

The Waiting Game

If you have ever had to wait for health care—whether an appointment, a test, or the result of a test—the anticipation of the possible outcomes and consequences can be nerve-racking. Imagine now what it must feel like to be newly informed of a cancer diagnosis. I’ve heard patients describe the ensuing onslaught of information, advice, and decision processing as being like drinking from a fire hose. The learning curve for newbie cancer patients is overwhelming for sure; even our highly educated patients and health care professionals can get lost in the minutiae of precision diagnostics, multidisciplinary approaches to treatment, and contradictory recommendations. Ultimately, most people will put their trust in one or more cancer specialists and move forward with a management plan. That trust can be tested early when results are less than ideal. But many of our patients who reach a partial or complete remission following their initial treatment experience the relief associated with a positive cancer outcome. What happens next is something that is much less talked about than remission rates—the psychology of living with a cancer diagnosis. An important part of this psychology is what I call “the waiting game.”

For my patients who have completed their initial treatment, whether surgery, radiation, and/or systemic therapy, the next step is usually a sequence of monitoring visits with or without some adjuvant or maintenance therapy. In these circumstances, we may see patients once every few months for imaging or blood tests to monitor their cancer status. These are easy visits for oncologists because we know that if the prior scan was stable, the next scan is likely to be stable as well, especially the further a patient is out from treatment. From the patient’s perspective, though, there is no such thing as a routine visit. Most patients begin to think more about the possible outcomes the closer they get to the test, trying to prepare themselves for what might feel like an inevitable relapse. Patients can lose sleep worrying about what a relapse would mean to their work, their family, and their life. When I enter the room with good news, I can almost see the pulse rate and blood pressure drop in some people. Immediate relief extends to the caregiver and anyone else present; it is as if they have all been thinking the same unsettling thoughts that no one wants to discuss.

Lately, I have been discussing these thoughts with patients. I usually start with a direct question, such as, “Have you ever thought about what it might mean if your

cancer recurred?” Of course they have, but some will downplay it and say that they don’t worry except at the time of their scans.

At this point, I move right into prognosis because most patients fear a much worse prognosis than they otherwise would have. Although no relapse is great, even a relatively short remission—such as 6 to 12 months before recurrence—can portend a much better prognosis than immediate progression or no remission at all. For patients with longer remissions, say 2 or 3 years, the prognosis can be extremely good, and patients with truly late relapses (after more than 3 years) are most likely to have slowly progressive or limited recurrences at one or two tumor sites. Sometimes, tumor-directed therapy such as radiation to these sites can put disease back into remission. At this point, I give them the real hope—the progress that medical research continues to supply.

In almost every field of cancer (now including pancreatic cancer), we’ve made significant strides with novel therapies, particularly targeted and immune-based therapies. In many of our fields, 10 to 20 different therapies have now been approved and are available for patients. On top of this, new diagnostics to detect measurable residual disease are allowing us to continue treatment beyond the initial radiographic response or to detect relapses early. With more sensitive and specific PET imaging, we can also feel more confident in cases of limited or oligometastatic recurrence. And although these therapies may not represent a cure on their own, each is a bridge to the future and a reality in which we have new breakthroughs to offer.

Taking a few minutes to address the worst-case scenario and offer a better prognosis and hope for the future can go a long way toward settling the unspoken fears of patients and caregivers. I like to recognize each patient’s accomplishment of getting through cancer treatment in the past, while building their resiliency for a possible recurrence. And lastly, I remind my cancer patients to live in the present. The line that I like to quote comes from “Anticipation,” Carly Simon’s classic song—“These are the good old days.”

Sincerely,



Daniel J. George, MD

