Medicare’s expenditures and shield beneficiaries from unnecessary imaging services. MedPAC has recommended a limited prior authorization program for practitioners who order substantially more imaging services than their peers.

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CMTP Releases CER Summit Final Report

On September 13, 2011, the Center for Medical Technology Policy issued its “2010 National Leadership Summit on CER Priorities, Methods, and Policy: Building a Strategic Framework for Comparative Effectiveness Research in Oncology” final report. The report highlights six key findings:

• CER studies in oncology are urgently needed.

• CER should fully engage patients and the general public.

• CER requires the development of new research methods. Of note, the report states: “The traditional RCT can be an inefficient and costly way to address research questions, but other study designs require us to navigate complex tradeoffs between the level of certainty and the usefulness of the resulting evidence for real-world decision-making. Registry studies, pragmatic clinical trials, and simpler variations of randomized trials offer alternatives that, when enhanced with innovative methodologies, can yield reasonably robust, clinically applicable results.”

• Genomics and personalized medicine must be central to all CER studies in oncology.

• CER results must be translated into clinical practice. According to the report, “The generation of reliable data requires the enrollment of patients from community settings who are representative of real-world clinical populations, as the vast majority of patients receive care there. Gathering data in community settings is challenging due to wide variations in practice patterns, limited systematic data collection, and a lack of financial incentives for community-based clinicians to participate in research.” The report further notes that “CER translation depends upon infrastructure development. Realignment of payment incentives would support the development of the information-technology (IT) infrastructure. Similarly, the development of methodological and data standards would provide a coordinated framework for data acquisition. The IT infrastructure must accommodate patient-reported outcomes as these data are increasingly recognized as a central feature of CER. Feedback loops that connect researchers, guideline panels, and practitioners must be “hard-wired” through IT pathways to ensure that information flows bi-directionally to support formulation of clinically important research questions, hypothesis generation, study conduct, translation of results, and evaluation of impact. This is the starting point for the development of rapid learning systems in oncology.”

• The CER enterprise must address cost and value. Of interest to health-policy observers, the report states, “While Congress limited consideration of cost and value in ARRA and PPACA, they will eventually demand attention.”

MedPAC Discusses Permanent SGR Fix

On September 15, 2011, MedPAC heard four draft recommendations to permanently move away from the current SGR system. In his opening statement, Chairman Glenn Hackbart conveyed the commission’s growing sense of urgency to repeal the SGR due to the ever-growing cost of fixing the SGR. Chairman Hackbart asked staff to keep the following principles in mind when developing recommendations:

• Sever the formulaic link between physician fees and Medicare expenditures;

• Preserve access to care;

• Encourage participation by physicians in new payment methods (i.e., ACOs, bundling);

• Accelerate revaluation of services within the physician fee schedule; and

• Achieve budget neutrality.

continues on page 6
Using the above principles, the staff presented the commission with the following draft recommendations to permanently dissolve the SGR:

- **Draft Recommendation 1:** Congress should repeal the SGR system and replace it with a ten-year plan. The plan would freeze the current payment levels for primary-care doctors and include an annual payment reduction of 5.9% for all non-primary-care doctors for the first three years, followed by a freeze.

- **Draft Recommendation 2:** Congress should direct the secretary to regularly collect data, including service volume and work time to establish more accurate work and practice expense values.

- **Draft Recommendation 3:** Congress should direct the secretary to use data specified in Draft Recommendation 2 to identify overpriced fee schedule services and reduce their RVUs accordingly.

- **Draft Recommendation 4:** Under the ten-year update path in Draft Recommendation 1, the secretary should increase the shared savings opportunity for physicians and health professionals who join or lead ACOs with a two-sided risk model.

The Congressional Budget Office estimates the cost to repeal the SGR and replace it with a ten-year freeze to be about $300 billion. The three-year cut to specialists, in addition to the freeze, is expected to reduce the cost of the repeal from $300 billion to approximately $200–$230 billion. On September 15, MedPAC released a list of proposals that could possibly offset the overhaul of the SGR.

The US Oncology Network is one of America’s largest networks of community-based oncologists. Radiation oncologists affiliated with the US Oncology Radiation Research program were ranked #1 globally in patient accruals to RTOG clinical trials in 2010.

