A Chance to Cut

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My gloved hand reaches for progressively sharper surgical instruments. The prior radiation therapy and recurrent cancer have made his neck tissues as stiff and hard as an old block of wood; everything appears too dull and feels too dry under the bright operating room lights. I push, dissect, urge, divide, prod, and spread with little effect.

The nursing staff keeps to its routine—completing computer entries, retrieving supplies, counting sponges—only intermittently aware that things are not going well at the point of attack. Nondescript music plays softly and the anesthesia machine continues to emit its gentle sounds. The junior resident—assisting me with the first of many neck dissections she will see during her five years of training—grips the retractor as she has been told and dabs the wound periodically to clear any blood or fluid.

I glance up to recheck the CT scan. It confirms that this man's recurrent cancer is just below the next layer of neck muscles. There are also some large blood vessels and major nerves nearby. I am confident, though, that I will be able to expose the mass, protect all of the critical structures, and safely remove the cancer.

Curing cancer with surgery is no small feat, mind you. Cancer is, after all, a molecular disease not easily confined to an obvious lump, even though we sometimes refer to a malignant mass being "like a walnut" or "as hard and round as a marble." The actual disease rests deep inside each cancer cell where the genetic code — the DNA — makes mistake–after–mistake. If cancer is to be cured with a surgical procedure, the surgeon must remove every last cell that is capable of making the same nonsensical, life–threatening error. Given Science's rudimentary knowledge of cancer cell dynamics and signaling, it's a miracle that surgery ever works.

Yet, we continue to try. And we succeed just often enough to keep on trying.

I rearrange the retractors and alter my approach.

My mentors would have known what to do next, I imagine.

My training included time well–spent with brilliant and technically–gifted surgeons. *How would they have approached this case?* Their experience and instincts might have told them to open the wound more widely, work the lateral and deep margins first, or position the instruments differently.

Perhaps, one of my mentors would have attacked this man's tumor using the same approach I am attempting but would have known exactly where to exploit some area of weakness that I cannot locate.

A few swift, confident moves and he would have held the mass in his hands. "That's it. We're done," he would have said.

I met this patient several months ago when his cancer was first discovered and have seen him throughout his course of treatment. Recently, his daughter had accompanied him to the office to review his options. "Treatment has been rugged,

Doc," he reminded me. "The cancer's still there and they said I can't get any more radiation. Chemo would only prolong things. I don't really want surgery, but what choice do I have if I want to be cured?"

"Supportive care is an option, but the only curative approach is surgery."

"Well, I'm not ready to quit yet, Doc. I got grandkids, y'know. I want to watch them grow up." He nodded to his daughter. "I'm in charge of spoiling her little boys."

The daughter smiled. We crowded around the computer screen to look at the scans. I showed them how the tumor was invading and destroying surrounding structures. I described the surgery and the risks.

"There are many things I will not know about your tumor until we are actually in the operating room," I explained. Surgery in the setting of recurrent disease involves a series of on–the–spot decisions and course corrections. The odds of success are unknowable. "Sometimes, the only way to find out if we can remove the cancer is simply to try."

He took a deep breath and looked at his daughter.

"Well then, Doc, if surgery is the only way, let's go for it."

I looked at them. "Okay. I promise you both that I will do my best."

I improve the exposure by lengthening the incision. The maneuver helps. *That's better. I can get this thing out after all.* I think forward through the case and try to anticipate the hurdles yet to come. The dissection has uncovered which important nerves and muscles are caught up in the mass; complete removal of the cancer will make postoperative articulation and swallowing much more difficult.

The main artery to the brain lies somewhere deepwithin the scar and still needs to be addressed. I realize that even if I remove every bit of the tumor I can see or feel, there would still be nests of cancer left behind that would soon begin to grow again.

Recovery might take weeks, requiring a prolonged stay in the hospital or a rehabilitation facility. *But*—I tell myself again—*if I can get this out, there is still a possibility that he might be cured*.

Surgery cannot cure every cancer. Yet, surely, there *must* be cancers that talented, experienced surgeons can cure that less talented, less experienced surgeons cannot. I realize that it is possible that if this man was asleep on an operating table in another hospital under the eyes and touch of a different surgeon, the path to a complete and safe removal might suddenly come into focus.

The dissection continues. The tumor proves even more extensive that I could have predicted from the CT scan. Two hours into the operation, we reach the point of no return. Either we continue on, making every possible effort to remove the cancer yet leaving him unable to eat, or we back out, intentionally leaving cancer behind but preserving function for the remainder of his short life.

I redouble my effort, spreading the tissues more vigorously, watching carefully for nerves and blood vessels. Nothing opens up.

I am stymied. A familiar, unwelcome sensation roils within me.

"That's it. We're done," I announce. There is no possibility of a cancer cure in this place today.

The operating room team members rise from their seats. A flurry of activity ensues.

The anesthesiologist checks her watch. "That was quicker than anticipated. What happened?"

"Can't get it out," I tell her. "I don't want to make things worse."

She peers over the blue sterile drapes and shrugs. "Too bad."

"Yeah. It is." I call for suture and dressings. "I'm going to speak to his family and then we'll close this up. We should be done in about forty–five minutes."

The resident looks at me. "This will be hard on his daughter."

I rest my gloved hand over the place where the cancer remains thoroughly enmeshed. The unyielding mass pushes back. *What if?* I think. I hope I have learned something today that will help the next patient I encounter in a similar situation.

I look across the operating table and nod at the resident. "Hard on everyone."

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