ELSEVIER

European Journal of Cancer 39 (2003) 2694–2695

European Journal of Cancer

www.ejconline.com

Postscript

> *I would that there were no age between ten and three and twenty, or that youth would sleep out the rest: for there is nothing in between but getting wenches with child, wronging the ancientry, stealing, fighting.*
> William Shakespeare: *The Winters Tale*—act III, scene iii

The recognition that children had different medical needs to those of adults, began to emerge in the 18th century and special hospitals were provided for them. Charité Hospital in Berlin and the Hôpital Enfant Malades in Paris were amongst the first, preceding London's Hospital for Sick Children at Great Ormond Street by more than 50 years. However, it took almost 200 years to recognise that there was a time period between being a child and adulthood which too had different needs. Indeed, before the Second World War, the concept of teenagers did not really exist. Writing in *The Times* in June 2003 on the occasion of the Jubilee of Queen Elizabeth, Richard Morrison wrote (of June 1953) "In the most far reaching change of all a new species of humanity was about to be created—THE TEENAGER. For the first time in history the unruly tastes of children would take precedence over their parents wishes. The 'generation gap' was born."

The Children's Hospital in Philadelphia has had a generic teenage/adolescent unit for many years, but it is only the last decade which has seen the development of separate adolescent oncology facilities in the United Kingdom (UK). Oncology is leading the way and the recent National Service Framework for England recommends that facilities for this group of children, whatever disease they may have, are available in all major hospitals [1].

So what is different about teenagers and is there anything special about the types of cancer which they get that should make us want to treat them differently? This Special Issue of the *European Journal of Cancer* covers the epidemiology well. There are no types of cancer which are exclusive to the teenage years, but some, e.g. bone tumours, span the age spectrum from infancy to the mid-40s, but have their peak in the teenage years. For others, e.g. Hodgkin's disease, there is a steady incidence throughout the age spectrum. Occasional cases of 'adult'-type tumours are seen in the teenage years, e.g. breast and bowel cancers, and the age distribution of testicular cancer stretches down to below 20 years.

The questions posed under the 'Quality of Care' section are important, e.g. who should be treating adolescents and where? Clearly, the answer should be the best person with the most experience in that disease in the most appropriate place. This, of course, can lead to conflict. Paediatric oncologists have their special expertise and 'diseases' and similarly for the adult oncologists. Both can feel comfortable treating adolescents and indeed there is no reason why they should not. What is more important is the environment in which the care takes place in which there must be 'adolescent-friendly' policies.

The Royal College of Paediatrics and Child Health in the UK have recently produced a report entitled 'Bridging the Gaps: Health Care for Adolescents' [2]. It highlights the importance of special facilities for this group, but also recognises the difficulties of setting up and maintaining such units.

As in most developments, if one puts the patient at the centre of the planning and design a service for them, rather than for the convenience of healthcare staff, then their needs will be better met. Adolescents need an appropriate environment in which to receive their care and to be treated by professionals who understand their special needs.

However, we must not forget that parents and siblings too have needs and somehow these have to be incorporated into the package.

The stress of working with adolescents is considerable and appropriate mechanisms must be in place to support staff. Adolescence is in any case an emotionally challenging time of life but, add to it the diagnosis of a life-threatening disease which, in the case of bone tumours, may require mutilating surgery, and the whole emotional maelstrom is compounded.

Although most young people with cancer can now be cured, there remains a group who will succumb to their disease. The palliative care phase requires special management where all of the particular needs of the adolescent are addressed. Most deaths now take place at home

0959-8049/$ - see front matter © 2003 Elsevier Ltd. All rights reserved.
doi:10.1016/j.ejca.2003.09.024

with support from both local and outreach staff from the hospital. The Association for Children with Life Threatening and Terminal Conditions and their Families (ACT) have produced a report on 'Palliative Care for Young People' [3] and, although most deaths in this category are not due to cancer, it does provide a useful framework for assessing the needs of this particular age group.

It is clear, therefore, that adolescents have special needs, as do the staff who care for them. Who then should be responsible for providing the necessary resources? In the UK, services for children with cancer are usually commissioned through a paediatric commissioning process, whilst those for adults are now through the adult cancer networks. There is a real danger, therefore, that adolescents fall between these two processes.

One of the problems in planning such services is the question of volumes of cases and priorities. Adult services are designed to cope with large numbers of cases with many fewer professional staff per patient than in paediatric oncology. Generally, the treatments are not so intensive in adult practice. Adolescent oncology is more akin to paediatric oncology in terms of the service requirements and it may well be best for developments to be led by the paediatricians. However, it must be done in conjunction with specialists in adult oncology. Commissioners of services must be made aware of the special needs of adolescents and provide the resources necessary to meet their needs.

Charitable funds can be an important catalyst for service development and the Teenage Cancer Trust are to be congratulated for their efforts over the past two decades in establishing units throughout the UK. They have also stimulated thinking and debate about the subject.

For many young people with cancer, the disease will be something that they come through and go on to lead a long and normal life. Some will have late effects of treatment and others will unfortunately die from their disease. We must ensure that we give the best possible support, tailored to their individual needs, so that, whatever the outcome, we will not have made the situation worse by inappropriate care.

References

1. Department of Health. *Getting the Right Start: National Service Framework for Children. Standard for Hospital Services*. London, Department of Health, 2003.
2. Royal College of Paediatrics and Child Health. *Bridging the Gaps: Health Care for Adolescents*. London, RCPCH, 2003.
3. Association for the Care of Terminaly Ill Children and their Families. *Palliative Care for Young People*. Bristol, ACT, 2001.

Alan W. Craft
Department of Child Health, Sir James Spence Building,
The Royal Victoria Infirmary, Queen Victoria Road,
Newcastle upon Tyne NE1 4LP, UK
E-mail address: a.w.craft@ncl.ac.uk