The end of my life was killing me

Actress and writer Annabelle Gurwitch was diagnosed with Stage 4 cancer early in the pandemic

My Stage 4 lung cancer diagnosis came out of the blue after I went in for a routine coronavirus test in 2020. In my first year of treatment, I made lemons out of lemonade, determined to squeeze every drop of whatever time I had left. I attempted a felony, got ground down by gratitude and wound up with two UTIs.

My newfound enthusiasm for life was made possible by the brave new world of biomarker-targeted therapies that granted me a welcome, if temporary, reprieve from this we'll-do-the-best-we-can-for-as-long-as-we-can disease. The plain-speaking oncologist treating me described the therapies this way: "Your cancer is a lawn. These medications keep the grass mowed but don't pull out the grass at the roots. Eventually, the cancer figures them out, and the meds stop working." Some people's cancer doesn't respond, some receive scant months of benefit, while others eke out five years before switching to protocols with potentially harsher side effects.

I braced myself for bad news and the onset of fatigue, intestinal discomfort and prickly skin rashes, side effects that can, in their more extreme forms, render the medication intolerable. While the rest of the nation hoarded hand sanitizer and toilet paper, I stocked up on Imodium, electrolyte drinks, intensive moisturizers, coffee and dark chocolate.

Though cancerous cell growth was held in abeyance, an existential dread set in as I realized that instead of fortifying my system, each day on the medication subtracted a day from the treatment's effectiveness. Between the unpredictability of the regimen's efficacy, the uncertain course of the disease and the threat of covid, I caught myself holding my breath through the day, as if taxing my lungs less might preserve them. Brain fog meant that composing sentences required herculean effort, so writing assignments went on indefinite hold. I was napping several times a day, like a toddler. Even driving became too stressful, so conscious was I of my vulnerability. Something had to give.

After my first dose of the vaccine in April, I hit the ground running, determined to carpe every diem. I double-masked and flew across the country for an "end of my life reunion tour," convinced that this might be my last ambulatory opportunity to see cherished friends. Each morning for two weeks last spring, I trekked to "my" table at a favorite cafe on the Upper West Side in Manhattan. Cherry blossoms swirling like confetti, these reunions careened between celebratory and funereal, leaving me flat on my back for the remainder of the day.

I was overcome by exhilarating, almost inebriating, episodes of gratitude overload brought on by an appreciation of small pleasures. That certain slant of light! French fries! A Katherine Mansfield sentence! (No, I take that back, Mansfield's prose should bring us to our knees.) A bout of weepy swooning, marveling at the acuteness of an aspartame-induced diet soda headache, was a bracing warning that even joy could be distractingly paralyzing.

My complexion was rosy and my constitution energetic. Through it all, the cough that led to my diagnosis persisted. Coughing during this pandemic, even when masked, is like shouting "Fire!" in a crowded theater. I felt compelled to reassure dining companions, elevator fellows or airplane seatmates, "It's not covid, just lung cancer."

But I had a full head of hair and hadn't lost any weight. Despite my life-altering circumstances, I appeared unchanged, all of which created a confounding cognitive dissonance. The assumption that chronic illness presents visually is deeply ingrained in our culture. My robustness elicited stupefying responses from even the most well-intentioned friends. "I'm sorry I don't look sick enough for you" turns out to be a reliable conversation stopper.

Side effects flared up, but they were staggeringly capricious, allowing for fleeting moments of invincibility. One day, I couldn't summon the energy to take even one more step a few blocks from my front door after my daily walk stretched into a satisfying but punishing uphill hike. I collapsed on a grassy median, lying there, inert, until I rallied the strength to shuffle home. If this level of enervation persisted, it could take years to make it through all three seasons of "Succession." I dialed back my overly ambitious exertions, but not everyone in my life found it hilarious that I had (with apologies to Elaine May) "Not dead, just resting" piped onto my birthday cake.

After learning that the meds had caused my fingerprints to disappear, I added "crime spree" to my bucket list. Why not liberate a favorite Yaacov Agam from the prized art collection at Cedars Sinai Hospital in Los Angeles, where I receive treatment? The drawing hangs in a basement corridor, outside the room housing the CT scan that forecasts my future in three-month increments. It was underappreciated on that dimly lit wall, my cancer dollars had paid for it, and what was the worst that could happen? A life sentence? I tested the security fastenings on two occasions just to be certain I'd made a valiant effort.

"Annabelle, you really need to stop having so much sex," my concerned gynecologist admonished. I'd shown up at her office, doubled over with discomfort but smiling, nonetheless. I was on my second UTI in the space of a month. Who had time to rest? I'd gotten sunburned on the first day of a Caribbean vacay, melanoma no longer a concern.

"Cancer is my bad boyfriend, and I'm cheating on him!" I giggled like a teenager.

"Just give it a rest for a few days."

I was still popping antibiotics when I hit my cancerversary. There'd been no progression since my last scan. "Break out the champagne," my oncologist suggested, but by the time I reached the parking lot of the doctor's office, I'd received the news that Frank, my first cancer buddy, who'd buoyed my spirits on numerous occasions, had succumbed to the disease. So instead of popping a cork, I took the occasion to declare a moratorium on friends and family sending me TED Talks by people with cancer who announce they've completed their first marathon. I vowed to remain an underachiever in Cancer World. I wasn't going to adopt an indefatigability or aspire to heroic feats that might transform me into anyone's idea of a cancer warrior. Just keep the cranberry juice coming.

