MEDICAL PRACTICE

If I Had . . .

If my wife had cancer of the breast

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If my wife had cancer of the breast, my first feelings would be ones of intense anxiety and despair; so much so that even contemplating the possibility in the preparation of this paper has been most unpleasant. I hope, however, that this feeling would quickly be replaced by the realisation that at least we were both having to face up to a malignant disease which carries with it a more reasonable prognosis for long-term survival than many others. Moreover, although a mutilating treatment will be required, at least its physical, if not psychological, effects can be disguised, enabling rapid return to a normal useful place in the community.

Let us hope that, being an intelligent girl, she will have seen her doctor when the lesion was found to be a small, painless, recently noticed lump (usually in the upper outer quadrant of the breast). Our general practitioner's duty is quite clear cut: to examine her, confirm the presence of a lump, and ensure early consultation with a surgeon. I doubt very much if delay of even several weeks much influences subsequent prognosis, but I do know that every day of delay to the patient must seem like a year and I squeeze women with breast problems into the next available clinic, no matter how many cases are already booked on that day.

Now, the choice of the surgeon. This is all-important because we need a man that we—particularly my wife—can trust. He needs, of course, to be a good technician but he needs also to be humane, gentle, tactful, and communicative. Much of the psychological side of the management of cancer depends on the first interview with the surgeon and all these virtues need to be his.

Let us assume that his clinical examination, while confirming

the presence of a small, hard, slightly irregular lump in the breast, fails to show the presence of involved axillary nodes or other evidence of metastatic disease. There is naturally some satisfaction from this, even though it is realised that there is something like a 25% error in clinical examination in both directions; enlarged nodes may prove to be free from disease, whereas impalpable nodes may show microscopic foci of cancer. I hope that he will now order a chest x-ray film and skeletal survey which can be carried out the same day. A mammogram is really a waste of time with these findings, since whether it suggests malignancy or benignity, the lump must be removed, so why delay?

Urgent admission

After the surgical consultation, urgent admission to hospital. It is unkind to put patients with breast lumps on a waiting list: they must know at once the date of admission which, again psychologically, must be into the next possible bed. The only thing to sustain the patient in the meantime is the confidence that she has chosen a surgeon that she can trust to see her through the coming ordeal. This is why I am certainly not going to ask for other advice; for second and third opinions; for alternative suggestions concerning treatment. I always pity patients with serious disease who undergo this pilgrimage from surgeon to surgeon. Of course, if the patient has no confidence in her surgical adviser or comes from a country or an area where the necessary ancillary services are unavailable, then transfer to a reputable centre is well justified. But in normal circumstances I want my wife (and indeed all my patients) to have faith in her surgical team.

I should certainly like her to be admitted to a hospital with facilities for immediate frozen section examination of the excised specimen to be carried out by a competent pathologist. No waiting for several days, please, while the diagnosis is established on the biopsy with the ordeal of a further, now major, operation once the diagnosis has been confirmed.

Since surgery is inevitable, I must leave the operation in

the hands of my wife's surgeon. Indeed, the greatest principle which must apply to a doctor-patient or his relative is not to interfere. The task of the surgeon is hard enough without his colleague breathing down his neck. Having chosen the man that we trust, I hope that he will give my wife the best possible treatment, which I am sure is just the same treatment he will give all his other patients. Accidents occur only when a "special" patient gets "special" treatment.

Operation

A wide range of operations is available, ranging from lump-ectomy at one end of the scale to super-radical mastectomy, and even removal of the opposite breast at the other. Some surgeons employ radiotherapy before or after surgery as a routine, and others believe in oophorectomy in premenopausal women. Yet in all the published results and controlled trials, there is no evidence whatsoever that any one operation offers any increase in *life expectancy* over the others. For that reason, I would hope that the surgeon would have my own middle-of-the-road compromise ideas and that he will carry out a simple mastectomy (thus completely clearing the tumour and obviating the real risk of the development of further tumour in the residual breast tissue) and, at the same time, that he will clear the axilla so that the nodes may be examined histologically. This remains the best, even though still crude, marker to indicate prognosis: no metastases in the lymph nodes in the breast and axilla is associated with an 80% five-year life expectancy; fewer than four affected nodes present and this drops to 60%; four nodes or more present and it drops to 30 to 40%. There is no evidence that radiotherapy improves life expectancy, and I would be very anxious indeed for my wife not to be irradiated at this stage. I should like this held in reserve as a most valuable treatment should there be a local recurrence.

