DÉJÀ VU ALL OVER AGAIN AND AGAIN

JAMES D. GOWING

Last year, I reported on the failure of provinces to support best treatment of chronic lymphocytic leukemia (CLL) with rituximab, a drug which produces durable remissions. I asked "how many times will this have to happen?" Well, it is still happening, and here in Ontario it is getting worse.

I regularly see patients with CLL who might benefit from rituximab. The latest case involved a 55 year old woman whose disease I was able to control for 12 years with conventional treatment but recently her disease accelerated. Her lymph nodes became enlarged, obstructing urine flow from her kidneys, threatening her life. She was weak from anemia and seriously predisposed to infections (neutropenia). Chemotherapy that had previously controlled her disease was only partially effective, failed to relieve the urinary obstruction, and caused intolerable side effects. We couldn't get rituximab for her by simply stating her diagnosis, but after frustrating delay we obtained it via another route. The first two doses normalized her blood counts, resolved her nodes, and restored urine flow, without any side effects. She should be well on her way to complete recovery with the last two doses .

I fear that in many provinces, with the exception of BC, oncologists frustrated with the inability to treat their patients will move to other jurisdictions where treating their patients is supported by expedient access to effective treatment. Patients in Ontario may suffer grave consequences waiting for the government to make rituximab available.

Caregivers are also constantly frustrated by lack of access to diagnostic tools. A 60 year old patient, in remission for five years after bone marrow transplant for lymphoma, coughed up a small amount of blood. A chest CT scan was normal. He did not fit any of the Ontario "trials" for PET scanning. However, a PET scan obtained through other means showed slight activity in a bronchial tube. A bronchoscopic exam directed to this difficult-to-reach location revealed cancer cells but no tumour. Successful surgery for invasive lung cancer was then performed giving him an excellent chance for a prolonged and useful life. Had we not pursued the clinical suspicion that his symptoms were not due to lymphoma, we probably would have had a negative routine bronchoscopy. We would then have waited until the lung cancer grew to be visible on a CT scan, but perhaps by then it would have become inoperable.

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