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OCTAVIO JONES/REUTERS

Some wore masks and some didn't at the Florida State Fair last month. Now, federal officials say that most Americans can go without masks in public settings as coronavirus cases decline.

The CDC just guaranteed we'll be too slow for the next covid surge

Epidemiologists Julia Raifman and Eleanor Murray on the flaws in the agency's new mask guidance

The Centers for Disease Control and Prevention recently unveiled new guidelines for coronavirus control in the United States, increasing the thresholds of disease that trigger recommendations for mask-wearing. In the blink of an eye, the CDC pivoted from recommending that nearly everyone wear a mask to saying it was necessary for only about 30 percent of Americans.

The guidelines' chief innovation is to combine case levels with hospitalization figures — those related to hospital admissions as well as availability of staffed beds — rather than using case numbers alone. Under the old guidelines, a coronavirus case rate of 50 per 100,000 in a county was enough to trigger a recommendation that individuals mask indoors; now the case rate must be four times as high for the recommendation to kick in. (At lower case rates, high hospitalization numbers can also trigger masking recommendations.)

While it is true that strain on hospitals is an important public health consideration, there is much about this approach that could be improved. The virus may be with us for years, causing severe illness, long covid, deaths, and social and health-care disruption, with a high and inequitable cumulative toll. A sounder public health strategy to address it would be tailored to respond more quickly and effectively to surges.

A recommendation for universal masking should turn on when case counts alone are on the rise, even if they are not yet high. In the context of a highly transmissible variant such as omicron, just a one-week delay in implementing control measures could lead to twice as many cases, as well as to preventable hospitalizations and deaths (which do not follow cases in a 1:1 relationship).

Masks are far more powerful as a public health tool implemented through mandates than as an individual protective measure. But the new guidelines on masking are squarely directed at individuals. Even when transmission is considered "high" under the new formulas, the CDC does not provide clear recommendations for states and municipalities, offering this advice instead: "Consider setting-specific recommendations for prevention strategies based on local factors." And under what the CDC considers "medium" community spread, the agency tells even immunocompromised people to simply "talk to your healthcare provider about whether you need to wear a mask," punting on the question its officials should lead in answering. (Mask mandates in surges are more popular than the vocal minority opposed to them might suggest. According to a recent Washington Post-ABC News poll, 58 percent of Americans think controlling the spread of the virus remains more important than having no restrictions on behavior.)

At the same time, the CDC recommends that in some settings — notably, hospitals and nursing homes — everyone should mask, regardless of vaccination status, and masking should be particularly emphasized when community transmission is substantial or high under the old standards (50 to 99 cases per 100,000 and 100-plus cases per 100,000, respectively). This exception tacitly acknowledges that in settings where it's really important that people not get infected, the new guidelines are insufficient.

But hospitals and nursing homes are not the only settings in which vulnerable people need protection, nor should we normalize rates of infection that, until last month, were considered high. Schools and many workplaces are settings with high exposure to shared air, over a long duration, increasing risk of transmission of the coronavirus. These are also spaces that most people can't choose to avoid — including children and adults with any of several health conditions that increase the risk of severe illness or death. So far, covid has tended to produce less-severe symptoms in children than in adults, but it has still caused 1,500 child deaths in the United States, with more than 500 of those since Jan. 1. And there is no guarantee that we will not encounter a future variant that is more severe for children.

Loosening mask guidelines is likely to exacerbate already large disparities in covid-19 by race, ethnicity and income. In January, according to the Census Bureau's Household Pulse Survey, workers in the lowest income bracket (making less than $25,000) were 3.5 times more likely to report missing a week of work because of covid than workers in the highest income bracket (making more than $100,000).

Preparedness to turn on mask mandates is one key element of reducing the harms of surges, but so are vaccines, tests, ventilation and treatment access. Especially because these new guidelines will mean fewer people wear masks, the CDC ought to redouble efforts to spread the word — in multiple languages — about the importance of vaccination for adults and children, letting them know as well where they can go for walk-in vaccinations. The federal government took a step in the right direction by beginning to make free masks and tests available; ideally, officials would prepare to make masks and tests available in every high-exposure setting at the start of every surge, ensuring that distribution focuses first on the communities, occupations and individuals most at risk. Previous distribution efforts often overlooked Black and Latino neighborhoods, for example, despite high rates of covid-19 in those populations.

The new "test to treat" program is also promising: The Biden administration has said a positive test at a drugstore or clinic will lead directly to the prescription of antiviral drugs. But that plan requires a mass communications campaign, in several languages, to inform the public about the importance of early diagnosis and treatment. And it should not be an excuse to eliminate prudent steps to reduce viral transmission — especially given that even moderate cases of covid-19 can lead to long covid, cognitive effects and higher risk of cardiac events.

This period of lower transmission is something to be thankful for, but we cannot expect the lull in cases to last forever. The United States has a bad record of handling surges, experiencing higher death rates than other high-income countries. The CDC's new masking guidelines make it more likely that we will repeat that performance, exacerbating inequities in the process. All in all, the CDC's messaging and policies should better conform to the agency's mandate, as reflected in its name. That mandate is not to keep hospitalization rates manageable or to balance political goals with public health. It is to control and prevent disease.

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