Pain-relieving Drugs

In the terminal stages of cancer the need for pain-relieving drugs is essential; of these morphia and its derivatives remain the most important. Their use, however, should be postponed as long as other remedies can offer alleviation. Skeletal pain can be relieved by palliative X-ray therapy. Uncontrollable pain from involvement of nerves can be achieved by injections of nerves, cordotomy or leucotomy. Morphia and its derivatives should remain the last resort and their function in the end is to help the patient to die and, in massive doses, morphia shortens life.

The management of advanced cases of cancer is nearly always the responsibility of the family doctor. Specialized forms of treatment are of importance and often of value but the risks, discomforts and disabilities not infrequently associated with such treatment need to be considered from the general background of the individual patient, his mental distress, his fear of treatment which often is greater than the fear of the disease, the desire to live, the severity of symptoms, the age and the likely expectation of life.

The Management of Advanced Cancer

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I HAVE no experience of treating advanced cancer beyond that which falls to the lot of any general physician. In cases of advanced cancer surgeons and physicians can give each other much assistance.

The technical advances of surgery and anæsthesia allow much more massive surgical removals to be done and the discovery of new hormones allow more and more of the endocrine system to be taken away without killing the patient. I think it was Sir Henry Cohen who remarked here once "The feasibility of an operation is no indication for its performance", so, while admiring the skill of these surgical feats we must also pause to examine the fruits of victory and decide if they are worth the fight.

Firstly, radical surgery. In advanced cancer this is rarely possible. In deciding whether to attempt it, it is worth considering the mode of death without surgical treatment; death from carcinoma of the œsophagus for instance is so particularly unpleasant that there is much to favour attempting even a hazardous case. Another point concerns the commonness of a disease. Carcinoma of the lung is so common that doubtfully operable cases should not be sent to the thoracic surgery units when chest clinics and mass X-ray units are already finding so many early cases. If a man is pretty certain to die soon, the fewer bronchoscopies, bronchographies, biopsies and chest operations he has in his last few months the better.

Secondly, palliative surgery—the severity of the symptoms which the operation is designed to palliate is the important factor. Jaundice, for instance, is sometimes a distressing death and cholecystogastrostomy well worth while. When I was a student Russell Howard taught us "It doesn't matter whether you die white or die yellow, but nobody likes to die scratching"; he thought the skin irritation the important thing but probably the other symptoms of jaundice including the depression are worth relieving in most cases. On the other hand a colostomy may sometimes produce as much distress as it relieves. Each case for palliative surgery is a separate problem and the doctor has to ask himself: How much distress is there? How much relief is the operation likely to give? How much distress is the operation likely to produce?

Radiotherapy

Though often responsible for many brilliant results radiotherapy has its disadvantages. First, some people guess they are suffering from cancer if they are treated with deep X-rays. Secondly, there are often severe general malaise and uncomfortable skin reactions. In my experience people with carcinoma of the lung often react badly to radiotherapy and the little span of life allotted to them is made less tolerable without being lengthened. The exception is where there is superior mediastinal obstruction. The relief of this by radiotherapy can be dramatically rewarding.

If one includes chronic leukæmias among the cancers I would observe here that radiotherapy should not be used too early, unless a patient's splenomegaly or adenopathy are mechanically a nuisance to him and unless he is anæmic. There is little point in producing dramatic changes in the size of his spleen or the number of his white cells, impressive though these are on paper. "Don't treat blood counts treat patients" is the motto. Many leukæmic people, particularly the chronic lymphatics, can attend for six-monthly observation without any treatment for several years, free of symptoms and in ignorance of the diagnosis.

The Hormone-dependent Cancers

It is now recognized that cancers of the breast and prostate in some way depend for their existence upon sex hormones manufactured in the suprarenal glands and the gonads. Bilateral suprarenalectomy with or without gonadectomy has, in certain cases, given remarkable results. What little I know about it is from Sir Stanford Cade's Hunterian lecture. In favour of this latest advance in endocrine surgery is that it is only used in cases of otherwise hopeless prognosis and that about 1 in 5 (9 out of 46 cases of disseminated breast cancer) of those operated on make a really dramatic (though not permanent) recovery. Furthermore the knowledge of the endocrine physiology of certain cancers which is being gained all the time is a very valuable asset to everyone fighting against cancer.

Yet there are also certain points against the operations: (1) Patients have to submit to fairly extensive and risky operations whose result is so uncertain that it is just as likely not to benefit as to benefit them. (2) The operation leaves them dependent on an expensive and scarce drug, cortisone. (3) It may improve the patient only for a brief while and so give him the sorrows of downward progress on two occasions instead of one.

In summary, it certainly represents an advance in knowledge: the operation seems ethically justifiable, but it cannot yet justify the term "satisfactory treatment".

Lastly there is the purely medical approach which consists in managing the patient's journey to the grave in the way which gives him the greatest physical and mental comfort. Until active treatment is more uniformly successful most cases of advanced cancer will have to be treated in that way, so it is worth saying a little about it. First should the patient be told he has cancer and is dying? It is my experience that people as a whole are far happier if they do not know. Some of them I feel sure know in their heart of hearts, but prefer to play a game of make-believe with the doctor: others remain in complete ignorance and modest contentment to the end. To assist in this beneficial deception it is important to avoid *sotto voce* murmurings at the foot of the bed or the use of words like tumour or carcinoma. Relatives, too, can play their part by a cheerful demeanour at the bedside; in fact there is something to be said for keeping relatives as well as patients in ignorance of the downhill progress until it becomes obvious.

A most important thing in managing these people is to treat their minor complaints if anything more assiduously than the one they are dying of. A patient with extensive carcinoma may worry about some wax in his ears or a fungus infection of his feet and by treating these we can sometimes both make him more comfortable and distract his attention from the major complaint.

Also if a hospital patient has only about a week to live it is unkind to transfer him from the acute medical ward, which he already knows, to a chronic ward where the nurses and patients are strangers to him.

For the relief of pain there is still probably little to touch the well-tried morphia or pethidine but they need not be given purely because a patient is going downhill from cancer, for sometimes it is a surprisingly painless progress; nor need the dose be increased automatically for some people seem to lose their pain towards the end and do not need to be kept continuously drugged. It is often wise to give the substances by mouth so that the patient is less aware of being drugged than if injections are given.

To sum up: The endocrine surgery of extensive cancer is a great advance, but at present more of an advance in knowledge than an advance in treatment.

If it is highly probable that a patient is going to die in a few months, the less operations and investigations he has to submit to in that time, the better.

Prolongation of life is not the only aim of treatment; it should be a tolerable life. It is better to be wholly alive for one month than half alive for two.

It is not always worth the discomforts of major surgery to get minor recovery.

It is better to go steadily downhill towards death than to pursue an undulating course to the grave buoyed up by temporary recoveries.

The Use and Limitations of Skin Tests in Asthma

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Skin tests offer no short cut to the diagnosis or treatment of asthma. Their use is limited and the technique of testing though simple must be precisely carried out, to achieve reasonable results. The following remarks apply mainly to tests carried out with inhalant allergens: food tests, which present special difficulties of their own, are not considered here.

Table I shows a comparison between the results of skin testing in asthmatic patients and in a carefully selected control group (Pearson, 1937). The figures indicate the percentage of reactions obtained when these two groups were tested with two common inhalant allergens