

# It's a wonderful life

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**M**any years ago, when our children were young and we moved into our current home, we were invited to a number of neighborhood parties to meet the other families. After being introduced to the guests, we'd start to get to know each other and the inevitable question would come up, "So, what do you do?" When it was my turn to answer the question, I would reply, "I am an oncologist," and the responses would always be the same: "That must be so hard!" Initially, I responded, "No, it's great! I love what I do," but after a few too many strange looks from the other parents, I decided to go along and give the reply they were expecting, "Yes, it's very hard."

But is it? In reflecting on those times and comparing how we practiced oncology then and how we practice today, I am struck by just how much has changed in 25 years. What we do certainly has its ups and downs. We can be so terribly sad with and for our patients when we lose them, but we are just as excited and enthusiastic with those whom we can help or save, especially if they are cured.

Training 25 years ago was simply an education on how to use our toxic chemotherapy drugs, in what combination for what tumor, and how to avoid the most significant toxicities of cytopenias, be they infections, bleeding, or gastrointestinal. As they say, it's a whole new ballgame these days. Chemotherapy is not going away. I still have first- and second-line choices, but the proliferation of biotechnology has greatly enhanced my ability to care for patients with terrible tumors and to offer them other therapies I would never have had before. Most universities, including my own, now offer a mutation-molecular analysis that can take either hematologic or solid tumor malignancies, analyze them for as many as 250 mutations, and try to find an "actionable" mutation using a currently available drug (often approved by the US Food and Drug Administration for a different tumor) or a novel drug in clinical trial. This is all thanks to the incredible technology now available to us. Of course, some would say technology has slowed us down. I need say only one "word": EMR – yes, the electronic medical record. It is certainly less than time neutral, with endless screens and clicks and the need for more screens and clicks when changes can be made only by the

caregiver or doctor. Although most of us currently feel that the EMR weighs – and slows – us down, I am confident it will improve (it has to!) and get us back on the track of more direct and intimate patient care as opposed to us spending our valuable time documenting, documenting, documenting...

So was I right 25 years ago about my enthusiasm for practice oncology. Indeed, my enthusiasm has only deepened over the years with the availability of more diagnostic and therapeutic tools with which to treat my patients and help them get better or face what might come. But one thing that hasn't changed is the human touch that we bring to our engagement with our patients. Years ago while I still training, my highly respected mentor gave me a very interesting patient, whom he would usually have kept for himself. When I asked him why he had done that, he said that she would likely not do well and he did not have the energy at that time to give her the care and attention he knew she would need and deserve. And therein is a message for all of us – love what you do, by all means, but take care of yourself and don't spread yourself too thin.

In our issue this month, we have a solid line-up of research articles for you, starting with reports on congestive heart failure during induction with anthracycline-based therapy in patients with acute promyelocytic leukemia (p. 390) and the impact of aprepitant on emesis control, dose intensity, and recurrence-free survival in head and neck cancer patients on cisplatin chemotherapy (p. 394). Two articles focus on patient quality of life (QoL): one examines peripheral neuropathy and its impact on QoL after chemotherapy (p. 401) and another looks at QoL and symptoms after stereotactic body radiotherapy in early-stage lung cancer (p. 407). A Case Report about a patient with superior vena cava syndrome as an initial presentation of low-grade follicular lymphoma (p. 415) rounds out the clinical-supportive section of the Journal. In the Features section, Patrice Wendling has written a fascinating article on choice of anesthesia during cancer surgery and outcomes (p. 418), and Bernard Mason, in his Journal Club column on page 421, provides us with a comprehensive and informative round-up of ASCO's 2013-2014 guideline releases, updates, and endorsements.

