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Is Surgery Necessary?

Not many of my patients ask me “is my surgery necessary?”, since by the time surgery is contemplated/planned by me, a thorough evaluation has been done, alternatives have been discussed, and a benefit-to-risk assessment for that individual patient has transpired.

Just as with non-surgical forms of medical treatment, as well as diagnostic tests, it is not only permissible but also advisable for the patient to have a goal in mind. Is the goal psychological peace-of-mind from excluding major illness? Is it improvement in symptoms (“palliation”)? Is it cure from a potentially lethal disease or at least prolongation of life? Do you care to share “what your goals are” with the doctor?

Let’s use prostate surgery as an example. Surgery for benign prostate hypertrophy (BPH)—usually in the form of transurethral resection of the prostate (TURP)—should rarely be done for peace-of-mind as regards prostate cancer. We should know in advance that prostate cancer, if suspected, has been excluded by a biopsy. Alternatively, cancer may not need to be diagnosed, because given the man’s age and/or co-existing health conditions, the chance of an incidentally discovered prostate cancer (in the pathologist’s report on the resected tissues) having an adverse effect on health or longevity is low. BPH surgery is usually done to palliate chronic symptoms of poor bladder function due to an obstructed prostate. Most of my TURP patients have already been on and failed medication therapy and have a realistic understanding of what can and cannot be achieved. In some cases, TURP could be an intervention to cure a disease/prolong life, especially if the degree of prostatism is such that it has caused reversible renal failure.

The wise patient should not only ask “what will happen if I undergo this surgery?”, but also, “what will happen if I do not have this surgery?” The 2nd question probably speaks more than the 1st to the issue of necessity. In the example of the TURP above, failure to have the surgery will mean continuation or usually a slow

progression of the same bothersome symptoms. It would be statistically rare that taking a pass on such surgery would imperil kidney function or lead to catastrophic illness.

TURP surgery is quite safe, so that even a man in suboptimal health can be considered a candidate as an alternative, let's say, to living with bothersome symptoms or having an indwelling bladder tube. Sometimes, a TURP can improve non-urological health. For example, a man with cardiac disease could benefit from fewer trips to the bathroom at night/more sleep, secondarily more daytime energy, and decreased anxiety about urinary flow, frequency, and urgency.

One of my maxims to patients is "not everything that is abnormal in the body needs to be treated". The following is illustrative. Men with certain benign scrotal conditions such as hydrocele, spermatocele and varicocele may seek surgery. In the back (or forefront) of their minds, they may be thinking "this is cancer" but that issue can be dispensed of rather quickly, by physical exam and occasionally ultrasound. If the scrotal condition causes discomfort, there may be justification for surgery; but one would need to know that occasionally, scrotal surgery, even without complications, could increase discomfort. A varicocele in a teenager could cause fertility problems in the future, but since most men with varicoceles can impregnate their wives, is it really prudent to subject a youth who has not "proven" his infertility to an operation? Studies that try to predict which teenagers with varicocele will have fertility issues are not very definitive; and it's not clear that an operation done "years in advance" is more beneficial to sperm counts than if done once the fertility problem is certain. Most of these benign conditions will not "get worse" or lead to more serious problems.

In my earlier career, I would operate on anyone with a bladder tumor. My goal was to eradicate it; in some cases to stop gross bleeding; and to diagnose more malicious invasive bladder cancers that could metastasize/cause death, and which might need removal of the bladder (cystectomy) to cure. Now I am more willing to "watch" certain smaller bladder tumors that are not bleeding and which, by sight inspection, are clearly not invasive. Experience gives me the confidence to avoid surgery in these situations, since the patients are often older and may

experience more problems from being in the hospital or surgery center/undergoing a general anesthetic and an invasive procedure than they would from the tumor alone.

Another example with bladder cancer may be whether to perform a large surgery (cystectomy) on a patient who has muscle-invasive bladder cancer, where the best chance of cure is with an operation. Failure-to-cure in this situation will likely be lethal. Therefore, I may want to “lower my threshold” and convince a medically higher risk patient to have the 4-5 hour surgery, provided his Internist and Cardiologist feel he is likely to survive not only the surgery, but typical complications seen postoperatively. I would also want to discuss the main alternative to radical surgery, so-called bladder salvage (combined radiation and chemotherapy), which is really not as effective in curing the cancer and, when all is said and done, may be just as rough a ride, or more so, than major pelvic surgery.

In my experience, surgery is necessary if

1. The patient and the surgeon have realistic common goals which are likely achievable.
2. Permanent organ damage or death can best be avoided by an operation.
3. Alternatives to surgery have been tried or discussed. A man with bad prostatism does not necessarily have to have taken medications 1st before having a TURP.
4. The risks are understood by the patient and put into context by the surgeon. For example, if the risk of scrotal surgery causing a vascular injury to the testis (and atrophy) is stated without an incidence rate (let's say 1 in 5000), a man may be dissuaded from having a surgery he otherwise may want. More risks can and should be assumed when the condition being treated surgically is a threat to one's life.
5. The patient has discussed with his Internist (and subspecialists such as Cardiologist, if appropriate) whether he is in suitable shape to have surgery; and what adjustments may need to be made, e.g., with medications used to thin blood, treat hypertension or control diabetes.

6. Surgeon needs to tell patient the downside of not having surgery for the condition; and must avoid scaring someone into accepting an operation using unlikely scenarios as a basis.

One final thought about surgery. I always consider the psycho-social context of the patient considering surgery. Experience tells me that the anxious patient who has too many pre-operative concerns seem to be at higher risk for complications-- or at least the perception that surgery has not turned out well. In addition, patients who are older and live alone may not be confident of their ability to care for themselves after surgery. They may, in advance, ask for a few extra days in the hospital or transfer to a skilled nursing facility. They may resist discharge from the hospital postoperatively out of unrealistic fears. These situations are a yellow but not a red light to proceeding with an operation. Such patients may need further preoperative counseling and reassurance...but in some cases, cancellation of a non-life saving surgery is the better course of action.

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