If the supply is limited, sample copies of pamphlets may be displayed and the patient instructed where he may obtain his own copy. There is evident benefit in stimulating the patient's interest in modifying his habits when this motivation can be immediately reinforced by conversing with his own physician.

Dr. J. Willis Hurst, Professor and Chairman, Department of Medicine, Emory University School of Medicine, has recently authored a superb book entitled *Four Hats* (Chicago, Yearbook Medical Publishers, Inc., 1970, used by permission). One of the essays in this volume dramatizes the importance of teaching machines in these environments. This essay, "The Waiting Room as an Educational Center," states:

"Members of the public—now called consumers of health services—deserve the best efforts of the medical profession. The education of the consumer should be a major concern of the profession because it will not be possible to deliver health services to an uninformed public. The consumer must be taught the value of preventive medicine. The consumer must also be taught the harm of excessive medicine. The consumer must learn that it is possible to underdo and also to overdo health services.

Someday there will be a health education system to assist in the execution of the concept mentioned above. What can we do while waiting for such a system to emerge? Where and how can the consumers have an opportunity to learn about health? There are many places where and many methods by which such is possible, but there is one neglected place in which one neglected method should be used. The place is the boring waiting room. The waiting room of every hospital and every doctor's office throughout the nation should be utilized as an educational center. This is where prevention of heart disease, the danger signals of cancer and the abuse of drugs should be taught. The method entails the proper use of teaching machines, thus sparing the time of teachers.

To dream of what might be achieved in such an educational center staggers the imagination."

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**Aggressive Therapy for Hodgkin's Disease**

It has been said that determinate survival of some neoplasms, such as breast cancer, has stood unchanged throughout the 20th century. Park and Lees, "those deft but dour wizards of biometry," have sought to prove that ultimate survival in breast cancer is uninfluenced by treatment. One need not go this far to be concerned with our inability to cope with cancer.

The traditional attitude toward Hodgkin's disease has been one of pessimism because of the low survival and youthfulness of many victims. Recent years have seen a significant change in reported results and consequently in physicians' attitudes. At least two factors have produced this change. First is a reappraisal of gross and histologic patterns of the disease. This culminated in the staging plan suggested at a symposium held in Rye, New York, in 1965. Staging has given the therapist a solid base from which to work. The second major change is concerned with radiotherapy. The fact that the massive adenopathy of Hodgkin's disease melted away with small doses of low kilovoltage treatment (often used as a diagnostic measure—the "test of therapy") understandably misled therapists into suboptimal treatment patterns. Improved knowledge of clinical variations has led to greater confidence in the use of larger doses of megavolt irradiation. Currently this consists of 3,500 to 4,000 rads of wide field megavolt therapy over a three-week to six-week period. This has been espoused with great force and clarity by Kaplan and by others. Kaplan has found that 50 percent of patients with previously untreated disease classified as stage 1 have survived five years. The actuarial likelihood of recurrence after this time is considered to be under 5 percent.

It was inevitable that this changing philosophy would attract the attention of surgeons. The persistent notion that mediastinal Hodgkin's disease is relatively favorable has been shown to have some truth. In Lukes World War II series, 59 percent of patients with intrathoracic disease had nodular sclerosis—a less anaplastic histologic variety. Burke et al reported a similar incidence in resected specimens. These authors are responsible for current interest in surgical treatment of this disease, although a kindred philosophy has been championed by Slaughter for many years.

In this issue of *CHEST* we find evidence that surgery, like radiotherapy, is being extended in Hodgkin's disease (page 446). This involves bilateral thoracotomy performed a few weeks apart for stage 2 cases. We have occasionally accomplished excision in bilateral hilar disease using median sternotomy, thus obviating a second major procedure. We have been deterred from radical surgery in patients with systemic symptoms, since this has appeared to us and to others to be an unfavorable omen. The
result reported by Levinsky and associates from Tel Aviv constitutes a courageous advance of an accepted technique, although the follow-up is short, and the basis is but one case. This report may serve to remind us of the significant changes in classification, in prognosis, and in therapy that have recently occurred.

It seems fitting to close these comments with reference to the critical importance of painstaking accuracy and staging and histologic assessment. In addition to hematologic study, gastrointestinal and urologic roentgenograms are required. Lymphangiography is mandatory. The addition of laparotomy has been advocated because of a 15 percent error in lymphangiography and to accomplish splenectomy. This in turn is performed for two reasons. One is the presence of minute lesions in many normal-sized spleens; the other is to allow the therapist to spare the left upper quadrant, especially the left kidney, if abdominal radiotherapy becomes necessary.

It is likely that even the severe scrutiny of Park and Lees would find some basis for optimism in current trends in Hodgkin’s disease. Much remains to be learned and done, but the direction being taken seems right.

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REFERENCES


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Bronchogenic Carcinoma, A Largely Preventable Lesion Assuming Epidemic Proportions

Bronchogenic carcinoma, which was an extremely rare disease until the mid 1930’s, is increasing faster than any other cancer in civilized countries. In 1919, its incidence was so rare that when I was a junior medical student in Washington University, the two senior classes were asked to witness the autopsy of a man having died of carcinoma of the lung because Dr. George Dock, Professor of Medicine, thought we might never see another such case as long as we lived. Being young and impressionable, this impressed me very much. It was not until 1936, 17 years later, that I saw my next case of bronchogenic cancer, and in a period of six months I saw nine cases. Having been impressed with the rarity of the condition in 1919, this seemed indeed an epidemic. Because all the patients were men, heavy smokers, and had begun smoking at the beginning of the first World War, and after determining that the consumption of cigarettes was relatively low in the United States until the first World War, when there was a tremendous increase, I had the temerity to predict that cigarette smoking was responsible for the increased incidence.

In Great Britain from 1916 to 1959, bronchogenic carcinoma increased in men 45 to 64 years of age from approximately 10 to 120 per 100,000 population, during which time the rate from all other types of cancer decreased from 280 to 125 per 100,000 population. (Smoking and Health, a report of the Royal College of Physicians, Pitman, London, 1962). According to Fletcher and Horn, consultants to the World Health Organization, there is a quantitative relationship between lung cancer mortality and cigarette smoking. “More than 30 retrospective studies in ten countries and seven prospective studies in Canada, the United Kingdom, and the United States of America, have shown that the risk of lung cancer increases directly in relation to the number of cigarettes smoked. In heavy smokers it is 15 to 30 times as great as that of non-smokers.”

An interesting study comparing the autopsy incidences of bronchogenic carcinoma in the Presbyterian Hospital in New York and the University Hospital in Iceland shows comparable increases in incidence in the two institutions with a 20-year lag between. The increase began in the Presbyterian Hospital group in the 1930’s, whereas in the University Hospital in Iceland, it began in the 1950’s. In the United States, cigarettes were smoked infrequently until the beginning of the first World War; the Icelander did not smoke until the second World War when we had bases in Iceland and American-made cigarettes became available to the Icelander. Rakower found in Israel that only one non-smoker in every 3,300 men age 55 years or older died from lung cancer. Whereas one in every 40 chain smokers dies from the disease, the chance of dying from