

## **Removal of large enchondromatous tumour / by J. Harry Thompson.**

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REMOVAL OF LARGE  
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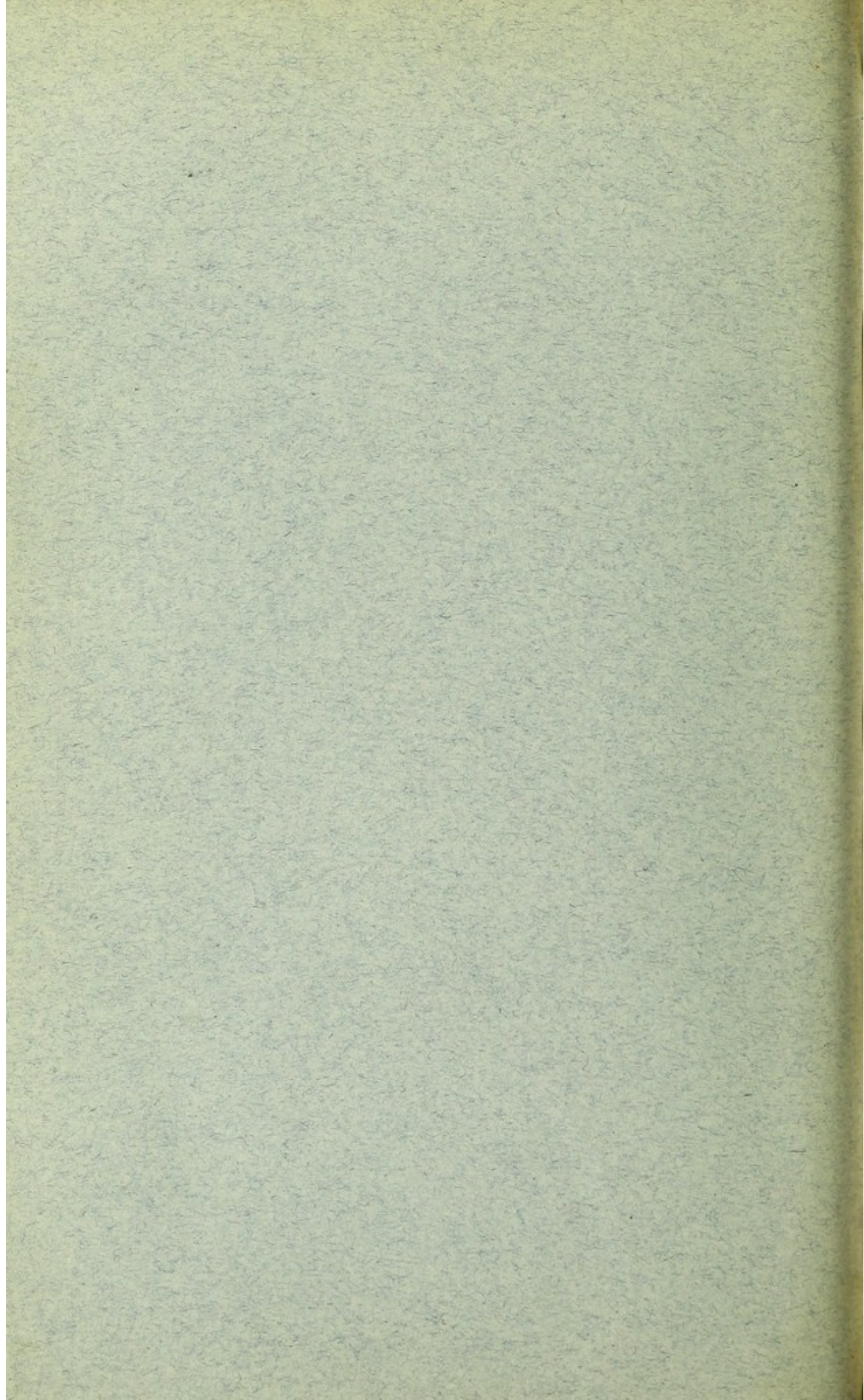
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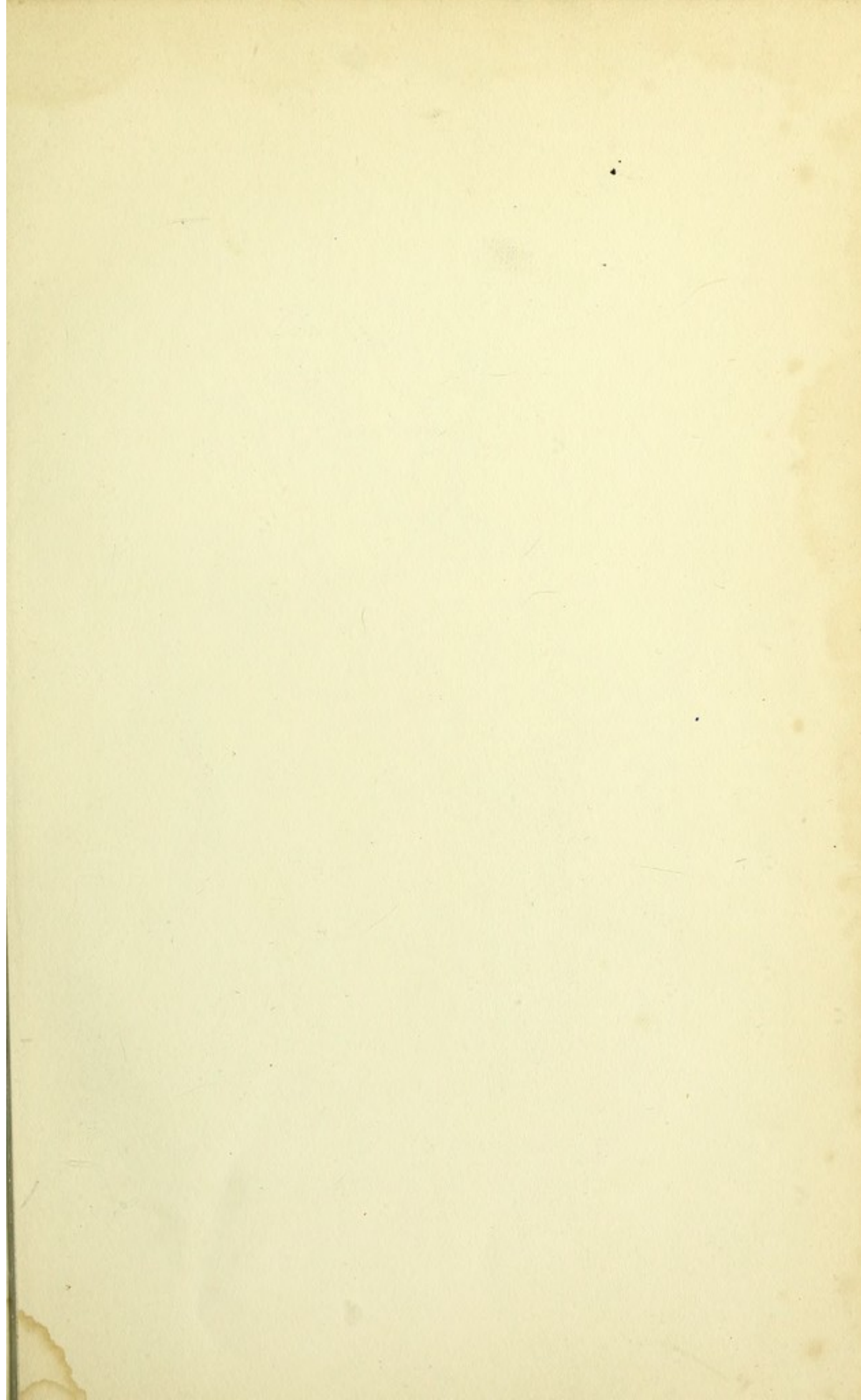
J. HARRY THOMPSON, A.M., M.D.

