EARLY AND TENTATIVE DIAGNOSIS OF GASTRO-INTESTINAL CARCINOMA

Translated from the German of I. Boas

Editor's Note: Boas' article appearing under the title "Über die Frühdiagnose und Vordiagnose der Magen- und Darmcarcinome," in Medizinische Klinik (26: 799, 1930) is so suggestive from an educational point of view that it has seemed worth while to reproduce it here in full. The translation is by Dr. Otto F. Krehbiel.

The early diagnosis of gastro-intestinal cancer is spoken of as if it were an established fact. In the earlier as well as in the most recent literature, clinicians of repute and experience look upon it as the solution of the problem of cancer therapy and expect from it a great reduction in cancer mortality and an almost unbelievable betterment of the prognosis of cases treated surgically or by radiotherapy. To disturb such conceptions is not agreeable and may not be opportune. Yet it must be done, since ideas unworthy of promulgation obstruct scientific progress. With false premises no advance is possible.

What is meant by the early diagnosis of cancer? Even the definition presents difficulties. Apparently the matter is a simple one. Cancer should be recognized in the very first phase of its development. But the prerequisite for the detection of the initial stage of the neoplasm is a definite symptomatic manifestation. Accordingly, mammary carcinoma, so accessible to palpation, should be discovered in its earliest stage in 90 to 100 per cent of cases. Yet this occurs so rarely that surgeons again and again attribute their unsatisfactory results to late diagnosis. If, therefore, only a relatively few breast cancers are recognized in the incipient stage, the chances for early diagnosis in cases requiring more difficult methods of examination must be remote.

The desirability of a specific reaction for cancer is frequently mentioned. In certain occult neoplasms, where our present diagnostic methods fail, such a reaction would be of value, but in regard to early diagnosis in general it would not yield any great advantage. Even granting that an incipient cancer could produce sufficient changes in the blood to render a serological test feasible (a condition unprecedented in the entire field of pathology), subjective symptoms would have to be present at the same time,
in order to induce the patient to seek medical advice. True, advocates of the early diagnosis have suggested that persons approaching the cancer age be examined at regular intervals. However, experience teaches that cancer patients are particularly indifferent in that respect and it is evident that coercive measures would be needed to put this suggestion into practice.

Justification for a pessimistic attitude towards the early diagnosis of gastro-intestinal cancer is found in Küttner's analysis of 1,300 cases of rectal carcinoma (Med. Klin. 25: 4, 1929). More than 60 per cent of the patients whom he found to be inoperable had not been examined rectally until operation was out of the question, although they had sought medical advice because of pronounced symptoms, much earlier.

Lubarsch's statistics (Med. Klin. 20: 299, 1924), based on the entire autopsy material of all the pathological institutes of Germany for 1920 and 1921, covers 86,216 cases, in 8,471 of which cancer was found. Analyzing this large material with regard to the differences between the clinical and anatomical diagnoses, it is found that 17.35 per cent of the carcinomata of internal organs had not been recognized and that in 15.99 per cent the location of the neoplasm had been incorrectly diagnosed. In 43.23 per cent of the internal sarcomata, a wrong diagnosis was made. Considering that these failures in diagnosis occurred in large hospitals and university clinics, and that some of the cases had reached an advanced stage, it is evident that in ambulatory practice the number of diagnostic errors must be much greater still and that an early diagnosis in the asymptomatic stage of gastro-intestinal cancer assumes an utopian aspect.

In contrast to the early diagnosis, which Boas looks upon as unrealizable in practice, he suggests a "tentative" diagnosis as more likely to yield results. By tentative diagnosis he means the recognition of certain symptoms which, without detailed examination of the patient, arouse a suspicion of the presence of cancer. When this suspicion is aroused, physicians not in a position to make use of modern diagnostic methods should immediately refer the patient to hospitals or specialists for further examination.

For the tentative diagnosis of gastro-intestinal carcinoma, the history is the first important point. It is usually typical. There is an abrupt onset of symptoms, the patient having been perfectly well. Regarding the sudden onset, a misunderstanding apparently exists. It does not imply that the patient has never before had
any gastric disturbances of any sort. Previous constipation or other temporary symptoms do not invalidate the assumption of a sudden onset. The point is that, just previous to the beginning of the present illness, the patient should have felt essentially well so far as concerns the stomach and intestines.

An unusually frequent occurrence of cancer in the family history may be significant; isolated cases are of no importance. The writer is skeptical toward an hereditary predisposition to cancer.

The second factor to be considered is age. Dyspeptic symptoms of any kind, combined with a cancer history in a person of cancer age, remain strongly suggestive of a malignant condition until its absence is proved. In carcinoma of the rectum such symptoms as tenesmus, hemorrhage, and the involuntary evacuation of small amounts of fecal matter, are so characteristic that they should immediately arouse suspicion. It seems necessary, however, to call the attention of inexperienced practitioners again and again to the tragic results of failure to differentiate between hemorrhoidal and neoplastic hemorrhage, and to impress upon them that rectal bleeding should never be definitely attributed to hemorrhoids, unless the patient clearly reports their extrusion or the physician brings them into view by means of a Bier suction cup. In patients of cancer age, previously free from intestinal symptoms, constipation or profuse diarrhea, or alternation of these conditions, should arouse suspicion of cancer of the colon.

Anorexia is worthy of mention in connection with gastric carcinoma, for when it occurs in an individual of cancer age, who has always had a good appetite, and develops to the stage of disgust for food, especially for meat, it is so significant of cancer of the stomach that functional tests and x-ray examination should be instituted at once.

In regard to the weight of the patient, the impression that cancer is always accompanied by loss of weight, and that constant weight or an increase speak against it, is still too prevalent. Weight is not a satisfactory diagnostic guide. Marked loss of weight and strength may be strongly suggestive of malignancy, but its absence should not dispel suspicion when other symptoms of cancer are manifest. Boas especially warns against the exclusion of cancer when the weight increases as a result of forced feeding. Frequently there is no loss of weight when the neoplasm is localized in the lower intestinal tract.
For those who have seen it, the facies of the carcinoma patient is so characteristic that it leads to the diagnosis forthwith. There are, however, numerous patients who continue to look perfectly well, although they have a cancer. Here again the localization is in the lower intestine and the characteristic facies does not appear until mechanical obstruction produces an acute decline in weight and strength.

Finally there is the characteristic voice. In the cachexia of cancer, this voice, broken and devoid of timbre, strength, and modulation, is frequently encountered. It is not specific for cancer, as it is found in other marantic conditions if it is looked for. Nevertheless, it is advisable for clinicians and physicians to pay more attention to this symptom.

Evaluation of the symptoms just described, will enable practitioners to arrive at a tentative diagnosis of cancer in many cases, even without an exhaustive examination. Accordingly it is suggested that physicians be trained to recognize these suspicious factors. This training is indicated especially for practitioners in localities where laboratories and roentgen apparatus are unavailable and for those who can not find time for detailed study of their cases. We can expect better results for the cancer patients of these practitioners only if they have at their command the simple methods, outlined above, to aid them in arriving at a tentative diagnosis, which in turn will induce them to refer patients to hospitals or specialists for detailed examination and treatment.