BRITISH MEDICAL JOURNAL:

BEING THE JOURNAL OF THE BRITISH MEDICAL ASSOCIATION.

EDITED BY ANDREW WYNTER, M.D.

No. CLXX.]

LONDON: SATURDAY, MARCH 31, 1860.

[NEW SERIES.]

Clinical Lectures

DELIVERED AT

UNIVERSITY COLLEGE HOSPITAL,

BY

JOHN ERICHSEN, Esq.,

PROFESSOR OF SURGERY AND OF CLINICAL SURGERY IN UNIVERSITY COLLEGE, ETC.

LECTURE III.

ON THE DIAGNOSIS OF TUMOURS OF THE BREAST.

GENTLEMEN,—Every woman who has a swelling in the breast fears it is a cancer. She knows no distinction between one kind of tumour and another, and imagines every tumour to be a cancer. Constantly dreading this disease, she believes, as soon as she finds she has a tumour, that she labours under it. She goes to a surgeon, and uncovers her bosom with great hesitation, and with earnest solicitude scans his countenance as if there to read her fate. If the surgeon be able to say, "My dear madam, this tumour need give you no uneasiness, it is attended with no danger, and will occasion no inconvenience hereafter," he sees by the smile which immediately illumines her features what a load of anxious care is removed from her mind. In many cases of tumour of the breast, as well as elsewhere, it is quite possible to pronounce positively, and at once, for good or for evil. If the patient be middle aged, if the tumour be hard and adherent to the skin, and more particularly if it be ulcerated; if there be a chain of indurated glands extending into the axilla; if the countenance be sallow, with glistening eyes, and the frame emaciated, the surgeon can seldom be wrong in at once deciding the tumour to be cancer; on the other hand, when the patient is young, the tumour hard but moveable, the constitution delicate but good, the surgeon may require time to perfect his diagnosis. This uncertainty with regard to diagnosis of the tumours of the breast is an inherent element of these diseases, and may even continue after the growth has been removed from the mamma. In many cases surgeons will be in doubt about its nature, and this doubt is not cleared away until the tumour is subjected to careful microscopical investigation. So great is this difficulty, that the most skilful surgeons will occasionally err. It is true that the progress of the disease, and the state of the constitution of the patient will eventually throw light on the nature of the disease; but there is nothing pathognomonic in the early stage of the growth of these tumours, and it is at this period that the great difficulty in their diagnosis arises.

In the early stages of all tumours of the breast, the surgeon is at last compelled to form his judgment of their nature by the manipulation of the mass. You can readily understand that, however skilled the sense of touch, however much he may possess the *tactus eruditus*, he may easily be deceived. For instance, if you were to put half a dozen apples under a napkin, and by simple manipulation you had to determine which one was a Ribstone pippin, which a golden one, you might in a few cases be right, but in many you would certainly err. This is precisely what happens in tumours of the breast, though the history of the case will often reduce to a certainty the opinion we had formed of a tumour from its feel, and which otherwise would have remained obscure and unsettled. There is no class of surgical diseases in which errors of diagnosis are so likely to occur as in that of diseases of the breast. The most skilful surgeons may err, and have frequently done so; and, indeed, you would gain more instruction from an account, if it were possible to write such a one, of the errors of surgeons in these matters, than by reading any account of the diagnosis of these diseases. It is in a great measure in consequence of, and by taking advantage of these errors, that the cancer-

curing quacks, who, whether lay, clerical, or medical, flourish in all large towns, derive much of their reputation with the public. They have this advantage over medical men. Suppose the "cancer-curer," as he calls himself, fail in effecting a cure, he is then no worse off than the regular practitioner, by whom the disease had previously been pronounced to be incurable. But if a medical man makes an error, and diagnoses cancer when in reality the tumour is a benign one, the patient, knowing that medicine affords her no relief, and that surgery only offers the palliative measure of extirpation, applies to a "cancer-curer"; he uses his caustics, and destroys a tumour, which, being non-malignant, though erroneously believed to be cancer, does not return. Such a case is ever after looked upon by her friends as an incontestable cure of a cancer, which had been pronounced to be incurable by medical men. Hence it is very necessary not to hazard a positive opinion in doubtful cases, or at all events not to throw one out on the gloomy side.

I recollect three cases sent into this hospital at no very distant date, which illustrate this last observation. The first was that of a man with a "tumour" of the lower jaw, which was sent in as a cancer of that bone. It was solid, firm, and prominent; but there was some oedema of the soft parts covering it. I passed in a grooved needle, and let out some pus. It was an abscess. I then put in a seton; the walls were thick, and lay close to the bone; but they rapidly melted down, and the "tumour" disappeared.

