



Recognizing and navigating barriers to hope in gastrointestinal cancer patients

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Cancer is a challenging diagnosis with significant physical and mental repercussions for not just the patient, but also their families. Despite advancements in medicine, cancer is still synonymous with negative emotions such as fear, trauma and death (1). On the opposite end of the optimism spectrum, the Oxford Dictionary defines ‘hope’ as “to want something to happen or be true and to believe that it is possible or likely”. Hope can assist cancer patients manage the disease more effectively by encouraging activities that promote wellness, while lowering the likelihood of depression (2).

For a cancer patient, hope is affected by multiple factors. It includes physical factors such as pain and energy levels as well as psychological factors such as anxiety and depression (3). Very few studies have investigated the relationships between hope and socio-demographic factors in this group of patients (3-5).

Gastrointestinal (GI) neoplasms are rising in incidence, and are typically associated with rapid progression, early metastasis, and unfavorable prognoses. Therefore, these cancers pose a significant health issue worldwide. Patients diagnosed with GI cancers often grapple with a wide set of symptoms including abdominal discomfort, nausea, GI bleeding, and altered bowel movements. Coupled with the physical toll, the emotional burden of confronting the diagnosis and navigating the multifaceted treatment modalities can be overwhelming (6). In patients with GI cancers, depression and anxiety have been associated with

poorer functional status and prognosis (7).

In the paper titled “*Cultural and social barriers to hope in gastrointestinal cancer patients*”, the authors have identified demographic traits which can be indicators of level of hope (8). Having a language barrier necessitating interpreter assistance, identifying as Asian American or Pacific Islander (AAPI), divorced relationship status, unemployment and female gender were found to be associated with lower Adult Hope Scale (AHS) scores among patients with GI cancer. It is intriguing to note that these sociodemographic factors were predictive of hope, rather than prognostic clinical features.

This is similar to data previously reported by Ballard *et al.*, which revealed males to exhibit increased levels of hope compared to their female counterparts, among those with newly detected malignancy. It was also noted that individuals who resided alone had decreased levels of hope (9). In a systemic literature review, the stage of cancer, receiving curative chemotherapy compared to palliative treatment and pain measured on a descriptive pain scale did not significantly affect hope in newly diagnosed patients with cancer (10).

Patients with limited English proficiency experience poorer healthcare quality and reduced access to cancer screening due to hurdles with communication (11). Given the complexity and nature of the information discussed in an oncology visit, ensuring adequate patient comprehension is quintessential. Communicating in the patient’s native

language fosters rapport. However, physicians treating patients with limited language proficiency must assess the appropriateness to request an interpreter as required. Delivering care that aligns with the patient's language preferences results in enhanced patient contentment, improved adherence to medication, and fewer unresolved concerns (12).

Patients experiencing unemployment often have lower levels of hope, attributed to diminished social support and financial instability, and heightened symptom burden. Job loss restricts social interactions with coworkers, reducing coping abilities in cancer patients and leading to decreased hope. Social support, including emotional, informational, and practical help from one's social circle, aids patients in dealing with their diagnosis and fostering hope. Cancer patients with stronger social support experience improved quality of life, treatment adherence, and overall survival rates (13).

In this prospective study conducted by Qu and colleagues (8), patients completed the AHS survey at only one point during their disease course and were not followed for consecutive clinic visits. This may have led to biases, as patients may have greater uncertainty and lower hope at the time of their first visit prior to a treatment plan being discussed and explained, whereas patients on treatment with a clear oncologic plan may have greater hope. It could also be considered to stratify the patients based on their age while enrolling for the study to assess potential variations amongst this patient population to determine the outcomes.

Additional well-designed prospective investigations are necessary to establish the contributory role of these psychological constructs and raise awareness of their potential impact. Although it can be challenging, hope can be fostered at every patient visit by reframing understanding of disease and expectations from treatment. Understanding psychosocial predispositions that lower hope may help providers identify at risk patients and inform the development of interventions to better quality of life, reduce psychological distress and symptom load, and improve oncologic outcomes.

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