

# Surgery

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To put cancer surgery into some kind of perspective it is worth looking at its history. Surgery was known to the ancients but was expressly condemned in the case of cancer, Hippocrates' famous comment was: "It is better not to apply any treatment in cases of occult cancer; for, if treated, the patients die quickly; but if not treated, they hold out for a long time." ('Occult' means hidden.). Here is the argument for doing nothing. It is a conclusion supported by some modern medical statisticians.

In Europe, medical practitioners between the twelfth and nineteenth centuries repudiated the use of any kind of surgery, leaving it to barbers to perform. Without asepsis or anaesthetics it was cruel and generally unsuccessful. The great doctor Paracelsus (1493-1541) said: 'It should be forbidden and severely punished to remove cancer by cutting, burning, cautery and other fiendish tortures. It is from nature that the disease arises and from nature comes the cure.' So doctors, six hundred years ago were able to talk of curing cancer. It was also their combined experience of the disease that surgery was the wrong approach. Now it is considered the standard approach – and natural cures are considered beyond the pale. Clearly something has happened to medical thinking on the way and, equally clearly, one has some support, whichever decision one takes with regard to surgery.

It was only with the discovery of asepsis and anaesthetics that surgery, against much opposition, became accepted. It became accepted as a necessity during the Napoleonic wars – because men needed treating for their battle wounds. The first recorded surgical cure for a cancer was in 1809, when a 22 pound ovarian tumour was removed from a patient who went on to live a further 30 years. Though whether this should be called a cure is a moot point – the tumour was clearly benign.

Since then surgical procedures and technology have improved by leaps and bounds. There is no doubt that for cases of severe physical trauma – resulting from war, traffic accident or any other cause – surgery is essential if many victims are to survive. Surgery offers wonderful gifts to children born with severe birth defects: hare-lips and so on. But cancer is not a severe physical trauma or a physical malformation that needs to be corrected. It matters not what great advances have been made in the area of surgery, the question of its appropriateness in the case of cancer remains contentious – and no amount of technological improvement can change that because the problem relates almost entirely to the nature of cancer rather than to the nature of surgery.

## The dangers of surgery

Surgery is an empirical science. Its methods and procedures develop from day to day and are not, generally speaking, subjected to the harsh judgements of clinical trials. It is therefore not a 'proven' form of cancer treatment in any real sense. It is subject to its own fads and fashions. To give an example unconnected with cancer, A certain Dr Joseph DeLee, in the 1920s, declared natural childbirth to be unnatural and severely traumatising to the baby. He therefore insisted that all babies should be delivered with forceps clamped round the head. Soon this became the standard approach in the States to birth. The consequence? Infant deaths from birth injuries rose by 50%. It took five years to realise this.

Surgical development still follows this path. The popularity of triple by-pass heart surgery is attributed by some to the charisma of surgeon Dr Denton Cooley who invited a TV crew into his operating theatre. There is, in chelation therapy, a very viable alternative to the by-pass but it doesn't require surgery so the heart surgeons are unlikely to be interested in promoting it. It doesn't give

them employment. And anyway, It isn't very heroic.

Keyhole surgery is another development that has resulted in greater numbers of complications and deaths. All new surgical techniques have to be learnt and the patient, ultimately, is the classroom where this learning takes place. The pioneers of any new development will have proceeded cautiously and carefully to build up their expertise – but as soon as the new techniques are publicised the next generation of practitioners believe they can master them in days. Patients are used as human experiments. It took almost ten years after its initial development before the Royal College of Surgeons issued guidelines on training in keyhole surgery – up till then they ignored the problem. Surgeons jumped on the bandwagon: it was a case of ‘see one, do one, teach one’ according to one anonymous surgeon quoted in the Independent. How many people suffered as a result? That is anyone's guess. How many operations are done simply to allow the surgeon to keep his or her hand in?