The next case was that of a young woman who came to me with a large "tumour" of the side of the neck, of the size of a coco-nut, on which was an ulcerated surface as large as the palm of the hand. She told us that it had existed a year or two; that she had been to a medical practitioner, who pronounced it to be "cancer of the neck"; that she then went to a "cancer-curer", who used caustic to it; this gave her such intense pain, that she could not return to him, under which circumstances she applied to this hospital. When I examined the swelling, I felt some deep fluctuation. I inserted an exploring trocar, let out a considerable quantity of pus, enlarged the puncture, and put in a seton. The patient was well in a month. Now, had the "cancer-curer" penetrated half an inch more deeply with his caustics than he did, he would have had the credit of curing a cancer of the neck by opening an abscess.

The third case occurred very recently. An old man came here from the country with two cicatrices on the lower lip, which, he said, were the result of two operations for "cancer"; one twelve years ago, and the other a year and a half since. There was a large tumour beneath the angle of the jaw, which several London surgeons had told him was a return of cancer under the lower jaw, for which nothing could be done; and that he had better return home. This tumour appeared to me more elastic, and not so circumscribed, as secondary cancers usually are. I passed a grooved needle into it, and let out a drop or two of pus. I then laid open the tumour. An ounce and a half of thick yellow pus escaped. The wound granulated; the cyst filled; and the man left the hospital cured.

These cases are by no means uncommon. Abscesses, as well as other tumours of the breast, are frequently mistaken for cancer. Some years ago, on going by invitation to the house of a notorious "cancer-curer", whose practice was open to the profession, I saw among his patients a young woman twenty-three years of age, with a chronic mammary tumour of the breast. I said to him, "Do you call this a cancer?" His reply was, "Wal, I guess it was sent to me as one by a surgeon; and that's enough for me." And no doubt it was enough for him. That was the very thing that men of his class want—a simple tumour, pronounced to be cancerous. They remove it as a cancer, and get the credit of a "cure".

So far as the breast is concerned, for all purposes of surgical diagnosis, its tumours resolve themselves into two classes; first, the simple; second, the malignant. The simple non-malignant tumours again resolve themselves into three classes; first, *abscesses*; second, *cystic tumours*; third, *solid tumours* of various kinds. These are the distinctions you may establish for

the purposes of diagnosis. Now let us examine these different classes a little in detail.

First, with regard to the diagnosis of abscess. Now, there are four kinds of abscesses of the female breast; three of these are not difficult to distinguish as abscess; the fourth often is so. The first is the ordinary subcutaneous abscess between the skin and gland, generally near the areola; it is accompanied by the ordinary symptoms of phlegmonous and suppurative inflammation—heat, pain, and throbbing. There is usually no great difficulty in diagnosing this variety; it is often met with at the age of puberty, in consequence of the increased action set up about this time. It occurs alike in single or married females, and usually without any uterine complications. In the diagnosis of this subcutaneous abscess, error will, however, sometimes creep in. For instance, a gentleman of considerable professional skill and acquirement, one day brought a patient to my house with "a tumour of the breast", which he said would require removal. On examining the bosom, I found one of these subcutaneous abscesses, with a good deal of oedema around it. I retired with my friend into another room, told him my opinion, and proposed to open it there and then. "For God's sake," said he, "don't do that. I have said it was a 'tumour', and I shall get into a scrape if you open it." I told him not to make himself uneasy about that, for I would soon settle matters to his and to his patient's satisfaction. I accordingly told the lady that I was glad to say that an operation would not be necessary, as we should be able to bring the tumour "to a head", and so disperse it. I accordingly ordered some resin cerate to be applied; and in a week the abscess had burst, and there was an end of the "tumour", to the great satisfaction of all concerned.

Two other of these varieties of abscess are of an acute and phlegmonous character. The first, that in the substance of the mammary gland; the second, that which forms behind the gland, in the cellular tissue lying between it and the pectoral muscle. These abscesses generally occur during lactation; and, by coupling the acute phlegmonous symptoms with the presence of lactation, there can be very little difficulty in distinguishing them.

