



# Use of the word “cured” for cancer patients—implications for patients and physicians: the Siracusa charter

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## ABSTRACT

Long-term survival for adult patients with solid tumours continues to increase. For some cancers, the possibility of recurrence after a number of years is extremely low, and the risk of death becomes similar to that of the general population of the same sex and age.

During the Fifth European Conference on Survivors and Chronic Cancer Patients held in Siracusa, Italy, June 2014, oncologists, general practitioners, epidemiologists, cancer patients and survivors, and patient advocates joined to discuss the possible use of the term “cured” in reference to some adult patients with solid tumours. The specific focus was the appropriateness of using the term in communicating with cancer patients, survivors, and their families. Initial results of the discussion, in concert with a review of the published literature on the subject, were later further discussed by all participants through electronic communication. The resulting final statement aims to suggest appropriate ways to use the word “cured” in the clinical and communicative setting, to highlight the potential impact of the word on patients, and to open a critical discussion concerning this timely and delicate matter.

## KEY WORDS

Long-term survival, cure, implications

## 1. INTRODUCTION

Use of the term “cured” for some cancer patients is being debated in view of the increasing survival rates in some cancers<sup>1</sup> and the development of survivorship care as an essential component of oncology<sup>2</sup>. The appropriateness of using “cured” relates to the scientific

evidence, summarized later in this article, and to individual and cultural differences in understanding of and perception by cancer patients of terms such as “chronic,” “survivor,” and “cured.” At the same time, some oncologists prefer to use “long-term survivor” instead of “cured,” in that, although patients prefer “cure,” practitioners believe that saying “cure” is impossible in some settings<sup>3</sup>.

In cancer patients, the risk for death from a specific neoplasm is highest in the initial years after diagnosis; it decreases progressively thereafter, until a time at which the risk becomes negligible, and surviving patients reach a life expectancy that matches that of a sex- and age-matched general population<sup>4,5</sup>.

Conditional relative survival—the probability of a patient surviving an additional 5 or 10 years after already surviving a given number of years—is a clinically relevant measure of long-term excess mortality in a cohort of cancer patients<sup>6</sup>. Favourable long-term survival has been reached in colorectal<sup>4,6,7</sup> and invasive cervical cancer<sup>4,7,8</sup>, with large studies consistently showing that, in comparison with a general population, lack of excess mortality is reached in approximately 8 years. For patients with breast cancer, a small but significant excess mortality remains for up to 15 years after diagnosis<sup>7,9</sup>, but approximately half of all breast cancer patients will not die from their cancer<sup>10,11</sup>, reaching a negligible excess risk of death at approximately 20 years after diagnosis. A similar pattern emerges from studies of men living after a prostate cancer diagnosis<sup>4,7,10</sup>.

Notably, 5-year survival is now more than 95% for thyroid and testicular cancers among adult Italian cancer patients. For patients who experienced those tumour types during 2000–2004, 10-year survival reached approximately 90%<sup>12</sup>, suggesting very good prognosis and a long-term life expectancy

similar to that of the sex- and age-matched general population. In addition, the outlook for patients with differentiated thyroid cancer is very optimistic: at 30 postoperative years, the cause-specific mortality rate is only 1%, and the rate for tumour recurrence at any site is less than 15%<sup>13</sup>.

On the other hand, even if recurrences of germ-cell tumours of the testis are rare, most relapses in patients with germ-cell tumours occur within the first 2 years of treatment<sup>14–16</sup>, and no excess mortality has emerged in population-based studies<sup>7,17</sup>. Increasing survival is also expected for other cancer types as a result of personalized treatments based on a better understanding of the biology and potential response to therapies of each individual cancer.

The statement that follows represents the outcome of discussions involving clinicians, epidemiologists, and patients. The discussions occurred during, and online after, the Fifth European Conference on Survivors and Chronic Cancer Patients that was held in Siracusa, Italy, June 7, 2014.

## 2. STATEMENT

1. The word “cured” refers to complete clinical remission of a cancer, regardless of the presence or absence of late sequelae of treatments. To correctly apply the word “cured,” the time from the cancer diagnosis must be such that the patient’s risk of death does not, because of cancer, exceed that of a sex- and age-matched general population. In other words, a cancer patient can be defined as “cured” only when his or her life expectancy is the same as that of a sex- and age-matched general population.
2. The word “cured” cannot be used for all cancer types, because cancer is a highly heterogeneous group of diseases with variable biologic features, clinical expressions, natural histories, responses to treatment, and outcomes.
3. At present, some cancers cannot and should never be defined as “cured” because their stage is too advanced; their cure rate, too low; or their risk of recurrence, too high.
4. The biologic characterization of a tumour and its site, stage, and disease-free interval are some of the variables that influence the correct applicability of word “cured,” given the conditions listed in point 1.
5. When appropriate, the word “cured” can be used in the clinical setting during the communication process with patients and their families. As discussed elsewhere in this paper, communication with individual patients and their families about cancer as cured, in remission, or evolved into chronic illness requires that clinicians develop and adopt a novel conceptual framework for understanding and explaining cancer in all its biologic, medical, and psychosocial complexities<sup>2,3</sup>. In the absence

of such a paradigm shift in communication, artificial dissonances among cancer patients could potentially be created when only a very carefully selected small group of patients are told that they are cured. Further confusion could arise if the use of “cured” during the communication process is not paralleled with different prevention, screening, and surveillance standards for the “cured” group.

6. Oncologists and family doctors are often reluctant to use the word “cured.” As a consequence, some cancer patients are dominated by a deep sense of uncertainty about their future and could worry excessively and ineffectively. They might focus their attention solely on the follow-up required for prevention or early diagnosis of a possible cancer relapse and tend to underestimate the need to prevent and address late effects of treatment, comorbidities, and secondary cancer prevention.
7. By contrast with point 6, using the word “cured” might help patients to better cope with the aftermath of their illness at both the medical and psychosocial levels. In the Italian culture (among others), patients—having been told by their oncologists that they are cured of the cancer for which they have completed treatment and initial follow-up—might be more willing to accept and follow broad intervention programs focused on restoring and maintaining general well-being by modifying potentially negative lifestyles and following screening recommendations for all cancers and other common diseases.
8. It is important to note that clinician-recommended follow-up cannot entirely be standardized or divorced from each individual patient’s perceptions and consequent needs and demands. It is therefore important to consider the pros and cons of using the word “cured” according to each patient’s individual and cultural variables.
9. Finally, considering the many social implications of a cancer diagnosis, the use of the word “cured” in certain societies and cultural contexts could facilitate the return of each cancer patient to his or her relational and professional life after cancer by reducing the risk of work and insurance discrimination.

## 3. CONFLICT OF INTEREST DISCLOSURES

We have read and understood *Current Oncology*’s policy on disclosing conflicts of interest and declare that we have none.

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