THE MANAGEMENT OF INOPERABLE MALIGNANT DISEASE IN GENERAL PRACTICE*

J. R. CALDWELL, M.B., B.S.
Newick, Sussex

AS IT is the purpose of this essay to present the problem of the care of inoperable malignant disease in general practice from the general practitioner's point of view, the matter will be approached from the personal angle by reviewing a series of cases actually encountered in the course of general practice and considering the points that arose in their care and management. This approach is best suited to general practice which, after all, is an essentially personal relationship between a practitioner and his patient, rather than the more usual approach, in which the history of the subject is reviewed, statistics analysed and subject matter classified under pathological or therapeutic headings.

There are two main differences in the general practitioner's and the specialist's approach to this problem. First, the general practitioner's interest continues right through till death closes the case; during this time the patient may enter various hospitals and come under various specialists for sundry treatments, but throughout the general practitioner should maintain a sympathetic and well-informed interest and be constantly available to comfort and inform the patient and his relatives. Secondly, the general practitioner is concerned, not with the running or prestige of special departments, not with national, regional nor local organizations, but solely with the care and well-being of his individual patient. Recently, at a symposium on the treatment of cancer, one speaker pointed out that it was obviously impossible for every patient to be treated at X or Y, naming two internationally famous treatment centres; obviously this was true but the general practitioner is not interested

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in ' every patient ' only in the individual by whose bed he is sitting or who faces him across the consulting-room desk; if that individual needs treatment in X or Y, then it is the general practitioner's duty to obtain it for him if it is humanly possible, whether that accords with the national or regional planning or not.

Of the incurable cases which general practitioners are called upon to attend, the inoperable cancer cases form an important and growing group. Cancer is now responsible for almost one in every five deaths and is second only to heart disease as the cause of death in both sexes. In this general practice a recent count revealed some 30 known cases of malignant disease; some of these were apparently cured, though as is shown in case 1 (W/Cmdr M.) it is quite impossible ever to be sure that a cure has been successful even after many years and, as case 2 (Mrs P.) shows, a patient may well have advanced malignant disease without any signs or symptoms. But already allusion is being made to patients, so it is time to tell their stories.

Case 1 W/Cmdr M. It was in 1948 that the commanding officer of a large service hospital rang me up to say that this officer was being sent home in an ambulance as it was his wife's wish that he should die at home. It appeared that, while serving in Germany, he had suddenly had an attack of haematuria and had on examination been found to have a mass in his left loin. He was flown home and at operation was found to have what appeared to be an inoperable tumour of his left kidney, adherent to the large bowel and causing obstruction thereof. A transverse colostomy was performed but no attempt was made to remove the tumour. It was considered that at the very outside he could not live more than three months and his wife was informed of the gloomy prognosis. When I laid down the 'phone I little thought that I had taken on a patient who would outlive his wife and still be alive 14 years later.

On his return home M. certainly looked unlikely to survive as long as the prognosticated three months. Gaunt and emaciated, with a sacral bedsore he appeared a dying man. The whole of the left side of his abdomen was occupied by a huge tumour. However the fresh air, good food and devoted care of his wife and a private nurse soon worked wonders, he gained weight, started to sit up and was soon walking round his garden. As the three month deadline came and went, it became increasingly difficult to parry his wife's demands that something be done to cure her husband. A letter to the consulting surgeon, who had seen him in the service hospital, brought a polite but negative reply that there was in fact nothing more to be done. In an attempt to at least appear active a course of H.11 was given with no obvious effect. Then, as so often happens if the medical profession appears helpless, the patient, or in this case his wife, turned to quackery. I was asked to send a specimen of his blood to some gentleman in Manchester, who then wrote to me that the specimen showed the patient to be suffering from "a very malignant condition ", which however, he assured me, would respond to a course of injections costing some £50. The letter went on to point out that I would of course be able to give the injections and charge my own fees for doing so. Feeling that the matter was getting out of hand, I once more contacted the surgeon asking that the case be reviewed, the patient having now lived twice as long as the maximum prognosis, if only to

prevent his wife squandering their money on quacks and charlatans. He then agreed to see M. at the teaching hospital where he now worked and was, I think, surprised when the patient walked into his room bronzed and apparently fit. M. was admitted for further investigation in October 1948 and over the next year had three major operations, which resulted in the removal of the left kidney and adherent bowel and the closure of his colostomy. The surgeon described the tumour as the biggest he had ever been able to remove, the specimen weighed 5 lbs., and histologically was shown to be an adenocarcinoma.

Following these operations M. returned to his home and led the normal life of a retired service officer, with nothing more serious to remind him of his illness than a large ventral hernia. In March 1955 the surgeon could find no evidence of recurrence and wrote, " That he has survived 7–8 years and appears in good health only goes to show how unpredictable cancer is in general ".

Towards the end of 1958 he began to complain of left-sided sciatica and in April 1959 a mass was palpable in his left loin and his liver was enlarged. An x-ray revealed a soft-tissue shadow in the region of the left renal site but no bone metastases. Further x-rays in hospital showed two opacities in the right upper and middle lung lobes. It was decided that this was not a suitable case for further surgery, nor for radiotherapy, so treatment was instituted with melphalan 10 mg. per diem at first, the dose being subsequently reduced to 4 mg. daily, when he was discharged in May 1959.

On 10 July 1959 the melphalan was discontinued owing to a dangerous drop in his red cell and platelet count. The treatment was later resumed on 31 July 1959 his blood being tested weekly at the local pathological laboratory.

In September he was feeling well enough to go for a fishing trip to Scotland and, as he was going to be 80 miles from Inverness and 25 miles from the nearest railway station, it was felt that regular blood counts would not be practicable, so the melphalan was again discontinued. Within a week the sciatica returned and persisted for the fortnight he was away; within a day of resuming treatment on his return the pain was considerably diminished. The mass in his left loin appeared rather smaller but he now had a small skin nodule.

On 16 October 1959 he became so anaemic that a blood transfusion was required and a month later while staying with his brother near London, he became extremely ill. He rang me up and I, being myself in bed with influenza, arranged for his admission direct to our local hospital for a blood transfusion. When once more up and about, I visited him in hospital and found him very miserable, in constant pain, unable to eat and to all appearances a dying man. The very experienced physician in charge of his case said that at most he could only live two months and that there was nothing more to be done for him. As M. was obviously unhappy where he was, it was agreed that he should be transferred on 12 December 1959 to a nearby nursing home where he could enjoy the privacy of a room to himself and the benefit of more individual nursing. His wife being dead, treatment at home was not possible.

