SYMPTOMATIC TREATMENT

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The symptomatic treatment of carcinoma of the lung, whether primary or secondary, is of the utmost importance since radical treatment is, unfortunately, only available in a relatively small proportion of cases. No doubt as surgical technique improves and as X-ray therapy advances the number of cases suitable for radical treatment will increase and include many cases which at the present time can only be treated symptomatically. Unfortunately, even X-ray and radium therapy must be included under the heading of symptomatic treatment, as the final mortality rate is still 100 per cent. in patients treated by these methods; but I do not intend to discuss these as they have already been dealt with in this number. I would merely like to mention that in both cases they relieve pressure on the bronchus or on the mediastinal structures, with the subsequent relief of symptoms.

The symptoms most commonly complained of by patients suffering from carcinoma of the lung, whether this be primary or secondary, may be divided into two main groups—the initial symptoms of cough, haemoptysis, pain, dyspnoea and hoarseness of the voice, and the later symptoms which will include the former group, together with anorexia, wasting and, not infrequently, dysphagia. The initial symptoms are due to a number of factors. Cough, sputum and haemoptysis are invariably due to the lesion in the lung itself, whereas pain may be due to pleuritic irritation, secondary deposits in the vertebrae, giving rise to root pains, together with vague but important generalised pain in the chest and upper abdomen associated with constant coughing. Dyspnoea may also be primarily due to the lung lesion, but there are other factors which must be borne in mind, such as enlarged mediastinal glands, pleural effusion, or occasionally empyema. Involvement of the phrenic nerve by itself causing paralysis of the diaphragm does not usually give rise to dyspnoea, unless there are other factors such as emphysema and chronic bronchitis.

Further symptoms in the later stage of the disease are those associated with any carcinomatous condition, together with pressure symptoms occurring on the mediastinal structures. Secondary deposits must also be considered, and the common places for these to occur in carcinoma of the lung are the vertebral column and long bones, the cerebral hemispheres and, more rarely, the liver, etc.

The symptomatic treatment of the cough, sputum and haemoptysis must be considered rather carefully, as, in the initial phases, these are the important symptoms. The cough can be controlled in most cases by the use of morphia or its derivatives, or by a linctus such as linctus heroin, syrupus codeine phos. or a menthol linctus. The latter is extremely useful but has one disadvantage for general use over a prolonged period—that is, the menthol tends to paralyse the cilia of the bronchial mucosa; but in the case of an inoperable carcinoma of the lung it is of little importance even if this does occur. In the early stages of a bronchial carcinoma partial obstruction of the bronchus may be present, causing spasm on the affected side, although this is usually of short duration because the bronchus soon becomes completely occluded, resulting in complete collapse of the lobe. This spasm is occasionally relieved by the use of ephedrine and which is worth trying, but, as mentioned above, this symptom is only transient. Usually when the lobe of the affected lung collapses completely, the cough is relieved temporarily. Later further symptoms arise due to secondary changes, such as suppuration and even abscess formation, occurring in the collapsed portion, and with these the cough returns. When these occur the signs and symptoms are those of increased cough, pyrexia, sometimes associated with a pleurisy, but the amount of sputum is not large, because the blocked bronchus prevents adequate drainage. The white blood count at this stage usually shows an increase in polymorphs. Owing to the fact that the abscess cavity is not draining into the bronchus, the prevailing organisms cannot be examined bacteriologically, nor are elastic fibres found in the sputum. The use of the sulphanilamide group of drugs at an early stage, if suppuration is occurring in the lung distal to the block, may often prevent the formation of an abscess. Should an abscess occur, then it is important to consider carefully the patient's general condition before deciding on the next step. If he is obviously deteriorating rapidly, then this should be left alone, and adequate doses of morphia or its derivatives given to enable the patient to be made comfortable. If, on the other

hand, the patient's general condition is good, and the abscess is superficial and easily accessible, then the question of draining the abscess surgically must be considered purely from the symptomatic point of view, for the relief of cough, pyrexia and toxæmia. This will mean that the patient must have a tube draining the abscess for the rest of his life and thus is seldom justified.