The fourth form is that most frequently confounded with solid tumour. It is the chronic, cold, encysted abscess of the breast. This is a sort of abscess which forms deeply in the mammary gland, slowly, and without any acute symptoms—usually, indeed, without any local symptoms at all. It is hard, deeply seated, and tolerably well circumscribed. This encysted abscess of the breast has been especially described by Sir A. Cooper and by Velpeau. Both these eminent surgeons record cases of it which have been mistaken and operated on for cancer. A story has been told me by a gentleman who was present, of a surgeon now dead, but one of the most eminent of the many great surgeons that France has produced, who, after lecturing to his class just before operating on a case of tumour of the breast, and explaining, with that minuteness of detail and that lucidity of arrangement which the French surgeons possess in so a high a degree, the reasons why the tumour he was about to remove could by no possibility be any but a scirrhus, made his first incision, when a gush of pus took place, and the supposed scirrhus was resolved into an encysted abscess, deeply seated under the mammary gland. Now this accident, happening as it did to one of the most eminent of his day, may occur to others of less professional experience; it has, to my knowledge, occurred six or eight times. But it may generally be avoided by attention to the history of the case, and especially to four points of diagnosis. These points, to which I would direct your special attention, are the following:—

1. Encysted abscess is invariably preceded by some uterine disturbance. You will find that the patient has lately been in the family way, and has either been delivered or has miscarried; or, if not pregnant, has suffered from some other uterine derangement—in most cases, however, of a parturient nature—a few weeks or months previously.

2. You generally find that the tumour, if an abscess, though hard and defined, is not distinctly circumscribed.

3. You almost invariably find—and this is a most important point—oedema of the subcutaneous cellular tissue, near the outer or under border of the gland.

4. There is also usually a spot on the surface of the tumour softer and more tender than the rest, possessing, perhaps, a certain degree of elasticity.

Now, by attention to these four points—namely, preexisting or concomitant uterine derangement, hard but non-circumscribed character of the swelling, the oedema around or beyond, and the soft tender point—you can rarely go wrong in making

your diagnosis. In illustration of this, I will mention a case which occurred here some time ago. A woman, thirty-six years of age, miscarried the sixth or eighth week of her pregnancy. Eight months after this, she applied to the hospital for relief for a tumour of the breast. On examination, I found a circumscribed painless swelling deeply seated in or under the mammary gland. There had been no pain or throbbing in it, and there was no redness over it. At the lower border, there was a spot which felt doubtfully elastic. I made an exploratory puncture into this, and let out about an ounce and a half of creamy pus. A tent was then introduced; and the induration of the walls, which were excessively thick, gradually disappeared, as the wound healed by granulation.

Besides these chronic abscesses of the breast itself, you may get another class of cases; that is, abscess in the neighbourhood of this organ, quite unconnected with the mammary gland. If there is any doubt in your minds, after examining such a case, always put in an exploring needle or trocar; its puncture can do no harm, and it will always clear up the true nature of a doubtful case.

In the next lecture, we shall proceed to the diagnosis of cystic and simple solid tumours of the breast, from cancer of that organ.

Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

UNIVERSITY COLLEGE HOSPITAL.

SCROFULOUS DISEASE OF THE KNEE-JOINT: EXCISION: RECOVERY.

Under the care of R. QUAIN, Esq.

[Reported by W. L. WINTERBOTHAM, Esq., House-Surgeon.]

HENRY S., aged 12, a pale looking scrofulous boy, with prominent forehead and light eyes and hair, was admitted into University College Hospital, under the care of Mr. Quain, June 25th, 1859. All the history that could be learnt of the complaint was that, up to October 1856, he was quite well; that he then fell and struck his right knee, causing it to swell and become very painful; and that this had continued to increase until his admission, when his state was as follows.

On examination, the right knee was found to be much enlarged (being an inch and a half more than the left in circumference), and much altered in shape. The leg was slightly flexed on the thigh, and neither the patella nor the depression at the side of the ligamentum patellæ could be distinguished. At the inner side, and above the articular surfaces, there were several openings, the largest of the size of a split pea, from which the patient stated that a great deal of yellowish matter had escaped, thereby, as he thought, somewhat diminishing the size of the joint. The enlargement felt bony, and was best marked over the situation of the condyles of the femur; so that it would appear that the increase in size was due to enlargement of the lower end of that bone. The patient suffered greatly from starting and jerking of the limb at night. The skin was cool; the tongue clean. He took his food pretty well. He was ordered cod-liver oil and good diet.

July 2nd. He had starting pains during the day. He slept pretty well. Lateral leather splints were applied to the joint.

July 7th. There was now some deformity on the outer part of the limb, as if the lower part of the leg were inclining away from the level of the femur towards that side, while over the lower part of the condyles there was tension, as if from fluid; but there was no effusion at the upper part of the joint. He had an attack of rigors last night. The odour from the joint was very offensive. He had no relish for his food. He was ordered five minims of dilute sulphuric acid, and five minims of tincture of opium, in half an ounce of water, twice daily.

July 14th. The joint was examined under chloroform, and an incision was made on the outer and upper part, which gave exit to a small quantity of pus. The part was poulticed.

July 20th. The discharge from the inner openings was profuse. There was great oedema of the foot, and tendency to dislocation outwards at the knee. The jerking pains were worse