

Opinion

The Emperor's New Clothes? Rethinking Modern Cancer Care

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Abstract

Modern oncology has achieved extraordinary advances. Surgery, radiation, chemotherapy, targeted therapies, and immunotherapies can shrink tumors, delay progression, and sometimes produce lasting remission. Yet cancer care can remain overly focused on tumor control, with insufficient attention to the systemic condition of the patient. For many people with advanced cancer, this approach is incomplete. A tumor may shrink and biomarkers may improve while the patient continues to lose weight, muscle strength, physical function, organ reserve, and the ability to tolerate treatment. **The uncomfortable truth is that a patient can die while the tumor is not progressing.** Cancer-associated cachexia illustrates this challenge, as it involves complex interactions among the tumor and the body's immune, metabolic, endocrine, and neurological systems. This Opinion Article argues that tumor response should not be regarded as the sole measure of therapeutic success. Early recognition of cachexia, functional decline, inflammation, nutritional problems, and organ complications should occur alongside tumor assessment. An illustrative patient experience further highlights the importance of maintaining vigilance for potentially serious complications even when imaging demonstrates tumor regression. Modern cancer care should therefore pursue a dual mandate: controlling the malignancy while preserving or restoring the physiological systems that enable the patient to survive and tolerate treatment.

Discussion

The Tumor Is Not the Whole Disease

Cancer is not merely a collection of malignant cells occupying an organ. It can become a systemic disorder in which tumor-derived signals and host responses affect the immune, metabolic, endocrine, cardiovascular, neurological, and musculoskeletal systems. Cancer cachexia is one of the clearest examples. It is not ordinary starvation and cannot be reversed by nutritional support alone. It can involve chronic inflammation, appetite loss, altered metabolism, insulin resistance, and progressive loss of muscle and fat. The National Cancer Institute reports that cachexia may occur in up to 80 percent of people with advanced cancer and may contribute directly to a substantial proportion of cancer deaths, often through complications associated with severe muscle loss [1]. A scan describes the tumor. It does not necessarily describe the condition of the person carrying it. Research increasingly presents cachexia as a multiorgan syndrome involving complex interactions among the tumor and the body's immune, metabolic, endocrine, and neural networks. These disturbances can affect tissue integrity, physical function, treatment tolerance, and survival [2-5]. The conclusion

is not that tumor-directed treatment should be abandoned. Such treatment remains indispensable. The conclusion is that it may be insufficient when used without adequate attention to the systemic complications associated with cancer.

When the Host Becomes the Battlefield

The concept of a tumor-associated systemic disorder does not imply that one pathway explains every cancer-related death. Cancer-associated systemic decline is complex and varies among patients. Nevertheless, substantial preclinical and clinical evidence implicates inflammation, immune dysregulation, metabolic disruption, and abnormal tumor-host signaling in muscle wasting, appetite loss, fatigue, organ dysfunction, and reduced treatment tolerance [2,5-6]. These problems can reinforce one another. Inflammation may suppress appetite and accelerate tissue breakdown. Muscle loss may impair mobility, breathing, and cardiovascular reserve. Frailty may force treatment delays, dose reductions, or discontinuation. The resulting loss of treatment tolerance may then compromise the ability to continue effective anticancer therapy. Even a highly effective anticancer drug may provide limited clinical benefit if progressive systemic deterioration prevents a patient from receiving or tolerating treatment as intended. Therefore, the familiar question, “Is the tumor responding?” must be accompanied by equally important questions:

- Is the patient maintaining muscle, weight, and physical function?
- Is systemic inflammation worsening?
- Can the patient eat, walk, sleep, and perform ordinary activities?
- Are emerging cardiovascular and other organ complications being recognized promptly?
- Is the patient becoming more capable of receiving treatment, or merely showing radiographic improvement while clinically declining?

European Society for Medical Oncology guidelines describe cachexia as an underdiagnosed and undertreated condition requiring early assessment and multimodal, multidisciplinary management. They emphasize nutritional and metabolic considerations, symptom relief, physical function, psychological needs, and individualized care alongside anticancer treatment [7].