To control the by now constant pain he was given injections of ½ gr. morphia three times a day combined with valoid to prevent nausea and vomiting. With this treatment he rapidly improved, began to eat and sleep better and was soon gaining weight and strength. Gradually the dosage of morphia was reduced and finally replaced by tabs. pipadone co. On the 6 May 1960 he was only having ½ tablet of pipadone co. daily, and was completely symptom free, though if he left off the pipadone entirely he complained of pins and needles in his left leg. The mass in his left side had virtually disappeared, although he had had no melphalan for six months. His liver, however, remained grossly enlarged. He was now obviously fit for discharge and so went to stay with his brother near London.

When he went into the nursing home I noted " He asked me if his present trouble was in fact a recurrence of his cancer and I rather vaguely said it was all linked up with it, the pain being caused by scar tissue pressing on the nerve. I think he had a pretty good idea what the true position is ". Yet while in the home he said to one of the nurses that if for a moment he thought he had cancer he would blow his brains out.

On 6 September 1960 M. wrote to me that he had just returned from a fishing trip in the Highlands. During the two weeks he had not had a blank day and had taken altogether 53 lb. of fish averaging about ½ lb. He was obviously back on his old form.

In October I wrote to the hospital in London to let them know where M. was now living and they replied—" We are indeed surprised to hear that he is still alive and relatively well ". And later after he had been up for a check over—" I saw this man in the clinic yesterday and was amazed at the excellence of his condition ".

However, in December 1960 his sciatica recurred and the mass had increased in size. Once more he was admitted to the nursing home and treated with morphine; once more his symptoms cleared and his general condition improved, an improvement that was maintained when the morphine was discontinued. On 10 February 1961, having gained a stone in weight and being symptom free he left the nursing home and went to make his home permanently with his brother. His last letter to me was dated 2 March 1961—" I am feeling much better and making good progress. . . . I think the B.U.P.A. must be beginning to look on me as a bad debt ".

In the summer of 1961 he was again in his beloved Highlands fishing for the trout; but in November, while staying with his son he suddenly collapsed and became very ill. He was taken direct to the hospital in London but was barely conscious on arrival and died soon afterwards. His son told me that right up to the end he did not seem to realize how ill he was and that he was confident that after a week or two in hospital he would be fit again. He never seemed to suspect that he had a recurrence of his cancer.

And so the story ended, 14 years after he was first given three months to live and 2 years after being given 2 months at the outside.

Consideration of this case illustrates many of the problems that arise in the management of inoperable malignant disease in general practice and the means of dealing with them. This case illustrated the advanced stage that a growth may reach without producing any symptoms. M's tumour was enormous and adherent to the bowel, which it was partially obstructing, before he had any symptoms and then it was only an attack of painless haematuria that sent him in search of medical advice.

Case 2 Mrs P. also illustrated this point. An old lady of 87 in apparently good health, she one day complained of slight frequency and dysuria of a week's duration. Thinking she had a mild urinary infection I prescribed sulphonamides; but during the next week she got much worse developing severe pain and a profuse vaginal discharge. Vaginal examination revealed two vaginal secondaries of transitional-cell carcinoma. Examination of the bladder showed it to be extensively riddled with carcinoma. This case is further considered later in this essay.

Then there arises the very important decision as to when a patient

should in fact be deemed to be inoperable. M. had in fact been operated on and sewn up as being beyond surgical assistance; yet events showed that this was far from being the case. The importance of reviewing a hopeless prognosis cannot be over emphasized and, by the very nature of things, it is only the patient's general practitioner who is likely to instigate this, once a surgeon has pronounced the patient inoperable. This point is forcibly illustrated in the next case.

Case 3 Mr D. This patient came under my care in October 1959. An Anglican minister, aged 51, he had been operated on in April 1956 to remove an adenocarcinoma of the rectum by abdominoperineal resection. At operation there was no evidence of involvement of the lymph nodes. In May 1959 he had a bout of coughing and produced some mucopurulent sputum streaked with blood but this was not regarded as of any serious import. In July 1959 the cough recurred but resolved while he was on holiday, only to return once more in August accompanied by retrosternal soreness, loss of weight, and transient wheezing in the right chest. He was then referred to a chest physician and x-ray examination showed that the right lower lobe was atelectatic and that there was a secondary deposit in the left upper lobe. Bronchoscopy showed that the right stem bronchus was almost entirely occluded by a tumour mass starting just below the right upper lobe and tomography of the left lung showed another small, peripheral secondary deposit in the upper lobe. The case was considered inoperable and the chest physician, thoracic surgeon, and radiologist in consultation agreed that the only practical line of treatment was small doses of T.E.M. and a course of irradiation in the hope of increasing the airway in the right main bronchus.

The patient's wife had been told that he had at best three months to live and in October 1959, when I was first consulted, he was an obviously dying man with a persistent cough and insufficient wind to permit him to preach. While not doubting the accuracy of the previous assessment, I suggested that he should seek a further opinion and he was seen by another thoracic surgeon, who advised surgical assault. Mr D. who had been told the diagnosis and the hopeless prognosis asked me whether he should accept this latter advice and I pointed out that he had really nothing to lose by doing so.

On 6 November 1959 a right lower lobectomy was performed, the right stem bronchus was opened to enable the extruding mass of tumour tissue to be withdrawn and several small lymph nodes were removed from the hilum. Histology showed the tumour to be an adenocarcinoma but the lymph nodes showed no involvement.

On the 19 November two tumours 1½ in. and ½ in. in diameter were excised from the left upper lobe with a wedge of normal lung tissue. These nodules consisted of moderately differentiated adenocarcinoma with mucous secretion and necrosis consistent with rectal origin.

He returned home on 3 December and was able to participate in the services in his church on Christmas Day. Since his operation he has in fact celebrated three Christmas Days, benefited from three Easter offerings and enjoyed three continental holidays, on the last of which he drove some 2,000 miles. Clinically and radiologically he has so far remained clear of any recurrence. Whatever the future holds the somewhat intrepid surgery of 1959 has surely justified itself.

Cases 1 and 3 both illustrate the possibility of attempting a surgical cure even when they have been judged to be "inoperable"; such

cases are obviously few and far between and for every success there are bound to be many disappointments, but with nothing to lose except a few months of wretchedness and pain, it is surely a risk worth venturing if there is the slightest hope of success. Even if a cure cannot be hoped for, alleviation of the patient's distress by surgery may still be possible in many patients deemed " inoperable " as illustrated by the three following cases:

Case 4 Miss N., aged 68, came under my care with a carcinoma of the left breast, which was firmly adherent to the chest wall, the axillary glands were affected and she had developed bone secondaries, which had just begun to cause her pain. Heretofore she had obstinately refused all surgical treatment, although her previous doctor had considered the case operable when first diagnosed; but now that she was suffering pain she rather belatedly changed her mind. She presented a very pathetic picture, a timid, frightened, little woman, obviously in great pain, and horrified by the predicament in which she now found herself. It was decided to seek the opinion of a neuro surgeon, who was known to perform hypophysectomies in such cases and he agreed to operate on her. The result was quite astonishing; not only did the bone pains abate but the mouse was replaced by a veritable lion. No longer the tearful, cringing, little creature, instead a masterful autocrat emerged, who hectored and bullied her neighbours, relatives, nurses and medical attendant without mercy and, when eventually her time came five months later, she marched truculently to meet her death chin up, all guns firing, rather like a very fierce casualty sister going to investigate unseemly noises in a distant cubicle. Seldom have I considered an operation more successful.

