



Impact of CME on Practice Patterns in Breast Cancer

Surgeon and medical oncologist has the daunting task of keeping up-to-date with the expanding knowledge base in breast cancer medicine. Relatively little is known about the effect of continuing medical education (CME) on oncology practice patterns. As part of the *Breast Cancer Update* Patterns of Care Study, 200 medical oncologists were surveyed about their participation in various CME activities, and the influence of listening to the *Breast Cancer Update* audio series on treatment patterns. Compared to nonlisteners, listeners of the *BCU* audio series were more likely to recommend: dose-dense adjuvant chemotherapy with AC → T, switching a postmenopausal patient who was not tolerating adjuvant therapy to anastrozole fulvestrant as second-line therapy for a woman with asymptomatic ER-positive metastatic disease, and trastuzumab monotherapy for a patient with asymptomatic HER2-positive metastatic disease. Future studies should continue to assess the impact of various CME activities on treatment patterns in medical oncology.

INTEGRATION OF NEW STANDARDS OF CARE INTO CLINICAL PRACTICE

I think general consistency exists across the country in terms of the actual implementation of generally accepted guidelines or standards of care. The question is: How long does it take for a new standard to be introduced into practice? I believe it takes a couple of years, but I think it also depends on what the new finding is. If it involves a great deal more technology or difficulty, it may take longer than if it is easy to do and not much more expensive, although exceptions occur.

I believe that meetings that are attended by a large number of people or are covered in the press to a great extent have a big impact. I strongly suspect that the majority of oncologists in the United States first hear about a new oncologic research finding from the meeting at which it was presented or through summaries of the meetings. In our group, somebody will go to the ECOG, NSABP or ASCO annual meeting and come back and tell us what is going on.

Another important part of the equation is continuing educational sessions and print and audio programs. These sources may not be the first time that someone hears new information, but they may be the second or third time, and that may be the point at which practice changes. Continuing medical education has an important role in reinforcing and expanding on data that a physician may have first encountered during a presentation or scanned in a paper.

— Gershon Locker, MD

NCCN TREATMENT GUIDELINES AND ASCO TECHNOLOGY ASSESSMENTS

As clinicians, we have the challenge of tracking data as it evolves and deciding when the evidence surpasses the threshold at which the data should change our clinical practice patterns. The difficulty in doing that task on an ongoing basis has led a number of professional societies to establish expert panels to establish clinical guidelines.

The National Comprehensive Cancer Network Breast Cancer Treatment Guidelines use an evidence-based consensus approach, and the ASCO Technology Assessment uses a somewhat more formal process in its deliberations. An evidence-based consensus develops recommendations that are based on high-level evidence, whenever high-level evidence exists. Scientifically sound interpretation and cautious extrapolation of existing data are used when necessary, and expert judgment may be used to derive recommendations where evidence is lacking. The latter is very important, because it allows us to establish a guideline across a continuum of disease states, even those specific decision points or treatment modalities for which we may not have any clinical trial data to directly apply.

The ASCO Technology Assessment methodology evaluates a narrow treatment option applied to a narrowly-defined subset of patients. The studies are rated for strength of evidence. The recommendations from the technology assessment must be based on the strength of the evidence, and in the absence of evidence, no positive or negative recommendation can be made.

— Robert W Carlson, MD

CONTINUING MEDICAL EDUCATION

“Traditional continuing medical education (CME) has been disconnected from the actual practice of medicine and has not focused on providing the most useful information in the most efficient way.

“...physicians will learn best when learning is in the context of patient care, answers their questions, does not take too much time, and is directly applicable to their work. ...

“It makes most sense, then, to provide new information in a manner that can be rapidly assimilated and at a time when it can be used immediately. In other words, CME has to be integrated into the practice of medicine, presented at the ‘point of care.’”

— Ebell MH, Shaughnessy A. *J Cont Ed Health Professions* 2003;23(Suppl 1):53-62.

TIME SPENT IN CONTINUING EDUCATION ACTIVITIES

How much time in a typical month do you spend doing the following?	
	Mean time spent (hours)
Reading any type of medical educational materials	15.7
Specifically reading medical journals	10.8
Searching for and reading oncology information on the Internet	4.4
Listening to any type of medical educational programs on tape or CD	3.4
Specifically listening to interviews with cancer research leaders	2.5

SOURCE: *Breast Cancer Update* Patterns of Care Study, 2004;1(3).

WHICH OF THE FOLLOWING JOURNALS DO YOU READ OR SKIM EACH MONTH?

