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EDITORIAL

Survivorship – the situation room

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For decades, psychosocial needs in cancer survivors across all cancer sites have been documented [1,2]. It has been illustrated how the lack of clinically attention to such needs influence quality of life [3], compliance with treatment [4] and survival [5–7].

Documentation of these psychosocial needs is one thing, while changes needed, based on this documentation of the clinical daily work among cancer patients, is a completely different challenge. However, this translational process between science and implementation of clinical practice change depends not only on your findings or level of evidence. It also depends on the area within which you observe an association, even a causal association. If a research team identifies a new chemotherapy, which benefit a certain group of patients, such drug will be implemented as soon as the authorities release the drug for specified conditions. There may be considerations about the price versus the benefit of the drug but each year several costly drugs pass this test and is introduced as an eligible treatment. When it is documented that a psychosocial problem exists, e.g., depression, fear of recurrence or loss of work related to cancer treatment, no authority exist which can enforce the implementation of an evidence-based screening, treatment, or specific follow-up, addressing this problem. Both ASCO and ESMO have guidelines indicating the need for addressing psychosocial issues [8–10], but this is not observed as a mandatory clinical service by most national health systems and oncological societies.

One may ask if this situation arise due to the lack of interventions, which may address such psychosocial problems. However, when reviewing the literature within these areas it becomes clear, that this is far from the case. Treatment of depression in cancer is not a specific treatment and depression in cancer patients may be treated along the guidelines applied in most countries for treatment of depression, in general [8]. Treatment of anxiety in cancer patients, which almost always has a focus on recurrence, has also been developed [11]. Loss of work is a huge social problem and due to national variations in the legislation associated with work and affiliation to the work market during treatment for cancer, one may refer to these national programs specifically aimed at cancer survivors or to the general programs for citizens having difficulties keeping their job due to illness [12,13]. Just to illustrate that when expecting the number of cancer survivors to continue their every-day life, the need for addressing life as a survivor concurrently with the problems arising from medical treatment of cancer, seems legitimate. Assuming that this argument is sound and true one may ask, who has the responsibility for the survivorship interventions?

On the one hand the increase in the number of cancer survivors present an argument for assigning a large part of the follow-up for problems arising in the survivorship phase to the general practice. However, patients express a wish to be seen by the most competent health professional, which in this case often is perceived as the oncologist [14]. Maybe this wish leads to a dead end?

One may speculate, if the constant development of new specialties in the medical profession both mirrors more knowledge and advancement in technology but also the inability to address more comprehensive or multifaceted problems experienced by a citizen when becoming a patient. In the current organization of the health systems, such complex problems, before being addressed must be sliced into pieces that fits into each medical specialty.

Is this always in the interest of the citizen? One may consider this question to which we do not have an answer. In parallel, the involvement of patients in decision making at all stages of the treatment illustrates the dawn of a new shared decision construction in cancer treatment, across all specialties and modalities. How are the medical professionals able to contain these challenges without changing the model of treatment and to a higher degree address the psychosocial problems, late effects, and the change of cancer as an entity into one of several chronic diseases, which needs care in the coming generations of multimorbid citizens?

We raise these questions on the background of presentations at the European Cancer Rehabilitation and Survivorship (ECRS) Acta Oncologica Symposium held in Copenhagen in September 2022. The twenty-one papers selected for publication from the Symposium reflect knowledge gaps and represents ongoing and diverse survivorship research across several countries. Several studies test interventions

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addressing late effects as neuropathy [15] or bone density [16]; test efforts to diagnose and manage early lymphedema after breast cancer [17] or optimize health before stem cell transplantation in myeloma [18]. However, no long-term effect on survival of a psychoeducational intervention trial in breast cancer was observed [19].

