

# Public Relations and Collaborative Support: Claiming a Seat at the Table When No One Else Is Buying It

Amishi Bajaj, MD;\* Qian Sophia Zhang, MD, PhD



**Dr. Bajaj** is a radiation oncologist at Northwestern Medicine.



**Dr. Zhang** is a PGY3 resident physician, Department of Radiation Oncology, Northwestern University Feinberg School of Medicine.

Before embarking upon a career in medicine, we assumed that scientific research aiming to save lives by elucidating optimal treatment paradigms would be largely unaffected by outside factors such as public relations and financial influences. As we have continued on in oncology, which remains at the forefront of scientific discovery in medicine, that assumption has proven idealistic and erroneous.

While treatment has advanced throughout the decades, public perception of the severity of deleterious side effects from yesteryear has lingered. Furthermore, there seemingly is always a cost to doing business. Funding, which is integral to scientific advancement, now often serves as the basis for determining just how distinguished and decorated an academic career is.<sup>1,2</sup> Even with the advent of cutting-edge techniques and expanding indications of treatment modalities, with radiation therapy having neither historical precedent as a primary treatment modality for treating many disease sites nor the financial support of the booming pharmaceutical industry, is radiation oncology getting its voice heard at the proverbial table?

Unfortunately, recent interactions between the media and publications by *The New England Journal of Medicine*, an esteemed journal with one of the highest impact factors worldwide,

suggest that the answer is no. In February 2023, 10-year outcomes from the PRIME II study were published. The study involved randomizing patients aged  $\geq 65$  years with early stage breast cancer treated with breast-conserving surgery and adjuvant endocrine therapy to whole-breast radiation therapy (WBRT) vs omission of radiation therapy.<sup>3</sup> Despite results demonstrating a nearly 10% risk of local recurrence at 10 years with omission of radiation (vs 1% for those who received WBRT), *The Wall Street Journal* soon after published an article titled “More Women with Breast Cancer Could Skip Harsh Radiation, Study Says.”<sup>4</sup> Harsh radiation? Modern treatment planning and patient positioning techniques—coupled, of course, with a thoughtful radiation oncologist—have markedly reduced the risk and severity of side effects.<sup>5</sup> The media influences perception, and we care what patients think. Even if patients are not attending tumor boards or sitting on specialty-specific editorial boards, their perceptions of treatment options matter if they are choosing for themselves. Patients and their loved ones sit on institutional review boards, read articles, invest in companies that drive investigational funding, and donate to cancer research. Their choices drive investigation.

A few months later in May 2023, *The New York Times* came under fire from radiation oncologists

---

**Disclosures:** Dr. Bajaj is the immediate past chair, Association of Residents in Radiation Oncology (ARRO) Executive Committee, the an ARRO representative to *Applied Radiation Oncology*. The authors have no other conflicts of interest to disclose. None of the authors received outside funding for the production of this original manuscript and no part of this article has been previously published elsewhere.

**Corresponding author:** \*Amishi Bajaj, MD, Department of Radiation Oncology, Northwestern University Feinberg School of Medicine, 675 North Saint Clair St, 21st Floor, Chicago, IL 60611. (amishi.bajaj@nm.org)

---

worldwide, objecting to their description of findings of the PROSPECT trial, stating that “brutal” neoadjuvant radiation can be avoided for rectal cancer,<sup>6</sup> in spite of the study looking at a select population of patients with more favorable risk features, including T2N1, T3N0, or T3N1 rectal cancers located 5-12 cm from the anal verge without circumferential resection margin positivity.<sup>7</sup> (Of note, that article underwent a name change after publication due to backlash.) This oversimplified title is dangerous, particularly if readers look beyond the abstract and see that the acute grade 3+ toxicity rate of 22.8% for the arm including radiation is actually less than the 41% grade 3+ toxicity rate for patients receiving chemotherapy alone.<sup>7</sup>

