

Excerpted from

***Facing Cancer with Hope:
Suggestions for Patients, Caregivers, and Patient Advocates
Based on a Surgeon's Own Cancer Journey***

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Introduction

"There are many things of which a wise man might wish to be ignorant"
—Ralph Waldo Emerson (1803-1882)

"Ipsa scientia potestas est (knowledge itself is power)."
—Sir Francis Bacon (1561-1626), "Meditationes Sacrae" (1597)

The Tide Rises, the Tide Falls

Henry Wadsworth Longfellow

The tide rises, the tide falls,
The twilight darkens, the curlew calls;
Along the sea-sands damp and brown
The traveller hastens toward the town,
And the tide rises, the tide falls.

Darkness settles on roofs and walls,
But the sea, the sea in the darkness calls;
The little waves, with their soft, white hands,
Efface the footprints in the sands,
And the tide rises, the tide falls.

The morning breaks;
The steeds in their stalls Stamp and neigh, as the hostler calls;
The day returns, but nevermore
Returns the traveller to the shore,
And the tide rises, the tide falls.

I have had, and may still have, cancer. I will die from my disease... unless I die from something else first. As Longfellow reminds us, the tide will ultimately go out for each of us.

Why write about my experience with cancer? The process of learning what my family and I have learned while facing cancer over the past 15 years has not been particularly pleasant. Revisiting memories from those times and recapitulating the lessons we learned has been painful. But there are several reasons why talking about cancer is important.

First, cancer is common. According to the U.S. Centers for Disease Control and Prevention, cancer is diagnosed in more than 1.6 million people in the U.S. every year¹. Almost all of us know someone who has had cancer or has been significantly affected by this disease. For readers who work in a health care setting, up to a third of our patients have or have had cancer.

Second, cancer is a high-impact disorder. It is second only to heart disease as a cause of death in the U.S., resulting in over 602,000 deaths in 2020². From an economic viewpoint, between costs of medical care, other caregiving expenses, and lost patient and family income, cancer is a very expensive disorder (some- times ruinously so) for patients and their families. The economic burden on a societal level is enormous as well. Estimates suggest that direct medical costs alone related to cancer have increased from \$125 billion in 2010³ to \$208 billion in 2020⁴, an increase of more than 66% over this 10-year period.

Cancer also takes a huge emotional toll. The medieval term for cancer, canker, was used as a metaphor for progressively destructive evil by Shakespeare in *Romeo and Juliet*. The writer Susan Sontag, herself a cancer patient, noted in *Illness and Metaphor* that cancer is all too often considered to be an “ill-omened,” “abominable,” and “disgusting” disorder⁵. We regularly anthropomorphize cancer, and use military terms to characterize individual and societal struggles with cancer. Patients are said to be battling cancer, while the U.S. government has been fighting a war on cancer since the passage of the National Cancer Act of 1971⁶. Although there are a number of medical disorders that may be more quickly debilitating or lethal than many cancers, there are few diagnoses that inspire in patients and family members the fear and dread inspired by the diagnosis of cancer. It is for good reason that the esteemed oncologist and Pulitzer Prize-winning author Siddhartha Mukherjee entitled his classic book describing cancer and its history *The Emperor of All Maladies*⁷.

I’m writing this book for more personal reasons as well. First, this represents an opportunity for me to thank (or thank again,) the many caregivers, colleagues, teachers, family members, and friends who have supported my immediate family and me during this time. Second, this book represents an opportunity for me to acknowledge with admiration and appreciation the many cancer patients and their family members I’ve met during the course of our respective treatments.

Last but not least, I hope that sharing my family’s experience during our cancer odyssey may prove helpful to other individuals and their family members, friends, co-workers, and advocates as they face cancer or other life-threatening illnesses. Fortunately, there are

reasons to be hopeful. Recent developments in cancer diagnosis and treatment have improved survival rates from several common cancers. Indeed, although cancer remains a leading cause of death in the U.S., there has been a 29% drop in U.S. cancer deaths since 1991⁸. In some cases, new treatment options can lead to cure. In other cases, even when cure isn't possible, new therapies may allow for intermediate- or long-term control, allowing cancer to be managed like a chronic disease, much like high blood pressure or diabetes. It can be challenging, however, to select from the increasing number of clinical and experimental therapeutic options. One of the main goals of this book is to help patients, caregivers, and patient advocates successfully manage this process. Knowledge is power.