The simple fact is that surgery is dangerous and results in deaths. What is the combined deathrate from all forms of surgery? Recent investigations in Britain suggest that the average surgeon has a patient mortality rate of between two and seven percent. This is measurably greater among those who have had the least experience. It is better to go to a big hospital than a small local one. It is better not to be in hospital when medical students graduate and relieve their more experienced superiors. Surgeons undertaking fewer than five breast cancer operations a year have a death rate of up 21 percent. A specialist is always better than a general surgeon.

### **Not a ‘proven’ treatment for cancer?**

Against this background we can now take a hard look at cancer surgery. Surgery can be categorised as specific or localised surgery when it simply aims to remove the tumour and nothing else. It is called ‘radical surgery’ when parts of the affected or neighbouring organs or lymph glands are also removed.

### **Simple surgery**

The argument for simple surgery to extract a tumour only – e.g. a lumpectomy, in the case of breast cancer – appears to make a degree of sense. As long as metastasis has not occurred and the tumour is small enough to be removed, and the tumour is accessible, the chances, most surgeons say, are reasonably good that surgery will, on its own, be quite sufficient. ‘Early stage tumors (e.g., carcinomas in situ) that have not yet invaded surrounding normal tissue can be completely removed and are virtually 100 percent curable.’ (Cooper, 1993)

This unfortunately neglects an important point. Cancer tumours are highly individualistic. Just because a tumour is small does not mean it hasn't metastasized; just because it is big does not mean it is going to metastasize. And, in any case, most tumours are relatively far advanced by the time they are detected – even though they may appear small. So, it is not at all obvious before an operation which tumours are best treated by simple surgery and which are not.

Added to this is the question of surgical competence on the part of the surgeon. One American study suggests that even when a tumour appears to be singular and operable, in only 50 percent of cases is the entire tumour removed. In half the cases some cancerous cells are left to rebuild the tumour. In other cases the cancer tumour may be inadvertently cut, releasing cancerous cells into the bloodstream. The result? A cancer that spreads much more quickly. When this happens, the result is

that surgery not only does not cure, it hastens death – just as Hippocrates observed. Even biopsies – that most frequently performed of minor surgical interventions – are not problem free. As we have noted, this procedure can itself release seed cells into the bloodstream. The more aggressive the malignancy the more dangerous the procedure is. In cases of testicular cancer, one of the most aggressive of all cancers, even biopsies must not be performed. So, even having a biopsy is something that the potential patient should make a decision about. The more aggressive the cancer, the more this procedure must be avoided.

It is also not widely known that a primary tumour in one site as well as seeding metastases to other sites, may also have the ability to control these metastases in such a way as to prevent them from growing. Once the primary tumour is removed, the means of control is also removed and the result is that each metastasis quickly blossoms into a full grown tumour of its own. This is another argument against proceeding automatically with surgery.

## **Radical surgery**

Radical surgery is almost always worse than useless. It is a desperate – and almost certainly vain attempt to remove a cancer that has spread by cutting out all the tissue surrounding a tumour – or trying to locate and remove all the metastases of a tumour. With any major surgery of this kind the mortality risk must necessarily be greater. And for the patient the pain and suffering is certainly worse than useless. Not only may they be seriously disfigured, lacking in basic bodily functions and weakened, but, on top of that they may have their remaining life-span reduced.

Dr Hardin Jones, professor of medical physics at University of California studied the effectiveness of standard cancer therapies. It was his opinion – based on statistical analysis – that there was no relationship between the intensity of treatment and survival rates. Radical surgery, in short, does not improve one's statistical chances of full recovery. He is on record as saying: 'radical surgery does more harm than good.' In fact he couldn't find any statistical evidence at all that any kind of 'proven' medical therapy worked: 'The possibility exists that treatment makes the average situation worse.'

One 1949 study on stomach cancers showed that there was no difference in survival rate between those having localised surgery and those who refused. However, survival rates were cut in half when radical surgery was performed.

For most cancer patients, the stated need for radical surgery will be for the reason that the tumour is known to have metastasized – or is strongly assumed to have done so. Once a tumour has metastasized, there is no knowing where the secondary tumours will appear. The tissue closest to the tumour will not necessarily be the tissue first affected by a new metastasis. The cancer cells will have been borne by the bloodstream to areas of the body far from the original site. Breast tumour cells may grow in lung tissue or in the bone or in the kidney – nevertheless it remains a breast cancer cell identifiable as such under the microscope. Once a tumour is suspected of metastasizing then surgery ceases to be an option that makes very much sense: what is the surgeon going to cut out? When will the surgeon finish cutting?