Case 5 Mrs W. When first seen in May 1960 this old lady of 91 had a carcinomatous ulcer of her right breast about $1\frac{1}{2} \times \frac{3}{4}$ in. firmly adherent to the chest wall. No glands were palpable and there was no evidence of distant metastases. She had been considered inoperable partly no doubt on account of her age; however, the ulcer was both painful and offensive, it discharged, it smelt and it was an unsightly reminder of something that Mrs W. would much preferred to have forgotten. A further surgical opinion was sought and in October 1960 the ulcer was removed and a skin graft used to cover the resultant raw area. The old lady's joy and satisfaction following this operation, the change in her whole attitude to life and the fact that messy and painful dressings were no longer necessary all fully justified this palliative operation. She moved away from my area a year later to go into a home for old ladies and when I last heard of her in July 1962 was in apparently perfect health with no evidence of any recurrence of her carcinoma.

Case 6 Mrs M. M. was one of those patients who, having presented with what appeared to be an operable carcinoma of the breast, was operated on and given a course of radiotherapy, but unfortunately proceeded to develop secondaries in the liver and bones. No longer need such a case be considered beyond surgical aid though many will still label such cases as inoperable. First diagnosed in April 1959, at the age of 62, M. M. insisted she had only noticed her tumour two days previously while drying after her bath. The mass, about 2 in. in diameter, was situated in the upper and outer quadrant of her right breast and was causing slight skin retraction. There were no palpable glands in her axilla. A radical mastectomy was performed within a month of its being noticed and one gland was found to be involved in the axilla and one in the internal mammary chain. The pathologist's report was that this was a spheroidal-cell carcinoma. Radiotherapy was given commencing a month after operation and this caused a certain

amount of skin burning. In August 1959 she seemed well except for some soreness of the skin round the right shoulder and some limitation of abduction of the shoulder, this being a not infrequent finding in such cases. In November the right arm became oedematous and in May 1960 x-rays showed collapse of the 5th and 7th thoracic vertebrae and deposits in the left femur and sacroiliac joint, these secondary deposits were giving rise to considerable pain.

In June 1960 a bilateral adrenalectomy and oophorectomy was performed and her pains were very much relieved. I believe that this operation is now falling into some disfavour as the results are not considered to be good enough to justify it in about 50 per cent of cases; this may well be true, but in this case the operation undoubtedly relieved her of great pain and enabled her to lead an almost normal life at home coping with most of her household chores for 15 months.

In September 1961 she was complaining of a recurrence of the pain in her right arm and there was a painful skin nodule over her sternum; however she was sure that the pain in her arm was entirely due to an over energetic examination at the hospital outpatient department on a recent follow up and in general remained confident and cheerful. The pain was very largely controlled by tabs. diconal 1 T.D.S. and paracetamol two or three as required.

In December 1961 she complained of pain in her left shoulder and arm and was getting occasional bouts of extremely severe pain requiring injections of sparine 100 mg., which seemed to relieve her and ensure that she got a good night's sleep, after which she would wake feeling fairly well. These attacks were occurring weekly or more frequently and, as she was now unable to attend hospital, even in an ambulance, the surgeon who had operated on her visited her at her home and advised her admission for further investigation. In hospital she became much better, probably as the result of the complete rest that she had refused to take while at home, although with a home help, relatives, and a host of kind neighbours she could well have lain back and done nothing; however, some women seem quite unable to relax in their own homes. X-rays now revealed collapse and consolidation of the base of her left lung, collapse of the bodies of several dorsal vertebrae and secondaries in cervical and lumbar vertebrae, ribs and pelvic bones.

A course of thiotepa 5 mg. daily for 5 days was given with apparent benefit and she was discharged home to have an injection of thiotepa 15 mg. once a week and a weekly blood count. On her return on 2 June 1962 she was in much less pain and although some aching in her shoulder persisted she was not having the severe attacks of pain that had required injections to control. She was very cheerful saying that she would not take in her skirts, which were now far too big for her wasted frame, as she was sure she would soon be gaining weight again. The opportunity was taken to impress on her that, while having the thiotepa injections, she must take things very easily, thus she was persuaded not to attempt a return to her housework.

After the third injection, which was given into her buttock, she had a very severe reaction, her right arm became swollen, red, and inflamed and her temperature rose to 103°F. An analgesic injection of palfium was given and all seemed well the next morning. Her blood picture was unaffected. Following this incident however, her condition deteriorated rapidly and a week later she was in constant severe pain, which was controlled by frequent injections of palfium, so that for the last four days of her life she was barely conscious. She died on 7 August 1962.

These patients have been deemed inoperable because of the advanced stage of the growth, others are however sometimes

deemed to be beyond surgical aid on account of age, like Mrs W. (case 5) or pre-existing illness like the next case, Mrs T. The decision to deny a patient the benefits of surgery even if these are only palliative is a very serious one, not to be taken lightly.

Case 7 Mrs T. Aged 74 this lady had suffered from severe Parkinson's disease for 16 years and was very severely paralysed and somewhat contracted. She spent her time in bed or in a chair, but was still able to go out for drives in a car and attend the theatre, church, and occasional social gatherings in a wheel chair. When she developed a carcinoma of the right breast the situation seemed well nigh hopeless. She was certainly not fit for a mastectomy, which would have been difficult to perform owing to her contractions. In any case, previous experience had shown that even a short period in bed led to a rapid deterioration of her neurological state, and she did not settle easily to hospital routine. Finally neither she nor her husband would consider any major surgery.

On the other hand, the tumour in her breast was growing, would soon ulcerate and metastasize, if indeed it had not already done so. It was finally decided to remove the tumour by local excision, which necessitated only 48 hours in hospital, and then treat the breast and surrounding tissues with radiotherapy. This was done over a year ago and so far there is no evidence of recurrence, while the patient, her husband, and her nurses are much happier now that there is no ominous lump to see or feel; there is a strong streak of the ostrich in all of us and what is out of sight is often out of mind.

