The art and science of cancer care

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Summer is winding down as we go to press with this month's issue, and while we might well reflect a little sadly on its departure, we can also look forward to the fall season with its promise of renewal and adventure. As I settled back in to my familiar work routine after the Labor Day weekend, I was reminded of how, despite the remarkable clinical advances in oncology, we are still caregivers, involved in our patients' every day lives and that we can never forget our humanity. The advent of high-tech personalized medicine or precision oncology, as I prefer to call it, has given oncologists a remarkable cache of treatment options for their patients and the hope that more – and better – therapies are to come. Next-generation diagnostics are helping us identify the cellular targets we need to take aim at to kill the tumor and globally, research is yielding more and more therapeutics to subdue those targets and hence the tumor.

For more than a year, I have been treating a patient, a lovely woman, both inside and out, with non–small-cell lung cancer, the adenocarcinoma type that occurs in nonsmokers and has no currently actionable mutations by EGFR, ALK, or ROS. She was unresectable, but with a paucity of symptoms. We began with a platin-containing regimen to which she had a response, and then she was on maintenance therapy with pemetrexed. However, in August she progressed, and we sent her tumor for a mutation analysis, to look for some actionable mutation either with currently available agents or novel drugs in a clinical trial. Her MET mutation was positive at high levels, so a MET inhibitor or clinical trial with one of the new PD-1 inhibitors seemed possible, giving her, her husband and family, and me some hope. Then, seemingly out of nowhere, she called early this month with new nausea and unsteadiness, which rapidly progressed to shortness of breath. I sent her to the emergency department.

In a few short few hours, her symptoms progressed in the ED, where her labs were all abnormal. Scans were being organized, but her vital signs plummeted, and she suffered a cardiopulmonary arrest. Efforts for an hour to revive her were unsuccessful and she died, leaving her husband, two small children, and an extended family all shocked and grieving. A post mortem revealed that she had died of an acute malignant cardiac tamponade.

We all have such a story, but it reminds me of how the most basic caring for patients, with its emotional aspect is so hard on them, their family, and of course, on us. So as my enthusiasm for all our hi-tech therapy continues to soar, I will remember her and her family and my sadness over losing her, especially in such dramatic circumstances, for a long time. It is a privilege to do what we do, and we should never forget it.

This month, we bring you a line-up of Original Report articles that offer findings and analyses that could help us refine how we practice. We are all acutely aware of the importance of meaningful, effective communication between patient and provider given the high symptom burden in oncology. Bacteremia is associated with an increased risk of complications in patients with febrile neutropenia, so early detection in apparently stable adult cancer patients is crucial and would go a long way to curb those risks. On page 312, Carmona and colleagues explore bacteremia in adult cancer patients with apparently stable febrile neutropenia and identify a number of variables that could improve diagnostic classification of clinically stable febrile neutropenia. Murray and colleagues (p. 329) identify important areas of practice where performance gaps among hematologists and medical oncologists may be hindering delivery of optimal care to patients with CML, ALL, or B-cell lymphomas. The findings reflect the increasing complexities in treating patients as the number of cancer treatments increase, and also raise the question about staying current in the latest developments in diseases that actually make up a small percentage of their case load.

Finally, on page 321, Walker and colleagues report on treatment patterns and clinical effectiveness in patients who are treated in the community setting for metastatic castrate-resistant prostate cancer after first-line docetaxel.

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