

## Common myths in surgery

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● According to the *Webster's New International Dictionary*, a myth is "A belief given uncritical acceptance by the members of a group especially in support of existing or traditional practices." Traditionally, the surgical profession is known to represent a group that tends to adhere, with its nails, to myths. As aptly stated by the great American surgeon William Stewart Halsted (1852–1922): "It is now as it was then and as it may ever be; conceptions from the past blind us to facts which almost slap us in the face."<sup>\*(p61)</sup>

Toward the end of the 19th century, the leading Philadelphia surgeon J. Chalmers Da Costa (1863–1933) described a classic myth-loving surgeon: "He follows customs even when it is unreasonable or actually absurd. His headlight, like the glow of the glowworm, is on the wrong end. He progresses but in a circle, like the hands of a clock. He is not the active man behind the gun, but the slow and often dull man behind the times. His ideas are from a reservoir and not from the spring."<sup>\*(p62)</sup> Are surgeons less addicted to myths as we enter the 21st century? Obviously not. Any surgeon who chooses not to spend his entire professional career in one town, one academic institution, or one hospital—thus succumbing to local myths, such as "The Mayo way is the only way..."—knows how whispered is the adherence to

surgical myths. Anyone who travels across the international surgical world is exposed to outdated practices entrenched within old local myths. Be it the developed or developing world, in outlying hospitals or ivory towers—the scenario is identical: a shrug of the shoulder followed by a remark in whatever local language or dialect: "Oh, this is how we do it."

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According to David Dent, MD, of Cape Town (personal communication), the paradigm in surgical myths has recently shifted from vehemence-based and eminence-based medicine, to evidence-based medicine. When you tell a surgeon today that his or her practice is based on myth, he or she would reply instantly: "What is your evidence?" In other words, they want you to provide a high level of scientific evidence to prove that their myth-based

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—William Stewart Halsted

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practice, that is, practice based on no scientific evidence whatsoever, is a myth.

The Table shows a list of common surgical myths. The list, which is based on

personal observations during my surgical career in four continents and extensive medical travels, is not pretended to be all-inclusive and does not list the myths in a

Common myths in surgery	
1. The duration of an operation does not matter.	23. A two-layered intestinal anastomosis is safer than a single-layered anastomosis.
2. Surgery can palliate asymptomatic patients.	24. Interrupted rather than continuous suture technique results in a better intestinal anastomosis.
3. Elective surgical procedures improve the overall life span and quality of life of the world population.	25. Routine use of nasogastric decompression after laparotomy is beneficial.
4. Patients do not die after minor surgery.	26. The nasogastric tube protects the downstream anastomosis.
5. Operations performed by an assisted resident are as good as those performed by the attending (consultant) surgeon.	27. Feeding the postoperative patient should be accomplished gradually.
6. In general, radical operations for cancer are better.	28. Leaving peritoneal drains in place after operations for local or diffuse peritonitis is beneficial.
7. Debulking of advanced tumors improves survival and quality of life.	29. Irrigating the peritoneal cavity after any type of operation is beneficial.
8. It is always necessary to find the primary site.	30. One should remove all visible peels of fibrin during operations for peritonitis.
9. There are cancer patients whom your oncologist would refuse to treat with chemotherapy.	31. Postoperative fever is an ominous sign that should be treated.
10. Axillary dissection in breast cancer patients is therapeutic.	32. Antibiotics should be continued after operations for peritonitis as long as the patient is febrile or his white cell count is elevated.
11. Pancreaticoduodenectomies (Whipple's procedures) improve the overall outcome in patients with pancreatic cancer.	33. The stronger and more modern the antibiotic agent, the better.
12. Simple adhesions cause pain; adhesiolysis alleviates pain.	34. Peritoneal cultures obtained during operations for secondary peritonitis are useful in selecting the appropriate antimicrobial agents, thus affecting outcome.
13. Incisions heal from side to side—not from end to end—thus length does not matter.	35. All grossly contaminated wounds should be left open for delayed secondary closure.
14. The bigger the incision, the greater the surgeon.	36. Hyperbaric treatment will help this condition (gangrene, necrotizing fasciitis, flap necrosis, chronically nonhealing wounds, etc).
15. Midline incisions are the best.	37. Modern, high-tech, expensive wound care is better than soap and water.
16. Layered abdominal closure is better.	38. It is unsafe to perform colonic anastomosis in unprepared bowel or obstructed bowel.
17. Subcutaneous sutures improve wound healing.	39. Preoperative bowel preparation decreases the morbidity of colorectal surgery.
18. Subcutaneous wound drains prevent wound infections.	
19. Wound dressings should be routinely changed and under sterile conditions.	
20. Retention sutures should be used in high-risk abdominal closures.	
21. Postoperative dehiscence of the abdominal wound always indicates reoperative closure.	
22. Stapled anastomoses are better than hand-sutured anastomoses.	

