Letters

Response to 'Modern radiation therapy for keratinocyte carcinoma'

We read with interest the article titled 'Modern radiation therapy for keratinocyte carcinoma: What the general practitioner needs to know' by Potter et al, which was published in the *AJGP* September 2024 issue.[1] Although in some ways this is a good overview of this useful modality, we would like to offer the following observations.

The authors describe radiation therapy as 'non-invasive'. Given that its use requires lead shielding to protect non-lesional skin and staff delivering the therapy, we feel this is an inaccurate description.

We congratulate the authors on addressing the short-term side effects of radiation treatment. Advising on management of the acute side effects, the authors state 'The treating department will be able to provide advice for referring clinicians if there is any uncertainty'. This seems to suggest that the authors expect referring clinicians to manage these issues? Most clinicians would consider management of complications of any therapy to be the primary responsibility of the treating clinician.

Furthermore, we would ask why the well-known, progressive and irreversible long-term complications of the modality received cursory attention? Radiation therapy is associated with significant side effects in the short, medium and long term. These include poikiloderma (atrophy, increased and decreased pigmentation and telangiectasiae).[2] Permanent alopecia is typical.[3] Induction of secondary malignancies and chronic ulceration are uncommon but important side effects.[4] Fibrotic changes in the skin render further surgery complex.[5] Idiosyncratic induction of multiple cutaneous malignancies in volumetric modulated arc therapy (VMAT) radiation treatment fields is described.[6] Should serious malignancies develop in fields treated with VMAT, further courses of radiation are problematic. The authors downplay these risks by saying their incidence is perhaps lower than previously reported. Even so, to term ionising radiation 'non-invasive' is inaccurate.

The article asserts 'VMAT is also an effective treatment for patients with extensive skin field cancerisation (ESFC), which is characterised by widespread actinic keratoses often with multiple in-field invasive cancers, achieving stable >96% field clearance and complete lesion response rates at the 24-month follow-up'. They reference a paper that had only low numbers of patients and no control group.[7] 'Extensive skin field cancerisation' was not well defined. Follow-up was only 24 months for a chronic condition and a treatment was used where side effects evolve over many years. Ten per cent of treatment fields had new keratinocyte malignancies developing within this brief follow-up period. Only one of the 10 authors declared no direct conflicts of interest. There was no demonstrated improvement in overall morbidity or mortality compared to usual care.

An unproven modality, the beta-emitting Rhenium-188 radioisotope is discussed. As the authors acknowledge, this is a very expensive treatment and there are minimal data to support its efficacy or safety. What little data are available is based on studies with very low numbers of lesions treated, follow-up times of less than two years and no control groups. To support their claims of utility and safety, the article references a paper where only 23 of 60 treated lesions were able to be reviewed at a 24-month follow-up. Is this really enough data to include this treatment in a review article?

Radiation has a very significant role in the management of skin malignancy. Indications are, however, limited. Its role in treating 'field cancerisation' is as yet uncertain and at best limited. This is especially so as this term captures mere solar damage through to skin with a very high burden of skin malignancy. Considering the long-term side effects, which this article fails to address adequately, and our increasingly long-lived population, a careful risk–benefit analysis is needed before advising radiation therapy as a treatment option.

Authors

Miranda Wallace BBioMedSc, MBBS, MS, Clinical Associate Lecturer, School of Medical Sciences, Faculty of Medicine and Health, The University of Sydney, Sydney, NSW; Dermatology Senior House Officer, Department of Dermatology, Mater Hospital, Brisbane, Qld

Jim Muir MBBS, FACD, Head of Department, Department of Dermatology, Mater Hospital, Brisbane, Qld; Dermatologist, South East Dermatology, Brisbane, Qld; Associate Professor, School of Medicine, The University of Queensland, Brisbane, Qld

Competing interests: None.

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a prospective cohort of 106 fields treated with widefield radiation therapy for extensive skin field cancerization, with or without keratinocyte cancers. JEADV Clin Pract 2024;3(2):487–97. doi: 10.1002/jvc2.312.

Reply

We would like to highlight several incorrect statements or assertions made in the original letter.

In keeping with the overarching aim of the original article to educate general practitioners (GPs) on the use of radiation therapy (RT) for keratinocyte cancer (KC), we clearly reference relevant treatment guidelines citing recommended usage only in a minority of cases. We noted that patient selection is complex and often requires consultation with multiple specialities – a fair and conservative approach for the scope of the article.

