

EARLY REMOVAL OF THE BREAST FOR CANCER.

The importance of an early diagnosis of malignant disease of the breast has long been insisted upon by all writers.

The following case is, therefore, reported as an example of an effort to operate as early in the history of the case as possible:

Mrs. H., fifty years of age, has been more or less of an invalid for several years. Has not yet had the change of life. Her family history is not good, her mother having died of cancer of the breast. As a young woman she was warned by her physician to be on the lookout for the appearance of a growth in the breast at a certain period of life. About a month previous to the appearance of the nodule she had noticed a new pain in the left breast, beginning at the spot where the tumor subsequently appeared, and crossing the breast diagonally. On March 21, 1893, she discovered a lump that was not noticeable on the 17th. The growth was, therefore, presumably of very short duration. It appeared to increase slowly from this date, gradually becoming more painful, until April 9th, when I first saw the patient.

On examination, a small lump was discovered near the inner margin of the upper inner quadrant. It was ill-defined, but did not appear to be much larger than a lima bean. No nodule was found in any other part of the breast or in the axilla. An exploratory operation was made on April 11th. Cocaine having been injected hypodermically, a small fragment was removed with the punch, and the diagnosis of cancer was made. On April 18th an operation for the removal of the breast was performed, and a clean dissection of the axilla was made at the same time. The fascia of the pectoral muscle was dissected away, but the muscle itself was allowed to remain intact. The wound was united throughout by sutures, no drainage-tubes being used, and healed by first intention, the patient returning to her home from St. Margaret's Hospital about three weeks after the operation.

"A microscopic examination of the tumor by Dr. Whitney showed a small dense nodule in the periphery, with an irregular retracting outline and small minute yellow points and lines on the surface. There was a second nodule, similar in character, in the midst of the breast tissue and near the nipple. The breast tissue in general was firm and fibrous.

"Microscopic examination showed the growth to be made up of solid masses of epithelial cells separated by a dense fibrous-tissue network. There were a few slightly enlarged axillary glands in which occasional epithelial cells were to be found.

"The diagnosis was scirrhus cancer, with commencing implication of the lymph glands.

"The diagnosis of typical carcinoma was confirmed by Dr. W. T. Councilman."

The points of interest in this case appear to be the early recognition of the presence of a growth in the breast by the patient and the establishment of a diagnosis of cancer, with prompt operation.

Notwithstanding the fact that an early operation was performed upon the breast containing a tumor no larger than a bean, the presence of cancer was revealed not only in other portions of the breast, but minute deposits were found already in the axillary glands. Such an observation as this emphasizes the importance of the complete dissection of the axilla in every operation for malignant disease of the breast.

An examination of the patient twelve months after the operation showed that as yet there has been no sign of a return of the disease.

In a previous paper on this subject, some cases were

reported which had enjoyed an immunity from cancer after amputation of the breast.² The subsequent history of these cases is as follows:

Mrs. B., patient of Dr. Leslie, of Amesbury, was operated upon for extensive carcinoma of breast and axilla, July 9, 1885. Dr. Leslie informed me of her death, about one year ago, of pneumonia. There had been no sign of a return of the disease.

Miss B. was operated upon for scirrhus cancer of the breast, December, 1884. The patient was married October 15, 1888, after an engagement of seven years' standing. She has reported to me from time to time since, and there has been no return of the disease.

Miss J. was operated upon in June, 1884. There was a small cancerous nodule in a scirrhus breast, and no involvement of the axilla. Dr. M. D. Clarke informed me recently of her death from apoplexy, at which time no trace of a return of the disease was observed.

Grace M. was operated upon in 1882, for colloid cancer of the breast. The breast alone was removed. A nodule the size of a hen's egg was removed in 1888 from the axilla. Within a few weeks she has been seen by me in perfect health, with no sign of a return of the disease.

Mrs. C. was operated upon, in 1887, for scirrhus cancer of the breast. There was an extensive infiltration of the glands of the axilla. She writes in March, 1894, "my general health continues very good indeed, and there is still not the slightest indication that there will ever be any return of the trouble."

