CLINICAL LECTURES

ON

THE DIAGNOSIS OF TUMOURS OF THE BREAST.

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LECTURE II. (Concluded.)

Recapitulation of last Lecture. Affections of Breast intimately connected with the Gland itself. Hypertrophy. Inflammation.

Cancer. True Cystic Disease.

WHAT, then, you may fairly ask, are the symptoms by which a cancer of the breast is to be made out? I have already informed you that cancer is essentially of a progressive character; that it never remains long in one tissue, but sooner or later involves all with which it comes in contact; and it is through this pathological peculiarity that it produces symptoms in the skin over it, and parts beneath it, of great diagnostic importance.

How Cancer affects the Skin.—The skin is affected slowly, but in a very characteristic way. It first becomes more or less fixed to the growth; and, instead of rolling freely over its surface, as it invariably does in a simple tumour, it seems tied or drawn down to the parts beneath. A dimpling of the skin next makes its appearance; this symptom passing into a complete puckering, at which stage of the disease the integument will have become completely fixed and immovable. As the disease progresses, the skin becomes infiltrated with the cancerous products, and is made a part of the diseased mass; and, as time progresses, so-called ulceration of the integument may make its appearance—this ulcerating surface always assuming a characteristic aspect. In some cases, the skin becomes infiltrated with isolated tubercles, varying in size from that of a millet-seed to tubercles of larger dimensions. When any of these conditions of skin exist with a tumour infiltrating the mammary gland wholly or in part, and more particularly the latter or tubercular form of infiltration, the cancerous nature of the disease is tolerably clear.

On the Mobility or Immobility of the Tumour.—As cancer affects the skin by infiltration, so practically it affects the parts beneath; and, as a consequence, we find symptoms produced of great value in a diagnostic point of view; for a cancerous tumour, instead of moving freely over the pectoral muscle, as it does in innocent affections and in health, soon becomes, as the disease progresses, somewhat fixed, and at last immovable; the breast-gland, pectoral muscle, and probably skin, all becoming, by general infiltration, involved in the same destructive influence at the last stage of the disease.

Infiltration of the Absorbent Glands.—Should you find enlargement and induration of the axillary or clavicular glands associated with a doubtful tumour of the breast, you must regard such symptoms as strongly indicative of the disease being cancerous; for cancers rarely exist any lengthened period without causing such symptoms. It is true, that you do find glandular enlargements associated with inflammatory affections of the mamma; but, under such circumstances, the axillary glands are usually more tender on manipulation than they are in cancer, and the enlargement is more rapid; the cancerous infiltration, as a rule, appearing, in its early stage, as a painless chronic infiltration.

Neuralgic Pains down the Arms, etc.—This symptom is one of great value in determining the nature of a tumour of the breast; for it is rarely present in any other affection of that organ than the cancerous. It indicates the probability that the deep cervical or axillary glands are infiltrated with the disease, and are pressing on the nerves, causing pain, although these glands may not be felt. Indeed, neuralgic pains in any part of the body, associated with cancerous disease, or after its removal, should be always regarded with suspicion; for they are often indications of secondary cancerous deposit having taken place either in the nervous centres or along the nerve's course.

Retraction of the Nipple.—I must again warn you not to place much confidence in this symptom as pathognomonic of cancer; for I have already told you that it frequently exists in other affections of the breast. It is a purely mechanical symptom, and rather reveals the manner in which the gland is involved in the disease, than the character of the affection; this opinion receiving support from the fact that the nipple may become retracted in the early stage of cancerous disease of the breast, and at a later stage reassume its prominent position.

Discharge from the Nipple.—In all cases of general disease of the

breast-gland, inflammatory, cystic, or cancerous, there may be a discharge from the nipple; in the inflammatory, it may be watery or purulent; in the cancerous, it is generally sanguineous, and little in quantity; in the true cystic, it is viscid, more or less blood-stained, but profuse. It does not exist in all cases of cancer, and is not typical of the disease. As a means of diagnosis in the true cystic disease, it is of great importance.

Cachexia.—I have no belief in the existence of a special cancerous cachexia. A cachexia may be present in cancer, as in any exhausting and wasting disease; but that of cancer differs in no single point from that of any other affection. When a cachexia exists, it indicates the presence of some affection which is undermining the patient's strength; it may be cancer, but it may be any other form of disease.

Cystic Tumours of the Breast.—Time will not allow me to enter fully into this important subject. You must rest satisfied, therefore, with the few remarks I feel bound to make. I must beg you to remember that cysts are accidental developments in the majority of tumours of the breast; that they may exist in the simple, as well as in the cancerous affections; and that, as a general rule, they may be disregarded in a diagnostic point of view—the diagnosis of tumours containing cysts, with one single exception, resting upon the same points as the diagnosis of tumours without cysts, to which your attention has been already drawn. That exception refers, however, to a *genuine cystic disease of the breast-gland*—a disease of the gland-ducts. It is one of an innocent nature; it affects the patient solely through local influences. It is to be recognised by the gradual and generally painless growth of the tumour; by the evidently cystic nature of the disease from the beginning; by the frequent presence of several cystic centres in the same gland; by the healthy character of the integument over the tumour; by its free mobility upon the parts beneath; by the total absence of all indications of induration of the absorbent glands, and the general good health of the patient from the first; but, above all, it is characterised by the fact that a *free* discharge of a clear or blood-stained viscid secretion from the nipple is always present, and that this discharge can readily be increased by steady pressure upon the part; the cyst or cysts in many instances being completely emptied by these means. When the cysts are full, great pain is often experienced; when empty, the tumour is comparatively painless; this discharge of a viscid fluid from the nipple in such cases fairly determining the nature of the disease.

