



the medical Review

Spotlight On: Rhabdomyosarcoma

Rhabdomyosarcoma (RMS) is the most common soft tissue sarcoma in children (>50%). 87% of cases are seen in children under 15 years old with the rest found in children ages 15-21. It is a rapid-growing, highly malignant tumor that arises from primitive muscle cells. It can arise from anywhere in the child's body, except for bone. The most common sites are head and neck, extremities, and the genitourinary tract. Its cause is unknown and it usually presents as an expanding mass.

patients into risk groups for treatment. The details of this are listed in the sidebar to the left.

Treatment for RMS includes surgery, chemotherapy and radiation. All patients require chemotherapy but the regimens vary with stage and group. Common chemotherapeutics include vincristine, cyclophosphamide, dactinomycin, adriamycin, ifosfamide and VP-16. Chemotherapy cycles are usually given every 3 weeks and may require inpatient administration.

There are three distinct cell types: embryonal, botryoid and alveolar. Embryonal is the most treatable form of RMS. The prognosis is affected by primary tumor site and stage at diagnosis. Orbital and genitourinary RMS has a better prognosis than head and neck, extremity, pelvic, and trunk locations. Patients are assigned both a surgicopathologic clinical group and a stage in order to categorize

Surgical excision of the tumor should be done even in cases of metastatic disease. The surgical result helps determine the clinical grouping for treatment stratification. Involved lymph nodes should also be removed to determine the need for radiation. Radiation is done after excision and the start of chemotherapy. Overall, 50% of the children diagnosed with RMS survive 5 years.

SURGICOPATHOLOGIC GROUP

Group I - Tumor completely removed

Group II - Microscopic residual tumor, involved regional nodes, or both

Group III - Gross residual tumor

Group IV - Distant metastatic disease

RMS STAGING SYSTEM

Stage 1 - Orbit, head, and/or neck (not parameningeal) involvement, and involvement of the GU tract (not bladder or prostate)

Stage 2 - Other locations, N0 or NX

Stage 3 - Other locations, N1 if the tumor is <5 cm or N0 or NX if the tumor >5 cm

Stage 4 - Any site with metastases

New CMS Rule: Medical Mistakes Will Not Be Reimbursed

As follow-up information to an article published in the Spring 2007 issue of *The Medical Review*, Medicare has announced that it will no longer pay for the costs of what it considers "preventable" conditions acquired in the hospital. This rule, issued in August 2007, will go into effect in October 2008. All of the eight preventable conditions are taken straight from the National Quality Forum's adverse event list also known as "never events." A complete list of these events can be found in the Spring 2007 newsletter.

rule will provide a stronger incentive to hospitals to prevent these errors from occurring at all. The biggest impact is expected to be in reducing hospital acquired infections.

Under the new rules, hospitals will have to cover the costs themselves because balance billing the patient is prohibited. Many believe that the new

The Centers for Disease Control and Prevention estimates that 2 million patients get hospital infections each year, at a cost of more than \$27 billion. Nearly 100,000 of those infections are fatal. The new rule is expected to save CMS millions as well as improve the quality of care provided by hospitals. This should also provide the Leapfrog Group further strength in their quest to have hospitals hold themselves accountable for these events.

Average Wholesale price for Herceptin is \$3,047/440 mg. Billed charges range from \$5k-\$20k/440 mg.

THE BOTTOM LINE



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The breast cancer mortality rate
is declining for the first time since
statistics have been kept.

Short Acting Opioids In Non-Cancer Pain Treatment

There are millions of patients with chronic daily pain from a variety of diseases. Treatment options often are unsuccessful and frustrating for both the patient and physician. The advent of newer opioid drugs have significant success in lessening the pain experienced by cancer patients. However, the use of these drugs has been widened to treat patients who do not have a malignancy diagnosis. Most commonly, patients who have chronic low back pain are being prescribed short acting opioids in large quantities.

Actiq and Fentora are both FDA approved short acting opioids. Actiq (fentanyl citrate) is a schedule II controlled substance. It is a solid form of fentanyl on a plastic stick and is commonly referred to as a "lollipop". The fentanyl is delivered through the mouth mucosa as the patient swabs the lollipop between the cheek and the gums. Fentora is also fentanyl citrate with the same mechanism of action as Actiq. However, it is not a lollipop but a dissolving lozenge. The entire

lozenge is placed in the buccal cavity above a rear molar and it is completely dissolved within 25 minutes. The difference is that Fentora does not require active administration where Actiq does.

Both drugs are indicated solely for the management of breakthrough cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid therapy for their underlying persistent pain. There are several different dosages of both drugs. Patients considered opioid tolerant are those who are taking at least 60 mg of oral morphine/day, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg of oxycodone daily, at least 8 mg of oral hydro-morphone daily or an equianalgesic dose of another opioid for a week or longer.

Both should only be prescribed by oncologists or pain specialists and narcotic usage should be monitored closely in patients taking each of these drugs.

DIEP Flap For Breast Reconstruction: The New Gold Standard?

Currently, one out of eight (1:8) women will develop breast cancer but these women are being diagnosed earlier and treatment has become more effective. Hormone targeted therapies, genetic screening and biologic therapies have all played a role in this. However, some women still have to undergo mastectomy and many pursue reconstruction.

Traditionally, surgeons have performed the Transverse Rectus Abdominis Myocutaneous (TRAM) flap procedure. In this procedure a section of abdominal muscle and fat is used to reconstruct the breast or breasts that have been removed. Although easy to accomplish, it does remove some abdominal muscle and patients can experience weakness or herniation.

The newest procedure to perform for reconstruction is the Deep Inferior Epigastric Perforator (DIEP) flap. In this procedure, the tissue still comes from the lower abdomen but it only consists of skin and fat---no muscle is removed. Due to this, the recovery time tends to be shorter and the abdominal wall remains strong. It is a more complex procedure because it requires microsurgery to reattach the blood vessels in the tissue removed from the abdomen to a new blood supply in the chest. The increased complexity will lead to increased costs. Reasonable costs for the TRAM flap are between \$7,000-\$10,000. The DIEP procedure is too new to know what reasonable costs are but some providers have billed in excess of \$25,000 for this.