HEMORRHAGE AFTER OPERATIONS ON THE NASAL SEPTUM.

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TRoublesome hemorrhage after operations on the nasal septum must be very uncommon. The books I have been able to consult make but slight note of such complication. Ingals does not speak of it. Sajous regards it as of no consequence. McBride says nothing about it; neither do Watson, Schech or Voltolini. Seiler says it can always be controlled by placing borated cotton on the spot for a few hours. "The hemorrhage is sometimes considerable, but rarely alarming" (Browne). "Surgical nasal hemorrhage, especially from the septum, is significant only as a temporary mask to the field of operation" (Jarvis in "Burnett's System"). "In no case have I had serious annoyance from hemorrhage" (Bosworth). "Occasionally the nose may need plugging" (MacDonald).

For literature on the subject I have carefully looked over the catalogue of the Surgeon-General's Library and the files of the "Index Medicus," and can find only a case reported by Dr. A. H. Smith, of New York, in the *Archives of Laryngology*, 1883, iv, p. 132.

This paper is based upon this case, three of my own bearing upon the question of hemorrhage following operations upon the anterior part of the septum, and one upon the posterior part.

The nasal septum gets its arterial supply from the two terminal branches of the speno-maxillary portion of the internal maxillary artery. Posteriorly the artery of the septum passes obliquely downwards

² Boston Medical and Surgical Journal, April 11, 1889.

and forwards and anastomoses with the ascending branch of the descending palatine which comes up into the nose through the anterior palatine canal of the superior maxillary bone. Both these vessels are of small size, and I can find no mention of any abnormality of either.

CASE OF DR. SMITH. E. N., aged about sixty-three, presented himself at the hospital clinic November, 1882, with obstruction of the left nostril, occasioned in part by a sharp horizontal ridge projecting from the cartilaginous portion of the septum. The apex of this ridge was removed with a bistoury, leaving a cut surface about four lines long by less than a line in breadth. The operation was accompanied by a profuse flow of blood, the stream as it left the nostril being as large as the shank of a laryngeal mirror. This continued for some minutes without abatement, when it was arrested by pressing cotton loaded with dry tannin upon the bleeding surface. During the following night the bleeding recurred, and was controlled by plugging the nose posteriorly and anteriorly. The plugs were removed after forty-eight hours, and soon after the bleeding recurred with great severity, requiring a repetition of the procedure, which controlled the bleeding for some hours; but later the blood forced its way past the plug, and was stopped by injecting persulphate of iron. Dr. Smith adds: "When I saw the patient six days after the operation, his lips were bloodless, and his face had the tallowy appearance indicative of severe hemorrhage. That so much blood should be lost from so small a surface would indicate that a vessel of considerable size must have traversed the ridge, reaching nearly to the crest, a very unusual occurrence.

The following four cases occurred in my own practice:

CASE I. R. D., aged forty-six, railroad conductor. A large, rather fleshy man. His general health has always been good, that is, he has never been kept from work. Has a good relish for his food and digests it fairly well. But he has for some time had some dyspnea on exertion, and has never been able to get a life insurance. The symptoms referable to his nose and throat were inability to breathe through the left side of the nose, coughing and choking at night, catarrh, hoarseness amounting often during the winter to aphonia. There was very marked thickening of the cartilaginous septum, the result, according to the patient's statement, of an injury early in life, quite occluding the opening and causing a deformity apparent from the outside. The uvula was very much elongated, and there was a chronic inflammation of the larynx so severe that the cords could not be differentiated by color from the other parts. The mucous membrane of the entire tract was inflamed and spotted with dirty brown crusts. Examination of the heart showed area of dulness not appreciably altered. The first sound was weak, and the second accentuated, especially over the lower sternal area. Rhythm regular, pulse 120. The urine was normal as to reaction, specific gravity, and the absence of albumin and sugar. The sediment contained an abundance of the crystals of the phosphate of lime.