It may be felt that it has been irrelevant in an essay on 'inoperable' cases to have considered so many that have been treated surgically, however, all except the last two had been previously dubbed as 'inoperable', and just as a patient may spend some time in hospital and some time at home only to return again to hospital; so he may be inoperable at one stage and then, as the picture alters, become not only suitable for surgery but in great need of operation. One of the essentials in treating advanced malignant disease, whether at home or elsewhere, is to keep an open mind so that any glimmer of hope can be acted on and no opportunity for curing or alleviating the disease will be missed.

Another point illustrated by the case of W/Cmdr M., is the improvement that occurs when a patient returns to his own home, or, as on the second occasion in October 1959, to a nursing home where he received more individual nursing attention and privacy than in hospital. Hospitals are excellent places to be in when special treatment is necessary, but there is no doubt that, if the patient is fortunate enough to have an adequate home, there is no place like it, especially if he can be cared for by those whom he loves and who love him in return. There was no doubt that when M. first returned home in 1948 he was a dying man, yet from that moment he steadily improved until six months later he was able to go up to London and attend a hospital outpatient department under

his own steam. In 1959 he was apparently beyond hope in a hospital ward; but again on transfer to what is admittedly a quite exceptional nursing home he rapidly began to mend. On the first occasion he had virtually no medical treatment, on the second only pain-relieving drugs. Anyone who has himself suffered a lengthy illness knows how important are factors like a well-made bed, a well-managed blanket-bath, a nicely prepared and served meal, a careful selection and rationing of visitors, clean, cheerful surroundings and above all peace and quiet, so that when one is tired one can sleep, and when one is asleep one can remain asleep. These and countless other apparently trivial details may vitally affect the patient's health and hopes of recovery; yet, alas, these are the items which seem to be becoming more and more difficult to find in hospital.

Generally speaking patients are happier and do better in their own homes provided that there are sufficient people, trained and untrained, to look after them and that the amenities of the home are adequate. The outstanding exception to this is a certain type of house-wife who finds it impossible to relax in her own home and will keep trying to do the work, even when it is not necessary for her to do so, as in case 6 (Mrs M. M.).

But however quiet the room, however kind the attendants, however dainty the meals, if one is in constant pain then all is in vain. Nothing is more tiring and demoralizing than nagging pain and the relief of pain alone will often produce a dramatic improvement in the condition of the patient whether this be achieved by analgesics, surgery or hormone therapy. This was clearly demonstrated in the cases of W/Cmdr M. (case 1), Mrs M. M. (case 6), and Miss N. (case 4).

Everyone will have their own favourite analgesics and, as in so many activities, the best results are usually obtained with the tools to which one is most accustomed. Personally, I start with tabs. paracetamol two or three as required, when these are insufficient to control the pain I proceed to tabs. tercin a combination of aspirin and butobarbitone, not more than eight a day, then as a much more powerful drug for oral consumption I use tabs. diconal, these contain dipipanol, which relieves severe pain, and cyclizine which reduces the incidence of nausea and vomiting, this preparation has succeeded tabs. pipadone co. which were used in case 1. Often with very severe pain an intramuscular injection of promazine 100 mg. (sparine), relieves the pain, relaxes the anxiety and tension, and produces a prolonged and deep sleep, from which the patient wakes

refreshed and comfortable as did Mrs M. M. (case 6).

Promazine is particularly useful in cases complicated by nausea and vomiting, like a patient of my partner's, who recently died of carcinoma of the pancreas, and Mr P. (case 9), who while not suffering from pain was troubled by vomiting. Another useful antiemetic preparation is valoid, available both as an injection and as suppositories which can be used by the patient or his relatives if no physician or nurse is present to give an injection.

Finally, most of these cases with severe pain require analgesic drugs by injection. Morphine has much to be said for it and the long-acting forms such as hyperduric morphine are especially useful in general practice, where there is not always someone competent to give an injection in the home. The chief drawback of morphine is the tendency to constipation, often a problem anyway, and for nausea and vomiting to develop. Constipation can usually be corrected by the judicious use of laxatives and vomiting controlled by the use of valoid either by injection or suppository (see case 1). More recently however, I have increasingly used palfium (M.C.P.) a preparation of dextromoramide, which seems to be as powerful as morphine without its unpleasant side-effects. While discussing the use of morphine in the inoperable case reference must be made to the famous ' Brompton Cocktail ' (morphine hydrochlor. 15 mg., cocain hydrochlor. 10 mg., gin 4 ml., honey 4 G. aq. chlor. ad. 15 ml.). In this traditional and extremely effective mixture the pain relieving qualities of the morphine are supplemented by the remarkable euphoric properties of cocaine and the final days may be transformed for all concerned by its use. The pain from accessible secondaries can also be relieved by the injection of a local anaesthetic, surprisingly this relief is often permanent.

Whatever analgesic is used, there remains one essential provision: enough must be used to ensure freedom from pain and in this type of case, where the prognosis is hopeless, it is ridiculous to hold back for fear of producing an addition or shortening life. Shortly after qualifying I was employed as a locum house-physician and was asked by the night sister to see an old gentleman dying of a gastric carcinoma, who was obviously in great pain. Not realizing that he was a private patient and that I was not supposed to treat such patients, I prescribed $\frac{1}{4}$ gr. morphine by injection. The next morning I was roundly berated by his physician for this breach of the rules, which I considered fair comment. Unfortunately he concluded by saying, "I do not want him given morphine in any case; he might

well become an addict ". This I thought one of the silliest remarks I had ever heard, a view that was confirmed when I heard a few hours later that the patient had died. Case 1 illustrates how morphine may often be given in quite large doses and then withdrawn without difficulty.

Contrary to the usual idea of cancer, at least in the lay mind, pain is not an inevitable symptom and when it does occur, as has been shown, it can usually be controlled. This is a comforting assurance for the relatives when the time comes to tell them of the diagnosis and is well illustrated by the next three cases:

Case 8 Miss C., aged 85, was the inmate of an old ladies' home. In January 1962 she suddenly became very confused and noisy, a state which lasted for about a week but settled on treatment with chlorpromazine. Investigation then revealed that she was suffering from an inoperable carcinoma of the thymus. She lived for a further seven months during which time she wasted quietly away. There was no recurrence of the agitated confusion and at no time did she complain of any pain, even when asked if she was in pain or any discomfort.