How to Use This Book

As a prospective reader of this book, you or your loved one may be confronting a frightening new diagnosis of first-time cancer, or cancer that has recurred or spread after previous therapy. My family and I have faced diagnoses of both initial and recurrent cancer. I know that this is an emotionally difficult time for you and your loved ones. I remember feeling a lot of uncertainty and having many questions about what would happen next, including treatment options and side effects, as well as what I could expect regarding the outcomes of treatment. As noted in Chapter 3, it can be hard to know how to even start facing cancer after receiving what can seem like an emotionally paralyzing diagnosis. This book seeks to provide a template for how to engage with initial evaluation and testing and how to proceed through required treatment as safely, comfortably, and successfully as possible.

Alternatively, if you're an advocate who supports patients and families facing cancer or a health care professional or professional in training who works with cancer patients, you may be seeking technical information that will assist you in helping your clients and patients navigate what are often complex and challenging decision-making processes.

Regardless of your role on the team facing cancer, we and our book production colleagues have tried to design the book to help meet your needs as readers. This book is organized roughly around a chronological narrative of my personal and family experiences with cancer, with chapters beginning at my diagnosis and proceeding through various surgeries and chemotherapy regimens to the present day. Most chapters begin, and some end, with details regarding my personal experiences presented in **Futura** font.

The step-by-step descriptions of my personal experiences are accompanied by general suggestions that may be relevant to patients and their caregivers at that particular stage of their own journey. The chapters discussing my chemotherapy experience, for example, contain advice about how to get through chemo most comfortably. These recommendations are presented in **Minion** font.

Some of the chapters (particularly Chapter 2, which describes how cancer starts, grows, spreads, and, ultimately can kill; Chapters 6 and 7, which discuss chemotherapy; and Appendix 1, which reviews radiation therapy) contain a lot of detailed scientific, technical,

and clinical treatment information. This optional technical information is surrounded by thick bars to differentiate it from the personal narrative and general recommendations portions of the text.

While some readers may prefer to read all of the technical material, it is *not* necessary or expected that you do so. Many readers may choose instead to skim or skip some parts and refer to this information for reference as needed. In many cases (and hopefully in your situation), there are standard surgical, medication, and radiation regimens that yield excellent results. In these cases, it may not be necessary for you to look beyond these standard approaches, or try to decide among other therapy options including experimental treatment and clinical trials.

For a second group of patients, however, the best choice of treatment may not be clear. For yet a third group, including me, cancer may persist, recur, and spread despite standard therapy. Although I believe that every cancer patient can benefit from self-education, the scientific and technical information sections may be particularly useful for the latter two groups of patients. This material is included to provide a foundation, if needed, for researching treatments and discussing specific therapy options (that may include experimental therapy or clinical trial participation) with members of your care team.

While my extensive research was largely driven by the lack of effective treatments in my personal situation, you do not need to be a medical expert to gain valuable information from this book. You are, in many respects, the most well-informed expert on you; bringing your knowledge, experience, and research insights to the table is a key way you can partner with your health care providers to optimize your care outcomes.

As noted above, the book is roughly organized chronologically in the sequence of our journey from diagnosis on. While I underwent multiple surgeries, multiple courses of chemotherapy, and an interventional radiology procedure and participated in two clinical trials, I did not undergo other common forms of cancer treatment including radiation therapy and stem cell transplantation. The placement of the discussion of these treatment options in appendices at the end of the book is not intended in any way to diminish their importance in cancer therapy.

With apologies to readers who are writing professionals or editors (which I clearly am not), different parts of this book are written using first, second, and third person voices in an attempt to maintain as conversational a tone as possible, while maximizing clarity of communication. “I” refers to me (John), and “we” refers variously me to my wife, my kids, our family and friends, and/or my care providers and me.

A glossary with definitions of medical terms can be found at the end of the book. Technical terms that appear in the glossary are printed in **Futura** font. In addition, if you’re reading this as an e-book, the search function can be used to locate information of interest. A comprehensive index has been provided in print versions of the book for this purpose as well.

For readers who want more detailed information about points discussed in the text, many chapters have numbered endnotes referring to further reading in the Endnotes section at the end of the book. Clicking on the superscript in the e-book text will bring you to the corresponding reference in the Endnotes. Those references, in turn, are formatted as active hyperlinks in the e-book version, preceded by a brief description of what's covered in the reference. I've made every effort to ensure that the hyperlinks are intact and working prior to publication, and I apologize in advance for links that may no longer be active.