## **Mastectomy: a special case**

The most common form of radical surgery is mastectomy, the amputation of the breast. Any mastectomy could be termed 'radical surgery', as it involves removing tissue surrounding a tumour, but confusingly, there is a particular kind of the procedure known as a 'radical mastectomy'.

Around the turn of the century, William Halsted of John Hopkins Hospital in Baltimore developed the radical mastectomy. His procedure involved removing the entire breast, removing the two underlying main chest wall muscles leading to the shoulder and removal of all the lymph nodes in the armpit. Ewan Cameron and Linus Pauling comment: 'This was an extensive and very mutilating procedure, leaving the woman not only without a breast but also with a deep depression where the underlying muscles had been removed, an ugly scar, and almost always a permanent brawny swelling of the arm because of the surgical interference with the lymphatic drainage.'

What Cameron and Pauling don't say is that this swelling – oedema – is extremely painful and debilitating in its own right.

After the Second World War, Scottish surgeons started to do a simplified mastectomy – removing the breast but not the underlying muscles or the lymphatic nodes. This was accompanied by radiation. The results appeared to be rather better than the Halsted procedure.

In the 1950s, American surgeons developed a super-radical-mastectomy, This was the old Halsted procedure plus removing the lymph nodes on the side of the neck and dissecting out all the lymph nodes beneath the breast bone. Results did not show any benefit – and this procedure has few proponents today. It developed partly because technological developments permitted it.

Also in the 1950s, Finnish doctors developed the lumpectomy – and claimed even better results than with the mastectomy. This seems to have been supported by later studies.

Scottish surgeons then announced that patients who had a mastectomy without radiation are doing better than patients who had radiation.

Statisticians looking at the whole picture, comparing different cohorts of women with breast cancer choosing different treatments have found that there is no difference at all in the death rate of women who have had mastectomies and women who have had no treatment at all. Read that last sentence carefully.

Despite this, until the 70s or 80s, American surgeons still tended to do radical mastectomies while European surgeons tended to do 'simple' mastectomies or lumpectomies. The reason for American surgeons' preference for the radical mastectomy appears to be a combination of income – they earned more for doing more – and fear of litigation – you can't be sued for doing the maximum possible.

The current trend even in America is away from the Halsted procedure to lumpectomies or resections – the cutting away of part of the breast. However, the Halsted procedure may still be advised where there is significant spread. In such a case the patient might prefer not to undergo any surgery whatever, as there is no proof that extensive surgery in breast cancer has any impact on survival. The survival rates for women who have a mastectomy are no greater than for those who have a lumpectomy – about 50% will survive 5 years. Yet women undergoing breast surgery very often don't know which procedure will be done on them. Sometimes, women undergo mastectomies simply because there is too great a pressure on the radiotherapy unit of their hospital – lumpectomies, in Britain, are often accompanied by radiation.

Amazingly, of those women who survive long term after a mastectomy, 5-10 percent will later find a cancerous nodule on the mastectomy scar. Despite this, in America, large numbers of mastectomies are performed as a preventative measure. These women have volunteered to have their breasts removed in order to avoid breast cancer. Figures from one New York hospital showed that

such prophylactic mastectomies accounted for 20% of the total !

Ewan Cameron and Linus Pauling, who were by no means opposed to surgery as a first line of attack against cancer had this to say:

"The observations from Halsted on seem to be showing that the less that is done for breast cancer patients, the better their chances of survival. The damage done to the body by surgical or radiotherapeutic intervention may be greater than the benefit resulting from partial control of the disease. This trend has led many thoughtful surgeons to question seriously whether they should treat breast cancer patients at all – whether these patients might not better be left alone. The question is a serious one, demanding an answer." (Cameron & Pauling, Cancer & Vitamin C).