Case 9 Mr P. In January 1962 this retired shop assistant, aged 71, was diagnosed as suffering from carcinoma of the colon with a single umbilical secondary. These were both removed and an ileocolostomy was performed. He developed a further umbilical growth, which seemed to be continuous with a large intra-abdominal mass, and he was considered beyond surgical or radiological aid. At this stage circumstances brought him under my care, and I attended him for the last six weeks of his life. A dour, independant recluse, he made it quite clear that he did not want medical or nursing attention and resented any fussing. At no stage did he complain of any pain or discomfort, even when directly asked if he was suffering, nor did he ever seem to be in pain either to myself or to the very experienced nurse who was attending him. During the last two weeks of his life he suffered from frequent vomiting, but this was controlled by twice daily injections of sparine 50 mg. He died apparently peacefully in his sleep, although by then his abdomen was distended by a large, rocky hard mass of carcinomatous growth.

Case 10 Mr A. T., aged 80, also illustrates the painless course malignant disease may follow. In July 1962 he became jaundiced and on laparotomy was found to be suffering from advanced carcinoma of the head of his pancreas. cholecyst-jejunotomy and jejunojejunostomy were performed but no attempt made to remove the tumour. Two months later he became very dirty in his habits and mentally confused, and for these reasons had to be transferred to a long stay annexe. He died in October 1962. At no time did he complain of any pain even on direct questioning, nor did he at any time appear to the medical or nursing staff to be in any pain.

Next to the relief of pain comes the provision of sleep, and here it must be stressed that the relief of insomnia is not purely a matter of selecting the appropriate sleeping pill. First the cause of the insomnia must be determined; anxiety—after all any patient with cancer has plenty to worry about even if they have not been told the diagnosis, pain—which always seems worse in the long night watches, noise, an uncomfortable bed, or a restless bedmate. Having found

the cause, it is often possible to do much to relieve the insomnia without any recourse to drugs. A room on the quiet side of the house, perhaps a change of room on retiring for the night. The suggestion that the patient might sleep better in a separate bed. A few well-chosen words to relieve the patient's anxiety, which is often quite irrational, such as the cancer patient who fears that he is infectious and a danger to his family, or dreads going mad or having a colostomy, fears that are frequently quite unfounded. Anxiety and depression may cause insomnia in the healthy and the same applies to the inoperable patient with malignant disease, who indeed has plenty of cause for both anxiety and depression as days run into weeks with deterioration instead of improvement to mark their progress. Of the tranquillizing drugs, promazine in the form of sparine as tablets, suspension or injection is of great value; for depression parstellin. When pain is preventing sleep tabs. codein co., tercin or sonalgin, a combination of aspirin and butobarbitone, are all helpful though, later on treatment must be with stronger analgesics as discussed above.

Another enemy of sleep is the persistent cough, especially in cases of carcinoma of the bronchus or larynx. In mild cases pholcodeine is useful as ethrine or combined with a resin in pholtex for longer action; but for advanced cases heroin or methadone (physeptone) may be required and need not be shunned for fear of addiction.

Smooth sheets, well arranged pillows or a warm drink will often induce sleep and alcohol deserves a special mention—analgesic, tranquillizing, palatable and above all normal, unlike all these drugs and medicines, this old, well-tried, and often beloved remedy may be a great standby. As far as hypnotics are concerned the choice is legion: syr. chloral is preferable to most of the barbiturates, most patients take it if the taste is masked with fruit juice, especially pineapple juice, which will mask almost any taste. If pain and restlessness are present nepenthe may be added. If the patient wants a tablet, welldorm has a similar effect to chloral. Of the barbiturates tuinal or nembutal are useful, the latter being particularly so for the patient, who wakes at two or three in the morning and needs something to get him to sleep but does not want to be too dopey in the morning. Barbiturates are best avoided, however, as they tend to produce mental confusion and sometimes even nocturnal incontinence in old and debilitated patients.

A further difficult problem in management, especially towards

the end, is the prevention of bedsores. Here the great essential is good nursing with frequent changes of position, care of the back with soapy washing, massage and the application of spirit or one of the silicone creams, maintenance of a dry, clean bed if the patient is incontinent and avoidance of lumps and wrinkles in the bedding. However, the most important prophylactic measure is to prevent the patient becoming bedridden for as long as is practically possible. Next to that is the preservation of the attitude of mind that, while acknowledging that bed-sores can occur in the best managed case, still regards the occurrence of such sores as a reflection on the patient's attendants unless there can be shown to be extenuating circumstances. Ripple bed mattresses designed to change constantly the area of skin bearing the patient's weight can be hired for a very moderate charge; unfortunately, many patients find them uncomfortable if the pressure has not been properly adjusted to the patient's weight, and it is important to impress on the attendants that this gimmick in no way permits a lessening of the measures of general care listed above.

The nurse must also give constant attention to the mouth to avoid infective parotitis. Mouthwashes, drinks, acid drops, chewing gum and in the terminal stages swabbing are useful.

Incontinence is not a frequent complication among these patients when treated at home. This is partly due to the fact that the patient does not suffer the break from a well-known routine and departure from his usual environment, which inevitably occurs on admission to hospital, and which often results in confusion and incontinence in elderly and debilitated patients. Also the more individual care and attention given to a patient in his own home makes it less likely that his requests for a bottle or help to get on to the commode will pass unnoticed.

Who it may be asked is going to provide all this care and attention to the patient at home? If funds permit it is of course possible to employ one or more nurses, as was done in case 1 when W/Cmdr M. returned home from the service hospital. More often than not however, that is going to be beyond the means of patients, who tend to be elderly, retired, and living on fixed incomes eroded by inflation. Then the district nurse is the expert, who will visit the patient's home, undertake any special nursing and help and instruct the relatives who while willing to help are probably not skilled in these duties. Home helps and night sitters are now available, while in some areas, meals on wheels and special laundry facilities are

provided; the Red Cross and other organizations are willing to help by lending special equipment such as bedpans, urine bottles, and back rests; also the national assistance office will always help if funds are low or if a relative has to give up her job to look after the patient causing further strain on the family finances. But the main burden of the patient's care will inevitably fall on the relatives, often helped by the neighbours; it is often wonderful how well the family copes, especially if there is a kind and competent nurse to help and advise them. Certainly experience in a rural practice does not support the view that, since the inception of the welfare state, all family loyalty and sense of duty have been discarded. But when the strain is too great or too prolonged it can often be arranged for the patient to be admitted to hospital for a short time to give the family a rest; once the patient realizes that this is only a temporary measure much of his reluctance to leave home will disappear.