In the course of his treatment the excessive tissue in the uvula was removed with scissors without any inconvenience as to pain or bleeding, and much to the relief of some of his symptoms. It was deemed advisable to remove the obstructing cartilage in the nose,

which was done at a subsequent time. Cocaine was used. The piece was removed entirely by the knife, somewhat to my surprise, as I usually have found some bone in these growths. The cut surface was about half an inch in either diameter. The bleeding was exceedingly profuse; indeed, the blood ran in a steady, rapid stream, and looking into the nose an artery of considerable size was seen spurting in the upper part of the wound. It was with a good deal of difficulty that the bleeding was checked, and only after the loss of a large amount of blood. In a very short time, however, it recurred as badly as ever, and all efforts to stop it were unavailing until the nose was solidly plugged, posteriorly and anteriorly. Even then the blood forced its way past the plugs, and was finally stopped by firm pressure from the outside. From the time of the operation till the bleeding was finally stopped, fully three hours elapsed, a good deal of this time being taken up by keeping direct pressure upon the bleeding surface, the only way in which the bleeding could be stopped even temporarily. The plugs were removed after thirty-six hours, and the subsequent history of the case was uneventful.

CASE II. Miss A. D., aged nineteen, had a small projection from her septum in its anterior part. I had previously, within a month, removed enlarged faucial tonsils with no unusual hemorrhage. The bleeding that followed the very slight operation on the septum was very profuse and exceedingly difficult to control.

CASE III. L. L., a farmer boy, aged twenty. This patient had a ridge running along the right side of the septum which was causing trouble enough to justify its removal. When I cut into the spur at its anterior extremity, I opened an artery that pumped very markedly. But there was very little hemorrhage at the time of the operation. Later in the day the bleeding troubled him some, but it was annoying only.

CASE IV. Miss A. T., aged about twenty-seven, teacher. About four P. M. I removed with a saw a bony spur from the posterior part of the septum. There was no unusual hemorrhage at the time. At six she returned with the report that she had been bleeding freely for a short time. Blood was passing down the throat in considerable quantities. Both nasal cavities were full of clots, which were washed out. After ineffectual attempts to stop the bleeding, with the aid of a gum-elastic catheter I drew a plug into the posterior nares. Before this was secured there was a gush of blood into the throat and the plug was found washed into the mouth. I then gave ergot and inserted a tampon soaked with persulphate of iron into the nose wedging it against the sawn part, and, as the patient had lost a good deal of blood, placed her in a semi-recumbent position with an ice-bag over her nose. The bleeding stopped. The loss of blood affected the patient's health for some time. About two months later I again operated in the same place with a burr, with no untoward results.

The artery opened in Case III was undoubtedly the ascending terminal of the descending palatine. Although I did not detect any pulsation in Case II (I did not look for it), it is fair to infer that there was a vessel of unusual size; else why should the patient have bled so? She had no hemorrhagic diathesis, as is shown by the previous tonsillotomy. In Case I, it may be that the altered nutritive conditions occasioned by the injury, and the increased amount of tissue deposited about the part, had made a larger blood-supply

necessary, and accordingly there resulted enlargement of the vessels. Furthermore, both in this case and that reported by Dr. Smith, it may be stated with positiveness that the blood-vessels had become atheromatous and consequently would not contract.

In both these cases the artery which was opened must have been an enlarged terminal of the ascending branch of the descending palatine. This artery may be of quite appreciable size as it enters the nose, as is shown by Case III, where for a time there was distinct spurt-ing. This case is not by any means a rare one in my experience; indeed, it is a type of a class. But the hemorrhage is very exceptionally, even annoying, because the artery contracts and bleeding ceases soon of its own accord.

If the supposition be true that the vessel divided in Case I was the terminal of the descending palatine, one would expect to have found two bleeding points — one in the upper, another in the lower part of the wound; and that I am inclined to think was the case. But as the blood accumulated so very rapidly in the lower part of the nose, I could not demonstrate it to my own satisfaction or that of Dr. Homer Gage, who saw the case with me.

