THE MISSED MALIGNANT CASE

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There is no doubt that the vast majority of delayed diagnoses in malignant disease are due to fear and ignorance on the part of the patient. This delay is appalling, as the figures from the Registrar General 1957 show. The mean delay in cancer of the breast is 6.2 months but 17.3 per cent wait over two years. In the cervix uteri it is 5.7 months and 8.4 per cent wait over two years, and for rectal cancer in men the mean delay is 5.4 months but 25 per cent wait over a year; in women the delay tends to be longer.

This delay is sometimes contributed to by the family doctor, or may be entirely due to him. Attempts have been made to estimate the amount of delay due to patients or due to the doctor or to both. In Massachusetts in 1925 the total delay for all types of cancer was 11.9 months, and the patient was responsible for 6.5 months, and the doctors for 5.4 months: by 1948 this had been reduced to 3.9 months and 2.3 respectively, total 6.2 months. In 1949, Howson and Montgomery published a paper on 1,140 cases of " Pelvic Cancer " (no definition of cases stated). There was " delay ", i.e., over 3 months in 74.6 per cent of cases. Of these in 44.0 per cent the delay was due to the patient, in 14.9 per cent it was due to the doctor, in 12.9 per cent due to a combination of both, and in 28.2 per cent there was no delay. Of course, 3 months is a very generous allowance for making a diagnosis, and would not be tolerated in any other disease.

The value of treatment during the " early stage " is shown in every statistical table, for example in the international figures concerning 120,738 cases of carcinoma of cervix of whom 45,028 were cured. The cure rate (5 years survival without sign or symptom of the disease) was 63.7 per cent in Stage I, 43.5 per cent Stage II, 24.2 per cent Stage III and 6.7 per cent in Stage IV. While it is not always possible to discover a cancer in the " early stage " even among the accessible cancers, because some do disseminate very rapidly even before symptoms, this rarely happens among the accessible cancers. It is, perhaps, unnecessary to call attention to the difference between *early diagnosis*, that is, the discovery of a tumour as soon as symptoms are noticed, and *early stage* diagnosis—the

discovery whilst the tumour is still localized. It is obvious that the more early diagnoses that are made the greater the chance of making an early stage diagnosis.

In this article it is unnecessary to deal with the faults due to the patient, and only the mistakes due to the doctor will be discussed. We all make mistakes at times, and, indeed, a mistake made over 30 years ago was the original reason why the author became interested in the subject of early stage diagnosis (see *Lancet*, 11 Oct. 1958).

Anybody may be excused for missing the early stage diagnosis in some cases of cancer, e.g., cancer of the lung, cancer of the ascending colon, cancer of the pancreas, etc., which often give no symptoms before they metastasize, but to neglect the early stage diagnosis of the accessible cancers, if the patient visits the doctor as soon as symptoms arise, is more difficult to excuse. The accessible cancers, i.e., breast, uterus, rectum, bladder, larynx, skin, vulva, lip and mouth, account for approximately 25 per cent of the 100,000 deaths each year due to malignant disease.

Perhaps the most fundamental cause of mistakes is due to lack of knowledge of what the patient is thinking, which for want of a better word must be called the psychology of the patient. So many doctors think that if a patient is physically ill they must also be mentally ill, and treat them as imbeciles, but it is true that many " cancer apprehensives " hesitate to go to a doctor. Patients will always justify to themselves a visit to the doctor if they have pain, so they may subconsciously invent a pain in the hope that the doctor will discover the real cause of their trouble, for example they may complain of a pain in their toe when they are really worried about a lump in the breast. In my gynaecological outpatients it was easy to spot such cancer apprehensives but in general practice it is much more difficult. I used to deal with such people by examining them carefully and then saying " I am glad to say that there is nothing serious and there is no evidence of cancer ", emphasizing the word " cancer ", and more often than not the patient would reply " Thank God, that is what I really came about." Occasionally, one would say, " I did not think anything of that sort," which was probably not true but difficult to prove.

Objection may be raised to such a proceeding on the ground that it is not possible to say that early cancer in one cell is not present, but the doctor does *not* say that, he says there is *no* evidence of the disease. If a patient does develop a cancer a few weeks after such a visit nobody can prove that it was already present at the examination.

