MDForLives

MDFORLIVES · ONCOLOGY INSIGHT REPORT

Cancer Survivorship Care: Balancing Recurrence Risk and Long-Term Toxicity

How oncology HCPs approach surveillance intensity, persistent treatment effects, long-term follow-up, oncology-primary care coordination, and the next generation of recurrence monitoring.

RECURRENCE RISK → SURVEILLANCE → TOXICITY → LONG-TERM FOLLOW-UP → COORDINATED CARE

113	6	73.5%	9007321
Survey records	Countries represented USA · UK · Canada · Italy · France · Germany	Completion rate	SGID

WHY THIS REPORT

Cancer follow-up changes after treatment, but the clinical work does not become simpler.

Survivorship care asks oncology teams to manage two timelines at once: the possibility of recurrence and the long-term consequences of treatment. A patient may have stable disease surveillance yet still be living with neuropathy, cardiotoxicity, cognitive change, fatigue, multimorbidity, or fear of recurrence. At the same time, responsibility for care may begin to shift toward primary care or other specialists.

This creates a practical tension. Follow-up must be intensive enough to detect clinically meaningful change, but targeted enough to avoid unnecessary testing and preserve limited specialist capacity. Persistent toxicities need active management, but treatment modification may affect cancer control. Long-term handoffs can improve continuity, but only when oncology and primary care roles are explicit.

The MDForLives survey explores where oncology HCPs intensify follow-up, what drives surveillance choices, which late effects most change strategy, what makes coordinated survivorship care difficult, and which emerging tools clinicians believe could improve the next phase of follow-up.

METHODOLOGY

A cross-market survey of professional oncology HCPs.

The survey included professional HCP respondents across the USA, UK, Canada, Italy, France, and Germany. The source file contained 113 survey records with a 73.5% completion rate. Question-level response bases varied as respondents progressed through the survey.

The quantitative findings are reported exactly as provided in the survey response export. The open-ended case question is analyzed qualitatively; no percentages were assigned to themes that were not formally coded.

> Administrative fields such as live-change tracking, bad-ID reasons, required-text fields, and honeypot validation were excluded from the clinical analysis. Country punching was used only for geography metadata.

EXECUTIVE SUMMARY

Six signals define the survivorship-care challenge.

01

46.1%

Higher-stage disease intensifies follow-up

Stage III-IV disease is the most selected profile warranting closer surveillance.

02

46.1%

Recurrence risk anchors surveillance intensity

It is the most selected finding shaping how closely survivors are monitored.

03

44.3%

Persistent toxicity can change treatment

Dose reduction or modification is the leading reported response to ongoing treatment toxicity.

04

46.6%

Cardiotoxicity reshapes survivorship strategy

It outranks cognitive impairment, neuropathy, and secondary malignancy risk.

05

54.0%

Coordination is the biggest system barrier

Fragmented oncology-primary care coordination is the strongest operational signal in the survey.

06

32.2%

Biomarker recurrence detection leads future priorities

AI-based recurrence-risk prediction follows at 28.7%.

01

WHO NEEDS CLOSER FOLLOW-UP

Stage III-IV disease is the clearest signal for intensified survivorship follow-up.

46.1% identify stage III-IV disease as the survivor profile most warranting intensified follow-up.

CONTEXT

Follow-up intensity cannot be uniform across all survivors. Disease burden, treatment exposure, residual toxicity, comorbidities, and recurrence risk all influence how much specialist surveillance is reasonable.

WHAT THE DATA SHOWS

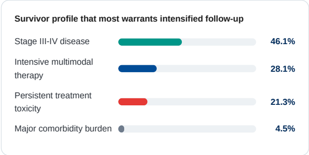
Stage III-IV disease leads at 46.1%, followed by intensive multimodal therapy at 28.1%, persistent treatment toxicity at 21.3%, and major comorbidity burden at 4.5%.

THE INSIGHT

Respondents appear to give disease stage the greatest weight when deciding who needs intensified follow-up, while treatment intensity and unresolved toxicity act as additional reasons to maintain closer oncology involvement.

WHY IT MATTERS

Risk stratification can help distinguish patients who need ongoing specialist surveillance from those who may safely transition toward shared or primary-care-led follow-up.



02

WHAT SETS SURVEILLANCE INTENSITY

Recurrence risk is the central surveillance signal, ahead of stage, toxicity, and symptoms.

