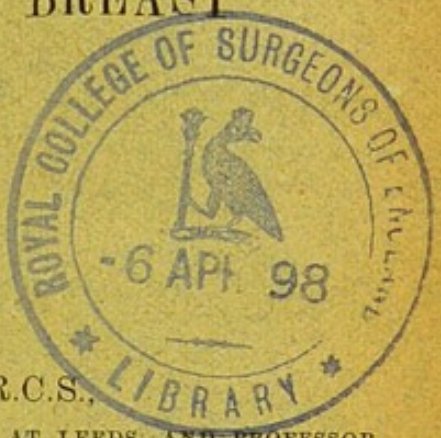
A method of obtaining a complete skin covering after ablation of the breast / by Mayo Robson.

A METHOD OF OBTAINING A COMPLETE SKIN COVERING

AFTER

ABLATION OF THE BREAST



BY

MAYO ROBSON, F.R.C.S.,

SENIOR SURGEON TO THE GENERAL INFIRMARY AT LEEDS, AND PROFESSOR OF SURGERY IN THE YORKSHIRE COLLEGE OF THE VICTORIA UNIVERSITY

[*From Vol. VIII (3rd Ser.), of the 'Royal Medical and Chirurgical Society's Proceedings'*]

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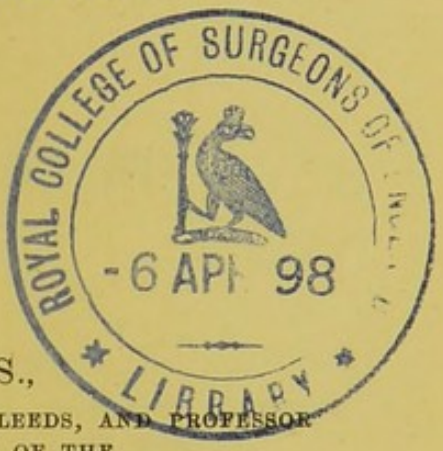

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Complete amputation of the breast with thorough removal of the axillary glands is now generally recognised as the appropriate treatment for carcinoma mammæ, and where the disease is at all advanced, especially if the skin be involved, a clean sweep not only of the breast but of the skin covering it, is considered essential. The only difficulty arises when an effort is made to bring the edges together in order to secure primary union, this being at times impossible to effect without further operative procedures.

The general practice among surgeons has been to draw the parts together as far as possible, and to leave the remaining uncovered surface to heal by granulation.

The text-books advise one of two courses,—either the leaving of the raw surface to granulate, the healing involving a long and tedious convalescence, or the covering it by Thiersch's skin grafts, an uncertain and tedious process which is not always successful.

It is certainly not generally recognised, though probably other surgeons may have adopted similar methods without making them known to the profession, that by means of one or two simple incisions, with sliding ot the flaps, the whole of a very extensive wound may be closed, and that primary union may thus be secured.

As some tension is necessarily present, the observance of careful antiseptic precautions is necessary, otherwise sloughing of part of the flaps may occur. I have, however, never experienced trouble in this way, and recovery is, as a rule, uninterrupted. I have employed the method in quite a number of cases, both for primary amputation and recurrent growths, but the accompanying photographs of two cases will sufficiently serve to illustrate my remarks, and the diagrams will serve better than a multiplicity of words to indicate my meaning.

I have to thank my house surgeon, Mr. A. S. Robinson, B.A.Cantab., for the notes and the photographs.