I have, thus, gentlemen, gone over as carefully as time will allow the principal points by which the diagnosis of a case of tumour of the breast is to be determined; and I trust I have convinced you that the majority of the difficulties generally experienced in the diagnosis of such cases will be found to vanish by making a systematic use of our eyes, our ears and hands, in the investigation of the subject. In certain cases, it is true, difficulties may be experienced; but, in the majority, a fair degree of certainty is to be attained by the adoption of such a systematic mode of investigation as I have explained and illustrated.

By way of a general summary of the whole subject, the following conclusions may be drawn up, contrasting the cancerous with the innocent affection.

1. *Cancer* generally attacks patients during the functional decline of the mammary gland—that is, after forty years of age; but *innocent* affections, as a rule, occur during the functional activity of the gland's life.
2. A *cancer* in the breast of a single woman is generally observed at an earlier age than in that of a married woman, the functional activity of the gland lasting longer in the latter case.
3. *Cancer* always infiltrates the gland, wholly or in part; but simple tumours, as a rule, seldom involve it to any great extent, with the exception of the true cystic disease.
4. *Cancer* generally affects the breast in a single centre, and from that rapidly develops. Innocent growths, cystic or otherwise, often appear as multiple tumours in connexion with one or both breasts.
5. *Cancer* generally runs its course within a period of three years; but *innocent* tumours may be developing for many years without causing much distress, affecting the patient only from local causes.
6. *Cancer* does not exist for any lengthened period without involving the skin by infiltration or ulceration; but, in *simple tumours* of the breast, the skin remains uninvolved to a late period of the disease—until, indeed, it is ruptured by over-distension.
7. *Cancerous tumours* soon become more or less fixed to the parts beneath, and immovable; but *simple tumours* are, with rare exceptions, moveable throughout the whole period of their existence.
8. In *cancers*, the axillary absorbent glands become indurated at an early period of the disease; in *innocent tumours*, they are rarely affected.
9. Neuralgic pains down the side and arm are common in *cancer*; in innocent affections, they are rarely present.
10. Retraction of the nipple is found in both simple and malignant diseases of the breast, and consequently is of slight diagnostic value.

* From Notes by Mr. Samuel Jackson.

11. A discharge from the nipple exists in all affections of the true breast-gland. In *cancer*, it is sanguineous and scanty; in *true cystic disease*, it is viscid and abundant, and can be readily increased by pressure on the cysts; in *inflammatory*, it is watery or purulent.

12. In cases of tumour of the breast, when the skin has ruptured or become ulcerated, the margin of the opening or sore reveals the character of the disease; in *simple* cases, presenting the appearance of being ruptured, cut out, or punched; whilst in *cancerous* diseases there is no such distinct margin, the edges of the wound appearing thickened, indurated, and everted.

OBSTETRIC MEMORANDA.

UNDER this head we shall from time to time, as materials come to hand from correspondents, publish records of cases remarkable in themselves, or illustrating points of interest in obstetric practice, therapeutic or manipulative. We shall probably in this way preserve from oblivion the notes of very many useful and instructive occurrences in private practice; for the great obstetric experience is that—for the most part hitherto unwritten—of the great body of general practitioners throughout Great Britain. We will only ask those who may forward cases for record to relate them with the utmost brevity, and equally to condense any appended remarks.

MATERNAL IMPRESSIONS.

By E. GARRAWAY, Esq., Faversham.

SCEPTICAL as many of us are in attributing the various deformities which we encounter in new-born children to the effect of maternal emotion, cases do every now and then occur which compel us to believe. A more marked instance I never met with than the following, which has just come under my notice.

A young woman, *not aware that she was pregnant*, though the sequel proved that she was six weeks advanced, saw a rat advancing towards her. She shuddered, clutched her left arm below the elbow with her right hand, and shut her eyes. The child, at the completion of gestation, was born with the left forearm undeveloped, as if it had been amputated below the elbow, and totally blind—amaurotic.

FIBROID TUMOUR OF THE UTERUS.

By ARTHUR W. EDIS, M.B.