46.1% select recurrence risk as the finding that most influences surveillance intensity.

CONTEXT

Post-treatment surveillance is meant to detect clinically meaningful recurrence while avoiding unnecessary testing. The difficult part is deciding which signal should drive intensity when several risks coexist.

WHAT THE DATA SHOWS

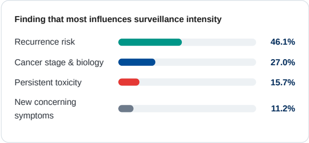
Recurrence risk leads at 46.1%. Cancer stage and biology are selected by 27.0%, persistent treatment toxicity by 15.7%, and new concerning symptoms by 11.2%.

THE INSIGHT

The ranking suggests that respondents think prospectively: the estimated probability of recurrence matters more than any single symptom or toxicity when setting the baseline surveillance pathway.

WHY IT MATTERS

Clear recurrence-risk frameworks can support more consistent follow-up intensity while leaving room to escalate when new symptoms, toxicities, or disease-specific factors emerge.



03

HOW SURVEILLANCE IS DELIVERED

Guideline-based imaging and individualized risk-based surveillance are almost evenly matched.

42.0% primarily use guideline-based imaging, while 38.6% use individualized risk-based surveillance.

CONTEXT

Guidelines create consistency, but cancer survivorship rarely fits a single template. Stage, treatment history, recurrence biology, age, comorbidity, patient preference, and late effects may all justify adaptation.

WHAT THE DATA SHOWS

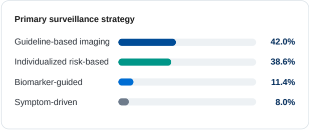
Guideline-based imaging leads at 42.0%, individualized risk-based surveillance follows at 38.6%, biomarker-guided surveillance at 11.4%, and symptom-driven follow-up at 8.0%.

THE INSIGHT

The small gap between the two leading approaches suggests that standardized schedules and individualized judgment are not competing philosophies. They are complementary layers of the same follow-up process.

WHY IT MATTERS

Surveillance programs need enough structure to be reliable and enough flexibility to respond to changes in recurrence risk, treatment toxicity, and patient context.



04

WHY SURVIVORSHIP GETS DIFFICULT

Uncertain recurrence risk leads a tightly clustered set of management constraints.

28.4% select uncertain recurrence risk, but capacity, comorbidity, and toxicity follow closely.

CONTEXT

Survivorship management can be constrained by uncertainty even when the patient is clinically stable. Risk may be difficult to quantify, follow-up slots may be limited, comorbidities may compete for attention, and persistent toxicities may require specialist input.

WHAT THE DATA SHOWS

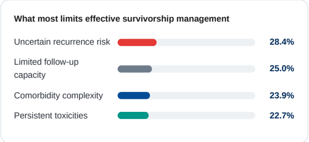
Uncertain recurrence risk is selected by 28.4%, limited follow-up capacity by 25.0%, comorbidity complexity by 23.9%, and persistent treatment toxicities by 22.7%.

THE INSIGHT

No single issue dominates. The near-even distribution suggests that survivorship pressure is created by an accumulation of clinical uncertainty and operational constraints rather than one isolated failure point.

WHY IT MATTERS

Improving survivorship care therefore requires both better risk stratification and practical capacity to act on that risk.


What most limits effective survivorship management

05

WHEN TOXICITY PERSISTS

Dose reduction or modification is the most selected response to ongoing treatment toxicity.

44.3% choose dose reduction or modification, compared with 33.0% selecting symptom-directed pharmacotherapy.

CONTEXT

Persistent toxicity can blur the boundary between active treatment and survivorship. The clinical team may be trying to preserve treatment benefit while reducing harm that is affecting function, quality of life, or long-term organ health.

WHAT THE DATA SHOWS

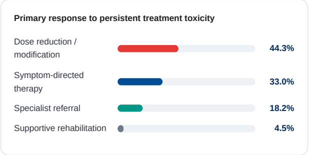
Dose reduction or modification leads at 44.3%, symptom-directed pharmacotherapy at 33.0%, specialist referral at 18.2%, and supportive rehabilitation at 4.5%.

THE INSIGHT

Respondents most often report changing the treatment exposure itself rather than adding another layer of supportive management. That response, however, is highly dependent on treatment intent and disease control.