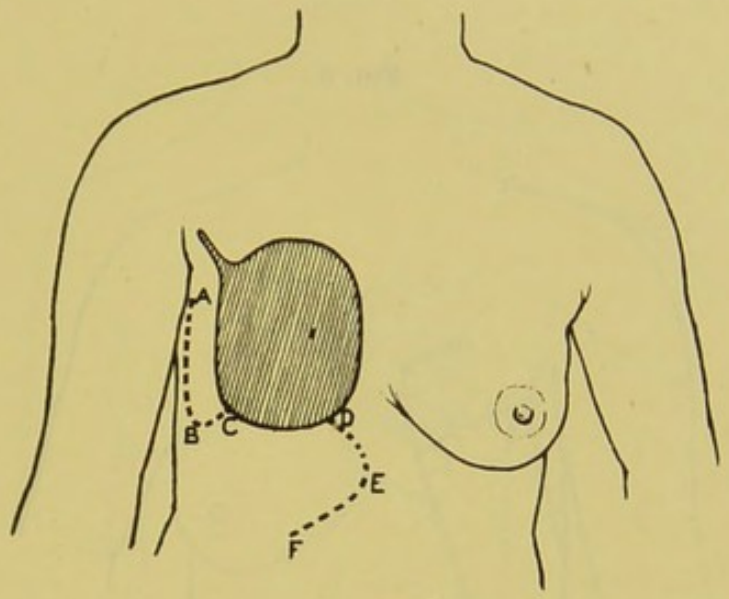
Case 1.—M. J. T—, æt. 46, admitted to the Infirmary for extensive scirrhus of the breast, which involved the skin as well as the axillary glands. Complete amputation of the breast and skin covering it was performed on July 18th, 1895, and in order to remove effectually the axillary glands it was necessary to lay bare the axillary vein for about 3 inches. The skin removed with the breast, after shrinking, measured 8 × 6 inches, and the raw surface left to be covered measured 12 × 9 inches.

The bleeding was arrested by means of pressure-forceps, with the exception of about four points which required ligatures.

The incision (A, B, C) was then made (Fig. 1) outlining a flap which was detached except at its axillary end;

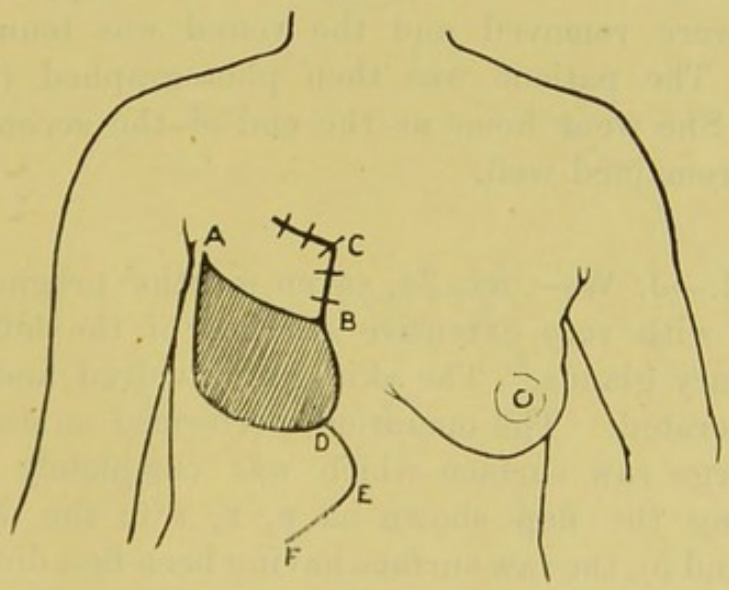
this was placed in position (Fig. 2) and fixed with silkworm-gut sutures. The raw surface was thus much

FIG. 1.



reduced, both by the flap and by the axillary border being drawn forward. The incision D, E, F (Fig. 2) was

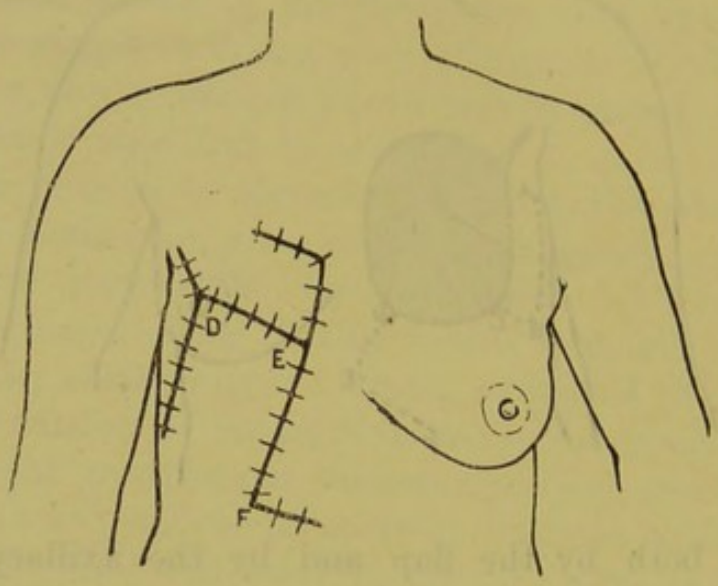
FIG. 2.



then made, and the flap undermined, slid into position (Fig. 3), and fixed by silkworm-gut sutures.