**Table**

*(Continued on next page)*

Common myths in surgery (continued)

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| <p>40. Administration of oral antibiotics before colonic surgery is better than systemic prophylactic antibiotics alone.</p> <p>41. It is impossible to safely repair late esophageal perforations.</p> <p>42. After partial gastrectomy, Billroth II anastomosis is as good as Billroth I.</p> <p>43. Partial gastrectomy is the best operation for bleeding gastric (and duodenal) ulcer.</p> <p>44. Suture ligation of the bleeding ulcer is an unsatisfactory management for upper gastrointestinal bleeding.</p> <p>45. Omentopexy of perforated peptic ulcer entails suturing of an omental flap on top of the closure of the perforation.</p> <p>46. Delay in diagnosis is a common cause of perforated appendicitis; early surgery prevents perforations.</p> <p>47. Diagnostic laparoscopy decreases the incidence of negative appendectomies.</p> <p>48. Diagnostic laparoscopy for nonspecific, obscure abdominal pain has more than a placebo effect.</p> <p>49. The stump of the appendix should be cauterized or disinfected and then buried within a purse string suture.</p> <p>50. Acute appendicitis is always a surgical disease.</p> <p>51. An elective interval appendectomy is indicated 6 weeks after successful conservative management of an appendiceal mass.</p> <p>52. All gallstones deserve operative treatment.</p> <p>53. Laparoscopic cholecystectomy is safer than open cholecystectomy.</p> <p>54. Cholecystectomy will cure dyspepsia and nonspecific abdominal discomfort.</p> <p>55. The T-tube has to be inserted after common bile duct exploration.</p> <p>56. Partial or subtotal cholecystectomy is an operation for frightened surgeons or weaklings.</p> <p>57. Recurrent diverticulitis indicates sigmoidectomy.</p> <p>58. Arterial blood gases (pH) and serum lactate levels are accurate in the diagnosis of ischemic bowel.</p> <p>59. Early arteriography improves outcome in mesenteric ischemia.</p> | <p>60. Localization studies (radioisotope and arteriography) improve outcome in lower gastrointestinal bleeding.</p> <p>61. All inguinal hernias should be repaired.</p> <p>62. Bassini's repair is an adequate operation for inguinal hernia.</p> <p>63. Hernias are the most common cause of groin pain.</p> <p>64. Groin pain after inguinal hernia repair is not due to the surgery.</p> <p>65. All incisional-ventral hernias deserve to be repaired.</p> <p>66. Mesh is usually not required in the repair of incisional hernias.</p> <p>67. Uncomplicated hemorrhoids represent a disease—not merely physiological anal cushions—and thus should be treated.</p> <p>68. Radical excision down to the sacral fascia is the optimal treatment for pilonidal disease.</p> <p>69. For optimal outcome, surgical intensive care units should be staffed only with surgeons.</p> <p>70. Pulmonary arterial catheters (Swan Ganz) improve results in critically ill surgical patients.</p> <p>71. One should keep the hemoglobin above 10 gr% in critically ill patients.</p> <p>72. Early postoperative total parenteral nutrition improves outcome.</p> <p>73. The pneumatic anti-deep vein thrombosis device is properly applied and used during the postoperative period.</p> <p>74. Postoperative myocardial infarction is an unavoidable complication.</p> <p>75. Low-dose dopamine protects the kidneys in oliguric patients.</p> <p>76. Adequate back bleeding implies that the runoff is patent.</p> <p>77. A good pulse at the atrioventricular fistula implies good function.</p> <p>78. Leaving the abdomen open after operations for ruptured abdominal aortic aneurysms is dangerous because of the risk of graft infection.</p> <p>79. Bleeding patients benefit from rapid infusion of intravenous fluids to normalize the blood pressure.</p> <p>80. Surgical patients should be well hydrated and pass at least 1 cc/kg/hr urine.</p> |
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Table

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#### Common myths in surgery (continued)

81. All penetrating abdominal wounds that violate the peritoneal cavity indicate abdominal exploration.
82. All penetrating neck wounds that violate the platysma indicate neck exploration.
83. State-controlled medicine is the worst.
84. The better insured you are, the better care you will receive.
85. Academic surgeons cannot operate.
86. Religious surgeons care more for their patients.
87. Published evidence is equally relevant to all of us.
88. What is not published in English is usually s\*\*\*.
89. All senile patients must die with a gastrostomy and/or tracheotomy tube in situ.
90. Placebo-controlled trials in surgery (operation versus nonoperation) are impossible.
91. Emergency department physicians understand “acute abdomen.”
92. Most surgical procedures performed are indicated and necessary.

#### The claims:

93. When we closed, it was dry.
94. The patients bled after the operation because of disseminated intravascular coagulation.
95. The patient who developed an anastomotic leak died from pneumonia.
96. I am the best surgeon in my hospital; no one can do this procedure as well as I do.
97. Our surgeons (American, British, German, Russian—whatever) are the best.
98. Such a case was never reported before.
99. I searched the entire literature.
100. Our mortality rate was 0%.
101. I never had any complications with this procedure.
102. We were the first to describe that technique.
103. Initially the patient did well.
104. We had to do something—the family wanted us....

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*“We think so because all other people think so; or because we think we in fact think so; or because we were told to think so, and think we must think so.”*

—Rudyard Kipling

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hierarchical order of importance. It simply lists the first 100-plus myths that came to my mind. Many more myths are floating around, and I hope that each reader will expand this list for his or her own community. If anyone thinks that one of the entries is not a myth, please provide me with the evidence!

#### Conclusion

It was Rudyard Kipling (1865–1936) who said: “We think so because all other people think so; or because we think we in fact think so; or because we were told to think so, and think we must think so.”<sup>\*(p62)</sup> Obviously, the average human, surgeons included, finds comfort under the sheltering wings of dogmatism wrapped in myths. Well-entrenched myths are notoriously resistant to rational critique and even evidence—just look at the thousands of years required to dismiss the great therapeutic values attributed to bloodletting by world leaders of medicine and surgery.

But try we must, and this list represents a modest effort. Scrutinize it and then reflect on the many myths to which you are enslaved personally. As time goes by, new myths will appear and old myths will disappear—albeit very slowly. Let us try to hasten the latter. ●●

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#### Reference

\*Schein M. *Aphorisms and Quotations for the Surgeon*. United Kingdom: TFM Publishing; Shrewsbury, UK, 2003.

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