ADVANCED ABDOMINAL MALIGNANT DISEASE*

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It is unfortunately true that surgeons usually adopt a pessimistic attitude towards their patients with advanced abdominal malignant disease. Certainly the situation is grave in many cases, but in this lecture I wish to point out that this may not always be so, and to try and put forward a more optimistic approach to this depressing subject.

The problem must divide into two parts. In the first we have patients who present to the surgeon as a fresh clinical problem with what first seems to be hopelessly advanced abdominal cancer. In the second group, perhaps even more depressing, are patients who have already been submitted to what was apparently a curative resection but who now return with features which suggest recurrence of the malignant condition.

Advanced Primary Malignancy

Thanks to improved anaesthesia, blood transfusion facilities and advances in surgical technique (for example, vascular reconstructive surgery), surgeons are now able to carry out successful resections of cancer which only a few years ago would be considered inoperable. For example, age is now no longer considered a bar to surgery provided that the patient's general condition is satisfactory. We have now carried out radical surgery in many patients in their 80's and have even performed an abdomino-perineal excision of the rectum in an old lady of 90. Involvement of major blood vessels by tumour is now no longer in itself a contra-indication to radical surgery since the involved vessel can be removed, together with the tumour, with graft replacement of the resected artery.

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The presence of secondary deposits was once considered a complete contra-indication to radical surgery, but this is now no longer necessarily so. Isolated deposits in the left lobe of the liver can be resected at the time of initial surgery. A solitary deposit in the right lobe is technically more difficult to remove, requiring right hepatic lobectomy, but every now and then a long term survival may follow this radical approach. It is true that the great majority of patients with liver secondaries have deposits affecting both lobes but even in this situation we consider that, wherever possible, the obstructing neoplasm in the alimentary canal should be resected. In a review of our experience at Westminster Hospital of 112 patients with carcinoma of the large bowel with liver metastases found at the time of laparotomy, 6 had exploration only without further procedure and all were dead within twelve weeks. Nineteen had either a palliative colostomy or short circuit and 17 of these were dead within a year. However, 32 out of 86 patients submitted to palliative excision of the primary tumour, either by colectomy or abdomino-perineal excision of the rectum, lived for more than a year and one patient survived for five years. As well as increasing the chance of survival a probably more important feature is that the quality of the patient's life is improved by this approach, since death from liver secondaries is far kinder than the terminal features of unresected bowel cancer.

Even when local tumour is completely irremovable we should always consider whether a useful short circuit operation or intubation should be performed. Dysphagia due to hopeless advanced carcinoma of the oesophagus or cardiac end of the stomach can be overcome by threading a plastic tube through the obstruction. The average length of survival of our patients after this procedure is only in the region of three months and the longest survival that we can expect is about a year, but at least they are allowed to swallow fluid relatively easily up to the time of death.

To sum of this first group of patients, whenever confronted by a case of apparently hopeless abdominal cancer presenting as a fresh problem, we should consider first whether after all the cancer is indeed resectable. If this is not the case, we should decide whether a palliative resection indicated even though secondary deposits will have to be left behind. If the growth is entirely irremovable we must at least consider whether some sort of short circuit or intubation may relieve obstruction so that the patient can die in comfort.

Suspected Recurrent Disease

There are few situations in practice which are more depressing than when a patient who has undergone an apparently successful resection of his abdominal cancer develops features which suggest recurrence of the original disease. There may be loss of weight or appetite, abdominal pain or distension, vomiting or jaundice, or perhaps a mass is felt in the abdomen. Immediately the general practitioner, the surgeon, the relatives and the patient himself thinks that a hopeless recurrent cancer has developed and that there is little or nothing that can be done. Undoubtedly in the majority of cases the situation is indeed grave, but there are

enough exceptions to keep us from being entirely gloomy. I always advise that the following catechism should be considered under the circumstances:-

1. Could the clinical condition be produced by some entirely non-malignant condition ?
2. Could the patients have developed a second primary resectable tumour ?
3. Even if a secondary deposit or recurrence has now developed, could this itself be resectable ?
4. Even if the patient has irremovable recurrence, is there any palliative surgery which may relieve symptoms ?

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

It is a common and serious mistake to attribute every symptom and sign which a patient develops after a successful cancer operation to recurrence of the original disease. Pain, distension and vomiting may be nothing more than sub-acute obstruction due to adhesions. We have had a patient who developed a large painful mass after resection of carcinoma of the colon some years before; at laparotomy this proved to be a twisted benign ovarian cyst! We have seen anastomotic strictures following resection of oesophagus or colon which were at first regarded as recurrences but found to be completely benign at surgery. We have had deeply placed abscesses which had mimicked recurrent abdominal cancers and we have even seen jaundice due to gall stones which was thought at first to be due to multiple liver deposits from a previous cancer of the rectum.

It is not so rare for a patient who had one cancer to develop a second primary tumour and this is particularly true in cancer of the large bowel. This second cancer may itself be entirely operable. A second primary tumour in another organ is also far from unknown and for example we have had two patients who developed cancer of the colon some years after removal of a malignant ovarian tumour.

Even if a tumour has recurred it does not invariably mean that it cannot be resected. This applies to solitary deposits in the liver and lung and even in the brain. Recurrences at the anastomosis may still be operable in the oesophagus, stomach and large bowel and deposits in the abdominal scar may be localised and perfectly resectable.

Even if the secondary deposits are found to be irresectable at laparotomy, it may still be possible to perform some palliative surgical procedure to overcome obstruction. In particular, it may be useful to short circuit an obstructing but irremovable recurrence at an anastomosis, and we have also treated recurrent obstructing cancer in the oesophagus and cardia by intubation.

We feel that there is much to gain and little to lose in offering laparotomy to patients with apparent recurrent cancer. From time to time a completely benign condition is revealed which can be entirely cured by surgery and this alone is worth all the endeavour. Occasionally long term survival may follow resection of a second tumour or of a recurrence. Even if exploration reveals a surgically hopeless situation, the laparotomy at least defines the extent of the problem, allows consideration of further treatment by means of radiotherapy or cytotoxic drugs, gives some idea of the prognosis and finally ensures that the patient and his family realize that no effort has been spared before the surgeon has given the final hopeless prognosis.

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