Correspondence

The New England Journal of Medicine

February 4, 2016

Vol 374

Correspondence

n engl j med
nejm.org

Vol 374

February 4, 2016

495

Involving this pathway has great promise in the treatment of stage IV Merkel-cell carcinoma.

However, the interpretation of this case requires some consideration. The authors do not mention radiation therapy as a possible confounder in the spectacular response. Indeed, the patient received hypofractionated radiation to the liver shortly before treatment with idelalisib was initiated. Given the high response rates afforded with the use of single-fraction radiation therapy among patients with metastatic Merkel-cell carcinoma, we would caution against concluding that idelalisib alone was responsible for the complete remission observed in this case.

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No potential conflict of interest relevant to this letter was reported.


DOI: 10.1056/NEJMc1514347

The authors reply:

The National Comprehensive Cancer Network guidelines suggest the use of hypofractionated radiation therapy for palliative care, but it is not recommended as a form of treatment for stage IV Merkel-cell carcinoma. We are very familiar with the study by Iyer et al. regarding single-fraction radiation therapy, and recently we have provided hypofractionated radiation therapy for patients with Merkel-cell carcinoma that has metastasized to the brain or liver. So far, in our patients, hypofractionated radiation therapy alone has not eradicated any visceral metastases of Merkel-cell carcinoma.

Although hypofractionated radiation therapy might have had a synergistic effect, idelalisib played an essential role in eradicating the liver tumor in our patient by targeting the aberrantly activated PI3K pathway. Moreover, idelalisib suppressed tumor-cell growth in our patient and induced cell death in vitro (data not shown). Data from clinical trials regarding the efficacy of idelalisib in patients with advanced Merkel-cell carcinoma are lacking.

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Since publication of their letter, Dr. Gao reports receiving idelalisib for this patient from Gilead Sciences. No further potential conflict of interest relevant to this letter was reported.

DOI: 10.1056/NEJMc1514347

Reexamining the Ecology of Medical Care

To the Editor:
The “Ecology of Medical Care,” initially published in 1961 and updated in 2001, offers a framework to explore trends in the choices that patients make in seeking medical care. Understanding how individual persons seek care offers insight into the persistence of patterns despite dramatic changes in the organization and financing of health care. In addition, it may reveal intractable disparities between demographic groups in the use of health care. Given the substantial changes in health care delivery since 2001 and the availability of new data, we sought to update and expand the model.

We used data from the 1996 and 2012 Medical Expenditure Panel Survey (MEPS), a nationally representative survey of the noninstitutionalized civilian U.S. population compiled by the Agency for Healthcare Research and Quality, with response rates of 70.2% and 56.3%, respectively. Replicating methods described by Green et al., we calculated estimates using survey weightings of the number of persons per 1000 in an average month who had a medical visit and the types of services used. This study was further augmented by data from the 2002 MEPS (response rate, 64.7%), which were used only to investigate physician specialty; 2002 was the first year that physician specialty was included in the survey. (For a description of visit categories and service types, see the Supplementary Appendix, available with the full text of this letter at NEJM.org.) Subgroup analyses were conducted according to age (<18, 18 to 64, or ≥65 years), race and ethnic group (non-Hispanic White, non-Hispanic Black, Hispanic, non-Hispanic other), and sex.

The results were consistent with those of Green et al. We observed that women had slightly lower visit rates and lower rates of visits to a primary care provider than men. However, there were no differences in visit types among the sexes. In contrast, women had slightly lower rates of visits to an urban area and slightly higher rates of visits to a rural area (there were no statistical differences between the sexes in the rates of visits to a mixed area). We also observed that non-Hispanic Black persons had slightly lower visit rates and lower rates of visits to a primary care provider than non-Hispanic White persons. The rates of visits to urban and rural areas were similar among non-Hispanic White and non-Hispanic Black persons. Hispanic persons had slightly higher visit rates than non-Hispanic White persons, and non-Hispanic other persons had slightly lower visit rates than non-Hispanic White persons. We also observed that persons aged 65 years or older had slightly lower visit rates and lower rates of visits to a primary care provider than younger persons. The rates of visits to urban and rural areas were similar among younger and older persons. The rates of visits were also similar among men and women aged 65 years or older.

Since publication of their letter, Dr. Gao reports receiving idelalisib for this patient from Gilead Sciences. No further potential conflict of interest relevant to this letter was reported.

DOI: 10.1056/NEJMc1514347

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495
Figure 1. Use of Medical Care Services in 1996 and 2012.

The graph shows the number of persons per 1000 in an average month who used various types of medical care services in 1996 and 2012. Diamonds above the dashed line indicate an increase in the proportion of persons who used an aspect of care between 1996 and 2012, whereas diamonds below the line indicate a decrease in the proportion who used an aspect of care during the same period. For primary care physician (PCP) visits and specialty physician visits, the data used were for 2002 and 2012. A magnification of the boxed area at the lower left is shown in the inset. Asterisks indicate a P value of less than 0.01. Alt/Comp denotes alternative or complementary medicine visit, ED emergency department, Opt/Pod optometrist or podiatrist visit, and PA/NP/NMW physician assistant, nurse practitioner, or nurse midwife visit. For details on the values in the graph, see Table S1 in the Supplementary Appendix.

Although we continue to see stable use of services in the face of changes in the U.S. health service delivery system and in supporting technology, we are seeing shifts in the kinds of care that patients are seeking.

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Disclosure forms provided by the authors are available with the full text of this letter at NEJM.org.