COMMON PROBLEMS IN CANCER SURGERY

Harold J. Wanebo

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CANCER SURGERY

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PREFACE

Common Problems in Cancer Surgery was written for the practicing surgeon who has a special interest in the patient with cancer. It has attempted to cover the major problem areas most frequently encountered by the general surgeon. In particular, it is directed to the younger surgeon or the resident completing his surgical residency, who though knowledgeable about the current literature has not had the time to develop the breadth of experience frequently needed in managing the individual problems presented.

We have attempted to glean a distillate of the wisdom of the expert on individual problem cases that might add a "little touch of gray hair" to the younger surgeons.

I must thank my wife, Claire, and my children for their forbearance during the writing and editing of the manuscripts, and special thanks are due to our editor, Kay Terrell, for her efforts to complete the work.

HAROLD J. WANEBO, M.D.

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INTRODUCTION

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The field of oncology, in particular cancer surgery, has continued to expand rapidly. Whereas the initial involvement by the surgeon was primarily surgical, with only modest interaction with the other colleagues in oncology, this has changed dramatically in recent years. Surgeons have taken an active leadership role in developing multimodality therapy and integrating the findings of basic science and biology into the clinical practice of cancer surgery. The numerous protocols that have been organized under the auspices of the National Surgical Adjuvant and Bowel Project that have evaluated the modalities of surgery, radiation, and chemotherapy in the management of primary breast cancer exemplify this new role. The surgical concerns regarding the adequacy of primary treatment have evolved—through the scientific dialogue—from a unified approach using radical mastectomy or any of its permutations to one utilizing a more conservative surgical approach complemented by radiation and chemotherapy. The ability to select proper therapy has been expanded with the use of numerous biologic markers and functional assays, such as carcinoembryonic antigen, various tissue hormone receptors, flow cytometry to determine DNA ploidy, and even the use of oncogene markers to better select patients for the optimum therapy. We are truly at the dawn of a golden age in surgical as well as general oncology, in which scientific advances are rapidly integrated into clinical evaluation and use. Surgery, however, continues to be an art form practiced on the individual patient. Numerous questions arise for which scientific answers are not always available. The surgeon frequently must act on the basis of incomplete information and must rely heavily on judgment, which has been fine-tuned by assimulating clinical and scientific information, and apply it in a reasoned and compassionate way.

The major objective of *Common Problems in Cancer Surgery* is to direct attention to many of the current issues and problems that confront the practicing surgeon. The questions are addressed to acknowledged experts in the field. Although "final answers" are desirable, frequently they are not available. Commonly, the experts and the younger surgeon who is developing experience can only formulate a clinical solution that is based on imperfect information, but maximized, reasoned judgment. The various chapters in this book, therefore, attempt to bring out a distillate of some of these reasoned judgments as portrayed by surgical experts in their responses to specific clinical problems. We have attempted to address the common issues facing the surgeon who manages the patient with cancer.

In the section on breast cancer, the question regarding interpretation and diagnosis of the nonpalpable but mammographically defined breast lesion, and the man-

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agement of the patient with small-sized cancer of the breast is addressed. The question of conservative vs. more aggressive therapy for primary cancer is also brought into sharp focus in a discussion by two proponents of opposing views. They discuss the management of patients with small and intermediate size lesions, highlighting the national debate that continues on this issue. Although the national experience with frequent breast screening and better public information has detected smaller cancers, some patients still present with more advanced disease, and the most effective management of these patients is discussed.

Similarly, in the area of colorectal cancer—the second most common neoplasm in both sexes—questions about the effectiveness of methods of early diagnosis and the extent of the initial diagnostic evaluation are also presented. Our experts have then addressed the question of managing the precursor lesions—polyps—in both the rectum and the cecum. What do we do with the larger tumor there? Can we still preserve function in the management of carcinoma in the middle and lower rectum? What is the optimum treatment? Can sphincter-saving surgery be done safely and what are its indications? What should we do with the patient who presents with simultaneous colorectal cancer and liver metastases? What about postoperative management? How should we monitor patients after resection? What is the role of tumor markers such as CEA? What do we do with the patient who is found to have advanced disease either in the pelvis or in the liver?

Last, epidermoid carcinoma of the anal rectum is relatively infrequent, but still occurs frequently enough in the experience of most surgeons to raise various questions of management. Can these lesions be treated adequately without the need for abdominal perineal resection? What are the indications for using this more conservative approach (emphasizing also the need for multimodality therapy in these patients)?

In discussing other areas of the gastrointestinal tract, we have posed questions about the more serious gastric lesions, whether a gastric ulcer or a fungating lesion in the proximal stomach. And how should we manage gastrointestinal lymphomas? These are infrequent tumors, but still common enough to disturb the peace of mind of the practicing surgeon. Should these be resected? Should they be treated with chemotherapy and radiation? What do we do with the jaundiced patient? What about the need for biopsy and what about the surgical options for the patient with a confirmed cancer of the head of the pancreas? Here, because of the controversy in this area, we posed the question to two experts who are asked to take a singularly opposing viewpoint (resect vs. bypass), as this is frequently the dilemma facing the practicing surgeon.

The equally formidable problem of primary cancer of the liver, though uncommon in the United States, is also frequent enough to tax the ingenuity of the clinical surgeon. The problem of the esophagus, both the thoracic and the distal esophagus at the GE junction, are also issues that are encountered and are in need of a clinical solution. Of course, there are the numerous gastrointestinal complications of malignancy that commonly perplex all of us, and for which there are frequently no easy answers; there are solutions, however, which are outlined by an expert in the field.

