



ASO Editorial: Could Physician–Patient Communication Make a Difference in Cancer-Related Fatigue in Esophageal Cancer?

Joonas H. Kauppila^{1,2}

¹Department of Surgery, Oulu University Hospital and University of Oulu, Oulu, Finland; ²Upper Gastrointestinal Surgery, Department of Molecular Medicine and Surgery, Karolinska Institutet, Karolinska University Hospital, Stockholm, Sweden

Cancer-related fatigue (CRF) is one of the most common symptoms related to cancer, prevalent in half of cancer patients, and occurring during all phases of illness and treatment.¹ CRF is typically severe and persistent, sometimes lasting for years, and not alleviated by sleep.² It occurs more commonly in female patients and varies across cancer types.¹ Severe CRF is associated with poor health-related quality of life.² The exact mechanism of CRF remains unclear and is likely a complex process involving numerous physiological, psychological, and biochemical systems.² In cancers with poor prognosis, such as esophageal cancer, the trajectories of CRF are largely unknown.

In their recent study, Tsou and colleagues prospectively enrolled 73 stage II–III esophageal cancer patients undergoing neoadjuvant chemoradiotherapy and surgery in Taiwan.³ They examined CRF in these patients using a validated Taiwan cancer-related fatigue cognition questionnaire (TCRFCQ-V1.0)⁴ during the initial treatment phase before any treatment, after neoadjuvant therapy, and 1 week after surgery. Not surprisingly, CRF experienced by these patients increased in most domains from prior to any treatment to after neoadjuvant chemoradiotherapy, peaking in the end of follow-up at 1 week after surgery. The feeling of treatment helplessness already started to alleviate 1 week after surgery. The most striking finding in this study,

however, was the association between worries of physician invalidation at baseline and more severe CRF in later phases of treatment.

There are some potential ways to alleviate CRF. Even though the study by Tsou and colleagues³ provided only indirect evidence that the quality of communication may reduce CRF, the results spark some intriguing questions. Are we as physicians contributing to patients' CRF by our modes of communication? Are fatigued patients more prone to experience physicians' communication invalidating their worries than those without fatigue? We do not know the answer yet, but it is easy to reason that the dialog with our cancer patients, or the lack thereof, can have significant impact on the rest of their lives. Even malpractice claims have been linked to communication with patients.⁵ The good thing is that paying attention to how we communicate with our patients is inexpensive and lacks any potential harms. Like operating, communication is a skill we can practice. In light of the authors' findings, prevention of poor outcomes should begin already at the first office visit related to esophageal cancer diagnosis. During the time spent with our patients, we should be careful to avoid only listing potential outcomes, risks, and problems occurring during treatment and pushing patients forward, but have a clear aim to engage in shared decision-making with the patients. Identifying and addressing individual worries and setting the expectations for the upcoming treatment is equally important. Also, several aids for these discussions are available. I find the Best Case/Worst Case discussion tool,⁶ popularized in the acute care surgery setting, useful in guiding shared decision-making with cancer patients regarding informed consent for neoadjuvant therapy and surgery, as much as in the decisions on acute care surgery patients.

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First Received: 20 December 2021
Accepted: 23 December 2021;
Published Online: 19 January 2022

J. H. Kauppila
e-mail: Joonas.kauppila@oulu.fi

Previous studies have also suggested that living with a partner is associated with CRF,⁷ singles typically experiencing worse CRF. This is probably related to the lack of psychological support from significant others, but may be compensated by support from the friends and family of the patients. In this study by Tsou et al., there was a weak and nonsignificant association between being single and worse CRF,³ potentially due to low number of patients. Nevertheless, discussing the social support networks in each individual patients may help identifying those at high risk for CRF. Directing psychological interventions to these patients lacking social support networks may be one efficient way to reduce overall burden of CRF in our patients.

Most of the patients included in the study were male, which reflects the fact that esophageal cancer predominantly affects males, and most had squamous cell carcinoma, the prevalent esophageal cancer histology in many Asian countries and the most common esophageal cancer histology globally. These factors may pose some limitations on the generalizability of the findings to other settings. Also, the analysis was limited to 1 week after surgery. Severe complications occur in approximately 30% of patients after esophagectomy,⁸ and relatively few patients can be discharged prior to 7 days post-surgery, especially when they face a complication. A previous Swedish study in 1-year survivors of esophagectomy for cancer suggested that CRF, measured by European Organisation for Research and Treatment of Cancer (EORTC) questionnaires, continued to increase until 1.5 years of follow-up after surgery, after which CRF stabilized.⁹ In that study, those with medical and pulmonary complications experienced worse CRF compared with those without complications,⁹ which may also be reflected in patients undergoing minimally invasive esophagectomy experiencing significantly less fatigue in the initial months after surgery compared with open surgery.¹⁰

While there are treatment options, few ways of preventing CRF in esophageal cancer patients are known. Even with minimally invasive surgery and patient optimization, complications are more or less unavoidable. In the future, it will be interesting to see whether the worries of physician invalidation prior to surgery are further reflected in worse CRF at 6 months, 12 months, or even

later timepoints after surgery. It will be important to assess physician invalidation in future research of CRF and quality of life after major cancer surgery in the short and long term. The saying “one ounce of prevention is worth a pound of cure” might apply also to cancer-related fatigue.

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