**President’s Economic Growth and Deficit Reduction Plan**

On September 19, 2011, President Obama released his *Plan for Economic Growth and Deficit Reduction*. Among the proposals included in the package are a $298 billion proposal to “prevent reduction in Medicare physician payments” and a $2.1 billion savings proposal to “end add-on payments for hospitals and physicians in frontier states.” Also included are proposals to “cut waste, fraud, and improper payments in Medicare,” including the following:

- **Update Medicare payments to more appropriately account for utilization of advanced imaging.** Medicare spending for imaging services paid for under the physician fee schedule has grown dramatically in recent years due to an increase in the number and intensity of these services. MedPAC has stated that this volume growth may signal that these services are mispriced and have supported Medicare payment changes for expensive imaging equipment. Beginning in 2013, this proposal implements a payment adjustment for advanced imaging equipment to account for higher levels of utilization of certain types of equipment. This proposal will save approximately $400 million over ten years.

- **Require prior authorization for advanced imaging.** The rapid growth in the number and intensity of imaging services in recent years raises concerns about whether these services are being used appropriately. This proposal would adopt prior authorization for the most expensive imaging services, beginning in 2013, to ensure that these services are used as intended and protect the Medicare program and its beneficiaries from unwarranted use. This is consistent with practices by private health insurance to manage spending growth and a GAO recommendation to consider prior authorization and other approaches to address rapid spending growth on these services. This proposal will save approximately $900 million over ten years.
IOM Releases Second Edition of Geographic Adjustments Report

The IOM has been tasked with making recommendations to improve the accuracy of the data sources and methods used in making geographic adjustments. On September 28, the IOM released the second edition of the phase I report and included the recommendations made in the first edition, plus the following four recommendations:

- **GPCI cost share weights for adjusting fee-for-service payments to practitioners should continue to be national, including the three GPCIs (work, practice expense, and liability insurance) and the categories within the practice expense (office rent and personnel).**

- **Proxies should continue to be used to measure geographic variation in the physician work adjustment, but CMS should determine whether the seven proxies currently in use should be modified.**

- **CMS should consider an alternative method for setting the percentage of the work adjustment based on a systematic empirical process.**

- **Nonclinical labor-related expenses currently included under professional-expense office expenses should be geographically adjusted as part of the wage component of the PE.**

Hearing on Medicare Provider Payment Policies

The House Ways and Means Health Subcommittee held a hearing on Medicare provider payments, set to expire on September 21. In opening remarks, Chairman Wally Herger (R-CA) said that Medicare provider payments that were set to expire should be closely examined and justified before being reauthorized. He continued by saying that it would cost more than $2.5 billion to reauthorize Medicare extenders for a year.

Four out of the five witnesses (including the AMA and the AHA) stated their case for why extenders affecting their practice area should be extended. In his testimony, Robert Wah, MD, the chairman of the Board of Trustees of the AMA, advocated for an extension of the physician work GPCI in a way that did not require budget neutrality. Dr Wah also noted the ongoing work by the IOM on geographic adjustments and stated that a "supplemental report that discusses physician-payment issues further will be issued, along with a report that is expected to be released in 2012." He also noted that "once these reports are complete, they should be a starting point for Congress in examining geographic payment adjustments for physician work and physician expenses." Bruce Steinwald, president of Steinwald Consulting, was the only witness to express skepticism in regard to reauthorizing the Medicare provider payments.

Supreme Court Asked to Review ACA

On September 28, 2011, the Justice Department filed a *writ of certiorari* asking the U.S. Supreme Court to review the constitutionality of the 2010 Affordable Care Act. The Administration is asking the Court to review the 11th Circuit Court ruling, which ruled Congress exceeded its power in passing the law. The Administration's petition completes the conditions generally needed for a Supreme Court review: Decision by a lower court that an act of Congress is unconstitutional, conflicting opinions at the appeals level, and agreement by both parties that the Court needs to settle the dispute. If the Supreme Court agrees to hear the case, a decision would be expected by the end of the Court session in June 2012.
Save the Dates!