WHY IT MATTERS

Survivorship planning may need to begin before treatment completion whenever toxicity is likely to alter therapy, require specialist follow-up, or persist after cancer treatment ends.


Primary response to persistent treatment toxicity

06

LATE EFFECTS THAT CHANGE THE PATHWAY

Cardiotoxicity stands out as the complication most likely to change survivorship strategy.

46.6% select treatment-related cardiotoxicity.

CONTEXT

Cancer survivors may carry treatment-related risks long after a regimen ends. Cardiac dysfunction, neuropathy, cognitive changes, and secondary malignancy risk can require new monitoring, specialist referral, or a different balance of priorities.

WHAT THE DATA SHOWS

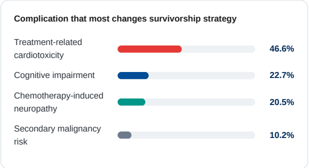
Treatment-related cardiotoxicity leads at 46.6%, followed by cognitive impairment at 22.7%, chemotherapy-induced neuropathy at 20.5%, and secondary malignancy risk at 10.2%.

THE INSIGHT

Cardiotoxicity is not simply another symptom burden. It can create a parallel chronic-disease pathway that changes how the survivor is monitored and which clinicians need to remain involved.

WHY IT MATTERS

ASCO guidance recommends careful clinical assessment after cardiotoxic therapy and cardiac evaluation or cardio-oncology referral when indicated. Survivorship systems therefore need clear routes for treatment-specific late effects.


Complication that most changes survivorship strategy

07

TRANSITIONING TO LONG-TERM FOLLOW-UP

Stable surveillance findings matter more than simply reaching the end of a surveillance period.

39.8% select stable surveillance findings as the strongest support for transition to long-term follow-up.

CONTEXT

Moving a patient toward longer-term follow-up is a risk decision, not an administrative milestone. The team needs confidence that recurrence risk is manageable and that major treatment-related issues are stable enough for the next model of care.

WHAT THE DATA SHOWS

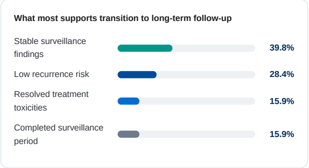
Stable surveillance findings lead at 39.8%, low recurrence risk at 28.4%, resolved treatment toxicities at 15.9%, and completed surveillance period at 15.9%.

THE INSIGHT

Respondents favor evidence of stability over elapsed time alone. A patient can complete a scheduled period of follow-up and still need specialist involvement if recurrence risk or late effects remain unresolved.

WHY IT MATTERS

Transition criteria should therefore capture disease stability, recurrence risk, treatment effects, comorbidity needs, and clarity about who will own the next phase of care.


What most supports transition to long-term follow-up

08

THE COORDINATION GAP

Fragmented oncology-primary care coordination is the clearest system-level barrier.

54.0% select fragmented oncology-primary care coordination as the biggest barrier to coordinated survivorship care.

CONTEXT

Long-term survivorship frequently involves multiple clinicians. Oncology may continue recurrence surveillance while primary care manages preventive health and comorbidity, with additional specialists involved for treatment-related effects.

WHAT THE DATA SHOWS

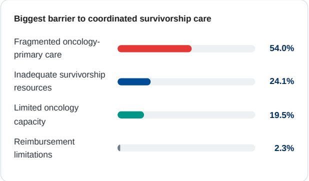
Fragmented oncology-primary care coordination leads at 54.0%, inadequate survivorship resources at 24.1%, limited oncology capacity at 19.5%, and reimbursement limitations at 2.3%.

THE INSIGHT

The largest barrier is not a lack of oncology expertise; it is the connection between parts of the system. This aligns with survivorship-care frameworks that emphasize treatment summaries, follow-up plans, clear roles, and information exchange.

WHY IT MATTERS

Better coordination can make risk-stratified follow-up more practical by clarifying who monitors recurrence, who manages late effects, and when a patient should return to specialist oncology care.


Biggest barrier to coordinated survivorship care

09

WHAT COULD CHANGE NEXT

Respondents expect biomarkers and AI to make recurrence surveillance more risk-sensitive.

32.2% select biomarker-based recurrence detection, followed by 28.7% for AI-based recurrence-risk prediction.