With all these necessary precautions and points of care to be considered, it is important to remember that these patients are dying and to avoid unnecessary restrictions and shibboleths, which cannot relieve their discomforts yet may prove in themselves irksome and tedious. For example there is nothing to be gained by forbidding such patients the comforts of alcohol, for intoxication, a hang-over, alcoholic gastritis or cirrhosis of the liver are of little importance to one already suffering from a disease soon to cause his death. Neither need an obese patient, whose expectation of life is a matter of weeks or months be irked with dietetic restrictions. Nor should a man dying from carcinoma of the prostate be refused the solace of tobacco, lest he develop carcinoma of the bronchus. This may seem obvious yet these things are done. An old lady once lay dying and demanded a welsh rarebit and a glass of guinness; her family exclaimed in horror but agreed to ask her doctor, a wise old Scot, who immediately told them to provide the patient with her requirements. They were accordingly served to the old lady, who devoured them with relish and died a few hours later. One likes to think that her last few hours were made happier by his humanity and commonsense.

Sooner or later the patient's relatives must be informed of the diagnosis and hopeless prognosis of these cases, though this is sometimes difficult, as in case 7, Mrs T's husband had some years previously particularly asked me never to tell him anything his wife should not know as he could never keep any secret from her. I accordingly informed her sons when the diagnosis of carcinoma was

made. But " it is a tangled web we weave when once we set out to deceive " and the husband learnt enough to guess the truth from a chance remark made by the radiotherapist treating his wife, when I reminded him of his previous instructions he looked very surprised and said " But that was a long time ago ".

This inevitably leads to the question that is so often raised in the lay press, in television brain-trust programmes and the like. " Should the patient be told that he has cancer and that he is incurable? " The only answer surely must be that it all depends on the patient. W/Cmdr M. (case 1) was an agnostic, and did not have to make any special provisions financially; in his case I prevaricated and hedged. He never followed up his questions and according to his son did not realize how ill he was right up to the time of his death. Perhaps he just did not want to know definitely what he suspected; perhaps this was an example of the human mind's wonderful powers of self-deception; anyway I felt it none of my duty to break in upon any delusions he harboured especially as my intervention could do no good.

Mrs M. M. (case 6) also showed the most amazing euphoria when in the month before her death she refused to consider altering her skirts as she felt she would soon regain her lost weight. No-one could justify shattering this illusion in the interests of strict honesty or truthfulness.

On the other hand Mr D. (case 3) is a fervent and convinced Christian with a young family. Before he consulted me he had insisted on being told the truth and it would, I believe, have been very wrong to have attempted to deceive him. In any case knowing the facts enabled him to discuss the matter with his colleagues and to receive religious consolation and help, which would have been impossible if he had been kept in ignorance of the true state of affairs; indeed he is convinced to this day that his really remarkable recovery was a miracle and a direct answer to prayer, I for one am not prepared to challenge his conviction and can only envy him so strong a faith.

There are also, of course, cases in which the patient requires some warning so that his worldly affairs may be put in order, unfortunately the warning is not always heeded as the next case will illustrate.

Case 11 Mr H., aged 63, and a christian scientist. This patient developed carcinoma of the bronchus. Loath to submit to surgery on religious grounds he insisted on being told the diagnosis and prognosis. I told him that if he did not have the operation he would almost certainly be dead within three months, if he had it he would have a fifty-fifty chance. He decided to have the operation;

but, in spite of his knowledge of the risk involved, he made no will; so that when he died on the operating table his estate was divided among his three sisters, and his wife, to whom he was devoted, was left destitute.

While discussing the advisability of telling the patients his diagnosis and prognosis reference has to be made to questions of religion. W/Cmdr M. was an agnostic, Mr D. a devout Christian, Mr H. a christian scientist. This raises the relationship that should exist in these cases between doctor and parson. Some, like M., wish no contact with the clergy, others like D. already have the spiritual side of their illness well organized; but most have probably less idea how to cope with their spiritual affairs than with their physical state. Many will benefit from the parson's ministrations, but often they hesitate to make the first move from shyness or even a fear that in doing so they may offend the doctor. In a rural practice this problem is perhaps easier to deal with than in the cities; be that as it may, I have always made it my duty to let the parson know when one of his parishioners is very ill or dying; I then leave it to him to proceed as he thinks best. So far I have never had cause to regret this course, my confidences have not been betrayed, I have not found the parson intruding into what I consider to be my province, I have tried not to overlap into his and generally I am sure the patient has benefited from this collaboration.

Case 1 also illustrated the importance of the practitioner keeping the initiative; once he allows that to slip from him the patient, or in this instance his wife, cannot be blamed if they seek assistance elsewhere. On this occasion several factors united to produce this unfortunate state of affairs; first there is no doubt that the service surgeon did not assess the prognosis accurately; secondly I, as the general practitioner, had just returned from war service during which I had had no experience of this type of case; perhaps also service life had made me too ready to accept the opinions of others, so that I embraced the surgeon's prognosis and clung to it long after it was obviously mistaken. The result was that the confidence of the patient's wife in orthodox medicine was rapidly and quite understandably dissipated and she not surprisingly turned to quackery, which exuded confidence and absorbed her money, a combination that the desperate find irresistible. It behoves us to remember that hungry jackals are always loitering in the shadows round the fires of honest medicine and that it is usually our fault if our patient turns to them for the hope, confidence, and comfort that for some reason we have failed to supply.

When things look darkest for our patient and the risks of treat-

ment loom most forbidding, it is well to remember the unpredictability of cancer cases in general. W/Cmdr M. (case 1) at first appeared moribund, he recovered sufficiently to stand major surgery, he remained clear for ten years, once more he appeared on the verge of death, once more he recovered to laugh, to fish, and to walk the world. Case 3 also illustrates this unpredictability; it would have been a brave man who would have given Mr D. much chance of surviving his double operation let alone recovering to return to health and work for more than three years. A further example of this is instanced below as case 12. This case was not one of mine but was recounted to me by a very able surgeon now dead.

Case 12 An elderly man was referred to a dermatologist, who diagnosed a malignant melanoma on his foot. The dermatologist took him upstairs to his surgical colleague and they both advised an immediate amputation above the knee; the patient however declined, saying at his age he would rather die than suffer an amputation. Shortly after this consultation the second world war broke out and the surgeon had other things to think about; so it was not till some five years later that he remembered this patient. Called out in the blackout to see an old lady with acute appendicitis he found the door opened by her husband the little old man with the malignant melanoma, who laughingly recalled his wisdom in refusing to have his leg off five years before. Unfortunately the rigours of visiting his wife in a nursing home that winter proved too much for the old gentleman, and he caught pneumonia from which he died. His wife agreed to an autopsy which showed his body to be riddled with secondary deposits of melanoma, which had however apparently regressed and fibrosed.

So far in our consideration of the care of the inoperable case of malignant disease in general practice we have considered the problems of general care and management, and paradoxically the question of surgery for the " inoperable " case; but nowadays there are other more specific attacks, which may be launched in our attempts to relieve, if not to cure, these dreaded conditions, and, although these may be more often carried out in hospitals, it behoves the general practitioner to bear them in mind so that his patient will not be deprived of them and so that he can discuss them with his patient if asked for his opinion. Radiotherapy, hormone treatment and chemotherapy come under this classification and will now be considered from the general practitioner's point of view.