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2012

Meet Your Speakers...Discuss your cases...Prepare your entire practice for 2012 and beyond.
The Dr. Luther Brady Lecture
Friday, Feb 24 / 1:45pm
- Present Status and Future Directions of the RTOG and Cooperative Research Efforts
  Dr. Walter Curran, Emory University

Plenary Sessions

Thursday, Feb. 23
8:30am
- Breast
  Dr. Eleftherios Mamounas • Dr. Larry Marks • Dr. Karen Hoffman
1:15pm
- Lower GI Malignancies
  Dr. Chris Willett • Dr. Hope Uronis • Dr. Linda Farkas • Dr. Lisa Kachnic

Friday, Feb. 24
8:15am
- Presidential Symposium on Brachytherapy
  Dr. Jeffrey Demanes • Dr. William Small • Dr. Robert Kuske • Dr. Arve Gillette
2:45pm
- Politics and Economics
  Dr. Sheila Rege • Dr. Arve Gillette • Mr. Andrew Woods

Saturday, Feb. 25
8:15am
- Radiosurgery
  Dr. Peter Gerszten • Dr. Brian Kavanaugh • Dr. Andre Konski
1pm
- Prostate
  Dr. Larry Krestin • Dr. Allan Pollack • Dr. Joe Hsu

Special Sessions

Friday, Feb. 24
2:45pm
- Symposium for Radiation Oncology Residents
  An expanded resident-focused session that will answer important questions to help young physicians make crucial decisions about their futures.

Saturday, Feb. 25
4:15pm
- Malpractice Litigation Workshop
  Don’t Bring a Knife to a Gunfight: Arming Your Attorney to Win the Battle

Accreditation, CME Credits and Disclosure Statements

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Indiana State Medical Association (ISMA) through the joint sponsorship of Community Health Network and American College of Radiation Oncology. Community Health Network is accredited by ISMA to provide continuing medical education for physicians.

Community Health Network designates this live educational activity for a maximum of 22 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

In accordance with the Accreditation Council for Continuing Medical Education (ACME) Standards for Commercial Support, educational programs sponsored by Community Health Network must demonstrate balance, independence, objectivity and scientific rigor. All faculty, authors, editors and planning committee members participating in a Community Health Network sponsored activity are required to disclose any relevant financial interest or other relationship with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services that are discussed in an educational activity.

Community Health Network has implemented a process whereby everyone who is in a position to control the content of an educational activity has disclosed all relevant financial relationships, with any commercial interest. In addition, should it be determined that a conflict of interest exists as a result of a financial relationship it will be resolved prior to the activity.

While offering the CME credit above, this activity is not intended to provide extensive training in the field. ADA accommodations are available upon request.
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For the Annual Meeting check ONE of the boxes in the fee schedule below. For the pre-conference courses select the appropriate box based on your status and course selection. Pre-conference course registration is not included in Annual Meeting registration. Note: Pre-registration closes January 20, 2012. Registration forms received at ACRO after January 20 will be processed as on-site registrations. For more information about the meeting and pre-conference courses, visit acro.org or call (301) 718-6515.


20% Discount on Annual Meeting Fees Only if you Register by Dec. 16, 2011!

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*Proof of status required.

Additional Conference Activities – February 22-25

Workshop on Contouring (Wednesday, 1-5:45pm) Powered by Anatom-e

Registration required

ACRO Member (incl. new member) $150 $175
Non-Member $175 $200
Resident $50 $75

Women in Radiation Oncology Forum (Thursday, 7-8pm)

Registration required

Please check box $0 $0

Symposium for Radiation Oncology Residents (Friday, 2:45-6pm)

Registration required

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Billing & Coding Update Workshop (Wednesday, 1:30-3:30pm)

Registration required

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All current (2011) members can pay 2012 membership dues with this meeting registration. Non-members can join ACRO with this meeting and completion of an application and receive a discount.

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New Member (physician or physicist)  $275
New Associate Member  $155
New Resident Member  $0

*Proof of status required.

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RESIDENT CORNER

ACRO LAUNCHES WEBINAR SERIES IN DECEMBER AND ANNOUNCES RECORD YEAR FOR SCIENTIFIC ABSTRACTS

By Brendan Prendergast, MD

For residents in radiation oncology, there are many professional societies to consider joining—ASTRO, ACRO, ARS, RSNA, and still others—the alphabet soup of organizations can be mind boggling. Professional societies are often too broad to feel inclusive for residents, or on the other hand, appear focused on issues unimportant to residents. Given its smaller size and national footprint, ACRO stands apart from the rest. Although ACRO's mission is to ensure quality radiation-oncology practice through accreditation and political advocacy, ACRO is a useful resource for residents in training.