For this lack of skill in reading the patient's mind I blame the

teaching hospitals, but I can only speak of conditions twelve years ago before I retired. Hospital teaching staffs are made up of specialists, and each one teaches his subject as if the student was going to be a specialist in that particular subject, I plead guilty myself. The cases selected by the registrar or house surgeon for the senior to teach on had classical symptoms and signs; in cancer they were generally advanced growths. The result is that when the student gets qualified and goes into practice he recognizes such cases, but does not recognize the " cancer apprehensive " who has a lump in the breast, and complains of some other quite different symptom.

In this way the most important speciality of all, general practice, is completely neglected. This idea is backed up by a recent questionnaire sent round to students in one teaching hospital. The questions included "which subjects did they think were best taught?" and pharmacology and midwifery seemed to top the list, but 83 per cent felt that more instruction in general practice was needed.

Apprenticeship to a general practitioner, especially during the pre-registration period, is very important and should be made compulsory, but it may be difficult to make it sufficiently attractive for the family doctor to take such apprentices.

The next difficulty in the diagnosis of early stage cancer is the fact that any symptom met with is common to a great many other diseases which are seen more frequently. This, however, does not justify the following letter received by the author.

> Dear Sir,—I disagree with the aims of the Cancer Information Association. Many early symptoms are indistinguishable from normal variations in the body, in fact carcinoma is best diagnosed by meeting an ill patient and finding firm physical signs. The price of attention to early symptoms is the encouragement of psychoneurosis and much unnecessary investigating activity, for the sake of curing for longer periods a very few earlier cases.

In reply I pointed out that it would be even easier for him if he waited until the patient was dead and then signed the death certificate.

Of course it has been abundantly proved that talking frankly about cancer does *not* encourage psychoneurosis, exactly the opposite is the case, as pointed out by Emerson who wrote " Knowledge is the antidote to Fear ".

There are certain symptoms among the accessible cancers which should make the practitioner *consider the case a cancer until disproved.* This sounds a tall order but the disproof is not really difficult as a rule. For example every lump in the breast should be considered a cancer. To wait and see if it grows is waste of time, it is better to order the coffin.

Irregular uterine haemorrhage between the periods, particularly during the menopausal age, and after the menopause are often

neglected by the patient, and not infrequently by the practitioner in the belief that it is only the " change of life " a phrase that has killed thousands of women. The differential diagnosis can be made not only by inspection (a proctoscope with a high magnifying eye piece is useful) and palpation but by " vaginal smears ". Unfortunately in this country the only area where family doctors carry out " smears " is Edinburgh, but it is routine in other countries.

Rectal bleeding is cancer until disproved. Most rectal carcinomas are within reach of a finger, but *every case* should be examined with a sigmoidoscope. This is emphasized in a *British Medical Journal* editorial article, and it has already been mentioned that 25 per cent of rectal cancers are not treated for over a year because the patient and/or the doctor thinks it is " only an attack of piles ".

A word about malignant melanomata. These so often start as a melanotic wart, that it is well worth while, and so easy to do a simple excision with a fair margin of normal skin around it. To wait to see if it will grow larger is quite fatal.

The diagnosis of cancer of the lung whilst in an early stage is a very urgent matter as the death rate is going up rapidly. In 1947 the mortality due to this condition was 9,204 and in 1957 it was 19,019, but the solution of the problem is not in sight.

There is a difference of opinion as to whether the results from sputum smears justify the enormous amount of work entailed. A positive is of course of value, but a negative not much use, and x rays followed in suspicious cases by bronchoscopy seem to be the only method at present of arriving at a diagnosis.

This is not the place to discuss whether cigarette smoking is the main cause for this terrible increase, although there is overwhelming statistical proof that it is so.

