LETTER FROM THE EDITOR

Buy two tickets to Bermuda, please!

When some patients run out of treatment options, the best alternative is for them to enjoy what time is left with a minimum of medical intrusion, except for symptom management. I refer to that point in the clinical course as "Two tickets to Bermuda," because that is often one of the best alternatives remaining. It does take some insight on the part of the patient as well as the doctor to "Know when to hold'em' and know when to fold'em'" (Kenny Rogers, *The Gambler*). Patients should be able to trust the judgment of their physician, and the treating physician should be willing to move to the palliative mode, or at least seek another opinion if there is controversy. But, despite our best efforts, sometimes the process goes awry.

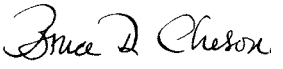
I recently experienced two encounters that emphasized the problems involved when a patient tries to dictate care when there is really nothing to be done. In the first, a 72-year-old academic from another university was diagnosed with an extremely rare lymphoid/myeloid/dendritic cell sort of tumor. He was refractory to initial multi-agent chemotherapy and then to salvage treatment. In the midst of all this, he developed a renal carcinoma that he had successfully resected elsewhere. He sought a possible bone marrow transplant but was rejected at multiple institutions. His performance status was 100% and he was still working full-time, and I recommended that he receive no further treatment but rather enjoy what little healthy time he had left. He insisted on trying additional drugs, but I couldn't think of any with a reasonable risk/benefit ratio. Thus, I told him that I would care for him, but I would not treat him further. Quite dissatisfied with that plan, he left my care for that of another physician at our institution. The patient died of his leukemia in a very few months despite being treated with several thousands of dollars worth of empiric drugs in sequence that were ineffective and associated with morbidity.

I didn't know that the second patient was sort of a celebrity until I Googled her, and I learned what an extraordinary life she had lived. This woman in her late 60s had been diagnosed with diffuse large B-cell lymphoma that was treated appropriately by her local oncologist, relapsed, was treated again, and now recurred. Unfortunately, she now also had evidence for an emerging myelodysplastic syndrome. Her performance status was normal, but her prognosis was quite poor. Her doctor's recommendation was, appropriately, enjoy what time you have left. However, this woman had considerable resources and sought out a medical consulting firm that convened a panel including two prominent physicians as moderators, as well as 14 experts from coast to coast in lymphoma, stem cell transplant, myelodysplastic syndrome, imaging, and pathology. A respectable honorarium was received by all. After meeting the patient and her family, we spent most of a Sunday reviewing the case, deliberating the various treatment options, lunching on crab cakes, and coming up with treatment options. The leading one was for her to enjoy what time she had left, as any kind of treatment—particularly a bone marrow (unrelated or cord blood in the absence of siblings) transplant—was likely to be quite toxic given her age and diseases and would have a low likelihood of benefit. Thus, tens of thousands of dollars were spent to confirm what her oncologist had recommended all along. Nevertheless, I recently learned that she was able to convince someone to perform a double cord blood transplant. What the long-term outcome will be remains to be seen.

All I know is that this month's issue is full of insights from our own panel of experts. Drs. Martha Wadleigh and Ayalew Tefferi review preclinical and clinical activity of ATP mimetic JAK2 inhibitors, and Dr. Brent Tierney and his colleagues examine advances in screening and treatment modalities in early cervical neoplasia. In our columns, Dr. Kimmie Ng considers the effects of vitamin D in colorectal cancer, Dr. Antonio Palumbo presents new data on first-line treatment of elderly multiple myeloma patients, and Dr. Alok A. Khorana outlines the role of the oncologist in the management of venous thromboembolism. In addition, Dr. George D. Demetri discusses disease state awareness in sarcoma, and Dr. Matthew P. Goetz discusses how tamoxifen therapy is affected by CYP2D6, an enzyme responsible for the metabolism of approximately 10–20% of drugs.

I guess there is a modicum of ego involved in these important decisions. Sometimes you just can't understand why patients don't take your advice. Yet oftentimes, their skepticism is appropriate. I can't imagine how difficult it must be to lay down your cards, yet sometimes the alternatives are far scarier. I hope that, when the time comes, I can do it more gracefully and with two tickets in hand.

Until next month . . .



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