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Historical Highlights of the Preoperative Practices in Cancer Care

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Abstract

The reign of anesthesia in cancer surgery was dated far to the 1844-1846 period. Therefore, the question arises concerning the preoperative practices of the medical masters before that era. It is the purpose of this paper to answer that important question. In sum, the historical texts will be handled chronologically in this pursuit.

Keywords: Chloroform; Onset; Previous practices; Medical masters; History

Introduction

Recent reviews date the onset of anesthetic care in surgery to 1844 [1] and 1846 [2]. Therefore, in keeping with the admonition by a great scientist [3], the historical antecedents should be subjected to recondite research. In this context, this paper sets out to provide some answers chronologically.

4. Historical Texts

i. 1676 – Richard Wiseman [4], the nicely named observer, was perceptive: That you may be the more successful in the operation, I shall offer to your consideration these few qualifications. First, that the patient be of a strong constitution, and of a tolerable good habit of body, and not in a declining age, when the *menstrua* are ceased. Secondly, that the cancer be loose, and the *axilla* free from painful glands. It was also to be wished that the cancer took its original from some accident, as a bruise. Thirdly, that the operation be performed in the spring or autumn of the year; lest through the great heat of the summer the spirits be resolved; or by reason of the extreme cold in the winter the native heat should be choaked.

ii. 1725 – Friend [5] wrote a history of medicine up to the beginning of the 16th century wherein he considered that even when "surgery is very bold, and what would now be called cruel, yet he never rashly stuck in his knife at a venture: but always made himself master of the nature of the case, and considered the probability of success, before he attempted the operation in any of these dangerous distempers."

iii. 1749 – Le Dran [6] drew attention to morbid growths in terms of "they may be removed by extirpation, but unless we are fortunate enough to correct the indisposition of the juices that produced them, the disease will almost certainly return, especially if it be of the carcinomatous kind.

iv. 1753 – Norford [7] noted that "in advising the stage of the operation, till all other means have failed, lest they should be thought rash." In his view, "the palliative method, hardly deserves the name of a cure; because "It is no more than relieving the urgency of the symptoms, and making the patient tolerably easy under his complaints, without removing the cause."

v. 1769 – Morgagni [8] was motivated "to propose, on the one hand, the successful instances of their extirpation, many of which he had seen; and; on the other hand, the examples wherein there had been great fear and danger, which he likewise was not ignorant of: and then leave to the discretion of those who consulted him what they would do, without interposing any judgment or persuasion of his own."

vi. 1783 – Benjamin Bell [9] believed in the circumstance of timing the extirpation "so that the most important matter to be here determined, is that period of the disease in which the operation is most advisable."

vii. 1816 – Charles Bell [10] bothered about the patient's consent and detailed a case: The tumour has increased in an extraordinary degree; it is larger than the fist, and quite open and full blown, like a flower. In its substance it is spongy and soft, and easily broken down; in colour it is cineritious, like slough, and bloody. It bleeds on being roughly treated, but has no sensibility. The young man's health begins to break. He had been informed of the change which would take place,

and now that it has come, he stands prepared for the worst, and has consented to lose the limb.

viii. 1816 – Earle [11] reflected on the surgeon's personal doubts. He exemplified clearly: As the disease had existed for nine months, and had resisted all applications, I did not think that any good would arise from prosecuting these measures, and much evil might be expected from the delay which they would necessarily occasion. I therefore thought it my duty to propose an operation, although from the unhealthy appearance of the child, and the unfortunate result of similar cases, I was not very sanguine of ultimate success; still however I was led to entertain some hope from the circumstance of being able to trace the spermatic cord distinct and free from disease, for nearly an inch above the tumor, and from the inguinal glands being perfectly healthy and natural.

ix. 1818 – Scarpa [12] was worried concerning the agony of the ill patient vis-à-vis surgery: Darting pains, extending to the head, disturbed the patient night and day, notwithstanding the use of opium internally, and externally, of anodyne cataplasms. In order to remove the disease effectually, I considered the excision of the anterior hemisphere of the eyeball necessary.

x. 1829 – Cooper [13] differentiated between niceties, i.e., "a nice manipulation" of the patient and "a careful examination of this disease by dissection."

xi. 1835 – Balfour [14] found favor in preparatory dieting, as did the approbation of Sir George Ballingall: who saw the case, ordered two grains of calomel, and half a grain of opium, to be taken twice a day. This treatment was continued for seven days, until the mouth became slightly affected. Saline medicine was then administered, and, as the throat had assumed an aphthous and œdematous appearance, a stimulating gargle was prescribed. The throat was also scarified, in order to afford relief from the feeling of suffocation which the patient experienced.

xii. 1836 – Mackintosh [15] gave a preparatory purgation that more or less obviated surgery as follows:

The doctor purged him well with drastic medicines, till he made the poor man really sick, and then, being resolved to make a good job out of a bad customer, he discovered some obscure disease of the liver, and as he knew mercury to be a remedy for affections of that organ, he mereurialized him well, so much so, that he kept up a salivation for many weeks. During this period, the patient felt for the first time that he had a stomach; his appetite became impaired, and as the doctor knew that tonics were good for that, he sent many bottles of such drugs. Bark, steel, and bismuth, were at last had recourse to, but, alas! The patient got weaker and weaker; the doctor grew tired of his patient, and the patient dissatisfied with his doctor, so that they parted, as it were, by mutual consent.

xiii. 1837 – Warren [16] had to follow the course of consultation thus: The patient, finding an increase in his sufferings, became more desirous of an operation. I then agreed to submit the case to a consultation of the surgeons of the Hospital, and if they should determine that an operation was proper, I would not shrink from performing it. Accordingly, a consultation was held, the case was fully considered, and the result was, that the patient should be made acquainted with the danger and uncertainty of a surgical operation, and that, if after a view of these, he desired it to be done, it was right to undertake it. The patient, after a consultation with his friends, determined to go through it, and it was performed at the Hospital.

xiv. 1842 – Budd [17] brought into prominence the pathological basis of surgical intervention: If we watch the whole course of cancer from its first origin in some external part,– as in the female breast, for example,–to its fatal termination, we observe the following series of events. At first all that can be discovered is a small, hard tumour, lying loose in the substance of the organ. This, now, constitutes the whole disease; for, at this time, there is no other tumour in the body, and the general health is not affected. If the cancer be cut out at this very early period, it sometimes happens that the disease never returns, and that the patient is radically cured.

Discussion

Elsewhere [18], I considered the pros and cons of the history of cancer surgery. Here, I have addressed the old preoperative practices. This is in keeping with the need to advance the literature of the life sciences using historical parameters [19]. Indeed, as was said of the historical milestones in cancer surgery [20], "There was of course, very little elective surgery prior to general anesthesia."

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