

## A Simple Wish. . . Unfulfilled

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This article is dedicated to Roza's and Robert's families. I will never forget what they went through.

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As a young oncologist who has been practicing for the last 4 years, I enjoy discussing novel therapies with my patients. I take pride in how quickly the field of oncology is moving and in the insights we have made in the molecular pathophysiology of a variety of cancers. I like educating patients about new available therapies and our ability to target malignant cells while avoiding normal tissues. Oftentimes, my enthusiasm, my desire to help, and my belief that we can transform cancer to a chronic disease blind me to our limitations and to the fact that, in many situations, cure or even meaningful prolongation of life is an unrealistic and unattainable goal.

Maybe I have learned to be optimistic in the hope that my positive attitude might provide some hopefulness to the people I treat. Many times, I have told patients that what I've read and heard is that cancer is evolving into a chronic disorder, like diabetes or hypertension. I have told my patients to realize that our therapies might control their disease, prevent progression, prolong their lives; however, the therapies are not curative. The ability to transform cancer from a relentless deadly disease to a chronic controllable one is a major advance, I would claim. Yet, despite the promising therapies, I often find myself helpless. Many times, I am not able to provide my patients with their basic needs. What is more basic than having a patient pain-free and able to relish a nice hot meal?

Two years after her death I still think of Roza, an elderly woman who was diagnosed with extensive-stage disseminated small-cell lung cancer. I recall sitting with her and her family members, trying to spin an optimistic outlook on a grave and terminal disease. I explained that systemic chemotherapy offers palliation, delays progression, and prolongs life. We discussed the supportive care measures available at the time and the means that we had to lessen the toxic adverse effects of chemotherapy. Roza consented to chemotherapy and achieved an impressive partial response. Over time, her disease progressed and therapeutic options became quite limited. She required multiple inpatient hospitalizations for dehydration and pain control. During one of these hospital admissions, I sat on the edge of her bed, looked her in the eye, and asked her how she wished to continue her treatment. I explained that from my

standpoint additional therapy would be too toxic and ineffective. We discussed advanced directives and that any heroic measures would be ill advised. Her response to my question was, "All I want is a Big Mac from McDonald's [Oak Brook, IL] with large fries." For many reasons, including poorly controlled brain metastases, Roza was having trouble with nausea and emesis. Chemotherapy had altered her taste buds and had precluded her from enjoying or even having a nice warm meal for days. Yet despite the nausea and her altered sense of taste, what she craved was a juicy burger and some salty fries.

I was astonished. Despite all the fancy therapies used, diagnostic studies employed, and an understanding of the biology of small-cell lung cancer, I found myself helpless and unable to fulfill the seemingly simple request. She was not complaining of pain or asking to be able to move around normally. She was not asking for a cure or prolongation of life. In fact, she accepted that her disease was terminal and that it would take her life away, separating her from family and loving friends. Yet her oncologist was unable to grant her small request. Of course, I could have run out and bought the Big Mac and fries that she wanted, but would Roza enjoy it? Or would her chemotherapy-altered taste buds provoke more nausea and vomiting at the mere smell or taste of the burger? I recalled how many chemotherapy patients found meat distasteful. Could she really enjoy the juicy burger? I stepped out of the room, trying to think of new ways to improve her appetite, to get her taste back, to control her nausea and periodic emesis, just to get her to enjoy her last requested meal. I didn't care about what caused her cancer, or how chemotherapeutic drugs worked, or what the newer promising therapies for her disease happened to be. All I cared about was finding a way to allow her to enjoy that burger. Roza passed away 2 weeks after our conversation and despite all the palliative measures, hospice care, and appetite stimulants, she continued to have profound anorexia; I was unable to fulfill her simple request. I still wonder about whether I should have driven to McDonald's and bought the Big Mac and fries. I may never know the answer, but I will never forget the question.

As I was grieving Roza's loss and dealing with the frustration that accompanied her death, I was

asked to provide a consultation on a patient named Robert. Robert was a young, vigorous man diagnosed with diffuse large-cell lymphoma that was invading his chest wall and pulmonary parenchyma. I was actually happy to see Robert after Roza's death. I was hoping that a patient with a potentially curable illness like Robert's would make me forget about Roza and my frustrating inability to improve her status. I remembered what one of my former professors had once said, "Despite patient loss, life and career must go on." I recall my initial conversation with Robert and my optimism toward our ability to cure his lymphoma. It seems that every oncologist believes that lymphomas are somewhat easy to treat and can be controlled with the many options available, and I certainly share such enthusiasm. I discussed with him and his wife that his lymphoma was likely to be highly sensitive to chemotherapy and that I was hoping for a cure. Soon enough, however, I came to realize that the type of large cell lymphoma that Robert had was quite refractory. I pictured his large cells laughing at every dose of the R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone) and the RICE (rituximab, ifosfamide, carboplatin, and etoposide) regimens. My efforts at salvage chemotherapy and hopefully autologous bone marrow transplantation did not thwart his aggressive disease. As his lymphoma worsened his pain worsened significantly, and every attempt to control it was largely unsuccessful. I recall the high intravenous doses of hydromorphone hydrochloride and the numerous fentanyl and lidocaine patches that covered his chest. I remember my numerous phone calls to the pain service staff asking for additional nerve blocks, begging for a magic remedy to a pain that rendered him sleepless for many

nights. Nothing worked. As Robert drifted away, I kept thinking of his wife, kids, and the last 4 months of his life that were miserable. I hoped that I would have been able to help more, to simply relieve his pain; all my efforts were unsuccessful. I continue to ask myself, could I have done more? It is another unanswered question with which I have to live.

As we make new strides and discoveries in understanding and treating cancers, we tend to brag to our non-oncology colleagues about these newer therapies. We brag about how much impact we have had on the survival rates and overall prognoses in many cancers in recent years. We try to forget our limitations. Robert and Roza are examples of the many patients who have taught me to realize that we are far from where we want to be. Roza and Robert taught me that researchers and practicing oncologists need to pay closer attention to quality-of-life measures and to supportive care methods. We need to focus on these basic needs instead of only focusing on clinical trial results, response rates, *P* values, Kaplan-Meier plots, survival curves, hazard ratios, and so forth.

We need to continually ask ourselves, how can we better control pain, how we can improve taste buds, how we can increase an appetite to simply allow a patient to enjoy a nice, warm meal. Researchers, investigators, and practicing oncologists need to step down from the high and mighty tower they have built and continue to pay attention to these basic issues, as they mean much more to our patients than a statistically significant 3-month survival advantage with a novel therapy.

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### **Author's Disclosures of Potential Conflicts of Interest**

The author indicated no potential conflicts of interest.