CONTEXT

Current surveillance often relies on disease-specific schedules, imaging, clinical assessment, and selected biomarkers. Emerging tools promise more individualized estimates of recurrence risk and potentially earlier signals of clinically important change.

WHAT THE DATA SHOWS

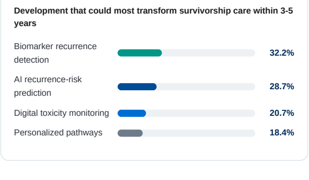
Biomarker-based recurrence detection leads at 32.2%, AI-based recurrence-risk prediction follows at 28.7%, digital toxicity monitoring at 20.7%, and personalized survivorship pathways at 18.4%.

THE INSIGHT

The leading future preferences are tools that refine risk and detection rather than tools focused only on symptom monitoring. Respondents appear to want better ways to identify who is truly at risk and when surveillance should change.

WHY IT MATTERS

New technology will only improve survivorship if it is validated for specific clinical contexts and linked to clear actions. A more precise risk score is useful only when the care pathway can respond to it.


Development that could most transform survivorship care within 3-5 years

OPEN-ENDED CASE LENS

Real-world cases show that survivorship can shift from recurrence surveillance to long-term treatment consequences.

The open-ended question asked respondents to describe a challenging survivorship case where management changed after treatment, what drove the change, and what remained unmet.

Persistent toxicity became the dominant problem

Usable comments described peripheral neuropathy, fatigue, cognitive difficulty, pulmonary toxicity, renal decline, and other treatment effects that continued after cancer control had improved.

Cardiac complications could limit future oncology options

One respondent described severe doxorubicin-related cardiotoxicity after lymphoma treatment, illustrating how late effects can alter both survivorship monitoring and future treatment choices.

Mental health and quality of life remained unmet needs

Follow-up adherence could remain difficult even after treatment

Comments described anxiety, depression, fatigue, sleep disturbance, sexual-function concerns, and the challenge of restoring daily function after intensive treatment.

Respondents noted missed follow-up, reluctance to continue surveillance, and the practical challenge of keeping patients engaged when they feel well or are fatigued by ongoing medical care.

Comorbidity and age complicated the surveillance decision

Some cases involved dementia, frailty, family dynamics, or other health problems that made a conventional surveillance pathway less straightforward.

Survivorship required broader team involvement

Several cases implied the need for cardiology, rehabilitation, mental-health, primary-care, or other specialist input once the survivor's needs extended beyond recurrence monitoring alone.

> The qualitative responses are not converted into percentages. They add context by showing how recurrence risk, late effects, functional recovery, comorbidity, adherence, and care coordination can compete for attention in the same survivor.

FREQUENTLY ASKED QUESTIONS

Common clinical questions about cancer survivorship care.

What is cancer survivorship care?

Cancer survivorship care is the ongoing care provided after or alongside cancer treatment to address recurrence surveillance, treatment-related and late effects, other health conditions, psychosocial needs, health maintenance, and coordination between oncology and other clinicians. The exact model and follow-up plan should reflect cancer type, treatment history, recurrence risk, current symptoms, and patient needs.

How is follow-up intensity determined after cancer treatment?

Follow-up intensity is usually individualized according to cancer type and stage, recurrence risk, treatment received, time since treatment, ongoing toxicities, symptoms, comorbidities, and disease-specific guidance. The appropriate schedule is therefore not the same for every survivor.

What is the role of surveillance imaging in cancer survivorship?

Surveillance imaging can be an important part of follow-up for selected cancers and risk profiles, but it should follow disease-specific recommendations rather than be used uniformly. Clinical history, examination, symptoms, laboratory or biomarker findings where appropriate, and treatment history also contribute to surveillance decisions.

How should persistent treatment-related toxicities be managed in cancer survivors?

Management depends on the toxicity, severity, ongoing cancer treatment, and the patient's functional priorities. Options may include symptom-directed therapy, treatment modification when oncologically appropriate, rehabilitation, and referral to specialists such as cardiology, neurology, rehabilitation, pain, or mental-health services.

When should primary care become more involved in survivorship care?

Primary care can contribute throughout survivorship, particularly for comorbidity management, preventive care, health maintenance, and long-term follow-up. Clear role definition, treatment summaries, survivorship care plans, and reliable information exchange between oncology and primary care help reduce fragmentation.

What role might biomarkers and AI play in future cancer surveillance?

