

SURGERY AND ADVANCED ABDOMINAL MALIGNANCY

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I am always amazed when I speak to doctors in many parts of the world by their pessimistic attitude towards their patients with advanced malignant disease. The same medical practitioners who are enthusiastic in trying every means at their disposal to palliate patients with incurable cardiac or renal disease seem to give up without a struggle when confronted by advanced malignancy. While I agree that in many cases the situation is indeed grave, I wish to show in this lecture that there are some grounds for optimism.

The problem divides itself into two major parts. In the first, we have those patients who present with fresh clinical problems which at first appear to be hopelessly advanced abdominal cancer. In the second group are patients who have already undergone what was hoped to have been curative resection of an abdominal cancer, but who now return with clinical features which suggest recurrence of the disease.

Primary Advanced Malignant Disease

The spectrum of what is now regarded as surgically removable is ever widening. Thanks to improved anaesthesia, blood transfusion facilities and advances in surgical technique such as vascular reconstructive surgery, we are now able to carry out successful resection of cancer which only a few years ago would have been considered totally inoperable. Age, for example, is now seldom a bar to surgery provided that the patient's general condition is satisfactory. Involvement of major blood vessels by tumour does not necessarily contra-indicate resection, since the involved vessels can be removed en bloc with the

tumour with reconstruction of the vascular trunk. Involvement of adjacent organs by no means indicates inoperability and we have described, for example, six patients in whom the invaded duodenum was resected together with a carcinoma of the right side of the colon.

The presence of secondary deposits, once considered complete contraindication to curative surgery, is now no longer necessarily so and occasional long term survivals follow resection of solitary deposits in the right or left lobe. I freely admit that the great majority of patients with liver secondaries have multiple deposits which are unsuitable for any form of resection. Until recently, many surgeons taught that the presence of such secondaries completely contraindicated resection of the primary tumour. However, we have recently reviewed our experience at Westminster Hospital and of 640 patients with carcinoma of the large bowel submitted to laparotomy, 112 (18%) had liver metastasis. 6 had laparotomy only and all were dead within a few months. 19 had palliative colostomy or short circuit and 17 of these were dead within a year. However, 32 of the 86 patients submitted to palliative excision of the primary tumour lived for more than a year and 1 survived for 5 years. We know, in addition, that death from liver deposits is far kinder than the terminal illness of the primary cancer.

Even when the local tumour itself is completely irremovable, we must always consider whether we can carry out some useful short circuit operation or intubation using a plastic tube. The average length of survival of patients after this procedure is only in the region of 12 weeks and the longest survival one can expect is about

1 year. However, anybody dealing with these unfortunate patients would agree that allowing them to swallow fluids relatively easily up to the time of their death is a tremendous advantage. In summary, when confronted by a patient with an apparently hopeless abdominal cancer, we should first consider whether the tumour is after all resectable even if this means removal of adjacent structures or distant deposits. We should consider whether a palliative resection is indicated, even though we know that secondary deposits will be left behind. Should the growth be totally irremovable, we must at least consider whether some sort of short circuit or intubation should be carried out.

Suspected Recurrent Disease

There are few situations which are more depressing to the practitioner, the surgeons, the relatives or to the patient himself than when months or years after an apparently successful resection of an abdominal tumour features develop which suggest recurrence of the original lesion. There may be loss of weight or appetite, development of abdominal pain or distension. There is vomiting or jaundice, or perhaps a mass has been found in the abdomen. Of course, everyone immediately assumes that the patient has now developed hopeless recurrent cancer and that little or nothing can be done about it. Undoubtedly this situation is true in many cases, but there are enough exceptions to maintain a flicker of optimism. I advise the following catechism under the circumstances:-

1. Could the clinical features be produced by some unrelated and benign condition?
2. Could the patient have developed a second primary tumour in itself perfectly resectable?
3. Even if a secondary deposit or recurrence has now developed, is this itself removable?
4. Even if the patient has irremovable recurrent tumour, is there any palliative surgery which might relieve his symptoms?

It is only after we have been through this list that we turn to other procedures such as radiotherapy or chemotherapy.

It is a common but understandable mistake to attribute every symptom and sign which a patient develops after a successful cancer operation to recurrence of the original disease, yet this is by no means an invariable rule.

Distension, vomiting and constipation may be due to subacute obstruction due to adhesions. An abdominal mass may be due to a twisted ovarian cyst or a deeply placed chronic abscess. An apparent recurrence at a suture line may be due to a benign stricture and even jaundice may be due to gall stones.

From time to time we encounter patients who develop a second and perfectly resectable primary tumour. This may occur in another organ but is particularly likely to develop as a metachronous second primary tumour in the large bowel following resection of a previous growth. Many of these are entirely operable so that the follow-up of patients after resection of colonic cancers should be most carefully pursued.

Even if the tumour has indeed recurred it does not mean that it is necessarily unresectable, whether the recurrence is at the anastomosis or a deposit elsewhere such as in the abdominal scar or in the perineum following an abdominoperineal resection of the rectum.

Even if the recurrence is found to be irremovable at laparotomy, it may still be possible to perform some palliative surgical procedure such as a short circuit of an obstructing but irremovable recurrence or by intubation of recurrent obstructing tumour in the oesophagus.

What sort of results may we expect to get from this programme of aggressive surgery in which we are prepared to carry out an exploratory laparotomy in a suspected case of abdominal recurrent cancer, provided there is no obvious evidence of widespread hopeless disseminated disease?

Over the last 11 years we have carried out 39 second look operations in the Surgical Unit of Westminster Hospital on patients who have undergone previous "curative" resections for large bowel can-

cer and who returned with clinical features suggesting recurrence of disease. 3 patients were found to have a non-malignant condition with no evidence of recurrence. 1 had obstruction caused by adhesions, 1 a granulomatous stricture at the anastomosis and 1 a twisted ovarian cyst. The first two patients remain alive and well five and four years after surgery. The third died three years after operation without evidence of recurrence.

3 patients developed entirely new cancers, a renal carcinoma, a carcinoma of the body of the uterus and adenocarcinoma of the ovary. The first two died within a year of second surgical excision and the third patient is alive but with pulmonary deposits, within a year of the second operation.

11 patients developed metachronous tumours in another part of the large bowel which were submitted to resection. 5 of these patients are now dead in periods of up to 24 months after the second operation. 6 patients are alive and well, 2 within 12 months, 2 at 2 years, 1 at 7 and 1 at 8 years post-operatively.

4 patients with local recurrences were only suitable for short circuit or colostomy. All of these died within 14 months.

6 patients had recurrences in the

abdominal scar, the perineum, ovary, pelvis or small intestine. 5 died in from 3 to 15 months of metastatic disease, but the patient with perineal metastasis after an abdomino-perineal excision of the rectum lived for 4½ years before dying of disseminated cancer.

4 patients were found to have disseminated deposits at second laparotomy and all died in periods of up to 17 months.

To sum up this small series of 39 patients, 12 achieved good long term results with survival of 2 years or more, 8 of these are still alive and 2 remain well and free from clinical recurrence within a year of their second operation.

We feel that there is much to gain and little to lose in offering laparotomy to these patients. The occasional case with a completely benign condition is alone worth all the endeavour, and long term survival may also follow resection of a recurrence or a second tumour. Even if the exploration reveals a surgically hopeless situation, the laparotomy at least defines the extent of the problem so that we can consider whether radiotherapy or cyto-toxic drugs should be used. At the very least, in such cases the patient and his family know that no effort is being spared before giving the final hopeless prognosis.