Although the area of thoracic surgery is highly specialized and is largely under the purview of the cardiothoracic surgeon, there are issues of importance to the general surgeon who has a major interest in cancer. The problems of the basic

management of the patient with a thoracic lesion, whether it is an occult lesion demonstrated by positive cytologic findings, or the more obvious radiographically defined lesion in the smoker, are addressed by experts in the field. The problems of the patient with hilar mass vs. one with a superior sulcus tumor are dilemmas for the thoracic surgeon. The information is important for planning purposes to the general surgeon.

Last is the problem of the management of the patient with the solitary coin lesion who has had another malignancy, such as a melanoma. This is not an uncommon problem as discussed by an expert highly identified with this entity.

The head and neck area is one that presents numerous challenges to the general surgeon, as well as the otolaryngologist and plastic surgeon. The management of thyroid cancer continues to be controversial. The questions of partial thyroidectomy vs. total thyroidectomy for papillary and/or follicular cancers showing angioinvasion are topics frequently debated heatedly at national and international meetings. The two protagonists on either side of this question discuss problems in two patients that highlight the question of the value of total vs. conservative thyroidectomy for differentiated cancer.

Other areas of the head and neck region that are of interest to surgeons with special interest in this area include diagnostic problems in patients presenting with unusual symptoms, i.e., ear pain or a neck mass. An adult presenting with ear pain without an obvious inflammatory process has cancer until proven otherwise. Similarly, a person presenting with a neck mass deserves a careful diagnostic evaluation before taking out the mass. The approach in these patients is outlined by one who has written extensively on the subject.

Other areas of interest to the general surgeon include the management of the patient with the simple or not so simple carcinoma of the lip, or the patient presenting with an obvious cancer of the tongue. Carotid body tumors are still seen by general surgeons as well as otolaryngologists, and a unified practical approach is needed. The patient presenting with a neck mass of unknown origin is another problem. Although in the past surgeons frequently erred on making an incisional biopsy before doing a detailed exam, this should no longer be a problem. The discussion of the extent of workup and the management of these patients (who are seen from time to time by all surgeons) provides valuable information.

Although genitourinary cancer is of obvious interest to the urologic specialist, it is also of importance to the surgeon who treats the patient with cancer. In addition to having some general surgical problem, the older male patient may also be troubled with cancer of the prostate. Of course, the management of the young man with a testicular mass or the problem of the patient with a renal tumor or carcinoma of the bladder are challenges in which at least adequate knowledge is essential for overall management by the practicing clinical surgeon. Knowledge of this specialty area is essential for proper referrals to be made and proper advice to be given to patients and their families. Also, because common things happen commonly, the occurrence of a bladder cancer or a prostate cancer in conjunction with another more frequent general surgical problem necessitates a reasonable knowledge of this field.

Similarly, in gynecologic oncology, the management of the patient with the positive Papanicolaou smear who is found to have an in situ cancer or an invasive

cancer of the cervix are problems of importance to the practicing surgical oncologist, who may be managing a second malignancy in the patient. The patient with breast cancer, who develops postmenopausal bleeding while undergoing adjuvant anti-estrogen therapy with tamoxifen would raise concerns about endometrial cancer. The general surgeon may be asked to see a patient with apparent ovarian metastases from a colorectal cancer, and be surprised to find that he may be dealing with an advanced ovarian cancer. Occasionally one cannot tell these two apart, hence, it is essential to have an adequate appreciation of the possibilities and to be able to formulate a solution (which may be required at the operating table).

Other tumor problems of interest to the general surgical oncologist are also discussed. Melanoma is a disease with increasing frequency that has raised numerous questions regarding the width of excision and the value of prophylactic lymph node dissection. The other tumors, including nonmelanoma skin cancers, are increasing in incidence because of population migrations to the Sun Belt and changes in life-style that include increased sun exposure. Soft-tissue tumors of the extremity, although infrequent, are also encountered by the busy general surgeon, and the proper management of these patients is essential. This is addressed nicely by experts who focused on the salient issues of soft-tissue tumors, one of which involves the extent of the primary surgery (limb salvage vs. amputation) for high-grade sarcomas of the extremity. The need to couple adequate surgical resection with multimodal therapy is most important in this patient group.

Last, in the miscellaneous tumors section, there are a variety of problems that face the surgeon and for which information is needed. The extent of surgical staging and its indication for Hodgkin's disease is an issue facing many general surgeons from time to time. Other problems encountered include the patient with breast cancer who suddenly develops a long bone fracture or who develops a malignant pleural effusion. The patient with an axillary metastasis of an unknown primary lesion (is it breast, melanoma, or other?) is discussed. Other problems occasionally thrust upon the surgeon include hypoglycemia of unknown origin and malignant carcinoid. A common issue is the management of the malnourished patient. The timing and extent of support prior to and subsequent to surgery in the jaundiced patient are addressed by a nationally recognized expert.

Overall, *Common Problems in Cancer Surgery* is not meant to be encyclopedic, but to provide an adequate number of appetizers for the main course, which is a lifetime of experience in the management of the patient with cancer. For more detailed information about cancer management, a reference list of major sources is included to provide additional information in extensive detail.

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