The raw surface having been thus covered with skin, the whole area was washed with warm boracic lotion and enveloped in double cyanide gauze, over which salufer wool was placed and fixed by means of a broad bandage firmly

FIG. 3.



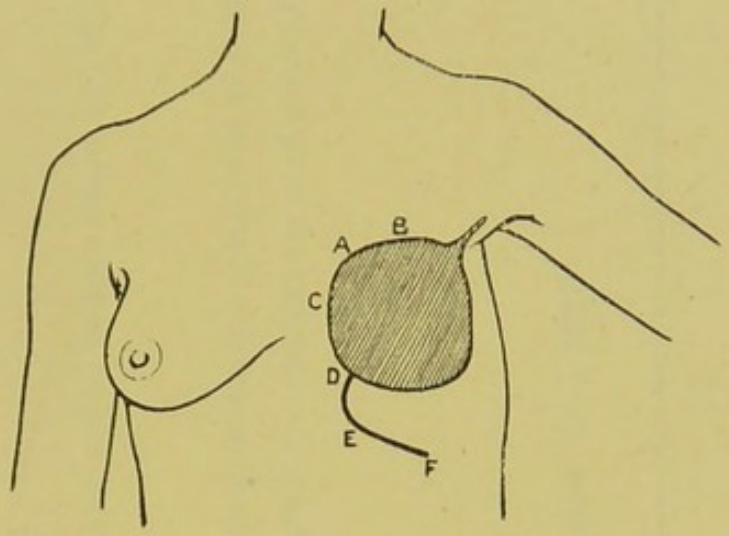
applied. The pulse and temperature remaining normal, the dressing was not disturbed till the tenth day, when the sutures were removed and the wound was found to be healed. The patient was then photographed (Plate I, fig. 1). She went home at the end of the second week, and has remained well.

CASE 2.—J. W—, æt. 34, seven months' pregnant, was admitted with very extensive scirrhus of the left breast and axillary glands. The skin was involved and at one point ulcerated. The operation, performed on July 25th, left a large raw surface which was completely covered by making the flap shown as D, E, F in the diagrams (Figs. 4 and 5), the raw surface having been first diminished by bringing the margins A, B, C together. The wound healed by first intention, and the sutures were removed on the tenth day.

She was photographed (Plate I, fig. 2) before going home at the end of the second week.

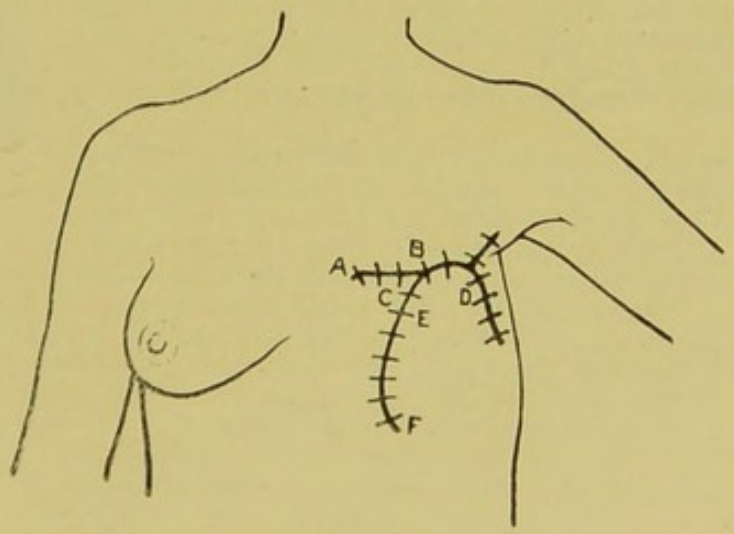
The pregnancy was not interrupted by the operation.

FIG. 4.



I think it will be found that the adoption of the method portrayed in my paper, or some modification of it, which will carry out the principle of completely covering the

FIG. 5.



large wound surface left in complete ablation of the breast, will not only render these extensive operations less for-

midable by shortening the convalescence, but will tend to greater thoroughness, as it will also enable surgeons to operate in cases otherwise inoperable.

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