

Struggling with survivorship

As a community oncologist, I fully embrace the opportunity to cure cancer, but I find the greatest services I provide are to palliate and enhance survivorship. We live in a tremendously fortunate time of scientific discovery. The weapons we have in our armamentarium of cancer killers grow in magnitude and specificity daily. Learning then to continue to balance each patient's battle with their quality of life is practicing the art of medicine. Although most patients hope that their cancer will be cured, the daily reality of a community oncologist lies in the subtle art of helping patients to manage life with cancer and to strike the right balance between cancer control and quality of life. This management challenge really lies in the individual variability of each patient and in being able to choose the agent that fits the patient, not just the disease.

Within this issue, we have many articles that touch on these subjects. In our regular Community Translations feature on page 214, we discuss the phase 3 AXIS data, which evaluated the role of axitinib compared with sorafenib in the second-line treatment of advanced renal cell carcinoma. The study's primary endpoint was progression-free survival, which was 6.7 months in the axitinib arm and 4.7 months in the sorafenib arm. Although mild adverse events were common, grade 3 adverse events were low in number. This drug, which was approved by the Food and Drug Administration in January of this year, adds to the targeted therapy choices in metastatic renal cell carcinoma.

On page 222, Kossoff and colleagues review the role of ixabepilone by describing the trials that led to the approval of ixabepilone in metastatic breast cancer. The epothilones as a class offer a new treatment strategy but ixabepilone, at the approved dose of 40mg/m² at 3-week intervals, is highly toxic, with neutropenia occurring in more than 50% of patients and sensory neuropathy in about 50% and without evidence of an overall survival benefit. Other dosing strategies are under investigation, but early data suggest that the

weekly dosing schedule is less efficacious. In addition, it remains a very expensive tool. As our primary goals in our metastatic patients are to palliate and enhance survival, I have to wonder whether this tool will do either well.

Jeffery and Linton used claims data among military health care beneficiaries to tackle the issue of depression prevalence and cost in survivorship (p. 216). This calls attention to an important challenge among cancer survivors, which is historically variably captured and reported so that the true cost is unknown. The authors do a solid job of quantifying health care costs, but loss of productivity and the cost of having a diminished quality of life are unmeasured. This is a nice first step in the complex issue of the things that matter and that can help us live well after our primary battle with cancer.

As we live in this exciting time of new treatments and targeted molecules, the landscape of oncology is changing. No longer are we just the bearers of weapons to fight cancer during the active treatment phase, we are also the guides along a diverse continuum of oncology services. We are still in the process of defining this continuum, but it begins with risk assessment, advances through diagnosis and treatment, and continues through survivorship, palliation, and hospice care. We need to do all of these things better.

It is my great privilege to be a community oncologist and take care of people in this time of discovery and expansion of service. Our advances across the landscape of oncology services will allow us to treat patients in a more personalized and specific way, and most importantly, to guide them in embracing wellness. Thank you for letting me take this journey with you.



A handwritten signature in black ink that reads "Debra A. Patt". The signature is fluid and cursive.

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