Haemoptysis, fortunately, is not usually severe in these cases, but it is important to warn the patient that this may occur at intervals. Little can be done to control it, but it is essential that the blood should be coughed up, and this should be stressed to the patient, for, if he does not cough up the blood it may drain into other bronchi giving rise to trouble there, occasionally blocking a bronchus with subsequent collapse of the lobe distal to the block, or, more commonly, focal atelectasis of a small portion of a lobe. Should the haemoptyses be severe, then it may be necessary to increase the amount of morphia being given, and this is the drug of choice since it not only quiets the patient but it also gives him great mental relief.

The types of pain which occur in carcinoma of the lung have already been mentioned. Pleuritic pain, when it occurs, can frequently be relieved by the simple measure of strapping the chest firmly with adhesive strapping. Elastoplast should not be used, since the object of the strapping is to splint the chest and prevent its movements, thus relieving the pain. At the same time analgesics should be given, such as morphia or its derivatives, or, if the pain is not severe, the simpler types such as aspirin, phenacitin, or veganin. Root pain from secondary deposits in the vertebrae is usually of a severe nature and is very difficult to relieve. Again the morphia group of drugs is invariably necessary. Should there be a collapse of vertebrae, the question of a plaster bed may have to be considered in order to relieve the pain, although this is seldom necessary because relief can be obtained in almost every case provided adequate doses of morphia are used. When the secondary deposits are situated in the lower lumbar vertebrae or the sacral region, intrathecal injection of alcohol is remarkably efficient as a pain reliever. There are certain difficulties with this procedure owing to the liability of picking off motor nerve fibres as well as the sensory ones, with the result that the patient may become paralysed or incontinent. Either of these conditions will make his life more unpleasant, but if the pain is severe this unpleasantness may be preferable.

Dyspnoea, in most cases, is due to mediastinal involvement giving rise to pressure symptoms. This is extremely difficult to relieve apart from deep X-ray therapy, but here again the morphia group of drugs is invaluable when used in adequate doses. When the dyspnoea is caused by a pleural effusion great relief can be obtained by removing the fluid, but in most cases it is necessary to air replace it. This should be done as often as is necessary, for the fluid usually recurs after being replaced.

Hoarseness of the voice is due to involvement of the recurrent laryngeal nerve, and this means that secondary deposits have already occurred in the mediastinum cords. The result of the nerve involvement is a paralysis of the left vocal cord, and hence hoarseness. Nothing can be done to relieve this condition, but fortunately it is not painful.

In the early stages of this disease after the diagnosis has been established the patient may continue for several months in relatively good health, but even during this period there is usually a gradual but definite loss of weight. If the patient is being weighed at intervals this soon becomes apparent to him. It is therefore wiser to dispense with this routine investigation as there is nothing gained by it clinically but it often worries the patient considerably.

Carcinoma of the lung occurs most frequently about the age of 40 and over, and not infrequently patients of this age group have other changes in the lung, such as chronic bronchitis and emphysema, giving rise to dyspnoea, and it is of the utmost importance that these should be treated since the relief of these symptoms helps the patient very considerably both physically and psychologically.

In the terminal stages when the symptoms are more severe, together with anorexia, wasting and dysphagia, anodynes must be used with boldness. The patient should not be forced to eat, as no good can come from it, but he should be encouraged to take just whatever he fancies. So far as dysphagia is concerned, patients frequently find that semi-solids are more easily taken than solids or fluids, and these attractively served often help patients considerably. Apart from this little can be done.

The psychological aspect of carcinoma of the lung is of vital importance. In almost every case it is wiser not to tell the patient the diagnosis unless he really wishes to know. Frequently the patient will ask whether he has a cancer or not, but there will be little doubt in the mind of the experienced physician whether the patient really wants to know. In most cases the patient

wants the doctor to tell him that he had not got a carcinoma, but at times the physician will see that the patient really wishes to know for various reasons, such as "putting his house in order," etc. In such a case without doubt the patient has a right to know the truth. Whether or not the patient himself is told, it is imperative that his relatives should understand everything so that there is no doubt in their minds as to the diagnosis on the one hand, and the prognosis on the other. They must be told, unfortunately, that this is a cancer and that, although we can relieve the pain, and so on, we cannot cure the patient. It is important that one should not lie directly to the patient; otherwise he may lose confidence in his medical adviser at a later stage when this confidence is all important. It is not, however, very difficult to explain his symptoms to him. For example, one can say that he has some "proud flesh" which is blocking a bronchus, which is perfectly true, without mentioning that this is a malignant condition for which nothing curative can be done.