Listened to <i>Breast Cancer Update</i> in past 6 months?	Yes	No
<i>Journal of Clinical Oncology</i>	99%	96%
<i>New England Journal of Medicine</i>	90%	80%
<i>Journal of the American Medical Association</i>	60%	54%
<i>Cancer</i>	38%	34%
<i>Journal of the National Cancer Institute</i>	33%	23%
<i>The Lancet</i>	24%	16%

SOURCE: *Breast Cancer Update* Patterns of Care Study, 2004;1(3).

A 65-YEAR-OLD WOMAN ON TAMOXIFEN FOR TWO YEARS FOR A 1.2-CM, ER-POSITIVE, HER2-NEGATIVE TUMOR AND THREE POSITIVE LYMPH NODES

How would you manage this patient's adjuvant endocrine therapy?

Listened to <i>Breast Cancer Update</i> in past 6 months?	Scenario 1: The patient is tolerating tamoxifen without difficulty		Scenario 2: The patient is having significant vasomotor symptoms		Scenario 3: The patient has gained 20 pounds	
	Yes	No	Yes	No	Yes	No
Stop tamoxifen, switch to exemestane	30%	37%	34%	41%	29%	41%
Stop tamoxifen, switch to anastrozole	12%	11%	41%	22%	38%	26%
Stop tamoxifen, switch to letrozole	10%	15%	11%	15%	15%	18%
Continue tamoxifen	48%	37%	14%	22%	18%	15%

SOURCE: *Breast Cancer Update* Patterns of Care Study, 2004;1(3).

A 35-YEAR-OLD WOMAN WITH A 1.2-CM, ER-NEGATIVE, HER2-POSITIVE, GRADE II TUMOR

What chemotherapy, if any, would you recommend?

Listened to <i>Breast Cancer Update</i> in past 6 months?	Node-negative		3 positive nodes	
	Yes	No	Yes	No
AC	43%	70%	4%	—
Dose-dense AC (with growth factors)	11%	4%	4%	4%
Dose-dense AC → T (with growth factors)	4%	4%	53%	28%
AC → T (not dose-dense)	8%	—	8%	8%
AC → docetaxel	15%	11%	21%	41%
TAC	1%	4%	8%	11%
FAC/FEC	14%	7%	2%	8%
No chemotherapy	4%	—	—	—

SOURCE: *Breast Cancer Update* Patterns of Care Study, 2004;1(3).

ASYMPTOMATIC 57-YEAR-OLD WOMAN WITH ER-POSITIVE, HER2-NEGATIVE METASTASES TO BONE AND NO PRIOR SYSTEMIC THERAPY

What endocrine therapy would you likely recommend, if any?

Listened to <i>Breast Cancer Update</i> in past 6 months?	1st-line		2nd-line	
	Yes	No	Yes	No
Fulvestrant	—	—	39%	23%
Anastrozole	50%	46%	4%	7%
Letrozole	36%	41%	9%	14%
Tamoxifen	11%	10%	22%	23%
Exemestane	3%	3%	26%	33%

SOURCE: *Breast Cancer Update* Patterns of Care Study, 2004;1(3).

A 57-YEAR-OLD WOMAN WITH AN ER-NEGATIVE, HER2-POSITIVE TUMOR AND ASYMPTOMATIC BONE METASTASES

What systemic therapy strategy would you recommend?

Listened to <i>Breast Cancer Update</i> in past 6 months?	Yes	No
Trastuzumab alone	26%	7%
Trastuzumab plus chemotherapy	68%	86%
Chemotherapy alone	6%	7%

SOURCE: *Breast Cancer Update* Patterns of Care Study, 2004;1(3).

MEDICAL MEETING ATTENDANCE

How many of the meetings below have you attended in the past year?

	Mean
Major scientific meetings (eg, ASCO, San Antonio)	1.2
Local CME meetings, grand rounds, etc	5.5
Pharmaceutical meetings and advisory boards	4.5

SOURCE: *Breast Cancer Update* Patterns of Care Study, 2004;1(3).

SELECT PUBLICATIONS

Bickell NA, McEvoy MD. Physicians' reasons for failing to deliver effective breast cancer care: A framework for underuse. *Med Care* 2003;41(3):442-6.
 Bloom BS et al. Breast cancer treatment in clinical practice compared to best evidence and practice guidelines. *Br J Cancer* 2004;90(1):26-30.
 Butler WM et al. Breast cancer care: Changing community standards. *J Healthc Qual* 2004;26(5):22-8.

Du XL et al. Discrepancy between consensus recommendations and actual community use of adjuvant chemotherapy in women with breast cancer. *Ann Intern Med* 2003;138(2):90-7.

Ebell MH, Shaughnessy A. Information mastery: Integrating continuing medical education with the information needs of clinicians. *J Contin Educ Health Prof* 2003;23(Suppl 1):53-62.

Stancic N et al. Continuing medical education: What delivery format do physicians prefer? *J Contin Educ Health Prof* 2003;23(3):162-7.

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