LEADING ARTICLE

CANCER - REVEALING THE DIAGNOSIS

P T Ang

SINGAPORE MED J 1993; Vol 34: 198

As medical practitioners, our most unenviable task is to handle bad news. Few of us ever have difficulty in telling a patient that he has a peptic ulcer or the common cold. When the prognosis is good, we do not mind revealing the diagnosis because in the next breath, we can expound on our understanding of the pathophysiology of the disease, advances in medical therapeutics, and our skills as healers of the sick. However, when death appears to be the eventual victor, we often have a hard time explaining to the patient the diagnosis and the likely outcome.

It is wrong to assume that it is always difficult to tell someone that he has cancer. Sometimes, it is not difficult because there is definitive treatment available and the outlook may not be too bad. Revealing the diagnosis of cancer is not the same depending on the type of cancer, its stage and context of practice. A patient who presents with a lump in her breast sees a doctor because she is concerned that it may be breast cancer. She wants to know the diagnosis and is somewhat prepared for the worst. From the lay literature and public health education, she may understand that breast cancer is not equal to death, because it can be cured if detected early.

In other cancers, the scenario may be different. A patient who presents with change in bowel habits may attribute it to some minor ailment. When the doctor investigates and discovers that he has colon cancer, the doctor has a more difficult task of revealing the diagnosis. Taken by surprise, the patient is more likely to go through the phases of denial and anger before eventual acceptance. However, as there is the therapeutic option of surgery, the doctor would follow the revelation of diagnosis with a referral to the general surgeon. The apparent urgency of seeing another doctor and sense of focused activity reassures the patient that something can be done. It makes telling the diagnosis of cancer easier for the doctor because the patient is likely to leave the clinic satisfied that something is being done for his cancer. It offers him some hope.

The most difficult task is to tell the patient that he has an incurable cancer. Most doctors shun this task. This is largely because they do not see any viable therapeutic options. In hushed tones, the diagnosis will be discussed with relatives and the patient will be left completely ignorant of the conspiracy.

In Medical Oncology, our patients can be divided based on therapeutic goals. Our therapeutic efforts can broadly be divided into curative, adjuvant and palliative/supportive. Curative ("potentially curative" may be a more accurate term) therapy refers to treatment with the purpose of curing the patient of his disease. Examples include the highly chemosensitive tumours like malignant lymphoma, germ cell tumours, small cell cancer of the lung. Adjuvant therapy refers to use of either hormonal drugs or chemotherapy after surgery[1]. It tackles the micrometastases, reduces the chances of tumour recurrence and improves survival.

The last category is dealing with patients with cancers which are not curable. The first step in management is disclosure of diagnosis. In revealing diagnosis, one of the cardinal rules is to ensure that some fragment of hope be preserved. Even if there is no hope for cure, there must be hope that life may be prolonged or hope that the end will not be painful. It is fair to say that there is no tumour whereby there is no hope of a response to treatment. In some tumours the likelihood of response to treatment may be quite high even though there is no chance of cure because of metastatic spread eg metastatic nasopharyngeal and breast cancers have response rates of 60% to 70%[2-4]. In others, the response may be dismally low, eg inoperable liver cancer has response rate of 15%[5]. However, in discussing the role of chemotherapy, one must balance between the likelihood of response and potential toxicities associated with therapy.

More importantly, in revealing the diagnosis of terminal cancer, the patient must be reassured that he will not suffer before he dies. Painful death is feared more than death itself. Our current armamentarium of medicines to alleviate pain and suffering should ensure a dignified death for all. The Singapore Cancer Society offers both counselling services as well as hospice care for cancer patients. Medical practitioners should be aware of these services so that patients may benefit from better supportive care.

While medical practitioners must decide for themselves whether to reveal the diagnosis, I hope that more will free their patients from the anguish of not understanding why they are growing weaker, but instead grant them peace of mind, a listening ear and supportive care.

In this issue of the Journal, the paper by Tan et al[6] which addresses the attitudes of medical practitioners to revealing the diagnosis of cancer, is timely and revealing. Cancer afflicted about 4,000 individuals in 1985 and this is predicted to double by the year 2000. One criticism of the survey questionnaire is that it did not specify the type and curability of the cancer. Presumably, those who participated in the survey responded as though the cancer was hopeless and incurable. It may sadly reflect doctors' lack of awareness of the treatment options in treating and alleviating the suffering of cancer patients.

Department of Medical Oncology
Singapore General Hospital
Outram Road
Singapore 0316

P T Ang, MBBS, M Med(Int Med), MRCP(UK), FAMS, FACP
Head

References

1. Harris DT, Mastrangela MJ. Theory and applications of early systemic therapy. Semin Oncol 1991;18:493-503.
2. Wang TL, Tan YO. Cisplatin and 5-fluorouracil continuous infusion for metastatic nasopharyngeal carcinoma. Ann Acad Med Singapore 1991;20:601-3.
3. Boussen H, Cvitkovic E, Wendling JI, Azli N, Bachouchi M, Mahjoubi R. Chemotherapy of metastatic and/or recurrent undifferentiated nasopharyngeal carcinoma with cisplatin, bleomycin, and fluorouracil. J Clin Oncol 1991;9:1675-81.
4. Sledge GS, Antman KH. Progress in Chemotherapy for Metastatic Breast cancer. Semin Oncol 1992;19:317-32.
5. Di-Bisceglie AM, Rustgi VK, Hoofnagle JH, Dusheiko GM, Lotze MT. NIH Conference. Hepatocellular Carcinoma. Ann Intern Med 1988;108:390-401.
6. Tan TKS, Teo FCP, Wong K, Lim HL. Cancer: to tell or not to tell? Singapore Med J 1993;34:202-3.