



The Role of the Gastroenterologist in the Management of Patients with Digestive Cancers

Results of a World Gastroenterology Organisation (Division: International Digestive Cancer Alliance) International Survey: Position Paper from a WGO Working Party

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Introduction Digestive cancers as a group have the highest incidence of all cancers worldwide. More than 3 million new cases occur each year, with 2.2 million deaths (Table 1) [1].

Table 1 Incidence and deaths: all cancers worldwide (men and women)

	Incidence	Deaths
Digestive cancers	3 000 000	2 200 000
Lung	1 250 000	1 100 000
Breast	1 000 000	400 000
Genitourinary	1 000 000	450 000
Gynecological	850 000	400 000
Leukemia, lymphoma	700 000	450 000
Total (all cancers)	10 000 000	6 200 000

The major digestive cancers are colon, and rectum, esophagus and stomach, liver, and pancreas. Colorectal cancer is the leading cancer in this group in terms of worldwide incidence (Table 2) [2].

Table 2 Incidence and deaths: digestive cancers worldwide (men and women)

	Incidence	Deaths
Colorectal	950 000	500 000
Stomach	875 000	650 000
Liver	560 000	550 000
Esophagus	400 000	330 000
Pancreas	200 000	200 000
Total (digestive cancers)	3 000 000	2 200 000



The gastroenterologist is often the first physician to see and diagnose cancer in those affected, but may not be involved throughout the course of the patient's illness. The patient may be referred from one specialty to another without a single physician acting as the overall "doctor." A Working Party was organized by the Organisation Mondiale de Gastro-Entérologie/World Organization of Gastroenterology (WGO) to evaluate the role of the gastroenterologist in the overall management of patients with digestive cancers and to make recommendations for improving the management and continuity of care of these patients.

Method: The membership of the Working Party was constituted, and a first meeting was held at Digestive Disease Week in May 2000. The mission of the working party, as stated above, was outlined, and in order to fulfill its mission an international survey was designed (SJW, AZ, MB). The survey was distributed to members of the committee for modification and then to member organizations of WGO. The results of the survey were presented to a Working Party meeting at the World Congress of Gastroenterology held in Bangkok in March 2002.

The survey asked questions in four main areas: practice directly relating to these patients, including prevention, treatment, follow-up, and administration of chemotherapy; training of fellows in gastrointestinal (GI) programs in the area of digestive cancer; postgraduate education in digestive cancer; and society interactions in digestive cancer. Ninety surveys were distributed to leaders of the member societies of WGO worldwide.

Results: Of the 90 surveys, 47 responses were received from 47 countries. The responses to the survey are listed below. Answers from several choices are combined in responses 1-4.

1. Gastroenterologists administer chemotherapy: often/occasionally (30%) and rarely/never (69%).
2. GI cancer treatment is administered by a multidisciplinary team of medical oncologists, gastroenterologists, radiation oncologists and surgeons: often/occasionally (57%) and rarely/never (40%).
3. GI cancer treatment is planned by a multidisciplinary team of medical oncologists, gastroenterologists, radiation oncologists and surgeons: often/occasionally (71%) and rarely/never (27%).
4. GI cancer prevention programs are organized by gastroenterologists: occasionally/often (68%) and rarely/never (30%).
5. The top two components of cancer prevention programs are educational lectures for a medical audience and cancer screening guidelines, regardless of whether gastroenterologists or other individuals organize the programs.
6. For respondents with a GI training program, fellows are trained most often in screening (94%), pathology of GI cancer (94%), and follow-up of GI cancer patients (91%), and trained least often in surgical oncology (51%), radiation oncology (20%), and alternative medicine (14%) (Table 3).



Table 3 International survey: gastroenterology fellowship

If you have a GI training program, are fellows trained in:

Chemotherapy?	56%
Follow-up of GI cancer patients?	89%
Radiation oncology?	22%
Surgical oncology?	48%
Biology of GI cancer?	74%
Pathology of GI cancer?	87%
Nutrition and lifestyle?	71%
Alternative medicine	10%
Chemoprevention?	62%
Palliative care?	75%
Screening?	91%
GI cancer research?	71%
Tumor board research?	56%
New therapeutic approaches?	77%

7. The top five topics that respondents believe should be presented at postgraduate courses and clinical symposia are: new therapeutic approaches (97%), chemoprevention (90%), screening (88%), palliative care (85%), and biology of GI cancer (84%) (Table 4).

Table 4 International survey: postgraduate education. Positive responses to the question of whether there should be more information on the following topics presented at postgraduate courses and clinical symposia

GI cancer treatment with radiotherapy, surgery, or chemotherapy	84%
Palliative care	81%
Chemoprevention	92%
Nutrition and cancer	86%
Lifestyle and cancer	75%
Alternative medicine	48%
Screening	92%
Tumor board presentation	68%
Biology of GI cancer	88%
New therapeutic approaches	94%



8. Ninety-one percent of respondents believe there should be more interactions between GI and oncology societies.

Discussion: The management of patients with cancer has become exceedingly complex, and the same applies to patients with digestive cancers. Many specialties have matured in the past 25-30 years, with increasingly complex skills, expanded knowledge, and an enormous increase in the range of options available for diagnosis and treatment. This usually works to the patient's advantage, providing benefits that have strikingly reduced the likelihood of deaths from cancer. However, patients may become lost in this maze of specialization, and at many critical points - especially if not cured - they may find that there is no single doctor who has been looking after them throughout their illness. This can be disconcerting to the patient and family, and counterproductive for the specialists involved in the case.

It was this perception that led WGO to organize a working party to evaluate the role of the gastroenterologist in the management of patients with digestive cancers. The gastroenterologist is often the first physician to see the patient, make the diagnosis and refer the patient for treatment. Often, however, the gastroenterologist does not remain involved during a long course of treatment, but may be called back to help in diagnosis or palliation at a later stage. As the patient is referred from one to another specialist, continuity of care may be lost.

The purpose of the international survey reported in this paper is to provide an initial step in evaluating the gastroenterologist's role and to serve as a basis for making recommendations to WGO. The recommendations made to WGO by the Working Party are shown in Table 5.

Table 5 WGO Working Party recommendations

More interaction among physicians in the management of patients
Gastroenterologists should be part of a GI tumor team
Gastroenterologists should be involved with patients throughout their management
Fellowship training should include the full range of cancer management
Postgraduate meetings should include multidisciplinary sessions on GI tumors

Others have also addressed this important issue as well [2,3]. A dialogue with other interested societies regarding this issue would be a good beginning with the framework provided by the newly formed International Digestive Cancer Alliance, the mission of which is to raise awareness of digestive cancers throughout the world [4].

References:

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