It has been said that medicine is an unusual industry in that its goal is to make itself obsolete. That may be the case in some circumstances, but I would say that it not likely to happen any time soon. In some areas of medicine, we may be closer to reducing the need for our services, while in other areas we are certainly generating increased demand for services. Also, given that health care as economic entity writ large represents approximately one-fifth of the US gross domestic product, there are substantial forces at play that must assure that any downward pressure on the need for medical care will be incremental at best.

Acknowledging the above, there is every reason to believe that even if the overall demand for medical care doesn’t change dramatically, the ways by which medical care is delivered will be much more amenable to shifts. Perhaps in no aspect of health care is this “internal shifting” more likely to happen than in the general field of oncology.

For much of recorded history, our options to treat cancer were fairly confined to extirpation. We have only had a basic accurate understanding of DNA for less than 80 years, and the improvements on understanding of cellular function, cell-cycle control, and neoplastic biology we have today are largely a function of knowledge gained over the last quarter century.

The use of knives and string (plus videoscopes and robots) to manage cancer has advanced over the last 50 years but at paces that are far outmatched by nonoperative means over the same timeframe. We have moved far past limited cytotoxic chemotherapy to biomodulation and have made some inroads into gene-manipulation for many neoplastic conditions—but not all. Advances in local control with radiation and other local therapies have been substantial as well. The days of operative management being the main focus of attention with all other therapeutic modalities in minor support roles are pretty well behind us now.

Some basic tenets of oncologic care from the early days remain true and likely will for some time. One still needs to be able to correctly diagnose neoplasms, stage...
neoplastic disease, and develop an accurate understanding and prediction of future clinical course to know how to treat the patient. How we evaluate the patient with known or potential cancer has and will continue to evolve and, it is hoped, improve.

A respected mentor to me and many, many others, Dr Blake Cady, once stated in his presidential address to the Society for Surgical Oncology that, as regards cancer, “Biology is king, patient selection is queen, and all the techniques are the princes and princesses of the realm.” The use of monarchy and gender-related terms put aside, the general concept is every bit as true today as when he first said it. Our goal must always be to understand the biology of the process we are faced with. That coupled with an understanding of which tools to use and how to combine them is how we will achieve maximum therapeutic effect with minimum harm.

This issue of the Surgical Clinics on Sarcoma developed by Dr Kane and his colleagues delves into a particularly challenging area of oncologic care. The biology of soft tissue tumors is complex. The anatomic distribution of these tumors frequently puts them in places where local control either by operative means or by other means of directed therapy is constrained by technical limitations and critical adjacent structures. Furthermore, the skill sets required—particularly operative skills—are not easily “cross-trained” for with other operative concerns. If one has performed a high volume of small bowel anastomoses, it should not be too hard to perform a colonic anastomosis. Even if one has done thousands of bowel resections, that may not train one too well to rummage about the retroperitoneum or near the critical neurovascular structures in an extremity.

The collection of articles in this issue should give the reader a sound foundation for the principles of diagnosing, assessing, and treatment options for soft tissue tumors. I think the reader will not only find useful information for the treatment of patients with these problems but also get excellent advice about how to avoid missteps along the way, most importantly, in the early portion of the process when small mistakes can have large long-term consequences.

The principle of “First, do no harm” is well ingrained in us as physicians—it is also wrong, or at least misleading. More accurately, we must strive for no net harm. More often than not, when we do something for someone, we also do something to someone. The mere act of operating upon a patient inflicts some harm for which the benefit must justify the action. Failure to do things for people can be as harmful or worse as well.

Neither nihilism nor zealotry is warranted in the care of patients—especially patients who suffer from cancer. We cannot, or at least should not, hate disease more than we love patients. Our ability to distinguish the correct path is to carefully remember what Dr Cady tried to teach us. We must understand the biology of the disease in question. We must select our patients carefully, fully applying the patients’ desires in that selection (in my opinion). Last, we must understand the techniques and treatment options in
general but also in our own hands. Being honest with our patients and with ourselves is the only way to serve properly those who count on us.

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