Radiotherapy is no newcomer to this field and may in many cases be of the greatest help. One such case is that of Mrs S.

Case 13 Mrs S., aged 79, was an old lady who suddenly developed a profuse extremely offensive, bloodstained and irritant discharge. Examination revealed an advanced carcinoma of the cervix. Surgery was out of the question and yet she could not be left untreated. A course of radiotherapy was given which completely relieved her of these unpleasant symptoms and some nine months later she remains old and infirm but comfortable.

Mrs. T (case 7) was also benefited by radiotherapy, where surgery could only be superficial, and although she suffered considerable burning of the skin, the results do appear to have justified the treatment. But this is not always the case and, when recommending radiotherapy, one should bear in mind the closing passage of Sir Robert Hutchinson's affirmation, quoted by Dr William Evans in his address to the Winchester Division of the B.M.A. in February 1962 " . . . from making the care of a disease more grievous than its endurance good Lord deliver us ".

Thus when Mr D. (case 3) was advised to have radiotherapy to his chest, he recalled from his experience as a parish priest and hospital chaplain some of the sad, pain-ridden wrecks that he had seen undergoing such treatment and shrank back. It must be the experience of most general practitioners to have had patients treated with radiotherapy and to have wondered afterwards whether it was indeed worth it. Dr Richard Gordon in *A Doctor in the House*, or one of its companion volumes, tells of the great radical surgeon, who, when he himself developed a cancer, retired to the country to be treated conservatively by a general practitioner, who was not sparing in the use of morphine; today, surgeons, having become more humane, since five-year cures ceased to be the goal of treatment, are less likely to shun their kind but perhaps it is the radiotherapists, who now have cause to hesitate before accepting their own prescription. This is not intended as a general condemnation of radiotherapy, which would be quite absurd and unjustified, especially with modern supervoltage machines and cobalt bombs with their bone and skin-sparing properties; but rather as a caution so that the full pros and cons of this form of treatment can be considered before embarking upon it. An old, presbyterian Scot returning from Rome used to insist that he heard a priest in St Peter's chant as he scattered the holy water " Tak' it mon tak' it; it'll do you nae hairm if it does ye nae guid ". This cannot be the chant of the radiotherapist. However once this form of therapy is embarked upon the patient will be under the case of a specialist and the general practitioner's role is purely supportive.

Hormone therapy has been practised since 1896 when oophorectomy was first performed for carcinoma of the breast. Since then it has been advanced until it is now the treatment of choice for carcinoma of the prostate and is increasingly used in cases of carcinoma of the breast.

Case 14 Mr G. G. Aged 72, this old gentleman was the absolute prototype

of Walter Gabriel, the character in the radio serial " The Archers ". He rejoiced in telling tales of his strength and prowess in days long past, when men were men indeed and the country was unpolluted by the cities' overflow. It was therefore a sad day when he sent for me complaining of acute retention of urine and examination revealed a carcinoma of the prostate. Surgery relieved the immediate obstruction and treatment was commenced with stilboestrol 5 mg. T.D.S. All went well for three months, then he was horrified to notice that his breasts were enlarging and becoming pigmented. Reassurance that he was not about to change his sex did much to restore his peace of mind but did not ease the pain in his breasts so that stilboestrol was abandoned in favour of stilboestrol diphosphate as tabs. honvan 100 mg. T.D.S. which did not cause him any mammary inconvenience. Five years went by with no discomfort and then, as so often happens with such cases treated with hormones, the effectiveness of the treatment suddenly weakened and the old gentleman's condition rapidly deteriorated. Within a month he was dead.

Case 15 Mr T. H. S. Aged 67, this retired grocer developed signs of prostatic enlargement and on examination was found to have a carcinoma. Treatment with stilboestrol 5 mg. T.D.S. relieved this and four years later he was relatively symptom free when he passed under the care of another doctor.

Case 16 Mrs G. J. Aged 68, this lady developed a carcinoma of the left breast which was treated by local excision and radiotherapy. All went well for about two years then she started to develop bone pains. X-ray at this stage revealed only the appearances of osteoporosis and treatment was started with injections of durabolin without much benefit. Two small skin nodules then appeared, which on section were shown to be secondary deposits and further x-rays showed her to have extensive secondary deposits in the bones of the spine and pelvis. At this stage the poor lady was in hospital and was in such pain that she could not bear the weight of the bedclothes on her legs; it was deemed pointless to consider further treatment and as she was anxious to return to her home and garden in the country she was allowed to do so. Treatment was started with stilboestrol 15 mg. T.D.S. Some nausea was experienced which was controlled by stemetil tabs. 1 T.D.S. Within a fortnight she was able to get up in a wheel chair and walk a few yards with elbow crutches, she seemed virtually free of pain and only required a tablet of pethedine (50 mg.) on retiring at night. Three months later although further secondaries had appeared in the skin she remained free of pain and had at least been able to enjoy what must be her last summer in her own home with her husband.

Case 17 Mrs A. T. Aged 72, this old lady developed a carcinoma of the breast which was treated by a mastectomy and radiation. Six months later she lost the power of her legs. X-rays failed to reveal bone secondaries and the possibility of this being a functional disability was considered. However, two months later she was losing weight and the weakness had extended to her arms so that she could neither feed herself nor knit. Treatment was started with stilboestrol 15 mg. T.D.S. and a month later she was sitting up in a chair, feeding herself, knitting and much more cheerful, an improvement that has persisted for six months, although x-rays have since confirmed the presence of secondaries.

Hormone treatment covers not only the administration of hormones by mouth or injection but also the surgical removal of the glands that produce the hormone, whose action it is desired to counteract. Thus the removal of testes in cases of prostatic carcinoma, oophorectomy in carcinoma of the breast, and more recently bilateral adrenalectomy or hypophysectomy for carcinoma of the

breast, the latter being more fashionably approached by the nasal route rather than through the vault of the cranium. Opinion is divided as to the merits of these procedures but cases 4 and 6 mentioned previously were apparently considerably, if only temporarily, benefited. Nowadays a medical adrenalectomy may be achieved by administering large doses of corticosteroids, and although I have not myself had experience of this method I know of a case in which it has been done with much benefit. This is a treatment that can be carried out at home.

