
EDITORIAL

Expectant Management - What is “limited life expectancy”

I recently gave a lecture on expectant management of small renal masses as a treatment option in patients with limited life expectancy. Recent media releases surrounding PSA testing for prostate cancer made me further reflect on patient selection for minimizing treatment risks/costs in patients who are unlikely to live long enough for progression to be a factor. The premise for observation management of small renal masses is not that different from other diseases with slow progression such as prostate cancer where the effects of treatment are likely to be more morbid than the disease itself especially in patients with limited life expectancy. Several things came to mind as I read many media releases on the topic. A first observation was that many proponents of not treating such diseases in patients of “advanced ages” are many times quoting life expectancy in the 70s for men and women in Western nations. Based on this life expectancy, it is not unreasonable to consider observation for a patient who is 75 since they had already met or exceeded the expected longevity. These numbers however, are not always reflective of the demographics. For example if one has made it to 70 or 75 then their life expectancy is 85 and 87 years respectively according to the National Vital Statistics 2009. People that have lived that long have selected themselves already to live much beyond the “average of 70s”.

In addition, medical advances have made a definite impact on life expectancy for some diseases. An excellent example is cardiovascular disease. With early detection of risk factors, the natural course of patients at high risk for progression can be altered with medical management. In addition, contemporary protocols and treatment modalities are able to better treat acute cardiovascular events if they occur. One great example the above is that of former United States Vice President Dick Cheney. When he took office as Vice President in 2001, there was widespread concern that he would not be able to survive the term of the George W. Bush presidency. Mr. Cheney suffered from his first cardiovascular event in 1978 at the age of 37, and was statistically unlikely to live into “advanced age”. We know through excellent cardiac management, he has outlived the Bush administration and survived beyond what the statistics would have predicted. I use this as an example because there are many patients with similar medical profiles that we recommend not treating based on medical co-morbidities. What seemed unlikely from a medical data 20 years ago may not be unlikely today.

As we evaluate patients for observation treatment options, whether it be for prostate cancer or kidney cancer, we must look at current management of medical co-morbidities and use life expectancy figures that truly reflect the situation. Old figures for life expectancy are not always indicative of the individual situation and improvements in medical management of disease may significantly prolong life. Observation as a management option that was appropriate for a population in the past may not be applicable to current and future populations. This may be especially true for diseases where medical advances had a positive impact with respect to longevity.

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