That is not an alternative to oncology. It is oncology made more complete.

Lee’s Story: When the Tumor Was Regressing but the Patient Died

Lee was a young patient with stage IV renal cancer. His experience illustrates the central concern of this Opinion Article. The author reports having obtained permission from Lee’s wife to discuss his experience.

As advanced cancer cachexia progressed, Lee became progressively thinner, weaker, and frailer. His wife watched his physical condition deteriorate despite the care he was receiving. She searched for answers and learned about research examining cachexia and its possible relationship to abnormalities in immune and systemic pathways. After Lee’s physician approved an approach informed by those research findings, his condition reportedly changed dramatically. According to his wife’s account, he gained two pounds within five days. Over the following weeks, he regained weight and strength and began enjoying life again. He recovered sufficiently to resume antitumor treatment, including immunotherapy. His tumor responded, and his scans improved. Lee’s experience illustrates why cachexia should not be dismissed as merely a supportive or palliative concern. Addressing the patient’s systemic condition may help preserve physical function and treatment tolerance and, in some circumstances, support the continuation of tumor-directed treatment. However, a single personal account cannot establish the effectiveness of a particular intervention or demonstrate causality. Yet Lee later developed a pericardial effusion, a buildup of fluid around the heart. According to his wife’s account, the complication was not recognized and treated quickly enough to prevent his subsequent deterioration. Lee subsequently died even though his tumor was responding and his scans were improving.

Here we confront the dangerous shadow cast by the label “stage IV cancer.”

Once a person carries that diagnosis, deterioration and death can too easily be regarded as inevitable. A potentially distinct complication may be overshadowed by the cancer label. The death may be absorbed into the broad category of “advanced cancer,” even when the tumor is regressing and the immediate cause of deterioration may involve another potentially manageable medical complication. Lee’s story does not establish that his death could certainly have been prevented, nor can one case demonstrate the effectiveness of a particular treatment. The account is based on the family’s experience and should not be interpreted as evidence of treatment efficacy or as

establishing the preventability of his death. However, it raises a question that modern oncology must not avoid:

When a patient's tumor is not progressing but a systemic complication proves fatal, should the death simply be attributed to cancer, or should we ask whether tumor-centered care adequately addressed the patient's broader clinical condition?

Stage IV cancer must never become a reason to take deterioration or death for granted. Advanced disease should demand greater vigilance, not less.

A New Standard of Success

Cancer care needs a dual mandate: control the malignancy while preserving or restoring the physiological systems that keep the patient alive. That requires early and repeated assessment of weight loss, muscle depletion, inflammation, appetite changes, fatigue, functional decline, and organ complications. It requires integrating oncology with nutrition, rehabilitation, cardiology, metabolic care, symptom management, and palliative care when appropriate. Clinical trials must also look beyond tumor response. Strength, physical function, treatment tolerance, quality of life, complications, and overall survival are not secondary considerations. They are measures of whether treatment is actually helping the patient. The emperor's missing clothes are not chemotherapy, radiation, targeted therapy, or immunotherapy. These treatments remain essential. The illusion is the belief that controlling the tumor is always sufficient to save the person.

Cancer care will become truly modern only when it treats cancer as both a tumor and a systemic disease. Its ultimate measure of success must not be merely whether the tumor shrinks, but whether the patient can survive the disease.

Conclusion

Modern cancer treatment should not be judged solely by what happens to the tumor on a scan. Tumor response remains an essential component of cancer care, but it is only one dimension of the patient's clinical trajectory. Cancer-associated cachexia, functional decline, systemic inflammation, treatment intolerance, and potentially serious organ complications can profoundly influence whether a patient survives and benefits from treatment.

A more complete model of oncology must therefore evaluate both the malignancy and the physiological condition of the person living with it. Early recognition of systemic deterioration, multidisciplinary supportive care, preservation of physical function, and prompt investigation of new complications should accompany effective tumor-directed therapy. The goal is not to replace tumor-centered oncology, but to expand it.

The ultimate measure of successful cancer care should be not simply whether the tumor responds, but whether the patient is given the best possible opportunity to remain functional, tolerate treatment and survive.

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