

## OPINION ARTICLE

# Advances, advances and more advances in Oncology. People, do you trust this statement? How do you feel when your doctor informs you that you have cancer?

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Cancer is responsible for every sixth death globally, making it the second cause of death, surpassed only by cardiovascular diseases [1]. Since its first appearance in medical history dating back to 1600 BC significant changes have been made, however the word "cancer" is attributed to Greek physicians who used the term "karkinoma" for nonhealing tumors and has since inspired fear and panic in people that catalyzed a continuous scientific effort to counteract this disease [2]. Despite the continuous increase in cancer incidence, the survival rates have also increased. In industrialized countries, the 5-year survival across all cancer types diagnosed between 1975-77 and 2007-2013 increased from 48.9 to 69.2 percent, attributable to two key factors: earlier detection and improved treatment [3].

Cancer treatment has made significant progress towards personalized medicine. Recent discoveries have shown that numerous genetic deregulations are common in multiple cancer types, raising the possibility of tumor-agnostic drugs targeting shared deregulations across tumor types, hence the concept of precision medicine. Currently, the number of therapeutic strategies is increasing at a fast pace, and the number of new drugs entering drug development continues to rise [4]. During these last years, novel immune therapy was added to the clinical armamentarium and has marked a groundbreaking milestone for cancer patient's treatment, with the number of immune-oncology agents entering drug devel-

opment at a continuous rise. Far beyond its outstanding efficacy in some patients, immunotherapy revolutionized the oncology field in numerous ways. It has changed the way physicians evaluate treatment efficacy or manage novel adverse events. It also resulted in a more integrative view of cancer patients beyond cancer cells' biology and created new networks between oncologists and other organ specialists [5].

The goal of increasing the length of survival in oncology has reached new lengths over the past decades, but cancer diagnosis remains a life-alarming experience for anyone. The medical community now agrees that patients have a moral and legal right to know the truth about their illness. However, the principle of *primum non nocere* may be at risk if a policy of full disclosure is adopted, since not all patients wish to know all the details of their disease. Hence the pertinent issue is determining which communication practices make a measurable difference to the patient outcome [6]. Some patients emerge from the cancer ordeal reasonably intact, while for others, the toll is more severe and their lives never return to a sense of order, and their emotional scars last throughout their lives [7]. Psychiatric disorders and clinically significant psychological distress among patients with cancer may be present in more than 80% of patients [8], and it has been demonstrated that this spectrum of disorders can be associated with an excess in mortality [9]. The nature of the patient's response to it will affect mood, adherence

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to treatment, and social support quality. Adequate coping with the diagnosis involves dealing with its direct and indirect effects, from managing the factual details of medical procedures to handling existential fears. Facing the illness and its consequences requires acknowledging and managing strong but inevitable emotions [10]. Despite the high prevalence of psychiatric and psychological issues, it is estimated that less than half of cancer patients are identified and referred for appropriate treatment [8]. Cancer has long inspired fear and even panic. Despite advances in early diagnosis and treatment of many cancers, a third to half the general oncologic patients say they fear cancer more than any other disease. The fears generated by a cancer diagnosis originate from its key view as a vicious, unpredictable enemy, evoking fears about its proximity, the lack of universal strategies to minimize its impact, the personal and social consequences of dying [11]. Some have even called for screening for distress to be the sixth vital sign [12]. Cancer patients usually have a state of pervasive illness, with a whole spectrum of effects that can be worsened independently of the disease, and it can be improved independently of the disease. A state of illness is worsened by cancer-associated symptoms but is also worsened by fear and uncertainty. Patients with adequate support can leave the state of illness even though the disease is not better, which is an important therapeutic goal. This can be primarily accomplished through symptom relief and talking with the patient (communication).

Patient communication is a clinical action. Therefore, talking with patients should have a goal, and it should help the patient be better. Communication with the patient should be truthful, but that should be only one of the functions that communication serves. The goal of increasing the length of survival in the treatment of cancer has achieved considerable progress recently. Although this is understandable, people do not get up in the morning just to survive; when they do, survival is in the service of living a life. The spoken language is the essential tool in medicine; almost nothing happens in its absence. Physicians commonly train themselves to meet very high standards of expertise, but this simple tool gets about as much respect and training in its use as paperwork. There is evidence why patients who comprehend what is happening to them and the reasons why are more cooperative and compliant with physicians' proposed therapies. Physicians are accustomed to talking and using words in their everyday life that they forget the impact of words on the listener. Moreover, they

forget that doctor-patient communication is not the usual conversation. In talking with patients, physicians themselves are the therapeutic agent. Cross-cultural differences in patient/family preferences must be acknowledged. In many Western countries, oncologists usually inform patients of their diagnosis, and the vast majority of patients want to know their diagnosis and prognosis [13]. However, in many non-Western societies, less than 50% of patients have an honest discussion about this, and there is a higher prevalence of situations where discussing prognostic information is avoided. A systematic review of studies examining patient preferences for breaking serious news noted that most patients in Western studies wanted to discuss life expectancy, but that figure decreased to less than 30% in Asian studies [13].