Lastly, many chapters include a table at the end listing "take home points" summarizing selected highlights from the chapter. The exception is the table at the end of this introduction that instead contains a number of recommendations that may be worth considering by all of us, given the potential for unexpected life-changing events like getting a diagnosis of cancer.

Important Caveats

Lastly, before we embark on this journey, a few important disclaimers are in order. First and foremost, recent improvements in treatment notwithstanding, cancer remains a formidable challenge. No book, including this one, can guarantee a good outcome. It is my hope, however, that the information shared here can help patients and their caregivers, family members, and advocates come up with an organized plan to address their illness. For the first two years after my diagnosis, it wasn't clear that anything would work. But following the strategies outlined in this book allowed me to feel that I was doing everything I could to prolong my survival and remain hopeful, while giving me and my care team a chance to ultimately identify a treatment that might be effective.

The scientific and clinical comments presented herein, although reviewed by two highly respected oncologists, represent my opinions and may not be current, complete, or accurate by the time you read this book. The primary purpose of this information is to help the reader gain insight into factors that influence decision-making when facing cancer. While I have tried to provide helpful information, my comments may be oversimplified, not relevant to your situation, or, in some cases, obsolete to some degree as time goes on. Many years ago, one of our wisest medical school professors told my class that half of the information that we would learn during our four years of medical school would prove to be incomplete or downright incorrect during the ten years following our graduation. The problem, he told us, is that no one knew which half would be wrong. This problem persists to this day and extends to the information I share in this book.

On a related note, with the acceleration in research and discovery (enabled in part by ever-expanding information technology capabilities), scientific understanding is often changing more rapidly than can reliably be tracked in printed form. One of the major things I've learned during my illness is that the published medical literature may not always keep up with relevant developments in the basic science, diagnosis, and treatment of cancer. This caveat pertains to the information shared in this book as well. As outlined in Chapters 10 and 16, directly contacting oncologists and scientists involved in cutting-edge research

regarding your type of cancer can sometimes yield valuable insights and suggestions that haven't been formally published yet.

Another important point to keep in mind is the highly individualized and varied nature of the biological process of cancer in patients with malignancies involving the same part of the body. Cancer is now understood to be a heterogeneous disorder, with many different underlying genetic and/or metabolic aberrations driving its development, growth, and spread. These genetic and metabolic differences may both guide the choice of treatment and influence the response of different cancers to therapy. Whereas previously cancers (and their treatments and outcomes) were classified according to anatomic location of the primary or initial site of the tumor (e.g., breast, lung, or colon), now physicians focus on determining the specific genetic mutation(s), protein-related abnormalities, and/or metabolic pathway variations that are central to the growth and spread of a given individual's cancer.

In this evolving paradigm of individualized cancer medicine, oncologists hope that identifying these genetic, protein-related, and/or metabolic abnormalities may allow them to develop treatments targeting these abnormalities—ideally with fewer treatment-related side effects as well as better outcomes. Under any circumstances, and particularly in view of the rapidly changing nature of cancer science and treatment, ***nothing in this book is intended to substitute for the input and guidance that an individual patient should seek and receive from their medical care team. I am not an oncologist by training, and it is important that your care be directed, supervised, and performed by appropriately qualified specialists who are familiar with your particular situation.*** If there's one overarching suggestion arising from my experience that I hope to share in the book, it is the importance and value of the patient, caregiver, and/or patient advocate doing the research and self-education necessary to participate actively and work effectively in partnership with their care team in the decision-making process.

What This Book Doesn't Cover

This book addresses what often happens after cancer is diagnosed, but it doesn't deal with the important topic of screening for cancer. Cancer screening technologies are getting more sophisticated and sensitive. Pap test screening has been shown to detect cervical cancer at an earlier stage than in the past, possibly allowing more limited and effective treatment. Screening strategies for breast cancer have expanded from breast self-examination and standard mammography to breast magnetic resonance imaging (MRI) and computer-assisted mammography. A five-minute noninvasive test (low-dose screening chest computed tomography [CT] of individuals aged 55-80 with a 30 pack-year history of cigarette smoking) has been shown to aid in early detection of lung cancer and increase survival rates.⁹ Colonoscopy¹⁰ and esophagogastroduodenoscopy¹¹ (EGD) may also allow earlier diagnosis and treatment with improved outcomes of colorectal and esophagogastric malignancies, respectively. More recently, a relatively straightforward stool test (Cologuard®),¹² when used in appropriate patient populations, can detect over 90% of colorectal cancers.