Though ACRO stretches coast to coast, its home offices are based at the center of healthcare policy in Washington, DC. Residents in radiation oncology understand the importance of advocacy to protect our field, and membership in ACRO is an important way to stay informed on issues facing our field, from self referral to health-insurance reform. ACRO residents are invited to attend a virtual web-based conference in January 2012 to discuss these important issues with Andrew Woods, ACRO's legal counsel, to better understand the challenging issues we face now and how we can become involved in policy discussions for the future.

Perhaps the greatest strength of ACRO is its relatively small, yet content-packed, annual meeting. ACRO's annual meeting is a collegial gathering of leaders in radiation oncology, set in an intimate venue. The unique annual meeting environment is beneficial to residents, as they have the opportunity to approach speakers and panelists in a friendly, often one-on-one environment. Additionally, residents enjoy a half-day seminar focused on resident-specific issues such as jobs, interviewing skills, and making the transition from residency to practice. From a resident perspective, ACRO 2012 looks to be one of the best meetings in the College's history, as an oral presentation session dedicated to resident research has drawn abstracts from across the country.

Although membership is free to residents, the ACRO Resident Committee is working hard to add value to membership. New services include an interactive calendar of national resident events as well as a planned textbook discount program. Future projects include the development of an international clinical rotation/service. New or existing members are encouraged to actively participate in all ACRO events. Your leadership and continued involvement in future projects will always be welcomed.

Dr. Prendergast, a member of ACRO's Resident Committee, practices at the University of Alabama at Birmingham.

Book Reviews Wanted!
After a long day of radiation oncology practice, have you sat down in the evening with an especially good book of fiction? If so, share your reading with other ACRO members!

Send your book review to:
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Department of Radiation Oncology
Kaiser Permanente Medical Group
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Los Angeles, CA 90027
(323) 783-3865
ADVICE TO THE CHIEF RESIDENT

From: Name withheld on request

Editor

I definitely have some strong opinions. Here are some that may help the chief resident in radiation oncology. Money isn’t everything. You should choose a job where you like and trust the people you work with and where you are happy with your life outside of work as well. Your first job doesn’t have to be your last job—that’s like getting married to somebody after your first date. Most young radiation oncologists have a high tolerance for putting up with crap because they are so thrilled to be getting a real paycheck for the first time. Many employers will take advantage of this, so watch out. If you are working in a practice where you feel that the ethics don’t line up with your own, get out immediately. Bad ethics can include things like fraudulent billing practices, groups that give kickbacks to referring doctors, protracted fractionation schemes for palliative cases, and anything else that doesn’t seem right. Average persons finishing residency have spent thousands of hours educating themselves between med school and residency—all of this to become great doctors who do a great job treating patients and to be happy doing it. So it makes little sense not to do your due diligence looking at prospective employers and jobs. If people spent half as much time studying jobs as they spent studying NNCN guidelines, there would be less dissatisfaction. Lastly, there’s no such thing as the perfect job. Just pick one you think is the right fit for you.

Letters to the Editor should be addressed to A. Robert Kagan, MD; Editor, ACRO Bulletin; Department of Radiation Oncology; Kaiser Permanente Medical Group; 4950 Sunset Blvd., Los Angeles, CA 90027. Please include your name and address. Letters may be edited for clarity or to fit available space.
**BOOK REVIEW**

**CHRIST STOPPED AT EBOLI: THE STORY OF A YEAR**

By Carlo Levi
Paperback, 1990 (originally printed in 1964), $39.49

Carlo Levi was a politically outspoken doctor who was arrested and exiled to the remote Basilicata region of southern Italy in 1935. *Christ Stopped at Eboli* is an account of his year there. Yet, being a physician, his memoir focuses, perhaps unsurprisingly, on the public health of the region. At first, Levi looks down on the “peasants” around him, but, as he is pressed into service as the area caregiver, he begins to recognize the kindness and generosity of those who have nothing themselves.

Soon Levi is a general practitioner, treating maladies from heart failure to appendicitis. However, his attempt to control the spread of malaria runs up against a local government that fails to give him the support to carry out simple tasks such as disinfecting pools of stagnant water and purchasing quinine, atabrine, and plasmochin. He subsequently writes a 20-page letter to authorities in Rome complaining of area conditions, but it is returned with an admonition that he is not to be practicing medicine.

This book, then, is a journey, not so much geographical, but psychological. At the end of his account, Levi is more insightful and more appreciative of humanity’s plight than he had been a year before.