Talking to patients necessarily transmits information, and in communication, it is the information that counts; therefore, physicians should be aware that they are involved in information control. The information that reaches patients should have specific objectives. First, it should reduce uncertainty and secondly, it should improve the patient's ability to react to his current situation. Finally, it should improve the relationship between the physician and the patient. It is important to note that information has degrees of detail, complexity, or sophistication and for these reasons it should be tailored to the patient's ability to understand. It has timing, and finally, information has truth content [15]. The way the news is delivered is equally important as what news is transferred. Qualitative studies of patients' views have revealed the importance of how patients are given serious news: in person rather than by telephone, an atmosphere that welcomes questions, using clear and direct language, optimism rather than pessimism, privacy, reassurance of an ongoing plan, and appropriate support are all essential aspects [16]. Ideally, prognosis discussions should take place when the patient is not in an acute state of illness and is, therefore, better able to process and understand information. However, these discussions frequently are initiated after an acute event or disease progression [17].

Although the skills required to discuss serious news is a distinct type of communication, and they are built upon fundamental communication skills. Most follow a linear approach essentially consisting of similar steps: preparation for disclosure, disclosure, and follow-up. The most commonly used models are SPIKES, ABCDE, and BREAKS [18-20].

Good communication skills are essential, and several guidelines provide some recommen-

dations about how to optimize communications about goals of care, treatment options, and prognosis [21,22].

Another part of good, routine clinical care is to obtain a working diagnosis and treatment plan for each patient regarding psychiatric problems, given that the reported minimum prevalence exceeds one third of the patients. A large registry-based study found a significantly higher rate of mental disorders in cancer patients versus controls, particularly in the first week after diagnosis which subsequently declined, however they remained elevated for up to ten years after the initial cancer diagnosis [23]. Numerous screening tools are available for clinical as well as research purposes [24]. A regular, ongoing evaluation of emotional distress affects management and treatment of psychiatric issues and contributes to better patient outcome, satisfaction, doctor-patient communication, and improved overall oncologic care. Adequate treatment for psychiatric issues associated with cancer can be adequately commenced after clarifying the exact nature of emotional distress [25]. It is important to determine if the psychiatric symptoms are: i) a normal reaction when confronted with the diagnosis of a life-threatening disease, ii) a psychiatric disorder newly installed or which has relapsed, iii) symptoms induced by cancer or cancer related-treatment. It is important to note that although more frequent after initial diagnosis, psychiatric symptoms can oscillate through the cancer patient's journey [26]. Adjustment disorders and psychological distress are some of the most common issues with a prevalence of 10-20% and 40% respectively [27,28]. Given the high prevalence a screening program should be in place with adequate follow-up. The most frequent instruments used are the Distress Thermometer, two-item Patient Health Questionnaire or the Generalized Anxiety Disorder (GAD-7) scale [29]. Anxiety disorders are also encountered with a prevalence of 10 and are mostly represented by panic attacks, agoraphobia, and specific phobias that may result from a range of potential etiologic factors [30]. Depressive disorders, either major or minor, are also common in cancer patients and adequate treatment can be beneficial [31]. The wrong conception that all patients with cancer suffer from depression can foster the undertreatment of such states, especially in high-risk patients from low-income areas or ethnic minorities [32,33]. This should be suspected and adequately assessed in front of patients with nonadherence to cancer treatment, impairment of social functioning, distress, irritability, negativity, and worthlessness.

Unfortunately, major depression is often not recognized and one possible explanation might be that the somatic symptoms may be falsely linked to cancer or treatment adverse effects. Patients with cancer often manifest acute and long-term cognitive impairment, the magnitude of which is typically modest. Cognitive dysfunction has also been observed more frequently in cancer patients, reaching up to 75% of patients during treatment. Cognitive impairment may be temporary or permanent and both cancer itself and cancer treatment are predisposing factors [34]. Other clinically relevant psychiatric issues are represented by fatigue, insomnia, grief, pain, personality disorders, posttraumatic stress disorders and sexual dysfunctions [35,36].

One issue of special attention is suicide in cancer patients. Although the prevalence of suicidal ideation in patients with cancer is similar to the general population, suicides attempts and death are more frequent [37]. Factors associated with completed suicide are sex, with up to 6 times more males committing suicide [38]. Additionally, it has been observed that most suicides take place soon after the diagnosis, usually within the first year and the risk declines over time [39]. Other risk factors that should be promptly recognized are the presence of mental illness, physical disability, poor prognosis, lack of social support and inadequate pain control [37].

Medical knowledge enhances the sense of control and mastery a person has over this disease, and educational interventions generally yield positive outcomes. Interventions are usually effective when they provide medical patients with cues for using the knowledge related to their disease and daily management. The psychological issues linked with cancer range from disease-related anxiety, depression, and stress to disruptions of relationships to circadian rhythm dysregulation. These problems can be readily assessed, increasingly with physiologic monitoring as well as self-report. There is growing evidence that a variety of interventions can improve the quality of life for patients with cancer at all stages of the disease and may, in some cases, positively affect survival. Consistent programs in cancer coping, survivorship, and palliative care are useful to better identify problem areas and increase the quality of life and deserve to be an integral part of overall cancer care.

### **Conflict of interests**

The author declares no conflict of interests.

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