Biomarkers and AI-based risk tools may help refine recurrence-risk assessment or identify patients who need closer monitoring, but their value depends on validated clinical performance, disease-specific evidence, clear action thresholds, and integration into workflows that improve rather than complicate follow-up care.

ONCOLOGY PRACTICE LENS

What this means across the survivorship-care pathway.

The survey suggests that good survivorship care depends on more than choosing a surveillance schedule. The clinical pathway needs to account for recurrence risk, treatment exposure, ongoing toxicity, comorbidity, patient capacity, and the handoff between oncology and other clinicians.

1. Stratify follow-up by risk, not time alone

Use disease stage, biology, recurrence risk, treatment history, symptoms, and toxicity to determine who needs continued intensive oncology surveillance.

2. Treat late effects as part of cancer care

Persistent neuropathy, cardiotoxicity, cognitive change, fatigue, and other treatment consequences need active pathways rather than being left outside the survivorship plan.

3. Define the handoff before it happens

Clarify who owns recurrence surveillance, preventive care, comorbidity management, late-effect monitoring, and re-referral when follow-up becomes shared with primary care.

4. Introduce new monitoring tools only with action pathways

Biomarkers, AI risk prediction, and digital monitoring should be linked to validated thresholds, defined responsibilities, and a clear next clinical step.

CLOSING PERSPECTIVE

The next phase of oncology care is not defined by the end of treatment. It is defined by changing risk.

The MDForLives findings describe survivorship as a dynamic clinical state. Recurrence risk sets the baseline intensity of follow-up, but persistent toxicity, cardiotoxicity, comorbidity, symptoms, and system capacity can change that plan long after active treatment has ended.

The survey also shows that transition is earned through stability rather than time alone. Stable surveillance findings and lower recurrence risk are more important signals for long-term follow-up than simply completing a surveillance period. That distinction matters because some survivors remain clinically complex even when their cancer is controlled.

The strongest operational finding is fragmentation between oncology and primary care. This is where otherwise well-designed risk-based pathways can fail: responsibilities are unclear, treatment histories are incompletely transferred, late effects fall between specialties, or new symptoms do not move back into oncology quickly enough.

Biomarker-based detection and AI-based risk prediction may help make surveillance more precise over the next several years. But precision technology does not replace continuity. The more individualized survivorship becomes, the more important it is to define who interprets each signal, who acts on it, and how the patient moves between oncology, primary care, and other specialists.

Risk-stratify surveillance

Use recurrence risk, stage, biology, treatment exposure, and current clinical status to determine follow-up intensity.

Build toxicity pathways

Create clear routes for cardiotoxicity, neuropathy, cognitive change, fatigue, and other long-term treatment effects.

Make shared care explicit

Use treatment summaries, survivorship plans, and defined re-referral triggers to reduce oncology-primary care fragmentation.

Connect innovation to action

Adopt biomarkers, AI, and digital monitoring only when a validated signal leads to a clear clinical response.

Help future oncology insights reflect the survivorship decisions HCPs make every day.

Share your perspective with MDForLives and contribute to the evidence-led conversations shaping healthcare.

Join the Panel

REFERENCES AND DATA SOURCE

1. MDForLives Oncology Survivorship Insight Survey, SGID 9007321. Source response export used for all survey statistics in this report.
2. National Cancer Institute. Follow-Up Medical Care after Cancer Treatment; updated December 2, 2024. NCI follow-up care.
3. American Society of Clinical Oncology. Survivorship Care Guidelines, Care Plans & Resources. ASCO survivorship resources.
4. Woofter K, et al. Oncology Medical Home Standards. ASCO; published ahead of print July 17, 2025. ASCO Oncology Medical Home Standards.
5. Armenian SH, et al. Prevention and Monitoring of Cardiac Dysfunction in Survivors of Adult Cancers: ASCO Clinical Practice Guideline. ASCO cardiac dysfunction guideline.
6. Hart NH, et al. Survivorship Care for People Affected by Advanced or Metastatic Cancer: MASCC-ASCO Standards and Practice Recommendations. JCO Oncology Practice. 2024. MASCC-ASCO survivorship standards.

MDForLives

MDForLives is a global healthcare insights platform where healthcare professionals, patients, and caregivers discover, share, and shape the future of healthcare. This report presents aggregated professional perspectives for educational and insight purposes.

The Global Pulse of Healthcare

© MDForLives