One process, two perspectives

Brendan Curley, DO, MPH

West Virginia University-Mary Babb Randolph Cancer Center, Morgantown, West Virginia

Eight months into my fellowship, and my first patient is still alive. Starting a fellowship at a new institution has been similar to starting my residency, however with a slightly hardened exterior that an inner city internal medicine residency program provides. As with my first patient, it was also my first time in the cancer center when I met her—for me, as a clinician; for her, as a patient. She presented the way many lung cancer patients do; a pneumonia that wouldn't go away. She thought it was just a cold, but her extensive smoking history, weight loss, and persistent symptoms indicated something much more sinister was lurking beneath the surface. Imaging suggested what she feared, and a biopsy proved it. She had metastatic lung adenocarcinoma. Her next few weeks were a crash course in oncology-PET/CT's, chemotherapy, and enrollment in clinical trials and plowing through with their lengthy consent forms. We were going through the same process from different perspectives.

The next time I would hear from her would be on the phone. As an oncology fellow, one of the most challenging aspects is that inaccessible evaluation. She was about a week out from her last chemotherapy regimen, leaving her most susceptible to infections. Objective signs, such as a physical exam, blood pressure reading, and pulse oximetry were no longer accessible. Instead, a tremor or hint of anxiety in her voice and concerned testimonials from family members became the new vital signs for me to rely on. After a lengthy and detailed conversation, she was able to be convinced to come into the hospital as a direct admission.

The following morning we would interact in a different setting, with her as an inpatient. She was experiencing one of the plethora of side effects associated with chemotherapy. Be it neutropenic fever, mucositis, or uncontrolled pain, she experienced side effects I and other fellows around the country are learning how to treat. While we are treating her adverse effects as an inpatient, new consults come in on a daily basis. Masses, anemia, thrombocytopenia and other consults are pouring in. Cancer and hematologic abnormalities are not a rarity. When I walk into the room, I am careful about how I introduce myself; a patient with an unknown reason for leukocytosis meets the hematologist, whereas someone with a known mass or new diagnosis meets the oncologist. As many of my mentors have taught me, "we will all get cancer—the question is if we live long enough to experience it."

A ward month and a bone marrow transplant month flash by. Terminology that once seemed foreign is now rolling effortlessly off of my tongue. My confidence starts to increase, and I am again in the clinic. I see a familiar name—my first patient is back for a report visit. Every time I open a PET/CT report I take a deep breath. I do that now for her. My silent prayer for good news is not granted. I see progression. As all oncologists do, I review the images myself hoping that the read is wrong; alas, it is not. As I walk in the room I am forthright, letting her and her family know that I do not have good news for them. She is incredibly strong and asks what is next. New treatment and new clinical trials are in her future as she dives headlong into a fight that she is losing but determined to win.

Eight months into my fellowship, and not only am I still alive, so is my first patient. A team of nurses, physician assistants, attending staff, residents, and fellows all have played a role in her treatment. Her disease is improving as her second-line treatment is slowing her cancer. She is determined to work and play with her grandchildren again. Her courage and tenacity, along with that of every other patient who walks through the doors of the cancer center, make me smile. I know that all the hard work we put in as fellows is appreciated and rewarded every day.

Correspondence: Brendan Curley, DO, MPH, 1 Medical Center Drive, Morgantown, WV 26506 (bcurley@hsc.wvu.edu).
Disclosures: Dr. Curley has no disclosures.

Commun Oncol 2012;9:174
http://dx.doi.org/10.1016/j.cmonc.2012.04.001