### **Not all doctors approve of surgery**

Medicine is an arena of contending ideologies. One of these ideologies is the surgeon's creed that the best thing to do with a tumour is to cut it out. This belief has become so dominant that it is now almost unquestioned within the temples of modern medicine – but there are doctors who disagree.

A hundred years ago years ago, homoeopathic doctor, Dr Compton Burnett, a scathing critic of surgery for cancer, scornfully described the surgical process:

(The woman)) was successfully operated on and thoroughly cured thereby of her mammary tumour; nine months later, she was again thoroughly cured of another tumour, by a perfectly successful operation; a few months thereafter she was again successfully operated on for another tumour, and just as she was getting well – she died.

Elsewhere he remarked: 'Surgeons may think the cutting out and cutting off processes "curing"; I think them a last refuge of helplessness.'

He was not alone. Dr Robert Bell, a senior staff member of the Glasgow Hospital for Women agreed. In 1906, he wrote the following:

I had been taught that this (surgery) was the only method by which malignant disease could be successfully treated, and, at the time, believed this to be true. But failure after failure following each other, without a single break, inclined me to alter my opinion..The disease invariably recurred with renewed virulence, suffering was intensified, and the life of the patient shortened...That cancer is a curable disease, if its local development is recognised in its early stages, and if rational dietetic and therapeutic measures are adopted and rigidly adhered to, there can be no doubt whatever.

Where has this wisdom gone?

### **Putting limits on surgery**

Whether or not any major organ is removed is a matter for patients not the doctors to decide – although they will try to convince you otherwise. Every patient has the right to say that a procedure may or may not be done on his or her body. Patients undergoing any form of surgery should therefore be very clear in their own minds as to how far they are willing to go. If a woman with suspected breast cancer, for example, is willing to have a lumpectomy but not a radical mastectomy, she needs to write this on the consent form before she signs it.

Unfortunately, the legal protections for patients are not as strong as they should be. Doctors are allowed a great deal of leeway as to what they can do in the operating theatre so it is best to get legal advice.

### **Surviving surgery**

However, in a particular circumstance there may be very good reasons why cancer surgery is an attractive or at least the preferred option. And, of course, there are many cases not involving cancer where surgery is clearly indicated. In these cases you should go into the operation with the most positive of thoughts. In your case everything is going to work out fine. Positive thinking works. It helps to boost the immune system. Spend as much time as you can watching funny films and laughing your head off.

After an operation, it is possible to improve one's healing through a number of procedures that few doctors will be aware of, or advise even if they are aware of them. One is to take very large doses of vitamins C, A and E starting a week or two before the operation and continuing for a month or so after. Similarly acidophilus and other friendly bacteria should be taken in capsule form. You should also smear undiluted lavender essential oil – available at any shop selling aromatherapy oils – on all the scars to aid healing. Lavender oil is a marvellous healing agent.

Another precaution that you can take, especially if surgery is not scheduled for a number of weeks is to build up a supply of your own blood to be used if necessary. This is to prevent the admittedly low possibility of catching hepatitis or HIV from infected blood. The estimated risk of HIV infection in the States is 1 in 225,000 while the risk of hepatitis is 1 in 6,000. Blood transfusion from other donors can also cause problems when there is a reaction to the foreign blood platelets and/or white blood cells – these may cause hives or fevers. The risk of one or other of these is apparently in the region of 1 in 15-20.

Another point that is not immediately obvious are the psychological effects that can accompany the removal of any limb or organ. Careful mental preparation needs to be undertaken. The importance of being properly psychologically prepared is demonstrated by the following sad true story. An eleven year old girl was discovered with advanced bone cancer and the result was that her leg had to be amputated. The operation was, it seemed, successful and the doctors were cautiously optimistic. They arranged for an artificial limb to be attached and she was given physiotherapy. Her condition improved and she was released from hospital. The very next day she climbed to the roof of the apartment block where she lived and jumped to her death.

Many people who have had less obvious parts of their bodies removed live on in pain and quiet desperation. Surgery should not be an automatic knee-jerk response to cancer.