choose breast-conserving therapy. This is an especially important issue in countries like Canada with its population dispersed over a wide geographic area, where many patients live some distance from radiation oncology centers and are required to be away from home for the duration of their treatment. It also allows for a more cost-effective use of resources. However, the final statement of the paper—“The shorter schedule also will permit more efficient use of resources, in that up to 50% more women can be treated with existing equipment and personnel”—is not supported by the data in the paper and is also open to misinterpretation, especially by those not fully familiar with the radiation therapy process.

A 3-week treatment schedule allows a 50% savings in treatment machine resources for this particular group of patients only. The potential savings include machine time, staffing of the treatment units, and patient monitoring during treatment. It has no impact on resources needed for patient consultation, the planning of treatment, or follow-up after treatment.

Furthermore, although we agree that breast cancer is a diagnosis that accounts for 25%–30% of all radiation therapy delivered, there are many indications for radiation therapy in breast cancer that this article does not address; for example, palliative radiation therapy, radiation therapy to the breast and regional lymph nodes, and postmastectomy radiation therapy. In our department, no more than 20% of all breast cancer treatments could now be treated with the fractionation schedule described in this article. This value represents 6% of all cancer patients treated by radiation therapy and only a 2% reduction in treatment machine workload.

We agree with Drs. Pearcey and Lees that our study was directed to women with early-stage breast cancer undergoing breast-conserving surgery (1). To fully understand the economic benefits of the adoption of the shorter schedule of breast irradiation, a formal cost-minimization analysis should be performed. It is important to note, though, that most radiation therapy resources are involved in the delivery of daily treatments rather than the costs for consultation or planning (2).

Robert G. Pearcey estimate that the shorter radiation therapy schedule would apply to 20% of all breast cancer treatments, in a city the size of Edmonton this would amount to a substantial number of women with breast cancer. In locations where 60% of women newly diagnosed with breast cancer have lymph node-negative disease and the rate of breast-conserving surgery is 70%, the shorter fractionation schedule could be applicable for up to 40% of newly diagnosed women.

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Mark Levine

REFERENCES


NOTES

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We welcome the contribution that Whelan et al. (1) have made in this recently published article in the Journal. Their article establishes level one evidence to support the use of shortened fractionation schedules for a selected group of patients undergoing breast-conserving therapy for breast cancer. For this group of patients, a shorter course of radiation therapy will be more convenient and may, in fact, encourage some patients, who would previously have chosen mastectomy to avoid the need for 5 weeks of radiation therapy, to

Re: Randomized Trial of Breast Irradiation Schedules After Lumpectomy for Women With Lymph Node-Negative Breast Cancer

Robert G. Pearcey
Alan W. Lees

RESPONSE

We agree with Drs. Pearcey and Lees that our study was directed to women with early-stage breast cancer undergoing breast-conserving surgery (1). To fully understand the economic benefits of the adoption of the shorter schedule of breast irradiation, a formal cost-minimization analysis should be performed. It is important to note, though, that most radiation therapy resources are involved in the delivery of daily treatments rather than the costs for consultation or planning (2). Although Drs. Pearcey and Lees estimate that the shorter radiation therapy schedule would apply to 20% of all breast cancer treatments, in a city the size of Edmonton this would amount to a substantial number of women with breast cancer. In locations where 60% of women newly diagnosed with breast cancer have lymph node-negative disease and the rate of breast-conserving surgery is 70%, the shorter fractionation schedule could be applicable for up to 40% of newly diagnosed women.

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