Lung cancer from the point of view of the physicians who have to deal with this condition is not, generally, very challenging in terms of diagnosis or treatment. The patient is or has been a heavy smoker who may be asymptomatic, but frequently presents with cough and blood spitting. The tumor or its effects, atelectasis or pneumonia, are usually evident on the chest radiograph. The diagnosis is confirmed with bronchoscopy and bronchial biopsy or washings, or in some cases, needle aspiration of nodes or the tumor itself. The choice of treatment requires staging with the aid of such modalities as CT, mediastinoscopy, and radioisotope bone scans. Unfortunately after all these tests, in the majority of cases, the patient has to be told that the tumor is inoperable and the only treatment is radiation or chemotherapy, with a poor prognosis.

Because of the exigencies of practice, and the depressing fact that the physician has little to offer, he or she may have limited time for such a patient, and may not realize how things look to the human being on the other side of the desk. As a chest physician who has seen many patients with carcinoma of the lung, and who has recently received a diagnosis of a disseminated form of the same condition, I thought my experiences might be of value to other physicians.

My history was not entirely straightforward. I smoked cigarettes from the age of 18 to 42 years, and was using a large package per day (25 cigarettes) by the time I quit. I had no chronic chest symptoms, but did suffer for many years from episodes of dry cough and hoarseness that I attributed to reflux, and which did respond to such agents as omeprazole. In December 1996, at the time of an inguinal hernia repair, I had a chest radiograph that showed a thin linear right upper lobe density; this was reviewed with radiology and thought to be simply a scar. My practice included tuberculous patients and this might have represented inactive disease. At about the same time, I was being treated for an asymmetric, migrating tenosynovitis, seronegative, diagnosed as a reactive arthritis. This was associated with a mild leukocytosis in the range of 11 to 12 × 10^9/L. This failed to respond to sulfasalazine or doxycycline, and was not controlled with nonsteroidal agents; eventually, a small dose of prednisone was required on a long-term basis.

In February 1998 while on a holiday in Florida, I developed a severe cough with purulent sputum and a small amount of blood spitting, as well as wheezing. A radiograph showed right upper lobe streaking. I was started on an antibiotic and interrupted my holiday, but my symptoms cleared completely shortly after returning home. Foolishly, perhaps, I failed to have a follow-up radiograph.

In September 1999, again while on holiday, I developed a persistent spasmodic cough, nonproductive and afebrile, and associated with lumbar back pain. My rheumatologist thought I might have torn muscle fibers in the latissimus dorsi and tried an injection of triamcinolone. When this proved to be ineffective, he recommended a radiograph of the lumbar spine. I thought a chest radiograph was also indicated in view of the cough. The spine radiograph proved to be negative, but the chest radiograph to my horror showed a large mass in the posterior segment of the right upper lobe. That afternoon, I had CT of the chest and upper abdomen, and this revealed a 4-cm lobulated mass in the right upper lobe. This was associated with enlarged mediastinal nodes in the right paratracheal and right parahilar regions. There was also extensive lymphadenopathy on the left side, and there were subcarinal nodes. Small lytic lesions were suggested in a few vertebral bodies.
I wanted to obtain relief from my symptoms, but my main concern was to stretch out as long as possible the months I had left. I was referred to an oncologist at the regional cancer clinic. It was thought at first that I might be a candidate for cisplatin therapy combined with another agent, but I was found to have moderate renal impairment; my creatinine was 128 μmol/L with a clearance of 0.86 mL/s. As a consequence, I was started on a single drug, gemcitabine, but a course of radiotherapy was added initially, 2,500 cGy over 5 days. The gemcitabine was to be given in weekly infusions of 1,000 mg/m² for 3 weeks, with 1 week off, but the regimen had to be altered to courses of 2 weeks because of a drop in my platelets.

I have improved both symptomatically and with shrinkage and blurring of the tumor on the chest radiograph, as well as disappearance of the scalene nodes. There have at the same time been some side effects and complications. I have developed deep venous thrombosis in one leg, and have had to be started on anticoagulants. I have experienced some nausea, and particularly after the radiotherapy, esophagitis was a problem. This is not surprising, since gemcitabine is a radiation sensitizer and Blackstock and coworkers² (A. W. Blackstock, MD; personal communication; November 1999) have found promising results in NSCLC with the combination of gemcitabine and radiotherapy.

Living with an incurable cancer means, above all, having to face the idea of dying. For religious people, the concept of an afterlife may or may not provide comfort. For an atheist like myself, there is only the blackness of the void. In childhood, there is a trust that one will live forever, and I find myself becoming, in effect, a trusting child again, at least transiently. However, repeated visits to a “cancer clinic,” reminding me that I have a fatal condition, don’t help. Besides death, I worry about dying, and what this will be like: massive hemoptysis, severe breathlessness, or simply progressive weakness and wasting, ending up like one of the emaciated souls I meet at the clinic being pushed in a wheelchair. My reaction to my encounters here has undergone a change from pained embarrassment at possibly meeting previous patients (this is a small city), to a friendlier feeling of riding in a train going to the same place with my fellow humans.

The medical profession and government bodies have been struggling with the question of what to do about smoking and its various risks. The profession, earlier on, by accepting funding for research from tobacco companies, has not distinguished itself, but has gone on to widely publicize the dangers of smoking; hopefully, no physician now accepts such funds. Official bodies are in an ambivalent position;
political campaigns are funded by tobacco, cigarettes are a major source of tax revenue, and of course this industry employs many people. Government initiatives have consequently been limited and tentative. Advertising on television and radio has been banned, and there have been health warnings placed on cigarette packages. In the United States, an attempt to place tobacco under Food and Drug Administration control as an addicting drug has not been successful. In both the United States and Canada, there have been civil suits to recover costs of health care by some states and one province. As a result of some of these efforts, smoking in men has declined from 52 to 28%, and in women from 34 to 23% in the period from 1965 to 1991. Smoking in high school students has plateaued at 20%. There are clearly still large numbers of people who continue to smoke, and we don't seem to be making any headway, particularly in young people. I believe the time has come to put the tobacco companies out of business, and this could be financed by the companies themselves; there is really no reason to allow the continuing commerce in a poison such as tobacco.

Turning finally back to myself, I am doing what the criminal system would call hard time, although I have committed no offense. What about the executives of Big Tobacco? They have known for many years that tobacco is addicting and is responsible for many deaths and much disability from lung and other cancers, obstructive airway disease, and vascular disease. They have nevertheless continued to sell cigarettes and to make large profits; to maintain sales, they are now apparently targeting the young and the Third World. Do they not also deserve to do hard time?

REFERENCES