Looking ahead, hopefully technologies such as liquid biopsy will facilitate noninvasive early diagnosis of multiple types of cancer through tests that look for tumor cells, tumor metabolites, and/or tumor genetic material in small samples of blood or urine. In June 2021, for example, scientists reported that a blood assay named Galleri® had the potential to detect more than 50 types of cancer¹³—many of which we currently have no way to screen for. Research continues on ways to increase the sensitivity (i.e., the proportion of cancers that will actually be detected) of this test. These and other noninvasive screening tests may prove to be real game-changers in the diagnosis, treatment, and follow-up of malignancy. Better screening tests may also allow detection of recurrent or new cancers—an issue of great concern to cancer survivors, as noted in Chapter 18.

The importance of screening has been driven home further by the events of the COVID-19 pandemic, during which parts of this book were written. According to an October 2020 article in the *Wall Street Journal*, hundreds of thousands of screening procedures for cancer such as mammograms and colonoscopies were deferred during the early part of that year due to pandemic-related disruptions of the U.S. health care delivery system. Data from one large clinical oncology provider revealed that 18% of breast cancer patients diagnosed in 2020 had advanced disease compared with 11–12.5% from 2015-2019. Delays in diagnosis like this unfortunately may translate to an increase in cancer mortality.

The enduring pandemic has affected cancer care beyond interference with cancer screening and resulting delays in diagnosis. Patients with cancer develop breakthrough infections (infections occurring despite vaccination) at a higher frequency than individuals of similar ages without cancer; COVID-19 infection in cancer patients is also associated with a higher risk of hospitalization and death¹⁴. In view of these risks cancer patients and their immediate family members and caregivers should discuss appropriate preventative strategies with their health care team.

In some cases, face-to-face oncology consultations have been replaced during the pandemic by telemedicine visits. While this book doesn't specifically address the impact of telemedicine on cancer care, the suggestions reviewed in Chapter 3 may still be helpful in preparing for virtual oncology consultations and visits.

As discussed in Chapters 6 and 7, chemotherapy regimens depend on an elaborate supply chain to support the production and delivery of medications and materials required for drug administration. This supply chain, like so many others, has been put under pressure during the pandemic. This book does not discuss other wide-ranging ramifications of the pandemic on cancer management, including potential delays in cancer treatment, as well as the diagnostic delays mentioned above. Pandemic-related disruptions of the clinical trial process that is ultimately responsible for advances in cancer treatment may negatively impact cancer care for years to come. On a more positive note, the challenges of the pandemic have led to the development and adoption of new technologies that allow better home monitoring of cancer patients for early detection of potentially serious side effects of treatment and, in some cases, that even allow delivery of hospital-level care at home.

This book also does not cover several other very important topics. Pediatric cancer is a devastating condition affecting the entire family. Although we hope that our comments on topics including cancer biology, chemotherapy, surgery, radiation therapy, stem cell transplantation, and the clinical trials process may be helpful to the families of children and adolescents with malignancies, we do not discuss psychosocial development and fertility preservation issues as well as other unique survivorship challenges faced by young people with cancer.

We also don't directly discuss the significant roles of social determinants of health and health care disparities and inequities in the development, diagnosis, and treatment of cancer. Major cancer centers across the country, including the UT Health San Antonio MD Anderson Cancer Center, the Karmanos Cancer Institute of Wayne State University, and the Mayo Clinic Cancer Center, are actively studying these issues. I have been very fortunate to have had access to excellent care, and realize that not everyone is so fortunate. We earnestly hope, however, that the information contained in this book may empower everyone, regardless of their individual circumstances, to derive greater benefit from available health care resources.

Additionally, this book is not intended to serve as an encyclopedic guide to addressing other nonmedical challenges posed by cancer. There is minimal discussion, for example, of the cost of cancer care and related affordability and insurance issues. Similarly, there is no coverage of the many issues confronting cancer patients associated with continuing to work while undergoing treatment. Recently the term "financial toxicity" has been used to encapsulate the multiple and potentially severe economic impacts of cancer on the patient and the patient's family. The lack of such discussion is certainly not intended to diminish the significance of these challenges on an individual, public health, and societal economic basis.

