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THINGS I WISH I HAD BEEN TAUGHT IN MEDICAL SCHOOL: A Family Doctor's Real-Life Education

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Ovarian cancer and faith

A sixty-seven year old woman came to my office for a first visit in the spring of 1985. For anonymity, I will call her Helen B. She had for some time been employed as a hairdresser. Shortly after her first visit she presented for a routine physical examination, during which I felt something vaguely abnormal in her vagina as if there were a mass present. Though she had previously had a total hysterectomy, it was as if part of her cervix had been left behind, or that she had formed an excessive amount of scar tissue. At this time her liver tests were abnormal, indicating compromised liver function; her tests also showed she was noticeably anemic.

Initial laboratory results:

Alkaline phosphatase: 181 U/L (normal 31-122); gamma GTP 61 U/L (normal less than 36);
 LDH 528 U/L: (normal 100-225); anemia: hemoglobin 10.4 gm/dl (normal 12.7-14.8) and hematocrit 30.5% (normal 37.5-45.4)

I referred Helen to a gynecologist, but she procrastinated, believing that her previous physician had described these same findings several years before. We lost time trying to get her previous medical records. Both of her previous doctors were retired and her records could not be located. I re-examined her six weeks later and the now-distinct mass was significantly larger.

At that time her liver functions were even worse. I viewed all these test results as ominous evidence for possible cancer and became very insistent that she follow advice. She agreed to an ultrasound and a liver scan and then a visit to a gynecologist "if the tests show something." She did *not* have the studies done, but did visit the gynecologist who found a "mobile mass" which he estimated as significantly larger at 4 ¾ inches x 6 inches. She then had an intravenous pyelogram (kidney x-ray), barium enema (bowel x-ray), liver scan and ultrasound. The liver scan was equivocal, and the kidney and bowel studies suggested an "extrinsic displacing mass" (read: cancer). Ultrasound confirmed a mass in the left pelvis consistent with ovarian origin.

From the gynecologist's letter to me: "I spoke to them ["Helen" and her husband] concerning the risks of this being a malignancy... Mrs. "B" is a very nice lady and appears to be strong willed. She is convinced that this is probably a benign process... She prefers to wait on the surgery until three weeks or so have passed because of her feeling of responsibility or commitment toward the new

owner's beauty salon she and her husband have just sold. I advised her the longer she delays the less likely she could be cured with surgery alone."

In about a month she came to operation, at which I assisted. Extensive cancer mass was present in the left and central pelvis, extensively involving the small and large bowel. In the face of a lack of a bowel preparation, definitive surgery was postponed. Widespread 1/8" to 3/8" sized masses were studded throughout the pelvic and abdominal cavities, exceeding one-hundred in number. Five of them were biopsied.

The surgeon's postoperative diagnosis was: "Large pelvic mass and possible ovarian carcinoma with tumor encroachment on small bowel in terminal ileum involving distal 2 to 2 1/2 feet as well as tumor involvement of serosal [outside] surface of descending colon; peritoneal studding of the surface of small bowel and peritoneal studding of pelvis." The pathology report of the biopsies revealed: "Malignant tumor with moderate variation in cell size and shape. The cells contain irregular nuclei and abundant eosinophilic cytoplasm. The tumor appears as a poorly differentiated carcinoma [cancer], possibly of ovarian origin." In everyday language: the ovarian cancer had invaded the large and small bowel, and had spread tiny cancers all the way up to the liver.

After a five-day bowel preparation [cleansing], definitive removal of the tumor was undertaken by a general surgeon. A large pelvic mass 8 3/4 in. x 7 in. x 3 in. was removed as one specimen. This included a 39-inch length of small bowel in at least two sections. An 11-inch length of large bowel was part of the resected specimen. The omentum [the mobile, folded extension of the lining of the abdominal cavity] was largely removed in a separate specimen. Clot and grossly bloody peritoneal fluid did not reveal malignant cells.

