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ORATOR: Charles S. Whalen, M.D.

Chief of Surgery at St. Vincent Hospital, 1944-1971; Emeritus Attending Staff; Associate Professor of Surgery, University of Massachusetts Medical School

ORATION: Under The Sign Of The Crab

It is both a privilege and a challenge to deliver this annual oration to the Worcester District Medical Society, the 182nd in a line of orations dating from 1795. My fervent wish is that this evening's presentation may be, even in small measure, worthy of so great a heritage.

I subscribe to the sentiment in Dr. George M. Morse's oration in 1888, "...and so having been appointed orator for this occasion, I will ask your indulgence while I, in a feeble manner, 'rattle around' in a place often filled by able, eloquent and profound members of the Society." I take heart from his further remark: "Nowhere else does a physician find so sympathetic, so responsive, so generous an audience as at these meetings of our Society." I lean very heavily upon your indulgence, even as did our orator of yesteryear.

The qualms of orator Dr. Francis Leland in 1866 I strongly share: "...I have had the utmost difficulty in the selection of a theme, wherein I could show the least unfitness for this occasion." Four years earlier during the Civil War, Dr. Thomas Hovey Gage admonished: "Each one should choose for himself some particular department that for which he has a special taste and natural fitness." I have selected as my theme tonight a subject within, I trust, my competence and experience.

In his book "The Language of Medicine", Dirckx writes that Celsius used the Latin word for crab, CANCER, to indicate an eroding and ulcerating lesion. Dr. Hayes E. Martin cites this quotation from Paulus, "But some say that cancer is so called because it adheres to any part which it seizes upon in an obstinate manner like a crab." At the Tenth International Cancer Congress in Houston, Texas, in 1970, the official symbol of the Congress was the Calder Crab. This contemporary metal sculpture was created by the late Alexander Calder, an American artist, recognized internationally as a leading sculptor. The Congress program read as follows: "In light of recent great advances in the fight against cancer the striking powerful lines and vibrant red-orange color of the metal structure create an image of progress and strength in keeping with the objectives of the international Union against Cancer."

I have chosen the title: "Under the Sign of the Crab." What follows represents the reflections of a surgeon involved in the management of cancer for many years. To paraphrase our orator in 1862–I have made this disease "the particular object of my studious hours." The main thrust of these remarks will be directed towards the patient with cancer viewed in the light of today's expanding technology.

The years have wrought many changes. In the area of solid tumors the overriding concern used to be the surgical removal of the growth and, where indicated, its regional spread. The surgeon occupied center stage. X-ray treatment was a secondary consideration.

In contrast, today's management of cancer is far more complex and must be on a multidisciplinary basis. The surgeon now finds himself a member of a team, each one of whom contributes a special expertise. The team comprises family physician or internist, surgeon, medical oncologist, radiation oncologist, pathologist, nurse oncologist and social worker. Since

cancer care is a chronic problem, affecting not only the physical but the emotional lives of patient and family, I anticipate that psychiatric help will be relied upon more heavily in the future.

Various factors have brought about this change. Research continues to unravel certain mysteries of the cell. Light is being shed on immune mechanisms. Various chemicals are available which are lethal to the cancer cell; sophisticated irradiation techniques have increasing effectiveness against malignant tumors. Surgical advances allow us to better handle the local and regional disease.

I cite a few examples of the "cancer team" in action. Following an operation for breast cancer the pathologist reports that several axillary lymph nodes contain metastatic tumor. Even as the surgeon was operating it was likely that distant (invisible) spread had already occurred. This challenges the belief that radical surgery is truly curative. It further implies that cancer is a systemic chronic disease and in the next decade a critical reappraisal of minimal or moderate but effective local procedures should be made With this report that several axillary nodes are involved, the medical oncologist enters the picture. We have finally begun to recognize what has been all too apparent that often the patient needs systemic treatment in addition to appropriate local care. In more advanced cases hormonal ablative or additive therapy may augment the systemic affect of cytolytic chemotherapy. The radiation oncologist may recommend preoperative or postoperative X-ray treatment for the breast cancer. Irradiation, in the proper case, may supplant surgery.

We are relying more and more upon the pathologist member of the team. As a result of recent studies it is no longer advisable to plan surgery for a melanoma of the skin until the pathologist has apprised the surgeon of the level to which the tumor has penetrated and of the lesion's precise thickness. The team would not be complete without the invaluable assistance provided by the nurse oncologist and the social worker. Periodic visits by the chaplain provide solace; his presence during times of crisis is a source of great strength to the cancer patient. |

Close continuing observation of the patient is an indispensable ingredient of good cancer care. Certain other diseases are episodic and self-limited. This is not the case with cancer. Having undergone treatment for cancer, the patient requires continuous surveillance. Formerly, it was common to refer to successful treatment as a five-year cure". This no longer obtains. Ten-year survival figures in most treated cancers are lower than those for five years. In fact we see recurrences after 15 to 20 or more years.

Only with conscientious periodic followup can any recurrence be readily detected. Retreatment at this point is more rewarding than when undertaken after undue delay. I am still following a breast cancer patient upon whom I operated as a resident 41 years ago. In the interval a mastectomy was performed on the opposite side when a second primary became evident.

How then, does all of this fit into today's multidisciplinary or "team approach"? I propose this working arrangement. Among the physicians involved in a certain cancer case one of them must be the "central figure”. This physician, in essence a patient advocate, implements the treatment protocol, monitors the follow-up and rehabilitation, counsels the entire family, becomes the confidant, defends personal integrity and recognizes the dignity of death. All other members of the team serve as consultants. Using the wheel as a model, these consultants are on the rim; at the hub is the "central figure".