The risks of RT toxicity, both acute and chronic, are clearly referenced in the original article while emphasising the improvement in technology and treatment planning that has improved patient outcomes. It is worth noting that the cursory reference by the letter authors to 'idiosyncratic induction of multiple cutaneous malignancies associated with VMAT' is highly misleading without prefacing that the cited article refers to a single case study in a patient with a history of multiple cutaneous malignancies.

Regarding usage of volumetric modulated arc therapy (VMAT) for field cancerisation, the original article cited the only study making a concerted effort to collect long-term data for this approach. We concur that longer-term data collection are required – indeed, it is underway. We acknowledged it is only recommended when other options are exhausted. It should be emphasised that this treatment approach, in addition to the mention of Rhenium-188 radioisotope therapy, was incorporated into the 'Advances in radiation therapy' section to emphasise they are emerging techniques. The latter treatment is referenced for consideration in patients with surgical cautions who are unable to attend multiple fractionated radiation therapy sessions. Recent Rhenium-SCT data presented at the Royal Australian and New Zealand College of Radiologists Annual Scientific Meeting [RANZCR ASM] – Perth) and international (European Association of Nuclear Medicine Congress [EANM] – Hamburg) conferences also demonstrated strong and durable complete response (CR) rates among Australian (100% CR at 12 months) and European (>94% CR at 36 months) patients with a favourable safety and toxicity profile.

Finally, regarding the discussion of the management of radiation-induced reactions, requests for continuing education on this topic, particularly for the GP community, are frequent. Therefore, it was pertinent to articulate strategies to manage them. All patients are managed as appropriate by the treating facility; however, patients are eventually returned to the care of their referring clinician for ongoing surveillance in line with the secondary or tertiary role for radiation oncologists in skin cancer management.

Authors

Andrew E Potter MBBS, BMedSc (Hons), FRANZCR, Radiation Oncologist, GenesisCare Radiation Oncology, Adelaide, SA

Siddhartha Baxi MBBS, GAICD, FRANZCR, Radiation Oncologist, GenesisCare Radiation Oncology, John Flynn Hospital, Gold Coast, Qld

Bradley Wong MBBS, FRANZCR, Radiation Oncologist, GenesisCare Radiation Oncology, Sunshine Coast, Qld

Competing interests: SB declares consultancy fees from OncoBeta. All other authors have no competing interests to declare.

RESEARCH LETTER

An incongruency in general practitioner availability and the discharge medication supply quantity from a regional hospital

Patients discharged from regional hospitals in New South Wales, Australia, are dispensed with as little as three days' worth of medicine for those that have been hospital-initiated or modified. The limited supply aims to provide patients with adequate time to visit their general practitioner (GP) for medication reconciliation and obtain prescriptions where appropriate to reduce missed doses and medication errors.[1] The GP shortage that disproportionately affects regional and rural areas brings to question whether this supply is adequate to ensure appropriate transition of care.[2]

Our cross-sectional study used a standardised two-question telephone survey to assess the congruency of discharge medicines supply to the closest booking availability with surrounding GPs. Overall, 16 medical centres and 73 GPs were surveyed in 2023. The average number of days until an appointment with a GP was 6.2. The minimum three days of discharge medicines supply led to a deficit of 3.2 days.

The medication supply deficit is likely underestimated as it assumes patients call to arrange an appointment with their GP on the same day as discharge. Although the authors appreciate there were several same-day appointments in the area, it is gold standard care for patients to be reviewed by their own primary care physician. Although only a small sample size in a single area, our survey raises concern for medication non-compliance at the point-of-transfer from hospital to the primary care setting.

Further studies would be useful to define the scope of this issue in a national context, and a review to increase existing medicine discharge supply quantities is warranted. Other considerations at a practice level could include routine telehealth reviews or emergency appointments made available to all recently discharged patients.

Authors

Aaya Der Sarkissian BPharm, Hospital Pharmacist, Pharmacy Department, Shellharbour Hospital, Shellharbour, NSW

Michael Quach BPharm, Director of Pharmacy, Pharmacy Department, Shellharbour Hospital, Shellharbour, NSW

Samuel Antranig Der Sarkissian BMed, DCH, Dip Dermoscopy, FRACGP, Honorary Clinical Senior Lecturer, Faculty of Medicine, University of Wollongong, Wollongong, NSW

Competing interests: None.

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correspondence **ajgp@racgp.org.au**