Diagnostic Centres

Some people still advocate the setting up of diagnostic centres for cancer diagnosis. Such centres are still very popular in U.S.A. but have been abandoned in Canada. The best known of these centres is the Strang Cancer Prevention Clinic, although it is doubtful whether it is justifiable to include the word " prevention ". Anybody can apply for an overhaul but a fee is charged. Nothing can be said against the principle of having periodic overhauls; it cannot at present be incorporated in a medical service, but should be made a special service for which the doctor is paid an extra fee. Such an examination should be looked upon as a preliminary diagnosis and it must be realized that only the accessible cancers can be excluded with any degree of assurance. The objection to a

special diagnostic centre is the amount of medical man-hours required for the discovery of a very few unsuspected cancer cases.

The only real advantages of such a clinic is psychological, because there are a considerable number of patients who will not face their own doctor if they think, generally erroneously, that they may be suffering from cancer. After a time, a patient may sum up courage to visit the doctor, but does not state the real reason for the visit, and, getting no satisfactory answer to the question they have not asked, return again week after week and are diagnosed " neurotics " or " neurasthenics " when the real diagnosis is " cancer apprehensives ". It is fear that they may be considered " fussy ", and fear that they will be laughed at that makes them hestitate. The profession can and no doubt will get rid of this absurd state of affairs by encouraging the public to talk about cancer frankly like any other serious disease, e.g., cardiovascular disease, its only rival for annual mortality. There is little doubt that there are a large number of these cancer apprehensives, and if they can be spotted and a few words said about early symptoms, it is more than possible that the crowded surgeries will be less crowded.

The figures from the Manchester area are instructive. After several years of cancer education of the public 108 doctors in the area were asked whether such education ever caused them any additional work or brought patients to their surgeries without observable symptoms. The answer from 105 doctors was no, and from three, yes. Some doctors argue that it is no use trying to make early stage diagnosis because of the delay in getting an appointment and treatment in hospital. This may be true in some areas. In my opinion every general hospital should have a *cancer team* consisting perhaps of a surgeon, gynaecologist, radiotherapist, and a physician, who must every day except Sunday be available to see suspicious cases sent up by the family doctors. Cancer is a greater emergency than an appendicitis, because the latter can sometimes become cured without treatment, but cancer never, and nobody can predict the day and hour that it will start to disseminate. Statistics show that within six months delay the number of early stage cases drops by 30 per cent.

Conclusion

This article is written in the hope of helping the family doctor to make more early stage diagnoses. At present the incidence of cancer is approximately 130,000 a year of which perhaps 30,000 are cured (five year test). Of the fatal cases approximately 25,000 are among the accessible cancers, and it is not perhaps too optimistic to believe that by giving the public more information about the disease, and by stimulating greater care, and more cancer conscious-

ness among the family doctors, another 10,000 to 12,000 could be added to the number cured. Some readers may feel insulted by a suggestion that they ever miss the diagnosis of a malignant case, especially as this article is written by a retired consultant whose only experience of general practice was a short locum more than 50 years ago. All who disagree with what is written will I hope write frankly to say so, I shall be delighted to cross swords with them.

REFERENCE

Brit. med. J. (1960), **2**, 444.

THE BRITISH MEDICAL ASSOCIATION AND COLLECTIVE INVESTIGATION

The subject of the year chosen by the British Medical Association for its new venture in collective investigation was "The Adolescent".[1] Though the planners of the project were disappointed in the number of divisions of the Association who took part, the result has certainly been worthwhile. Under the editorship of Mr Paul Vaughan, the chief press officer of the Association, a most stimulating report has been published which has received complimentary notices in the national press. The commentary by Dr Doris M. Oldham is a skilful summary.

The techniques adopted by the Association will be of interest to members of the College who are concerned in planning collective research. When a definite answer to a problem is required by enquiry of many people, experience shows that the question posed must be simplified so that the answers are capable of analysis. The Association has made no attempt to pose a problem but have chosen subjects about which much is already known and many opinions held. Choosing a wide canvas the steering committee painted in only the barest outline, and invited divisions to fill in the details in any part they wished. The composite picture, pieced together from reports from all over the country, while not authoratative in the strictest sense, gives a concensus of medical opinion which must carry considerable weight.

[1]*The Adolescent*—Observations arising from discussions among members of the British Medical Association (1961). British Medical Association. Price 2s. 6d.