The pathologist's final diagnosis was: "Large mass, terminal ileum and sigmoid colon: poorly differentiated carcinoma, of probable ovarian origin." She was left with a terminal colostomy (her large bowel emptying into a bag attached to her abdomen) and a remaining rectal colon segment, with obvious significant amounts of gross tumor remaining behind.

The surgeon's summary letter to me indicated: "I recommended oncological [cancer specialist] consultation and commencement of chemotherapy. The colostomy does not need to be considered permanent and after the first course of chemotherapy, probably within six months, we should re-explore her, and at that time, we could close the colostomy."

After recovery from surgery, this "nice lady" returned to my office, protesting her referral to an oncologist, and to my astonishment, said quietly to me "*I want you to tell me what I have to do to get well.*" I reinforced the necessity for a visit to the oncologist, knowing full well that she would refuse any treatment. I felt very uneasy about my relations with my colleagues if she did not complete that visit.

Nonetheless, I outlined a program, including:

- Regular meditation incorporating imagery of: tumor shrinkage and disappearance of the remaining cancer; a hyperactive immune system with scavenger cells destroying cancer cells; and picturing and feeling herself totally well and recovered. In her presence, I made an audiotape for her beginning with a standard relaxation routine followed by the imagery.
- A low-fat, low-sugar, high fiber diet with ample fruits and vegetables; elimination of meat from her diet and intake of all grains in whole unrefined form.
- Supplementation with a minimum of beta carotene 100,000 IU/day; a gradual increase in vitamin C to 12,000 mg/day; and a megadose vitamin which included vitamin E 600 IU/day, selenium 200 mcg/day, calcium, magnesium, manganese, zinc, and B complex with approximately 100 mg/day of each B vitamin.

- Modifying her attitude toward her husband whom she perceived as critical and controlling, including forgiveness (canceling her demands on him).
- Regular aerobic physical exercise (swimming was the only feasible possibility, and was postponed until definitive reduction of the colostomy).

On my stern insistence, she relented and did obtain an oncological consultation. From the oncologist's note to me: "...Some of this tumor certainly remains in her pelvis postoperatively. Mrs. "B", however, is convinced that she has no residual cancer that requires treatment, or that any residual she does have will be cured by her own body with God's help. She puts great weight on your opinion and said she would discuss any treatment with you. I made it clear to her that I was quite concerned that she has residual cancer and that as such, the time to treat would be now rather than later when the tumor is bulkier and our chances for a good outcome are much less. Her treatment clearly would not be without side effects and she's aware of that, and this, too, makes her reluctant to undergo any therapy now when she's feeling better from the surgery. Nevertheless, I did recommend chemotherapy now rather than later. She's refused for the moment, but is going to discuss this with you. In the meantime I'm going to get abdominal CT scan and tumor marker studies to see if there is any gross residual disease elsewhere."

In the meantime her blood picture and chemistries improved. Within a month after the colostomy surgery she was no longer anemic with a hematocrit at 40 percent; and all her previously abnormal liver function chemistries were normal.

<p>Second set of lab values: alkaline phosphatase 339 U/L (normal 31-122); gamma GTP 111 U/L (normal less than 36); and LDH 957 U/L (normal 100-225).</p>
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She began to look stronger and exuded confidence that she and God were winning the battle. Her belief in the divine was evangelistic and I reinforced her hope with every encouragement.

The surgeon was quite unwilling to undertake reduction of the colostomy until she had undergone chemotherapy for residual disease. She hated the colostomy and pestered the surgeon so persistently and aggressively that he finally relented and two and one-half months after her definitive resection, she went to surgery for a third time to have a bowel re-anastomosis (connecting the two parts of the bowel back together).

The surgeon reported, "The surgery was long and tedious. The adhesions encountered merely entering the peritoneal cavity were among the worst I had ever seen, and several near-perforations of small bowel occurred in delineating various structures. The hundreds of 3-9 mm. peritoneal tumors appeared as before. Seven of them from various abdominal and pelvic locations were biopsied. With considerable difficulty, the colostomy was taken down and an anastomosis (bowel reconnection) to the rectal segment accomplished."