In line with the increasing acknowledgement of the role that patient reported outcomes may play in management of treatment and follow-up care a number of studies report on how self-reported PROs are associated with cancer outcomes, like survival in bladder cancer [20], completion of first-line treatment in lung cancer [21], as well as physical and psychological functioning in the long-term follow-up following breast cancer [22]. All studies illustrating that comprehensive focus on patient resources and symptoms is essential in the planning of cancer treatment. When follow-up programs are changed from calendar-driven to patient-initiated or nurse-led follow-up in breast cancer, social differences are evident in fear of recurrence [23], but not in quality of life [24] and these findings inform the discussion on how best to ensure stratified follow-up to patients at high risk for both relapse and/or late effects.

The natural history of late effects is further elucidated through reports on how treatment for breast cancer affect sexuality in long-term survivors [25], how cardiovascular disease risk is increased after elective colorectal cancer surgery [26] with an impact on quality of life in colorectal cancer survivors [27] and how previous depression is a marker for suicide among prostate cancer survivors [28]. Return to work is a principal issue for cancer survivors of working age, with novel studies on work and education interruption by Hodgkin lymphoma [29], a review of interventions to improve work participation for unemployed or disabled cancer survivors [30] and an implementation study targeted managers to improve return to work after cancer [31]. Health promotion in cancer has not been much reflected at previous ECRS symposia, but a population-based study showed that cancer patients are as successful in quitting smoking as the non-cancer population [32] calling for action in this by many defined as a 'hard-to-reach' population, regarding both quality of life and survival. The value of and burden for caregivers in cancer survivorship is much debated and ECRS brought us studies showing that perceived caregiver burden among informal caregivers [33,34], but also that this caregiver burden may be alleviated in the palliative care setting by psychological interventions [35].

All in all, as illustrated by the variety in research topics, cancer patients and survivors face challenges in all areas of life. How do we integrate this knowledge in our definition of which services should be provided at the highly specialized cancer clinic and which would be best addressed in the primary health sector including the general practitioners? This is a decade-long discussion often being a roadblock for further development. We need more trials investigating the division and collaboration between sectors having responsibility for the care of cancer survivors. Hopefully more data will be presented at ECRS in 2024.

Disclosure statement

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References

[1] Caruso R, Nanni MG, Riba M, et al. Depressive spectrum disorders in cancer: prevalence, risk factors and screening for depression: a critical review. Acta Oncol. 2017;56(2):146–155. doi: 10.1080/0284186X.2016.1266090.

[2] Luigjes-Huizer YL, Tauber NM, Humphris G, et al. What is the prevalence of fear of cancer recurrence in cancer survivors and patients? A systematic review and individual participant data meta-analysis. Psychooncology. 2022;31(6):879–892. doi: 10.1002/pon.5921.

[3] Alwhaibi M, AlRuthia Y, Sales I. The impact of depression and anxiety on adult cancer patients' Health-Related quality of life. J Clin Med. 2023;12(6):2196. doi: 10.3390/jcm12062196.

[4] Barber B, Dergousoff J, Nesbitt M, et al. Depression as a predictor of postoperative functional performance status (PFPS) and treatment adherence in head and neck cancer patients: a prospective study. J Otolaryngol Head Neck Surg. 2015;44(1):38. doi: 10.1186/s40463-015-0092-4.

[5] Wang X, Wang N, Zhong L, et al. Prognostic value of depression and anxiety on breast cancer recurrence and mortality: a systematic review and meta-analysis of 282,203 patients. Mol Psychiatry. 2020;25(12):3186–3197. doi: 10.1038/s41380-020-00865-6.

[6] Suppli NP, Johansen C, Kessing LV, et al. Survival after early-stage breast cancer of women previously treated for depression: a nationwide Danish cohort study. J Clin Oncol. 2017;35(3):334–342. doi: 10.1200/JCO.2016.68.8358.

[7] Barber B, Dergousoff J, Slater L, et al. Depression and survival in patients With head and neck cancer: a systematic review. JAMA Otolaryngol Head Neck Surg. 2016;142(3):284–288. doi: 10.1001/jamaoto.2015.3171.

