SURGERY

IN CHARGE OF

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CARCINOMA OF THE BREAST.

The first case I shall show you to-day is a carcinoma of the breast of two years' standing. The important point in the history of the case is the advice given—unfortunately too commonly—regarding the matter of operation. At that time the disease was in a small area situated near the surface, and close to the nipple. Her physician advised against operation until she began to suffer pain. This reminds me of a case in which a physician brought to me a woman suffering from very extensive carcinoma of the breast, and remarked that he had been observing it for about a year, and congratulated himself that he had brought her to me at just the right time for operation. While in the present case it is our object to relieve the patient of an ulcerating process, our main object is to prevent a recurrence of the disease. The ulcerative cases I look upon as less favorable than others for two reasons, viz.: (1) The opportunity for doing an aseptic operation is not so good; and (2) the presence of ulceration in the skin itself shows a tendency to skin involvement, and I think one is more likely to find the lymphatics of the skin involved to a greater or less extent than occurs in other cases.

The operation that I shall do will be the one that I have been employing for about a year past. It is a very extensive operation, and the object of it is to remove all the tissues that are apt to contain deposits of the disease, or are likely at some subsequent period to become the seat of recurrence. Any procedure which falls short of gaining these objects is radically defective. The operation will be done in such a manner as to remove all that portion of skin which is likely to contain cancerous elements. It will then be carried on so as to remove all the contents of the axilla, because in the axilla and in its connective tissue are numerous lymphatics which will otherwise carry the disease up into the neck and adjacent parts. We shall also remove the pectoralis major muscle and the pectoralis minor with, perhaps, the exception of a small portion of the latter. One reason for removing these muscles is to allow of perfect dissection of the axilla, which cannot be done even by the most expert operator without their removal or displacement. Another reason is that very many minute lymphatic vessels are found running down from the seat of disease underneath the pectoralis fascia and the muscles. Microscopical examination, even after apparently a most thorough dissection, will show, usually, that unless these muscles are removed, some of the diseased tissues or infected lymphatics have been allowed to remain. No patient upon whom I have operated by this method has died from the effects of the operation, and they have all made good and rapid recoveries. There has also been excellent motion of the arm, and the whole result has been very gratifying indeed.

You can readily belive that a discharging, ulcerated area infects the skin in the vicinity to a much greater degree than where there is no such ulceration; for this reason we must be particularly careful about disinfecting the skin in the region of operation. A very good way of disinfecting the ulcerating area is by the application of thermo-cautery, and this is the plan which I shall adopt in the present case. The general plan of operation is to uncover the tendenious borders of the axilla, anteriorily and posteriorly, and subsequently to uncover the whole of the pectoralis muscle. I have now exposed the wall of the thorax, and shall proceed to make the innermost incision, which is practically outlined by the sternum. Although it is desirable to get as far away from the breast as possible, and, therefore, to make the flaps thin, they should not be made so thin as to endanger their vitality. The dissection can be made in two different ways, viz.: (1) The method recommended by Halsted, beginning at the sternal end of the pectoralis major, separating the muscle and approaching the axilla; and, (2) the method recommended by Meyer, to uncover in the first place the outer edge of the axilla, the part close to the vessels, and then explore the axilla from without inward, working towards the sternum. I consider the latter method decidedly preferable. Having thoroughly exposed the parts in this way, using my finger as guide, I divide the pectoralis major muscle, and carefully dissect it up from the axilla inward towards the sternum, following the axillary vein closely. During and after the dissection it is well to irrigate the field of