She recovered well from this surgery. Three days later the pathology report on the biopsies of the tumors appeared in the chart and described: "Inflammatory tissue with moderate cell variation." *There were no malignant characteristics in the biopsied tissue.* The surgeon's only comment about the report in his Austrian accent was, "Vell, she is a varry interesting lady."

Helen continued to progress, recovering rapidly from this third surgery, and delighting in her return to normal bowel function and her positive laboratory reports. "I knew they would be OK," she said. She returned to hairdressing and continued to be gainfully employed and delighted in regular attendance at the opera. She made a trip to Europe to revel in the best opera offered on the continent including Milan, Italy. She read Dr. Bernie Siegel's "Love, Medicine and Miracles" and participated in the audience at a television appearance in Seattle with Dr. Siegel. She had

persuaded her husband to build an outdoor Japanese garden in which she continued her daily regular meditations. The marital situation with her husband gradually deteriorated and she was divorced about two years after her third surgical procedure. My sense was that this relieved a considerable stress in her life.

In 1987, approximately three years following her first visit with me, she developed an abdominal incisional hernia at the site of the previous surgical operations. It became problematic and she underwent surgery for yet a fourth time to repair this large abdominal hernia. At the time of operation, the surgeon, with my assistance, took advantage of the opportunity to briefly re-explore her abdomen. The adhesions were totally gone; *there were no residual peritoneal tumors, and no evidence of cancer anywhere.*

Following this re-exploration I attempted to get Helen's case scheduled for my hospital's monthly Tumor Board review. I thought her recovery was a significant phenomenon that would interest many of our local physicians. The oncologist chairman, however, on finding that she had not had any definitive conventional treatment beyond surgery, refused to schedule a discussion of her case, saying, "If she didn't have any additional treatment, we couldn't learn anything from her case."

In the ensuing five years of her life, she exhibited no evidence of any recurrence of the ovarian cancer. She died at age 75 of totally unrelated causes (complications of an osteoporotic fracture), almost eight years after her original encounter with cancer.

Did she demonstrate spontaneous regression of cancer? Or did her immune system respond to the images, the change in attitude, the nutritional initiatives, the hope? I cannot prove that what she did and how she changed made any difference, but I believe that it did. She taught me a profound lesson in her recovery from metastatic cancer with no treatment beyond surgery.

Observations

The number of persons who recover from cancer unexpectedly and against rational prognostic predictions is probably much larger than we realize. In 1993, the Institute of Noetic Sciences published a compendium of over 3,000 documented cases of "spontaneous remission," a majority of which involved recovery from cancer. Caryle Hirshberg and the late Brendan O'Regan scoured decades of medical literature to find these published reports of unexpected recovery from cancer and other diseases. [Such reports of remissions from serious illnesses are not very common.] From thousands of claims of cures from pilgrims to Lourdes, France, the Roman Catholic Church has authenticated and validated only about sixty proven cases for which there is unequivocal medical evidence for cure.

These validated reports are probably the tip of the iceberg. It is very difficult in the conventional medical world to persuade editors of medical journals to publish documented, proven cases of spontaneous recovery from cancer.

The key elements in these healings are difficult to discern and often unknown, making it very problematic to extrapolate what should be imparted to cancer patients to enhance their healing. It may be sufficient for cancer patients to know about these valid healings to be able to inject the benefit of hope into their own program for treatment of their disease. We will learn more and more in the decades to come about how these healings occur.

The profound effect of stress in malignant disease

Kenneth was forty-one. I had been the family doctor for his wife, a registered nurse, and their three girls in their growing-up years. I had seen Kenneth infrequently, however, and never for anything major. He had never been one to be interested in a comprehensive health evaluation, and indeed it seemed to take considerable urging by his insistent partner to be seen for anything. When I did see him, he seemed introverted, never talked much and seemed to have a mildly flattened emotional expression, as if depression might be lurking beneath the surface.

