From the Editor

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Two articles in the November issue of AJHO highlight evolving management paradigms in low-risk cancers. There have even been challenges as to whether we should be diagnosing and treating very low-risk breast cancers, as the harms of therapy may outweigh the benefits in situations where survival from detection and therapy has not been demonstrated.

Of course, we are not yet ready to take that route, as our diagnostic assays are not yet able to fully discern the dangerous versus tame lesions, even for T1N0 and non-invasive disease. However, we are dialing back on treatment intensity, as illustrated in our article on radiation therapy approaches for DCIS by Drs. Vicini and Shah. In particular, the use of a shorter course of radiation using hypofractionated therapy has been demonstrated for both in situ and invasive disease. This therapy is being increasingly adopted in this country, whereas it has been the standard in the UK and Canada for some time.

Accelerated partial breast irradiation (APBI), using a variety of techniques as described in the review by Drs. Shah and colleagues, is another example of "less is more." This approach limits radiation fields and shortens treatments utilizing techniques that include interstitial brachytherapy, three-dimensional conformal or intensity-modulated external radiation, with the rationale that it could yield equivalent local control and better cosmesis.

As data from randomized trials are just beginning to be available, with many still pending, a conservative approach, using carefully selected patients, is generally recommended. However, the exact factors and cutpoints to be applied vary among the centers and organizations making recommendations. For now, intraoperative radiation therapy (IORT) needs to remain in a separate category, as higher local recurrences have been seen compared to standard external beam radiotherapy; yet there may still be subsets to be defined, in the future, for which this approach could be suitable.

Long-term cosmesis, fibrosis, and patient-reported functional/symptom measures, as well as convenience, patient preference, and cost are all factors that will need to be weighed as this field evolves with the release of data and further refinements to radiation techniques. It is fortunate that the radiation oncology community has persevered in the organization of randomized trials testing APBI, so that as its use expands, so does the base of evidence that informs us on how to do so wisely.