*Taken from an earlier review by Birte Twisselmann*

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**BULLETIN** WWW.ACRO.ORG • 13
Lower Cyclin D1 Levels May Make Cancer Cells More Sensitive to Radiation

Many cancers of the breast, colon, and prostate, as well as lymphoma and melanoma, develop due to increased levels of cyclin D1. A recent study at the Dana-Farber Cancer Center in Boston suggests that cyclin D1 also contributes to cancer-cell DNA repair after radiation exposure, making the disease more resistant to radiation therapy. A lowering of cyclin D1 levels makes the cancer more sensitive to radiation.

Researchers observed the cyclin D1 protein binding to DNA proteins, such as RAD51, that repair radiation-induced, damaged DNA instructions for cells to divide and multiply abnormally. Cancer cells with cyclin D1 levels reduced by RNA interference were administered to mice and were more responsive to radiation treatment.

“Our results potentially change the way we think about cyclin D1 and cancer and may encourage targeting cyclin D1 in a very large pool of human cancers, which do not need cyclin D1 for proliferation but may still depend on cyclin D1 for DNA repair,” said researcher Siwanon Jirawatnotai, PhD, to e!Science News.

Auto-Guiding Device Limits Adverse Effects of Lung-Cancer Treatment

The main problem with the treatment of lung cancer is that lungs move with breathing, thus exposing healthy tissue, as well as cancerous cells, to radiation. However, Kyoto University in Japan announced that it had spent tens of millions of American dollars to develop an auto-guiding radiation-therapy device in collaboration with Mitsubishi that pinpoints the cancer. It adjusts for lung motion and thus limits harm to healthy cells. It can also be used to treat liver and pancreatic cancer, which can also move when the patient breathes.

Consistently Combined Safety Procedures Can Sharply Reduce Radiation-Treatment Errors

At the end of this summer, researchers from Johns Hopkins and Washington University announced that a combination of already known safety procedures, used consistently, could greatly reduce radiation-treatment errors that harm patients. Although radiation oncologists use quality-assurance checks to prevent errors, such checks have not been thoroughly analyzed either singly or in combination for their effectiveness.

The researchers collected data pertaining to approximately 4,000 incidents from 2008 to 2010 during which an error was caught and corrected before a patient received too little or too much radiation. Ultimately, they found that the consistent and combined use of six common quality-assurance measures could prevent 90% of potential patient-harming errors.

The safety measures were as common as reviewing patient charts, using film-based radiation-dose measurements rather than the electronic portal imaging device built in to many radiation-delivery instruments, and a required double check of radiation dose according to the treatment plan. In contrast, for example, pretreatment intensity-modulated radiation therapy (IMRT)—a time-consuming use of IMRT without the patient—proved to be largely ineffective for preventing potential errors.

Additionally, the researchers support the implementation of a national radiation-therapy incident-reporting system in which a central organization would receive and evaluate reports of treatment errors or near-errors and publicize the information to all radiation-therapy centers.

One Radiation-Therapy Device Serves 30 Million in Nigeria

The 2008 World Cancer Report predicts that new cases of cancer will reach 27 million globally by 2030 and kill 17 million annually. The situation is worse in developing nations where medical facilities are few and those that exist are prohibitively expensive for the nearby population. Such is the case in Nigeria.

An investigation by an online newspaper of Nigerian issues revealed that the African nation of 150 million people is home to only seven radiation-therapy devices, two of which were not functioning at the time of the survey due to lack of trained personnel. In and around the country’s largest city, Lagos, cancer patients sometimes wait months before undergoing radiation treatment. Medical experts believe this shortage is the reason why 80% of cancer patients die in Nigeria.

This crisis is the result of the expensiveness of the equipment, a lack of knowledgeable individuals to operate the equipment, and the exorbitant cost of ancillary drugs for cancer management. In addition, Nigeria’s National Health Insurance Scheme does not effectively subsidize cancer treatment.

To make matters worse, young Nigerians are receiving cancer diagnoses at an increasing rate. Professor Muheez Durosini, consultant hematologist at the Obafemi Awolowo Teaching Hospital, says this is due to alcohol consumption, exposure to fake and ineffective herbal concoctions, obesity, and tobacco smoking. Durosini adds that the Nigerian government lacks the political will to discourage disease-promoting lifestyles and does not recognize its responsibility to reduce the costs of cancer treatment for the people.
Adverse Late Effects of Radiation Therapy for Head-and-Neck Cancers Limited in Non-Smokers

A report out of Copenhagen states that 33% of smokers with head-and-neck cancer experience swallowing difficulties one year after radiation therapy. In contrast, only 20% of ex-smokers and 10% of never-smokers experienced such a problem. Quitting smoking during treatment also seemed to correlate with a reduced severity of voice changes.