Chemotherapy will in most cases be carried on in co-operation with a specialist; but as shown in cases 1 and 6 the general practitioner can well supervise this form of treatment when the patient is at home, provided he has access to laboratory facilities for the weekly blood count to detect especially any fall in the red cell and platelet count. In case 1 the extraordinary efficiency of this form of treatment in the control of pain was illustrated when W/Cmdr M. had to stop taking his melphalan tablets on going to the remote highland fishing hotel; within a week his sciatica returned; within a day of resuming treatment it was markedly relieved. Another case treated with chemotherapy is Mrs P. already mentioned and now more fully described below:

Case 2 Mrs P. Aged 87, this lady enjoyed remarkably good health and had the previous year visited her son in the United States. In July 1962 she complained of some hypogastric discomfort, together with slight dysuria and frequency. Thinking she probably had a mild urinary infection I prescribed sulphonamides and expected a rapid improvement. Instead of this her condition rapidly deteriorated the pain increased and she developed a profuse, blood-streaked discharge. Full examination revealed two nodules in the vaginal wall which turned out to be secondaries arising from her bladder, which was riddled with carcinoma. The vagina was treated by a radiotherapist with three tantalum pins which were left *in situ* for three days. Four days later she was allowed to leave hospital where she had not been very happy. For domestic reasons it was decided that she could better be looked after in a nursing home rather than in her bungalow, where she had heretofore lived by herself.

On arrival at the nursing home, she complained of considerable perineal discomfort which made sitting for more than a few minutes very uncomfortable; she denied pain, except for occasional twinges at night, her general condition was obviously poor and deteriorating. She had however one great dread, that she might have to return to hospital, where the noise seemed to have upset her most. On the other hand it seemed possible that painful haematuria might render her readmission necessary.

Treatment with thiotepa was commenced on 17 September, 15 mg. being given intramuscularly. The next day she was very sick and felt ill and the dose was reduced to 5 mg. daily for three days; then 7.5 mg. daily for four days. She then looked and felt very much better and was able to sit up for three-quarters of an hour without discomfort. When she had had 60 mg. thiotepa she complained of some nausea and treatment was discontinued for three days; there-

after it was resumed on a maintenance basis, 7.5 mg. being given every fifth day. Now some ten weeks after commencing chemotherapy she seems very much better, is in no pain, complains of no tenderness, has no difficulty with her micturition and goes out for car rides whenever the weather is suitable; in fact she seems well and reasonably active for her age.

Case 18 Mrs M. H. Aged 82. This old lady became a patient of mine when she came to live with her son, she was then partially crippled with rheumatoid arthritis and suffered from indigestion attributed to a hiatus hernia. She was also hypertensive so that a severe epistaxis in February 1960 did not cause much surprise; as however packing did not control this an ear, nose and throat surgeon was consulted and he cauterized the bleeding point. In October 1960 her eyes were tested and found to be normal except for some early lens opacities. In January 1962 she developed a partial ptosis and an external strabismus of the left eye, which were considered to be due to a small cerebrovascular accident compatible with her age and hypertension, there was also a small haemorrhage in the macula. In May she was complaining of soreness of her mouth and was unable to manage her dentures. On 15 August she had a very profuse epistaxis and the left nostril was found to be full of polypoid tissue, on section this showed no evidence of malignancy; but an x-ray showed extensive bone destruction of the inferior margin of the left orbit on the medial side due to a neoplasm of ethmoidal origin. The ear, nose and throat surgeon did not recommend surgery, which would of necessity have been radical and mutilating, nor did a radiotherapist consider radiotherapy likely to help her. She was accordingly discharged from hospital " to develop her symptoms quietly and in peace ".

At this stage she was in a sorry state, unable to breathe through her nose, from the left nostril of which ran a thin, brown, foul smelling discharge, unable to sleep and in despair because " nothing could be done for her ". Reassuring her that the latter was not the case I commenced a course of thiotepa injections more with the intention of showing some activity than in the hope of giving her much relief. 5 mg. were injected daily and a blood count done every third day. After two injections she was breathing happily through her right nostril and the discharge had stopped; after the fifth injection she could breathe freely through both nostrils. It would be difficult to say who was most surprised at this stage the patient, her nurse, or myself. After the sixth injection the dose was raised to 7.5 mg., daily; but on 8 September, having had a total of 75 mg., she vomited and treatment was discontinued for a week and then resumed with a weekly dose of 15 mg. and a weekly blood count. On 23 October the dosage was altered to 7.5 mg. every fifth day. On 26 October she was able to open her left eye for the first time for six months. On 5 November, having received a total of 112.5 mg. of thiotepa her haemoglobin fell to 62 per cent and treatment was suspended. At the time of writing she is happy, contented and suffering no pain nor discomfort; she can breathe through both nostrils, there is no discharge and she can open her left eye almost fully, most important of all she is convinced that she is getting better. Her death is doubtless imminent, after all she is now 84 years old, but I am sure that chemotherapy has made her latter days much happier for both herself and her family.

Although in the last two cases chemotherapy was instituted by the general practitioner, this is a form of treatment more likely to be carried out in collaboration with a specialist, as in cases 1 and 6. Indeed in a branch of medicine that is so specialized and advancing so rapidly specialist advice will usually be desired.

The many treatments that may be employed in the releif of patients

with inoperable malignant disease in general practice have now been reviewed and illustrated by case histories; but of all the treatments available to the general practitioner in these cases, as in so many, the most important is himself and this is the least easy to explain or to illustrate. A trusted friend, an informed adviser, a comforter of both mental and physical distress, a co-ordinator of the many services available to his patient, all these the general practitioner must be, but first and foremost he must be a frequent and regular visitor: unless he is that, it is difficult if not impossible for him to be anything. The doctor's very visits are beacons of hope and inspiration for the patient to make that extra effort, which might otherwise seem hardly worth while; his interest and concern can help not only the patient but also his relatives and attendants and, perhaps more often than even he had hoped, he can help with his advice to relieve some heretofore intractable problem in the patient's care; after all he has seen all this too often before whereas the patient and the relatives are treading an unknown trail for the first time. Conversely a falling off of the doctor's visits will be interpreted as a decrease of interest or at best an admission of defeat and nothing can be more distressing nor more demoralizing to the patient and attendants, who need beyond all else hope. The decreased frequency of the doctor's visits may in fact be due to one or more of several reasons; a feeling of hopelessness because the game is so obviously up; distaste for the sight of the ravages of disease advancing unchecked; other pressing calls upon his limited time; a feeling of inadequacy; but all these must be resisted and overcome for in this crisis the family doctor comes into his own, and it is to him that the patient and family look, even in an age when it is fashionable to regard general practitioners as ignorant fuddy duddies or casualties in the scramble up the ladder to consultant status. These cases are among the general practitioner's most difficult and yet are often his most rewarding; as opportunities for service and justification they are constantly with him and frequently recurring. It is his loss if in failing his patient he also fails himself.