ON June 26th, I was requested to see E. D., aged 50, a married woman, who was in great pain in the pelvic region, blanched, puffy under the eyes, with very feeble pulse and great exhaustion. For the last ten years she had been subject to a continuous sero-sanguineous discharge from the vagina, occasionally sustaining profuse losses of blood, especially after any unusual exertion. During the winter of 1866, she suffered from severe weight and bearing down. On examination *per vaginam*, a large fibroid tumour was detected, filling up the cavity of the pelvis, and interfering with the pelvic viscera. By means of firm and steady pressure on the tumour, it was passed up above the brim of the pelvis, affording great relief to the patient. A dose of opium was given; and the liquid extract of ergot (mxv), with bromide of potassium (gr. x), in decoction of cinchona, was prescribed. In a few days, the patient was enabled to leave her bed.

On July 26th, she reported herself as greatly relieved. The discharge was less, and more watery than sanguineous. She was more lithe and active; and, from having been indifferent as to whether she lived or died, now stated that she felt better than she had been for years, and took a fresh interest in life. She was ordered to continue the medicine.

On August 7th, she had rather a sharp attack of hæmorrhage, from over-exertion; but, with this exception, she had improved daily.

On September 4th, the discharge was very slight. Quinine and iron were ordered, and an occasional aperient.

On September 21st, she reported that the medicine suited her admirably, and that she felt much stronger.

On October 15th, she reported herself as quite a different being. Her health was very good; she had scarcely any discharge, and could move about without discomfort. She was, she said, better in every respect than she had been for ten years.

REPORT OF THREE CASES OF LITHOTOMY: WITH REMARKS ON THE OPERATION.

By WILLIAM PAUL SWAIN, F.R.C.S.,
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THE following cases occurred in my practice at the hospital during October and November 1866.

CASE I. Henry Brown, aged 9, was admitted on October 16th. He had suffered for two years with symptoms of stone in the bladder. He was a delicate boy, and much emaciated with continuous suffering. There was prolapse of the rectum. He was cut for stone on October 20th. The lateral operation was performed, the groove in the staff being cut into immediately. The stone was caught on the first introduction of the forceps. Owing to its size, the external wound had to be enlarged to remove it. It was a large phosphatic calculus, perfectly round, measuring four inches in circumference, and weighing 3 vii gr. x. The urine ceased to run by the wound in a week, and the boy was discharged cured on November 18th. No incontinence remained.

CASE II. Albert Smart, aged 7, was admitted on October 18th. He was a well-nourished, but "rickety" boy. Owing to the length and tightness of the prepuce, circumcision was performed on admission. He was cut on October 27th, by the lateral method and direct puncture into the groove. The point of the forefinger of the left hand was passed into the bladder, and placed on the stone, before the staff was withdrawn. The forefinger of the right hand was then passed up the rectum, behind the stone, which was then pressed forwards through the internal wound, and removed, without the use of forceps. It was an oval phosphatic calculus, and weighed 3j gr. ix. Very little blood was lost. On November 14th, urine ceased to run from the wound. Between November 3rd and 14th, he had an attack of bronchitis, to which he had been previously subject. He was discharged cured on December 13th. No incontinence remained.

CASE III. William Mollen, aged 11, was admitted October 30th. He had suffered pain and sudden stoppage in micturition for more than twelve months. During the last fortnight, the pain had been more severe. He had never had incontinence, nor passed bloody urine. He was cut on November 3rd by the lateral method and direct puncture into the groove. The stone was removed, as in the former case, without the use of forceps, the forefingers only being used. It was a lithic acid calculus, and weighed fifty-six grains. There was slight hæmorrhage two hours after the operation, which was easily suppressed. The urine ceased to pass by the wound on November 12th. He was discharged cured on November 26th. No incontinence remained.

In the simple history of these three cases, there is nothing out of the common to arrest the attention of the profession. I wish, however, to refer to certain details in the operation of lithotomy which were followed in the above cases; viz., to the method of making the incision into the bladder, and to the manner in which the stone in two cases was removed therefrom.

First, then, with regard to the incision. In each of the above cases, I followed the practice of plunging the knife at once through the perineum down to the staff, placing the point in the groove, and then cutting outwards, and completing the external incision. In order to effect this, the following precautions must be taken; first, to place the patient perfectly "square" upon the table, having the buttocks brought exactly to the edge, and the thighs equally flexed and abducted; and, secondly, to have the staff held with the utmost precision, firmly in the median line, the handle being slightly bent backwards towards the abdomen, so as to make the curve prominent in the perineum. It must not be hooked up too close under the symphysis, and the finger must be placed in the rectum to regulate its distance from that intestine. It should then be distinctly felt through the perineum at a point about one inch in front of the anus; and at that point the knife (Liston's) should be entered with the blade lateralised, to correspond with the direction of the groove on the staff. The blade is then boldly thrust onwards until its point strikes the groove in the staff, along which it should be thrust until urine flows by the wound. Then leaving the groove, by a rapid sawing motion the blade is brought out, cutting the external wound in the integument to the required extent. As the blade recedes from the staff, the forefinger of the left hand is thrust along the roof of the incision until it reaches the staff, by which it is conducted through the opening in the urethra and neck of the bladder into the bladder, and in the majority of instances at once impinges on the stone. Should the incision in the neck of the bladder be insufficient to admit of this proceeding, it must be enlarged by replacing the point of the knife in the groove, and thrusting the blade a little further onward. The point of