“As nurses, we see patients every day with side effects during treatment,” said Dorthe Wiinholdt, MPH, a radiation-therapy technician from Copenhagen University Hospital at this year’s European Society for Therapeutic Radiation Oncology annual meeting. “We talk to them about quitting smoking before treatment because we know that smoking has an influence on efficacy and quality of life.”

In their study, Wiinholdt and colleagues used data from the Danish Head and Neck Cancer Study Group. They reviewed the records of 578 men and 217 women who received 66–68 Gy for larynx, pharynx, and oral-cavity cancer. Patients were categorized as smokers, ex-smokers, and never-smokers. Wiinholdt noted that 60% quit smoking during treatment, but a third of these patients resumed smoking after treatment. Complications after treatment included dysphagia and mucosal edema.

Cellphone Use Dangerous for Children, Study Shows

With multiple studies giving contradictory results, the potential dangers of cellphone use from radiation emissions is still an open question. Now, an article in *Electromagnetic Biology and Medicine* claims that children carrying a cellphone in a shirt or pants pocket absorb twice as much microwave radiation as adults.

The authors of the study criticize previous research that bases results on the anatomy of an adult male. They recommend that further research be based on various models of people, including children and pregnant women. This could better determine absorbed radiation in a variety of tissue types.

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Founded in 1989 with a current membership of approximately 800, the American College of Radiation Oncology is the essential professional society for success in the practice of radiation oncology.

www.acro.org

Dwight Fitch, MD • Website Editor
Mark Your Calendar

**Some 2012 Meeting Dates**

**American Society for Therapeutic Radiology and Oncology**
8280 Willow Oaks Corporate Drive, Suite 500
Fairfax VA 22031
Telephone (703) 502-1550

- **Multidisciplinary Head and Neck Cancer Symposium**
  January 26–28, 2012
  Arizona Biltmore
  Phoenix AZ

- **State of the Art Techniques in IMRT, IGRT, SBRT, Proton and Brachytherapy: Emphasis on Quality and Safety**
  May 4–6, 2012
  Encore at Wynn
  Las Vegas NV

**American College of Radiation Oncology**
5272 River Road, Suite 630
Bethesda MD 20816
Telephone (301) 718-6515
Website [http://www.acro.org](http://www.acro.org)

- **Annual Meeting**
  February 23–25, 2012
  Sanibel Marriot
  Fort Myers FL

**ICTR-PHE Conference Executive Office**
Department of Radiation Oncology
Clinique de Genolier 4
Route du Muids
CH-1272 Genolier, Switzerland
Telephone 41-22-366-9959

- **International Conference on Translational Research in Radio-Oncology and Physics for Health in Europe 2012**
  February 27–March 2, 2012
  International Conference Center
  Geneva, Switzerland

**European Society for Radiotherapy & Oncology**
Avenue E. Mounierlaan 83
1200 Brussels, Belgium
Telephone 32-2-775-93-40
Website [http://www.estro-events.org/Pages/ESTRO_Anniversary.aspx](http://www.estro-events.org/Pages/ESTRO_Anniversary.aspx)

- **World Congress of Brachytherapy**
  May 10–12, 2012
  Barcelona, Spain

**American Society of Clinical Oncology**
2318 Mill Road, Suite 800
Alexandria VA 22314
Telephone (571) 483-1300
Website [http://www.asco.org](http://www.asco.org)

- **Annual Meeting**
  June 1–5, 2012
  Chicago IL

**American Association of Medical Dosimetrist**
12100 Sunset Hills Road, Suite 130
Reston VA 20190
Telephone (703) 234-4063
Website [http://www.medicaldosimetry.org](http://www.medicaldosimetry.org)

- **Annual Meeting**
  June 10–14, 2012
  Omni Hotel at CNN Center
  Atlanta GA

**Radiological Society of North America**
820 Jorie Boulevard
Oak Brook IL 60523
Telephone (800) 381-6660
Website [http://www.rsna.org](http://www.rsna.org)

- **RSNA Scientific Assembly and Annual Meeting**
  November 25–30, 2012
  McCormick Place
  Chicago IL