He presented at his appointment with an ugly-looking skin tumor about 7/16 inches in diameter on the right upper chest above the nipple. He had noticed it about a month before and thought that it had grown. It was slightly raised, and faintly reddish-purple. Because of its ominous appearance as a malignant melanoma, I took the time at that appointment to surgically remove it with a generous margin.

While I injected the local anesthetic and performed the excision, Kenneth talked about what was going on in his life. He related that he had lost his job about 15 months before when his employer was taken over by another company. As I worked on the tumor, he described his loss of self-esteem, feelings of shame and worthlessness as his family went through a financial crisis, becoming totally dependent on his wife's income. They had spent their way through their savings. Self-loathing mounted as he had failed time and again to land another job, with high anxiety over the possibility of having to take a significant cut in pay to work at all.

The pathology report in three days confirmed that the tumor was a Clark's Level Three Malignant Melanoma, possessing aggressive characteristics. His wound healed well and there was no evidence that the tumor had spread into the regional lymph glands in the armpit or elsewhere. As I removed his sutures ten days later, he looked totally different and was quite upbeat. He had found a job in the interval and was scheduled to start work the following Monday. I did suggest that he consult an oncologist, and later confirmed that he had declined in spite of his wife's urgings.

Kenneth, however, remained well and over the years showed no signs of recurrence. I rarely saw him, but on numerous occasions inquired of his status on seeing the members of his family.

Nearly ten years later, to my surprise, he suddenly presented with two hard lymph nodes in the right armpit. On biopsy they proved to be a recurrence of his malignant melanoma. I learned that about fifteen months before he had lost the job which he had landed at the time of the original surgery, and again had become morose, withdrawn, defeated, depressed and exhibited profound loss of self-esteem. He had discovered the lumps four months before and had done nothing about it. He refused any treatment of any kind, and died quickly about four months later.

I was prompted to ask myself, "What was the melanoma doing for nearly ten years?" Rationally, I had to assume that there must have been residual tumor in the tissues since the original surgery. I could only conjecture that his immune system had held the tumor at bay for over nine years while he was earning a living and felt happier and relatively good about himself. With the onset of job loss, hopelessness and helplessness again set in, causing his immune defenses to be compromised by the negative effects of the stress of being unemployed.

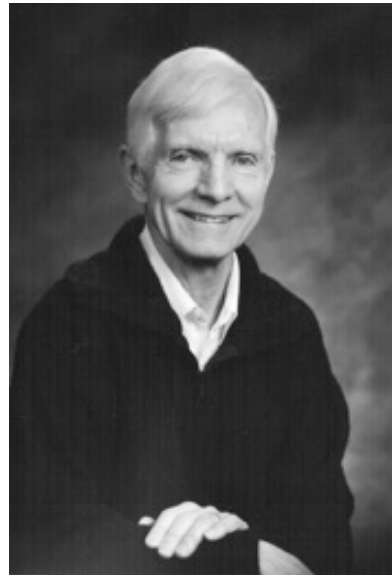
Kenneth's experience highlighted the relation of stress and depression to the onset of disease including cancer and cancer recurrence. It prompted me to pay much greater attention to the presence of stress in the lives of my patients, to acknowledge it, and take steps to neutralize its detrimental effects.

Observations:

The predominant opinion in medical cancer literature holds that stress is an unproven factor in cancer or its recurrence, or, at least that the influence is very minor. This may yet be true. Kenneth's story indicates that, at least in some instances, the influence of stress is major. Perhaps the best confirmation comes from the notable increase in several life-threatening diseases in surviving widows and widowers in the 18-month window of time following the death of a spouse.

The timing of Kenneth's stressful job losses to the original appearance and later the recurrence of his Malignant Melanoma seems too obvious to ignore. The lesson may be for all of us to be self-analytical enough to be aware of the impact of stress in our lives and take the steps to neutralize its effects. The medical evidence now clearly demonstrates that most persons can, with or without professional help, greatly limit the toxic effects of stress.

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