[8] Grassi L, Caruso R, Riba MB, ESMO Guidelines Committee., et al. Anxiety and depression in adult cancer patients: ESMO clinical practice guideline. ESMO Open. 2023;8(2):101155. doi: 10.1016/j.esmoop.2023.101155.

[9] Jordan K, Aapro M, Kaasa S, et al. European society for medical oncology (ESMO) position paper on supportive and palliative care. Ann Oncol. 2018;29(1):36–43. doi: 10.1093/annonc/mdx757.

[10] Andersen BL, DeRubeis RJ, Berman BS, American Society of Clinical Oncology., et al. Screening, assessment, and care of anxiety and depressive symptoms in adults with cancer: an American society of clinical oncology guideline adaptation. J Clin Oncol. 2014;32(15):1605–1619. doi: 10.1200/JCO.2013.52.4611.

[11] Butow PN, Turner J, Gilchrist J, et al. Randomized trial of ConquerFear: a novel, theoretically based psychosocial intervention for fear of cancer recurrence. J Clin Oncol. 2017;35(36):4066–4077. doi: 10.1200/JCO.2017.73.1257.

[12] de Boer AGEM, de Wind A, Coenen P, et al. Cancer survivors and adverse work outcomes: associated factors and supportive interventions. Br Med Bull. 2023;145(1):60–71. doi: 10.1093/bmb/ldac028.

[13] Stapelfeldt CM, Klaver KM, Rosbjerg RS, et al. A systematic review of interventions to retain chronically ill occupationally active employees in work: can findings be transferred to cancer survivors? Acta Oncol. 2019;58(5):548–565. doi: 10.1080/0284186X.2018.1559946.

[14] Mayo SJ, Ajaj R, Drury A. Survivors' preferences for the organization and delivery of supportive care after treatment: an integrative review. Eur J Oncol Nurs. 2021;54:102040. doi: 10.1016/j.ejon.2021.102040.

[15] van de Graaf DL, Smeets T, van der Lee ML, et al. Patient-centered development of *embrace pain*: an online acceptance and commitment therapy intervention for cancer survivors with chronic painful chemotherapy-induced peripheral neuropathy. Acta Oncol. 2023;1–13. doi: 10.1080/0284186X.2023.2187260.

[16] Jørgensen PL, Kreiberg M, Jørgensen N, et al. Effect of 12-months testosterone replacement therapy on bone mineral density and markers of bone turnover in testicular cancer survivors – results from a randomized double-blind trial. Acta Oncol. 2023;1–7. doi: 10.1080/0284186X.2023.2207218.

[17] Skjødt Rafn B, Jensen S, Bjerre ED, et al. Prospective surveillance for breast cancer-related lymphedema (PROTECT). Acta Oncol. 2023;62(3):1–6. doi: 10.1080/0284186X.2023.2197125.

[18] McCourt O, Fisher A, Ramdharry G, et al. Exercise prehabilitation for people with myeloma undergoing autologous stem cell transplantation: results from PERCEPT pilot randomised controlled trial. Acta Oncol. 2023;1–10. doi: 10.1080/0284186X.2023.2178326.

[19] Kirkegaard AM, Dalton SO, Boesen EH, et al. Effects on long-term survival of psychosocial group intervention in early-stage breast cancer: follow-up of a randomized controlled trial. Acta Oncol. 2023;62(4):422–428. doi: 10.1080/0284186X.2023.2203329.

[20] Stormoen DR, Taarnhøj GA, Friis RB, et al. Association of patient-reported pain with survival in bladder cancer: a post-hoc analysis of the iBLAD trial. Acta Oncol. 2023;1–6. doi: 10.1080/0284186X.2023.2199461.

[21] Hansen JM, Kjaer TK, Mellemgård A, et al. Association between anxiety and depression symptoms and completion of first-line treatment in newly diagnosed lung cancer patients. Acta Oncol. 2023;1–5. doi: 10.1080/0284186X.2023.2207745.