This book also does not cover the subjects of palliation and end-of-life care. Entire books (such as *Farewell* by the noted oncologist and palliative care medicine specialist Dr. Edward Creagan) have been written on these important topics.

The perspectives shared herein reflect our own opinions and experiences, and not necessarily the opinions, policies, or procedures of any of the institutions where we have trained or worked. Unless otherwise noted, individual names used in this book have been changed to respect privacy and confidentiality.

Chapter 1

The Beginning

It's cold in January in Minnesota.

The Securian Winter Run is part of the St. Paul Winter Carnival, an annual late January/February tradition rooted in the philosophy that the best way to get through the Minnesota winter is to aggressively embrace the cold through vigorous outdoor activity. Waiting at the starting line, a group of running club friends and I did our best to meditate on this point and center ourselves as we huddled together to stay warm on that 10° F. morning.

The starter's pistol went off, and with a feeling of mild euphoria we took off *en masse*. Once we got moving and warmed up a little, we enjoyed the picturesque route along the frozen Mississippi River under an impossibly blue sky. A running buddy once told me that this shade of blue can only be appreciated when the frigid air is too cold to retain any trace of moisture that would dilute the azure brilliance of the sky.

The route was there-and-back, with a turnaround at the midway point some 6.5 miles into the run. As we approached that point, I felt a strange burning pain in the central part of my upper chest. As a runner in my late 40s, I knew I was not immune to coronary artery disease, but the characteristics of the pain didn't seem typical for a heart issue. I nonetheless couldn't continue running at my normal pace.

As I slowed, I heard the familiar footsteps of my running buddy "Francesco" behind me. Francesco and I frequently ran together during our training and fun runs and have run as marathon teammates together. I'm a few years younger and usually a little faster than Francesco. It was therefore with a mixture of satisfaction and a little concern that Francesco caught up to me. He asked me whether I was OK. I smiled and nodded, and waved him past me.

The pain resolved at my slower pace, and I finished the race a couple of minutes behind Francesco. After everyone in our group had completed the run, we turned our attention to arguably the most important part of the event—the post-race celebration. We were particularly looking forward to enjoying the fare at Cossetta's, a St. Paul institution serving deliciously hearty Italian cuisine. I was ravenous, having had only part of a bagel prior to the run.

Savoring the tantalizing aromas inside the restaurant, I loaded up my tray along the cafeteria-style serving line with heaping portions of lasagna, chicken parmigiana, and homemade garlic bread. When I sat down to eat, however, I was puzzled to feel a curious combination of fullness and residual hunger after eating just a little bit. Although my body felt like it needed more fuel, I was unable to eat another bite. I ended up leaving most of my delectable meal untouched, and we piled into our van for our return trip home.

I felt fine without chest pain on Sunday, although I still wasn't able to eat very much at one time. I remained concerned about a possible heart problem, particularly in view of plans I had made with several running friends to complete the American Birkebeiner the following month. This event, known colloquially as the Birkie, is a 50 km (32-mile) Nordic ski race between the towns of Cable and Hayward in northern Wisconsin. While friends and family members of participants and volunteer race staff are scattered along the route, the picturesque course traverses a number of isolated areas in the deep woods where I might be alone without help available should I develop a medical problem during the race. My skiing abilities were, to be charitable, limited, and as a slow and inefficient skier I wanted to make sure I was in good shape to undertake this adventure.

I accordingly saw an internist and had a negative cardiac evaluation. Upper GI problems such as ulcer disease could cause similar symptoms, and testing for *Helicobacter pylori*, a bacterium associated with ulcer disease, was positive. I was started on metronidazole (an antibiotic) and omeprazole (a drug in the class known as proton pump inhibitors, which suppress the production of stomach acid) to treat presumed ulcer disease.

Over the course of a couple of weeks I felt a lot better. I was able to eat more, and felt good enough to continue my training regimen. I completed the Birkie (albeit as one of the last finishers). I subsequently trained for and completed a spring marathon.