It is important that, early on, each one involved in the case, the patient included, has a clear understanding as to who is the “central figure". Who might qualify for this role? It may be the family practitioner or internist. The surgeon is the logical one in a case of operable breast cancer.

The responsibility for a case of lymphoma would likely rest with the medical oncologist or internist. There will be cases in which the radiation oncologist will so serve.

What with the number of physicians involved in managing our cancer patient, the necessity for ready communication among team members is obvious. This applies to the initial consultation and treatment planning, the interval assessment of a therapy already initiated, the possible wisdom of ceasing such therapy when it is failing in its objective or affecting the quality of life. Therapy for therapy's sake or for protocol's sake is patient-destructive. Along the way drastic departure from the plan of treatment may be indicated. There is no place for blind adherence to one's own modality. Unilateral decisions may be ego-inflating but are not in the best interests of the patient. This is the time for group consultation.

It would ill-suit the occasion if I, a surgeon, made no mention of the role of surgery in today's cancer management. A look into the past sharpens our perspective. A few of us in this Society served as residents at Pondville Hospital, our State cancer facility. We were privileged to work under the giants in this field, Ernest Daland, Grantley Taylor and Joe Vincent Meigs. These men did much to standardize the surgical treatment of cancer.

Not long afterward cancer surgery took on more aggressiveness. Very formidable operations gained acceptance in the mistaken belief that cancer was a local and not a systemic problem. Little wonder and, I feel, tragically, that certain patients following radical surgery for cancer within the mouth were loathe to go out-of-doors.

Today this very radical surgery is on the wane. Take, for example, surgery for breast cancer. Not so long ago there was insistence upon the standard radical mastectomy. Most of us have turned to the modified operation popularized by Madden. Some surgeons combine a segmental resection of the breast with either axillary node dissection or irradiation, feeling that there will be less physical and psychological trauma to the patient. Simple, or more properly, total mastectomy may be preferred for certain poor-risk patients. These evolving concepts are challenging our previously established treatment principles in all areas of cancer care. Whitmore recommends a lesser operation for prostate cancer. A radio-active element is implanted into the gland along with a lymph node dissection. Patients with bone sarcoma are now being spared amputation through a combination of surgery, irradiation and chemotherapy. We have finally come to recognize the need to combine local adequate care with systemic therapy. In general, the needs of the individual patient play a more decisive part in today's treatment-planning.

My part in this trend toward moderation in cancer surgery has been a source of gratification. I have been using a technique alluded to in a paper presented to the Worcester District Medical Society in 1888. Dr M.J. Halloran, our orator in 1892, referred to this paper which was entitled "Electrotherapeutics in Medical Practice". The essayist told of the application of electrosurgery to certain neoplasms. He said that "it can be used and regulated as well as the knife". This evening, some 90 years later, I cannot improve upon this observation.

How does electrosurgery -- or electrocoagulation -- differ from conventional surgery? The latter removes the cancerous growth with the scalpel, thereby requiring a wide excision with significant sacrifice of normal tissue. Electrocoagulation works on a different principle. One directly destroys the tumor by the heat generated. Sparing tissue in this way enhances cosmetic and functional results and, in my experience, achieves as effective local control.

Electrosurgery is suited chiefly to cancers of the skin, the mouth and the rectum. Patients with skin cancers - even the bulky tumors - can be managed, with rare exceptions, on an ambulatory basis under local anesthesia. In treating cancers within the mouth this tissue-sparing method frequently allows the patient an equally good chance for cure with a lesser operation with less

immediate and long-term morbidity and less disfigurement. The patient whose rectal cancer is suitable for, electrosurgery is spared a mutilating operation, which has a significant mortality, frequent complications of impotence and bladder dysfunction and the inconvenience of a permanent colostomy.

Electrosurgery is not alone in this commendable trend away from the excessively radical approach to cancer. Judiciously applied cryosurgery, chemosurgery and the laser beam are indeed patient-sparing. We need to reexamine these so-called lesser procedures, which may be combined with irradiation, chemotherapy and immunotherapy to achieve effective local and systemic control.

There is a great hue and cry these days about excessive medical costs. The use of these modalities addresses this issue, eliminating the need for hospitalization in many cases and shortening hospitalization in others. There are added advantages, not the least of which is the patient's increased comfort and convenience.

The title of the 1976 annual oration of the Massachusetts Medical Society was "On Caring for the Patient with Cancer". It was delivered by a classmate, Dr: J Englebert Dunphys. I quote: "...but all too often the doctor followed by his team goes from bed to bed through the ward, until the room of a supposedly dying patient is reached. Then follows a whispered exchange with the nurse. The patient seems asleep, better not disturb him, so with relief and a suppressed sense of guilt, the procession glides by. This is a grievous mistake. The one patient on the service who wants most to be seen, examined and talked to is the patient who is or may be dying."

What clinician among us has not found himself in this position? Who does not feel a sense of defeat, when one's ministrations have failed of cure? Dr. Dunphy would have us "touch the patient, shake hands, take the pulse and gently palpate the areas of pain. Early in my practice it was said of a certain distinguished surgeon that he made it a rule never to sit down at the patient's bedside. Adhere to this general procedure or no, it would be well to make an exception for the cancer patient whose time is running out. We must recognize that death is a state as natural as birth, to be anticipated and not feared.

Those of us charged with the treatment of the patient with cancer inherit the fruits of research and clinical trials As a result we are better equipped to care for the patient with this unique disease. Our enemy is defiant. It clings, crab-like, obstinately. True, there are some instances in which the process is localized and our initial treatment breaks the vice-like grip, More often. though, it clings tenaciously, testing, often to the breaking point, the increased resources at our disposal. Herein lies the challenge.

We respond to this challenge by treating -- not the disease -- but the patient with the disease. Finally, I quote Dr. Francis W. Peabody : "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."