



**Howard S. Hochster, MD**

ASSOCIATE DIRECTOR FOR CLINICAL RESEARCH,  
RUTGERS CANCER INSTITUTE OF NEW JERSEY  
DIRECTOR OF ONCOLOGY RESEARCH,  
RWJBARNABAS HEALTH

# Increasing Breast Cancer Diagnosis in Rural Areas and the Evolving Access to Health Care

**W**e assume health care in rural areas is worse than it is at the bastions of education. However, the report by Ngyuen et al from the Cleveland Clinic titled “Shorter Time to Treatment Is Associated With Improved Survival in Rural Patients With Breast Cancer Despite Other Adverse Socioeconomic Factors” shows us this is not necessarily the case. The authors reviewed more than 1 million patients with stage I to III breast cancer in the National Cancer Database (NCDB) from 2004 to 2012. This is a select population out of about 4 million patients with such diagnoses in this period. According to the study’s findings, rural patients had a shorter time from diagnosis to first therapeutic intervention and a somewhat higher overall survival (OS) rate. Many of us find this surprising, but there are certainly interesting questions raised by the data.

However, additional thought should be given to this population. For example, sample bias is a key issue since patient records selected for listing in NCDB

are only from Commission on Cancer–accredited institutions. In this report, this results in only 1.5% of patients coming from “rural” areas by the definition in the paper. This contrasts with 18% of the general US population in such sectors, so these few patients receive optimal care in rural health care delivery. The difference in time to intervention is a week shorter for rural patients than for nonrural patients, which results in a statistical difference in OS, although clinically nonsignificant, which the authors note.

More surprising is that these results occur despite some other adverse factors in the rural patient population including older age, lower education level, more intercurrent illness, and much lower income levels. On the other hand, the rural patient group is predominantly White. The strongest key factor affecting OS is surgery as initial therapy (representing curative cases), and this is higher in the rural group also. Other key factors associated with worse outcomes include having stage III disease, nearly as great as having

surgery first, being 65 years or older, having government insurance, and race (either Black or White).

The key issue here is access to medical care. Where there is good access to comprehensive care, it does not matter if you are treated in a community center or an academic one. We need to lower these barriers to care everywhere. It will be interesting to see such an analysis with improved access through Medicaid expansion. Maybe some of the problem of poorer outcomes in academic centers comes from the higher private insurance rate, which, for practitioners, puts additional barriers in place through the precertification process every day of our lives. As practitioners, we know how much time we spend on getting approvals for all kinds of testing and treatment, such as PET scans and chemotherapy preapprovals and even obtaining the pain medications patients so desperately need, all of which results in key treatment delays. We must stand for equal and unfettered access to care, be it in a rural or urban setting. ■



## SUBSCRIBE TO OUR NEWSLETTER

ONCOLOGY® is focused on bringing practical, peer-reviewed content to community oncologists, oncology nurses, and other relevant health care professionals. Subscribe to our newsletter to receive **FREE** practical tips and valuable resources.

**Scan the QR code and subscribe today!**