After operation, I would not wish to interfere with post-operative management, but I would hope that our surgeon would do two things for my wife. One is to employ suction drainage for two or three days, which will almost guarantee speedy healing free from infection or from an accumulation of serum or haematoma under the flaps. The other is that he will remember that tissues heal best if rested. I just cannot understand surgeons insisting on forcible painful manipulations of the shoulder in the early days after surgery, but I can imagine how each stab of pain the patient experiences is accompanied by the tearing apart of delicate healing tissues. My own practice is to leave the arm alone, usually resting in a sling, for the first week or so.

Once the wound has healed, there is no difficulty in the patient very rapidly obtaining full painless movement.

The appliance lady should come up to the ward as soon as possible and the prosthesis should be available in time for my wife to slip this on as soon as the chest wall is reasonably comfortable.

Cytotoxic therapy

Now the question of postoperative cytotoxic therapy. Well, first I would hope that the lymph nodes prove to be completely clear on histological examination—this will save making the decision, since not even the most enthusiastic oncologist would advise treatment for a node-negative patient. But supposing that the lymph nodes are found to be implicated? The trials reported from Pittsburgh using phenylalanine mustard and from Milan using cyclophosphamide, methotrexate, and fluorouracil show a trend for the delayed appearance of metastases in the treated group among premenopausal women. When I spoke to Bernard Fisher in Pittsburgh a few months ago I was impressed with his wonderful warm personality, great honesty, and search for the truth. He does not know the answer yet but simply says, "these are the results, they are interesting, but the trial has been in progress for only a short period and I cannot say whether the trend will continue, disappear or even be reversed."

So, if my wife is in a hospital where a controlled trial is in progress, I would certainly feel no qualm in her being included in this trial, since no one yet knows the answer. When we do, I would want her transferred at once to whichever group shows a statistical advantage or, of course, if there is no difference between the treated and untreated patients, I would want her off the cytotoxics as soon as possible were she to be in the treatment group. If the hospital is not included in such a study, I would hope that our surgeon takes the advice of the British Breast Group and simply waits for the results of the trials to come through.

The next step is for me to get some leave and to take my wife away for a holiday, far away from doctors and hospitals.

She must then have a regular follow-up, by either the surgeon or the general practitioner. This is because early detection of local recurrences allows efficient radiotherapy to bring these under control. Detection of distant metastases is a nightmare made slightly more bearable by the thought that useful palliation and pain relief is often gained by radiotherapy, cytotoxic drugs, or hormone treatment. It is worth while battling on: victory *must* be round the corner.

An article in the BMJ (19 November 1977, p 1313) stated that "the physical and chemical properties of cereal and fruit and vegetable fibre differ substantially, so different physiological effects are to be expected." What are these differences? I thought that fibre was inactive and served only as roughage.

The question reflects a view of dietary fibre that was current several years ago but which has now been shown to be far too naive. Probably the reader has been confused by the term fibre. In the paper referred to the fibre was "dietary fibre"—the sum of lignin and all the polysaccharides not digested by the endogenous secretions of the human digestive tract.¹ The dietary fibre in fruits and vegetables is derived from young, rather immature cell walls, which are therefore rich in pectic substances and low in lignin. The other non-cellulose polysaccharide components of the wall are mainly arabinogalactans. The outer layers of the cereal grain (in high extraction cereal foods such as wholemeal bread, wholewheat breakfast cereals, and bran) contain large amounts of arabinoxylans, considerably more lignin, and little pectin. All these foods contain cellulose, which is present in all plant cell walls. Some components of dietary fibre absorb water and form gels or viscous solutions—these appear to affect cholesterol concentrations in the blood and the rate of absorption of glucose.² Some com-

ponents are readily fermentable by the microflora of the large intestine, whereas others are slowly fermented and contribute to faecal bulk. Dietary fibre is thus associated with many types of physiological effect³ and the different effects are probably related to the composition of the dietary fibre in question.⁴

¹ Trowell, H, *et al*, *Lancet*, 1976, **1**, 967.

² Jenkins, D J A, *et al*, *Lancet*, 1976, **2**, 172.

³ Cummings, J H, in *Fiber in Human Nutrition*, ed G A Spiller and R J Amen. New York, Plenum Press, 1976.

⁴ Cummings, J H, *et al*, *Lancet*, 1978, **1**, 5.

What is the hypo-osmolality syndrome in beer drinkers?

Alcoholic patients who drink large amounts of beer while eating little food may develop muscular weakness, dizziness, and confusion associated with hyponatraemia and a low serum and urinary osmolality. With a low dietary protein intake urea production is reduced and is insufficient to maintain the minimum urinary osmolality; sodium is therefore lost in the urine and hyponatraemia develops since beer contains little sodium. Patients usually improve rapidly on a normal diet.¹

¹ Hilden, T, and Svendsen, T L, *Lancet*, 1975, **2**, 245.