



Love in the Time of Cancer

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As a clinical oncologist for over 40 years, I have often wondered about the factors that drive patients to battle seemingly insurmountable odds with hope and determination. After all these years, I turn to love, in all its many forms, as a compelling force helping our patients combat the uncertainties associated with a cancer diagnosis. Love cannot conquer all—that we know only too well—but it can provide comfort in troubling and unpredictable times, and propel our patients ever forward against the terrible disease they face. The maudlin sentimentality of some works of fiction pales in comparison with the courage and resilience that characterize our patients. As I move toward the end of my career, I more fully realize that it is love that lies behind the resilience of so many of our patients, much like Noble laureate Gabriel Garcia Marquez described in his novel *Love in the Time of Cholera*, in which he demonstrated the power of devotion and enduring love during difficult times over the lifetime of his protagonists.

Illness as metaphor was a concept espoused in a series of essays by Susan Sontag. A paragraph from her work is very moving to me: “Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and the kingdom of the sick. Although we prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.”¹ It is difficult to navigate that night journey as a single passenger. Love, in its many manifestations, helps provide solace and a sense of peace, not just for patients, but also family members. We bear daily witness, as oncologists, to the power of love in the time of cancer.

W.G. was 23 years old when he was diagnosed with metastatic testis cancer. After complaining of pain in his left testis, his wife insisted he seek medical care, but by the time of the diagnosis, his disease had spread to the retroperitoneal nodes. He was treated with bleomycin, etoposide, and cisplatin, and achieved a serological complete remission. A postchemotherapy retroperitoneal lymph node dissection revealed teratoma. His tolerance of chemotherapy and surgery was aided by the constant presence of his wife, who appeared

far more concerned than W.G. Unfortunately, 7 years later, he had an asymptomatic late relapse manifested initially by an elevation of his serum α -fetoprotein level. During the ensuing 7 years, he endured frequent attempts at surgical extirpation, with each operation causing more physical and emotional distress. Several chemotherapy regimens produced temporary reductions in his α -fetoprotein level. His wife was always there for him in a very close and loving relationship. Finally, he reached a point where I had to tell him that further treatment would produce far more harm than benefit. W.G. was never enthusiastic about undergoing increasingly toxic treatments at the best of times. However, after the discussion regarding futile and harmful treatment, he asked about any type of therapy, no matter the adverse effects. His rationale was that even if it could provide one more day to be with his wife, he was willing to endure further toxicity. Sadly, we had truly exhausted all options. Shortly thereafter, he died at home with his wife as his constant comfort at his bedside.

E.S. was 16 years old when he was diagnosed with metastatic testicular cancer. He was treated with bleomycin, etoposide, and cisplatin on a pediatric oncology protocol and achieved a brief partial remission followed by rapid progression. He was then referred to Indiana University for salvage chemotherapy. He was a candidate for high-dose chemotherapy with peripheral blood stem cell transplantation. His probability for cure was, at best, 20% and, in my opinion, this was his only curative option. His college-educated parents accompanied him for his initial outpatient appointment and decided to take him to Mexico for alternative therapy, thereby eliminating any chance for cure. His parents loved E.S. just as deeply as W.G. loved his wife. We oncologists try to provide wise counsel and comfort on the basis of data, information, and evidence-based medicine. Ultimate decisions cannot be mandated, however, and even the best evidence for or against a particular treatment may not stand up to the power of love in its many varied expressions.

L.P. was 32 years old when she was diagnosed with stage IIIB (T4N0) adenocarcinoma of the lung. She was a never-smoker and her disease presumably

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was the result of mantle radiotherapy she received at age 10 years for childhood Hodgkin disease. She sustained injury to her left phrenic nerve, resulting in an elevated hemidiaphragm as a postoperative complication of her staging laparotomy. Her subsequent lung cancer was in the opposite right lung. She was treated at the time of diagnosis with cisplatin and gemcitabine, with stable disease; upon progression, she received docetaxel as second-line chemotherapy. She was subsequently referred to Indiana University and evaluated by our thoracic surgeon. He described a resection that would be high risk and low yield. She was informed that her complicated condition of stage IIIB lung cancer coupled with a paralyzed left phrenic nerve with elevated hemidiaphragm meant she was at significant risk of becoming ventilator dependent and that there was a real probability of postoperative mortality. She looked him in the eye and stated that she had two young children and, if there was any chance for meaningful survival, she was willing to take the risk. As predicted, she required ventilator support for 2 weeks, but fully recovered. Two years later, during a routine office visit, she had tears in her eyes and I had a lump in my throat as she declared she never thought she would be alive to celebrate this day, as both of her children had now graduated from kindergarten. She is still alive 15 years later and still finds joy in family milestones with her husband and children. Over this time, she has undergone a craniotomy for resection of metastatic lung cancer as well as a completion pneumonectomy. She has not responded to any subsequent systemic therapies. Last year, she underwent laparoscopic nephrectomy for simultaneous renal cell

carcinoma with a focus of metastatic adenocarcinoma of the lung. Her love of life and family had provided her the grace and courage to continue the fight. Tragically, as I write these words, there are no further systemic or surgical options, and she was recently enrolled in hospice, 15 years after the diagnosis of “inoperable” stage IIIB lung cancer.

There have been dramatic changes in the science and practice of medicine, and the chaos of a typical clinical day often detracts from the traditional doctor-patient relationship. Despite the chaos, we still learn to be humble and are continually inspired by our patients. We can mentor our students, residents, and fellows about medical facts, but the ability to convey empathy and compassion is just as vital as the knowledge of complicated pathways. Our patients deserve our knowledge and experience, but this only goes so far without love to guide them in their decision-making. To foster and understand the factors that keep our patients living in the face of terminal disease, we need to endeavor to have a better understanding of love in the time of cancer.

AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Disclosures provided by the authors are available with this article at jco.org.

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