I signed up for another marathon in early October, and began preparing for the race in July. Training seemed to be more difficult this time around. My energy level seemed to be lower, and I was having trouble completing the long training runs at my desired pace. I recall lying on the ground after one particularly disappointing 20-mile run with my legs twitching uncontrollably, wondering why I was having such a hard time getting ready for this race. I speculated that maybe I was just getting older. Although I didn't think much of it at the time, in retrospect I was still not able to eat much in one sitting, and had difficulty finishing even a single muffin despite feeling hungry after my training runs.

I wasn't able to prepare adequately for the early October marathon and ended up running a marathon in northern Wisconsin later in the month instead. Despite favorable course and weather conditions, this was by far the most difficult event I had ever run. Severe leg cramping during the second half of the race forced me to alternately walk and run, and I ended up finishing over 20 minutes beyond my goal time. As I limped over the finish line, I remember telling a running friend that this would be my last marathon. Prophetic words indeed...

After the race, we drove to a well-known pizza restaurant in Duluth, a Minnesota city on the shores of Lake Superior. Despite being very hungry, I was barely able to finish a single slice of pizza before feeling stuffed. My family met me there and we drove home.

The next week, I contacted "Dr. B," a gastroenterologist with expertise in gastric disorders including ulcer disease. I saw him a couple of weeks later, and upon hearing my story he thought I might have functional dyspepsia, a poorly understood disorder of sensation and

motility involving the upper GI tract that may be associated with abdominal pain and nausea. Dr. B also scheduled an upper GI endoscopy (technically termed esophagogastroduodenoscopy, or EGD) in early January after the upcoming holidays.

I continued on omeprazole during this time. One night shortly after Christmas, I woke up at 2:00 a.m. with severe upper abdominal and lower chest pain. Sweating profusely and pale from the pain, with my wife's help I managed to get to the hospital Emergency Department. One of the main immediate life-threatening concerns in this scenario was a heart attack. This was ruled out with an EKG and blood cardiac enzyme levels.

Given my history, it was thought that my symptoms were most likely an exacerbation of ulcer disease. I was given a thick local anesthetic mixture known as Haddad's solution to drink, with significant improvement in my pain. I was discharged home with instructions to see my gastroenterologist for follow-up. We met and confirmed the plan for the endoscopy in early January.

Following a morning largely spent tending to departmental administrative responsibilities, I reported to the endoscopy unit on the afternoon of a cold January day. After changing into a gown, I was wheeled into the procedure room. I was greeted by the endoscopy team and they started an IV to administer the sedation medications usually employed during upper endoscopy. The team confirmed my identity and the procedure to be performed (EGD), and the sedation medications were administered. I thanked the team before drifting off to sleep.

My next memory was sipping some deliciously cool apple juice as I set up in the recovery area after the procedure. My IV line was removed and I dressed and prepared to leave. I had understood that I would return home after the procedure and learn of the results from my referring GI physician over the days to follow.

I was therefore surprised when a nurse led me directly across the lobby waiting room to the GI clinic examination room area. She ushered me into an exam room where my wife and the gastroenterologist were waiting. Despite having had medications during my endoscopy which often result in amnesia for the entire day of the procedure, I don't think I will ever forget how pale, drawn, and shaken my normally calm and composed wife appeared when I sat down next to her in the consultation room. The gastroenterologist turned to me and said, without preamble, "You have cancer."

The gastroenterologist then showed me a photo taken during the endoscopy procedure. During endoscopy, the normal stomach demonstrates a series of regular folds or ridges lined by a smooth pink mucosal surface. The magnified photo taken during my procedure, in contrast, showed areas of massive thickening, ulceration, crater formation, and bleeding and crusting. It looked like an aerial photograph of a horror-movie version of the Grand Canyon. These changes extended from the lower end of my esophagus through the entirety of my stomach into the beginning of the duodenum (the first portion of the small intestine). I needed no convincing that this very ugly lesion was cancerous.

The gastroenterologist told us that biopsies had been sent to the pathology laboratory to identify the specific type of cancer and that the results would be available the next morning. An appointment would then be made for me to see a medical oncologist.

We left the examination room stunned. Only six hours earlier, I was an active and engaged father and husband, busy surgeon, department administrator, researcher, educator, and marathon runner with no known major medical problems. Now I was a patient with cancer.

CHAPTER 1 TAKE HOME POINTS
• Early signs and symptoms of cancer can be subtle and can resemble those of non-malignant condition.
• Listen to your body; if you're not feeling quite right, seek medical attention.
• If your symptoms don't resolve after initial treatment, seek follow-up care.