[22] Ebbestad FE, Ammitzbøll G, Horsbøll TA, et al. The long-term burden of a symptom cluster and association with longitudinal physical and emotional functioning in breast cancer survivors. Acta Oncol. 2023;1–8. doi: 10.1080/0284186X.2023.2185909.

[23] Larsen C, Kirchhoff KS, Saltbæk L, et al. The association between education and fear of recurrence among breast cancer patients in follow-up - and the mediating effect of self-efficacy. Acta Oncol. 2023;1–5. doi: 10.1080/0284186X.2023.2197122.

[24] Karlsen RV, Høeg BL, Dalton SO, et al. Are education and cohabitation associated with health-related quality of life and self-management during breast cancer follow-up? A longitudinal study. Acta Oncol. 2023;62(4):407–413. doi: 10.1080/0284186X.2023.2199128.

[25] Åsberg RE, Giskeødegård GF, Raj SX, et al. Sexual functioning, sexual enjoyment, and body image in Norwegian breast cancer survivors: a 12-year longitudinal follow-up study and comparison with the general female population. Acta Oncol. 2023:1–9. doi: 10.1080/0284186X.2023.2238548.

[26] Degett TH, Moustsen-Helms IR, Larsen SB, et al. Cardiovascular events after elective colorectal cancer surgery in patients with stage I-III disease with no previous cardiovascular disease. Acta Oncol. 2023;1–9. doi: 10.1080/0284186X.2023.2212844.

[27] Bonhof CS, Mols F, Widdershoven JW, et al. Colorectal cancer and cardiovascular disease: double the burden when it comes to your health-related quality of life? Acta Oncol. 2023. doi: 10.1080/0284186X.2023.2245131.

[28] Friberg AS, Carlsson SV, Vickers AJ, et al. Impact of previous depression on the risk of suicide among prostate cancer patients. Acta Oncol. 2023 Feb 7;62(1):89–99. doi: 10.1080/0284186X.2023.2173536.

[29] Juul SJ, Rossetti S, Kicinski M, et al. Work and education interruption in long-term hodgkin lymphoma survivors: an analysis among patients from nine EORTC-LYSA trials. Acta Oncol. 2023;1–9. doi: 10.1080/0284186X.2023.2195561.

[30] van Ommen F, Coenen P, Malekzadeh A, et al. Interventions for work participation of unemployed or work-disabled cancer survivors: a systematic review. Acta Oncol. 2023;1–12. doi: 10.1080/0284186X.2023.2187261.

[31] Berkhout MA, Tamminga SJ, de Boer AGEM, et al. Pilot implementation of MiLES: a web-based intervention targeted at managers with the aim of enhancing the successful return to work of employees with cancer. Acta Oncol. 2023;1–9. doi: 10.1080/0284186X.2023.2238886.

[32] Lauridsen SV, Jensen BT, Tønnesen H, et al. The Gold Standard Program (GSP) for smoking cessation: a cohort study of its effectiveness among smokers with and without cancer. Acta Oncol. 2023;1–8. doi: 10.1080/0284186X.2023.2228445.

[33] Elberg Dengsø K, ThomsenT, Christensen BM, et al. Physical and psychological symptom burden in patients and caregivers during follow-up care after curative surgery for cancers in the pancreas, bile ducts or duodenum. Acta Oncol. 2023;1–12. doi: 10.1080/0284186X.2023.2185541.

[34] Gjerset GM, Kiserud CE, Wisløff T, et al. Perceived burden and need for support among caregivers of cancer patients. Acta Oncol. 2023;1–9. doi: 10.1080/0284186X.2023.2240008.

[35] von Heymann A, Finsted E, Guldin MB, et al. Effects of home-based specialized palliative care and dyadic psychological intervention on caregiver burden: results from a randomized controlled trial. Acta Oncol. 2023;62(4):422–428. doi: 10.1080/0284186X.2023.2194491.