

Eye-witnessing cancer—an ever-challenging experience

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As a doctor with particular experience, when you see a patient with a certain unfortunate skin color, you feel “cancer in the air.” It has to do with knowledge, practice, and that indefinable “clinical sense.”

When a 46-year-old female patient, previously diagnosed with cancer, comes for a sudden major vision loss in both eyes, you, as an ophthalmologist, think about cerebral metastases ... nothing new under the sun.

The patient had undergone both head and thoraco-abdominopelvic computed tomography examinations. Investigations revealed lung cancer, with metastases to regional lymph nodes, brain, and ribs. Those findings were unsurprising, having in mind that brain metastases are a frequent complication in lung cancer patients^{1–4}.

The patient came to me with high expectations, and so I started to examine her eyes. Both eyes have a normal anterior pole. Now I feel both useless and unarmed, because I know that this evil is out of my interventional area. However, I look at the fundus of the eye, expecting to see nothing relevant ... or, eventually, papilledema. And here comes my surprise: in both eyes, the retina is detached! The choroid of both eyes has become the location for large metastases, which have developed on the entire inside of both eyes, looking like mountains surrounding the optic disk. I have seen many choroidal metastases, but never like these ones—occupying the entire choroid surface—and never bilaterally at the same time! They developed in just 3 weeks, because they weren't there at the time of the most recent magnetic resonance imaging of her brain.

My initial resignation now becomes anger. Anger against a disease that affects mostly male smokers, but this time is affecting a non-smoking woman. A disease that was causing only some rheumatism-like back pain for 2 months, before being diagnosed as stage IV cancer.

I was angry about my helplessness, about my entire knowledge and skill set, because they were abandoning me in face of such a case.

I was angry about the opportunity to discover some never-before-described (to the best of my knowledge) evolution.

But most of all, I was angry about not being able to answer a particular question: Who was to blame this aberrant evolution? Genetics? Chronic hepatitis C, contracted 5 years earlier and untreated because of an intolerance to antiviral medication? Fate? Was it avoidable? If so, by what means?

I prescribed my patient some drops to reduce intraocular pressure, which was still asymptomatic, and she told me that she would come back to me after “that rheumatism gets better” to change glasses, “because they don't fit anymore.” And I agreed.

I haven't seen the patient since then. I don't know if she is still alive. As an ophthalmologist, I have little cancer in my practice, but when I see it, I feel admiration for the strength of my oncology colleagues.

It has been a while since I saw that patient, who tragically enriched my professional knowledge, and my deepest hope is that such a case will remain a unique experience.

From the moment I chose to become a doctor, I considered cancer the biggest challenge to our profession since the days of Hippocrates. And the only way to defeat this silent and perverse enemy is to keep our anger alive, as a weapon of mind against cancer, in an endless and unfair war.

CONFLICT OF INTEREST DISCLOSURES

I have read and understood *Current Oncology's* policy on disclosing conflicts of interest, and I declare that I have none.

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