These considerations are of value in deciding upon operative procedures in adults. It is well recognized that disturbances of the upper air-passages affect different parts at different ages. In children and young adults it is the nose and upper throat that are affected by ordinary cold, while in older people the parts below the nose suffer. That obstructed nasal cavities are responsible for these conditions is also true, and the advisability of early restoring the nose to a normal condition is certainly well recognized. If these abnormal conditions are allowed to persist, distinct pathological changes take place in the naso-pharynx and throat which are more or less permanent in character. On the other hand, growths which would be troublesome in early life cease to be so later. It is not an uncommon experience to be consulted by elderly people for throat troubles and find spurs and other obstruction within the nose. Such patients have no disagreeable symptoms referable to the nose, but will recall that they did have earlier in life. The nose has adapted itself to the abnormal conditions, is doing its work fairly well, and as the mischief to the lower respiratory passages has already been done, the amount of good to be accomplished by intra-nasal surgery is questionable, especially in view of such accidents as this paper describes.

In Case I, however, the issue well justified the operation and would in a similar case justify operation. This was not one of the cases so common where a spur has encroached on a turbinated body which has adapted itself to the abnormal conditions and leaves some room, but the obstruction was in front of the turbinated body and blocked the nose as effectually at all times, as would a plug of cotton in the nostril. It also made cleansing of that side of the nose impossible, and after the removal of the growth, a large mass of blackish, friable matter was dislodged from the lower meatus. This extended around the curve of the lower turbinated body and had evidently been a long time within the nose, and must have contributed not a little to the diseased condition of the nose and throat. Furthermore, the removal of the growth permitted nose breathing nights, which was followed by a very considerable improvement of the patient's condition.

CONCLUSIONS.

(1) Operations upon the nasal septum may be followed by hemorrhage sufficient to very materially affect the health of the patient.

(2) The artery of the anterior (cartilaginous) septum may lie near the surface, be of considerable size, and if atheromatous may cause serious hemorrhage.

(3) Operations upon the nasal septum in adults should be advised only after carefully considering the good to be accomplished and the possible risks incurred.

Medical Progress.

REPORT ON DISEASES IN CHILDREN.

BY T. M. ROTCH, M.D.

At a Meeting of the New York Academy of Medicine February 15, 1894,¹ Dr. William P. Northrup made the following communication:

SCORBUTUS IN INFANCY.

Pediatricists have recently learned to recognize newly a disease, and believe that they have saved a few lives in recognizing it. It is for the purpose of making the knowledge of this disease more general that the Section on Pediatrics comes before the Academy to-night. Sailors used to have scurvy before they took lime juice to sea; but do children and infants now have it? You will hear speakers here this evening say that it has been observed in New York, Boston, Cincinnati, Philadelphia and elsewhere. It was reported in Germany in 1873. In 1878 Dr. Cheadle reported three cases. No cases were recorded in the United States until 1891. Northrup had then reported eleven cases before the American Pediatric Society. One of these cases died, and the pathological findings proved of great value. Scurvy is a disease dependent upon the prolonged use of improper food or absence of fresh food. Its most characteristic symptoms are spongy gums and a tendency to hemorrhages. Notably these hemorrhages are subperiosteal collections of blood about the femora and other long bones, escaped blood into and beneath the skin forming petechiæ, and ecchymoses into the gums and membranes of the mouth, intestines, and pelvis of the kidney. The following combinations of symptoms appeared in several cases: spongy gums and swollen thighs; swelling of both thighs, gums spongy and bleeding; "black eyes," bloody passages, anæmia; spongy gums, swollen thighs, petechiæ, demonstrated subperiosteal hemorrhages.

Most cases have been attributed to persistent feeding of the infant on prepared infant foods and condensed milk. Even a small proportion of cow's milk and breast milk, according to some observers, are not sufficient to protect against this peculiar form of malnutrition. It occurs most among the rich, where strict regimen which has persistently excluded fresh food and fruit juices has been carried out. Among the poor, where the children received mixed food from the table, and consequently fresh food, they escape scurvy but suffer from rachitis. The age most subject to the typical disease is the second year of life. The most typical symptoms are swollen and painful joints and spongy gums; the treatment, orange-juice and other fresh

¹ *Annals of Gynecology and Pediatrics*, March, 1894.