Lung cancer is the neoplasm with the highest incidence and mortality rates in Spain. Analyzing separately for men and women, the respective incidences in 1990 were 51.6 and 3.4 per 100,000 inhabitants. The mortality rates that same year were 46.2 and 3.5 per 100,000 inhabitants in men and women, respectively. These data indicate that the main cause of death related to neoplastic disease in males is lung cancer—which accounts for 27% of deaths from such processes, while prostate and colon cancer follow at a great distance. In women, lung cancer occupied sixth place, accounting for 4.5% of deaths.

Pulmonology is the medical specialty that deals with the prevention, diagnosis, and treatment of all diseases that affect its target organ, the lung. The need for both theoretical and practical training in the management of lung cancer, including knowledge of chemotherapy, is specified in the proposals of the European Union of Medical Specialists’ working party report on the training of pulmonologists in Europe.

Chemotherapy produces a high rate of objective responses in small cell lung cancer, with 2-year survival rates of 40% to 60% in cases of limited disease. In the nonsurgical management of nonsmall cell cancer, however, its role is controversial, and only recently have protocols including cisplatin been shown to increase both patient survival and quality of life. Moreover, induction or neoadjuvant chemotherapy administered before surgical treatment may make it possible to improve survival by eradication or reduction of tumor mass and subclinical metastases not evident at the time of diagnosis.

At present, it is specialists in medical oncology who supervise the greater part of chemotherapy treatments while pulmonologists are relegated simply to diagnosing the disease without participating in decisions about therapy.
overwhelmingly eloquent: 100% of the pulmonology services that have ceased to administer chemotherapy treatments did so when a medical oncology service was created in their hospital. But while the conflict of interest with oncologists is one reason, it is not the only one. Other more explicit findings are there to be examined. First, in hospitals where an oncologist is unavailable (30% of our sample), patients are transferred to other hospitals to receive their chemotherapy. A second point that we consider even more disturbing is that only 51% of those surveyed showed interest in beginning to use this type of treatment. How are we to interpret these responses? What is the reason for such lack of interest? Possible explanations are manifold. One is that, as pulmonologists, we do not consider ourselves qualified to administer chemotherapy. Díaz Lobato,1 in a recent editorial, defends the growth of our specialty by arguing the need to create separate units specializing in tobacco addiction, asthma, sleep disorders, and home health care. Yet the editorialist uses the term “lung cancer” only once, and on that single occasion does so to speak of a “conflict with other specialties.” Another argument that is often given by hospital administrators is that centralized units (in this case medical oncology services) are more cost effective than sub-specialty units and require less investment. To date, no studies have compared the cost-effectiveness of chemotherapy treatments carried out on oncology wards to those supervised by pulmonology units. Nevertheless, we could extrapolate from the arguments of Torres and Rodríguez-Roisin,8 who show that in a specialized pulmonology unit the care of patients with serious respiratory insufficiency is more rational and effective, at half the cost of care provided in a conventional intensive care unit.

Regarding training, Sobradillo9 wrote in 1990 that the future of pulmonology residents would be sustained by acquiring optimal preparation in their training period. Included in this training, we feel, should be a solid understanding of how to manage chemotherapy. Today, the notion that a former resident will be able to find a position at a tertiary care university hospital fails to square with the real opportunities available. At the same time, as Rosell and Ruiz10 argue, the expansion of regional hospitals, once staffed by internists, has led to their hiring of medical specialists to serve as consultants and to perform complementary tests. Mastery of chemotherapy can make a pulmonologist considerably more employable at such hospitals, given that medical oncologists are generally still unavailable on staff and the tendency is to avoid transferring patients to larger centers whenever possible because of budget limitations. The last finding from our national survey is quite significant: 52% of pulmonology services state that they would agree to initiating a protocol for chemotherapy to treat lung cancer as long as such a protocol were established by SEPAR. Like Martínez,11 we believe that it is precisely the Oncology Assembly of SEPAR that should be charged with developing an open, multicenter committee to establish a protocol for chemotherapy and thus extend its use by pulmonologists. This is feasible because in the not-so-distant future such treatment will be less myelotoxic than it is today and will be administered orally,12 thereby eliminating the complications involved in providing such treatment in a day hospital.

Finally, we continue to think that patients with lung cancer should be evaluated by a multidisciplinary team, although as pulmonologists we have the right and the obligation to participate directly in the management of patients with lung disease. Our duties clearly include taking direct responsibility for our patients’ well-being and treatment and the avoidance of pointless mistrust among all participating specialties.

REFERENCES