

ROLE OF SURGERY IN THE TREATMENT OF HODGKIN'S DISEASE

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Radical lymph node dissection was at one time rather widely advocated for Hodgkin's disease involving a single chain of lymph nodes. However, in most series in which good results of such surgical treatment have been reported, postoperative X-ray therapy has also been given, and it seems unwarranted to attribute the good results to the surgical procedure *per se*. The lymph node dissections are cosmetically disfiguring, and in the axilla or inguinal regions may be followed by severe edema and even functional impairment of the extremity. Now that modern megavoltage radiotherapy apparatus has become widely available, the argument for radical surgical dissection of locally involved nodes no longer seems tenable. With doses in the range of 4,000 rads delivered in approximately four weeks, megavoltage radiotherapy can eradicate Hodgkin's disease in entire chains of lymph nodes with a recurrence rate of only 2 to 5 per cent, and with far superior cosmetic results. I can therefore

see no justification for the continued use of radical lymph node dissection in Hodgkin's disease.

However, the surgeon still has a useful role to play in the management of this condition. We have observed a number of patients with a palpably or radiographically enlarged spleen, an equivocal lymphangiogram with some paraaortic nodes highly suggestive but not entirely diagnostic of lymphomatous involvement, and questionable liver function tests. In such instances, we have found it extremely useful to proceed with splenectomy, biopsy of the questionable paraaortic nodes, and open liver biopsy. Moreover, splenectomy has been useful in a number of patients with hemolytic anemia and thrombocytopenia due to hypersplenism. After splenectomy, such patients have again exhibited normal white blood cell and platelet counts, and those who had been on chemotherapy have been able to resume treatment safely, with significant prolongation and useful life span in many instances.

* Resumo das apresentações.

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Surgery as the definitive therapy of Stage I Hodgkin's disease has no advantage over aggressive radiotherapy directed to the involved lymph nodes and to adjacent areas.

The most frequent indication for surgery in the management of Hodgkin's disease is biopsy for diagnosis. Usually, a superficial lymph node is biopsied. The surgeon should choose a large node, preferably one **not** located in the inguinal area. A portion of the lymph node may be sent to the laboratory to search for tuberculosis, toxoplasmosis or other organisms. When lymph nodes are not readily accessible for biopsy, consideration is given to thoracotomy or laparotomy. Occasionally, the diagnosis is made following laminectomy or splenectomy.

In the course of Hodgkin's disease, certain complications arise which may lead to surgical intervention. Laminectomy should be done in those patients with chord compression whose symptoms are of recent origin and progressing rapidly, and whose lesion can be localized. Laminectomy is indicated particularly in the presence of vertebral bone destruction. Relief of obstruction or hemorrhage secondary to gastrointestinal Hodgkin's disease may require surgical intervention. More rarely, obstructive uropathy may require temporary

nephrostomy. Following surgical intervention in these complications, radiotherapy is usually indicated. Splenectomy may be performed, at times, in patients with hypersplenism. The very high operative mortality, together with the short survival periods of those patients surviving operation, lead Grace and Mittelman to conclude that splenectomy in this group of patients has a very limited indication. Selection of patients with clinical problems **largely** due to hypersplenism is essential. Red cell survival and sequestration studies are very useful in selecting candidates. The improvement following splenectomy may be striking, as evidenced by red cell survival studies changing from T/2 11.2 days pre-splenectomy to T/2 27 days post-splenectomy. A rise of hemoglobin values of 4 to 6 gram % occurred in 6 of 13 cases. Granulocytes and platelets increased substantially in 6 and 8 cases, respectively, of 13 patients studied.

For control of intractable pain, neurosurgical intervention — including alcohol blocks, chordotomy and other procedures — may at times be indicated.

Grace and Mittelman have summarized recently the role of surgery in the over-all management of Hodgkin's disease, noting that it is limited to excision for diagnostic purposes and to the management of unrelated problems which might require surgical intervention.