Of greater concern from the standpoint of scientific methodology was the recent publication of the INDIGO trial in June 2023. The trial sought to compare the isocitrate dehydrogenase (IDH) inhibitor vorasidenib with a placebo in the management of residual or recurrent low-grade gliomas after surgical resection alone.<sup>8</sup> Although the standard management would incorporate radiation therapy,<sup>9</sup> no radiation was used in either treatment arm. When discussing this trial, one author reported, “This will [allow] our patients to delay the use of radiation, particularly in this IDH mutant tumor population enriched with younger patients.”<sup>10</sup> However, the study design eliminating the use of chemoradiation therapy ignores data supporting enhanced longevity with this standard-of-care regimen—also important for younger patients—in favor of a placebo. We believe that this unfounded study design illustrates how pharmaceutical funding has the power to trump an established treatment paradigm for a phase III study if the paradigm does not promise lucrative revenue.

How does radiation oncology overcome historical strongholds in perception and the lack of a third party “buying” a seat at the table? Along with potential assistance from the American Society for Radiation Oncology (ASTRO), teamwork is needed, both in establishing strong partnerships with referring providers and patients, as well as providing open communication and education on the benefits and risks of radiation treatment. Truly collaborative multidisciplinary input may go a long way in eliminating misconceptions, historical precedents, or financial biases that impede optimal treatment paradigms.

We must also collaborate with our own. As the old quote goes, “United we stand; divided we fall.” While critical analysis and spirited discussion on topics such as photons vs protons, extent of heterogeneity or hypofractionation, and the use of adaptive treatment or not are essential for optimizing care, we must be wary of the optics that our patients and colleagues outside of radiation oncology perceive. In a unique specialty where myriad approaches often exist for a clinical situation, mutual respect among radiation, surgical, and medical oncologists, and heartfelt support to investigators in the trenches could enlighten attitudes in the media and within academia.

## References

- 1) Zaorsky NG, Ahmed AA, Zhu J, et al. Industry funding is correlated with publication productivity of US academic radiation oncologists. *J Am Coll Radiol*. 2019;16(2):244-251. doi:10.1016/j.jacr.2018.07.024
- 2) Connelly MT, Sullivan AM, Chinchilla M, et al. The impact of a junior faculty fellowship award on academic advancement and retention. *Acad Med*. 2017;92(8):1160-1167. doi:10.1097/ACM.0000000000001541
- 3) Kunkler IH, Williams LJ, Jack WJL, Cameron DA, Dixon JM. Breast-conserving surgery with or without irradiation in early breast cancer. *N Engl J Med*. 2023;388(7):585-594. doi:10.1056/NEJMoa2207586
- 4) Abbot B. More women with breast cancer could skip harsh radiation, study says. *The Wall Street Journal*; 2023. Accessed July 19, 2023. <https://www.wsj.com/articles/breast-cancer-women-radiation-study-8391efd9>.
- 5) Arsenault J, Parpia S, Goldberg M, et al. Acute toxicity and quality of life of hypofractionated radiation therapy for breast cancer. *Int J Radiat Oncol Biol Phys*. 2020;107(5):943-948. doi:10.1016/j.ijrobp.2020.03.049
- 6) Kolata G. Rectal cancer patients could be spared the effects of radiation. *The New York Times*; 2023. Accessed July 19, 2023. <https://www.nytimes.com/2023/06/04/health/rectal-cancer-radiation-treatment.html>.
- 7) Schrag D, Shi Q, Weiser MR, et al. Preoperative treatment of locally advanced rectal cancer. *N Engl J Med*. 2023;389(4):322-334. doi:10.1056/NEJMoa2303269
- 8) Mellinghoff IK, van den Bent MJ, Blumenthal DT, et al. Vorasidenib in IDH1- or IDH2-mutant low-grade glioma. *N Engl J Med*. 2023;389(7):589-601. doi:10.1056/NEJMoa2304194
- 9) National Comprehensive Cancer Network. Central Nervous System Cancers (Version 1. 2023); 2023. Accessed July 19, 2023. [https://www.nccn.org/professionals/physician\\_gls/pdf/cns.pdf](https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf).
- 10) Tucker N. Vorasidenib delays disease progression or death in IDH+ low-grade glioma Targeted Oncol; 2023. Accessed September 13, 2023. <https://www.targetedonc.com/view/vorasidenib-delays-disease-progression-or-death-in-idh-low-grade-glioma>.