The use of morphia and its derivatives has been stressed considerably, and I do feel it is of the utmost importance. It is, as we know, the best pain reliever available, it controls the cough, and also gives great mental relief. Its only disadvantage is that it is a habit-forming drug. If a patient has a disease for which we can do nothing and the duration of his life is to be reckoned in months or weeks, the question of drug addiction does not arise; thus these drugs should be started early and should be used boldly in increasing doses regardless of the official dose in the pharmacopoea. It is our duty to relieve pain where we cannot cure.

BOOK REVIEWS

PYE'S SURGICAL HANDICRAFT (13th Edition)

Edited by HAMILTON BAILEY, F.R.C.S. John Wright and Sons, Bristol, 1942. Price 25s. net.

This book was out of print last year. It was destroyed by enemy action. The opportunity which adversity provided was seized by the editor, and the book has been re-cast in parts and additional matter included. New illustrations have appeared and new contributors, drawn, wisely, from all over England, have added to its value. The whole book is of very high standard indeed. It is up to date in many sections, and may be said to be ahead of current practice, in a number of hospitals. For instance, the Miller-Abbott tube is described and illustrated, but not all institutions possess one. The sooner this is remedied the better. The illustrations in the anaesthetic section are below the standard set by the rest of the work. Fig. 149 shows a hospital radiator and the anaesthetist, uncomfortable and standing at the head of the table. What point is it intended to drive home? Fig. 152 is too small to show the contents of the trolley especially the lower shelf. And Fig. 161, if meant to be a demonstration of how to give an anaesthetic, is in effect the reverse. The patient is sitting fully dressed with collar and tie on and is being anaesthetised with ethyl chloride by the closed method!

Many patients are killed with carbon dioxide. This is such a common occurrence that in some institutions, the CO₂ cylinders have been removed from the anaesthetist's trolley. Should not the dangers of this gas be stressed?

The book is written for the inexperienced. The section on impending death under anaesthesia has been written more from the standpoint of the operating surgeon than that of the H.S. giving his first anaesthetic. Definite instructions to be followed by the anaesthetist should be laid down here. Many young men are frightened that the patient will come round and that the surgeon will curse them because of it. The anaesthetic is thus administered for many minutes after the unrecog-

nised warning signs of impending death have passed. The cardinal rule for all young anaesthetists should be that at the first sign of distress on the part of the patient stop the anaesthetic at once, remove all face pieces, drop the patient's head and pull the tongue out to free the air way. Although these directions are to be found in the anaesthetic section, on page 128, it is too far away and they would bear repetition on page 9 under the heading to be found there on "Impending death under anaesthesia."

The chapter on assessment of incapacity is a valuable addition as is that on hospital administration. Is it necessary to devote a whole chapter to the House surgeon and the nursing staff? Could not this form part of the succeeding section?

Not even bombs have stopped Mr. McNeill Love advocating a bottle of port a day for debilitated patients suffering from carbuncles.

Disparaging remarks are made about rectal salines administered by means of tube and funnel, or by the Murphy drip method. If the author prescribed water instead of saline and followed the Murphy technique accurately, he would probably change his views on this subject.

The book needs no recommendation and justly deserves its wide popularity.

AMPUTATIONS AND ARTIFICIAL LIMBS

By R. D. LANGDALE-KELMAN and G. PERKINS. Oxford University Press, 1942. 5s.

This valuable little book is one of a collection covering a host of practical subjects, and intended for the large number of medical personnel drawn into the fighting services. It can be said without question that, if the full series maintains the standard of this volume, both the authors and the publishers deserve the highest praise.

The size of the book makes it easy to carry about, a necessary point in war medical publications, and, in spite of the difficulty in obtaining good paper, the print is legible and the diagrams, well drawn, give point to the text more effectively than photographs.

The contents have been carefully written and arranged, one part dealing with the surgical aspect of amputations and the other with artificial limbs.