To cut or not to cut?

Why surgeons don't have all the answers

→ Alberto Costa ■ GUEST EDITOR

For more than one hundred years cancer was considered an external entity growing into the body and acting against it. The approach to treatment was: seek and destroy. Aggressive surgery, heavy radiotherapy, intensive chemotherapy were the norm. We now know that cancer cells result from genetic changes to normal cells, and we now try to 'cure' them without causing too much damage to healthy cells. Consequently, surgery has become more and more conservative.

When surgery was the principal way of treating most cancers, any cancer that was inoperable – for instance because it was so locally advanced that excision would inflict unacceptable functional damage – was, by definition, incurable. Nowadays, the use of combination treatments, radiotherapy and/or medical treatment can dramatically reduce the level of local invasion, making it possible to operate on previously inoperable tumours.

There are other ways in which the concept of operability is changing. For instance, poor cardiovascular health was always seen as a barrier to conducting cancer surgery. However, good pre-operative medical treatment can now address this problem and allow surgery to take place. Meanwhile, many surgical procedures that were once considered highly risky are now undertaken far more frequently, as cancer surgeons improve their results by specialising in particular types of surgery. Even the old rule of surgery – that you don't operate on a patient whose cancer has clearly spread to key organs – no longer applies. A greater focus on supportive care now means many more interventions are carried out to improve quality of life, for instance by treating intestinal occlusions or painful compressions.

With the greater weight given to the voice of the patient, their views are also influencing the concept of operability. Difficult as it is for health professionals to accept, patients sometimes refuse surgery because they dread the consequences of surgery more than the cancer itself, and they may not fully grasp the implications of their decision. The final word must be theirs, but effective communication and good psychological support can help them make a more informed analysis of the potential risks and benefits to reach the best decision for them. Some tumours will, of course, remain inoperable, and patients and health professionals will still sometimes have to accept this very frustrating reality, and leave the cancer to grow.

With multiple factors now influencing the concept of operability, the decision on whether or not to operate can no longer be left up to surgeons. The right decision can only be made through evaluation by specialists from multiple disciplines, communicated effectively to the patient, who will have the final say.

Alberto Costa is the scientific director of ESO, coordinator of the Breast Unit at the Maugeri Foundation, Pavia, Italy, and executive director of the Breast Unit of the Italian-speaking region of Switzerland (Canton Ticino), Bellinzona and Lugano, Switzerland