ROME, ITALY,

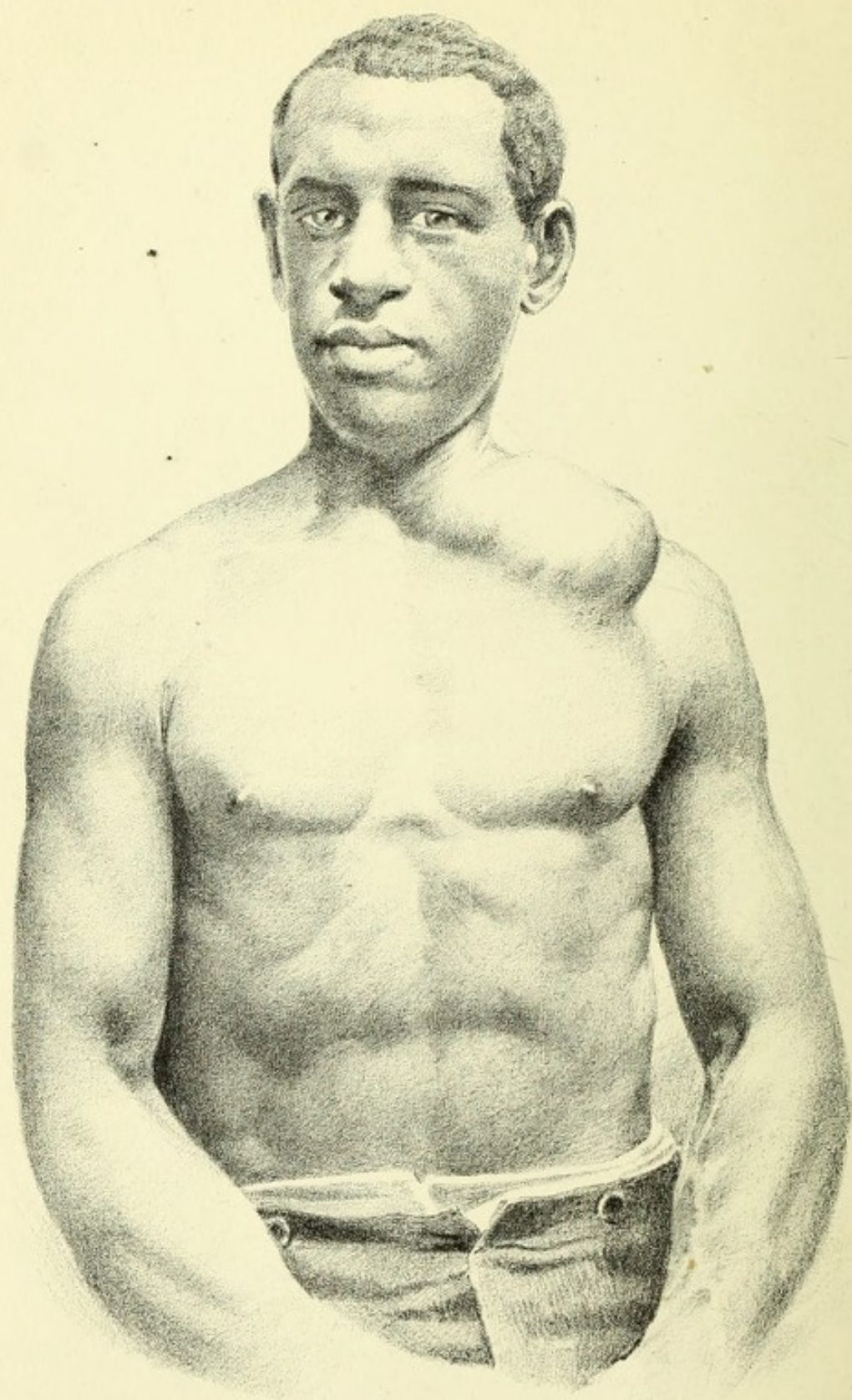
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BY

J. HARRY THOMPSON, A.M., M.D.

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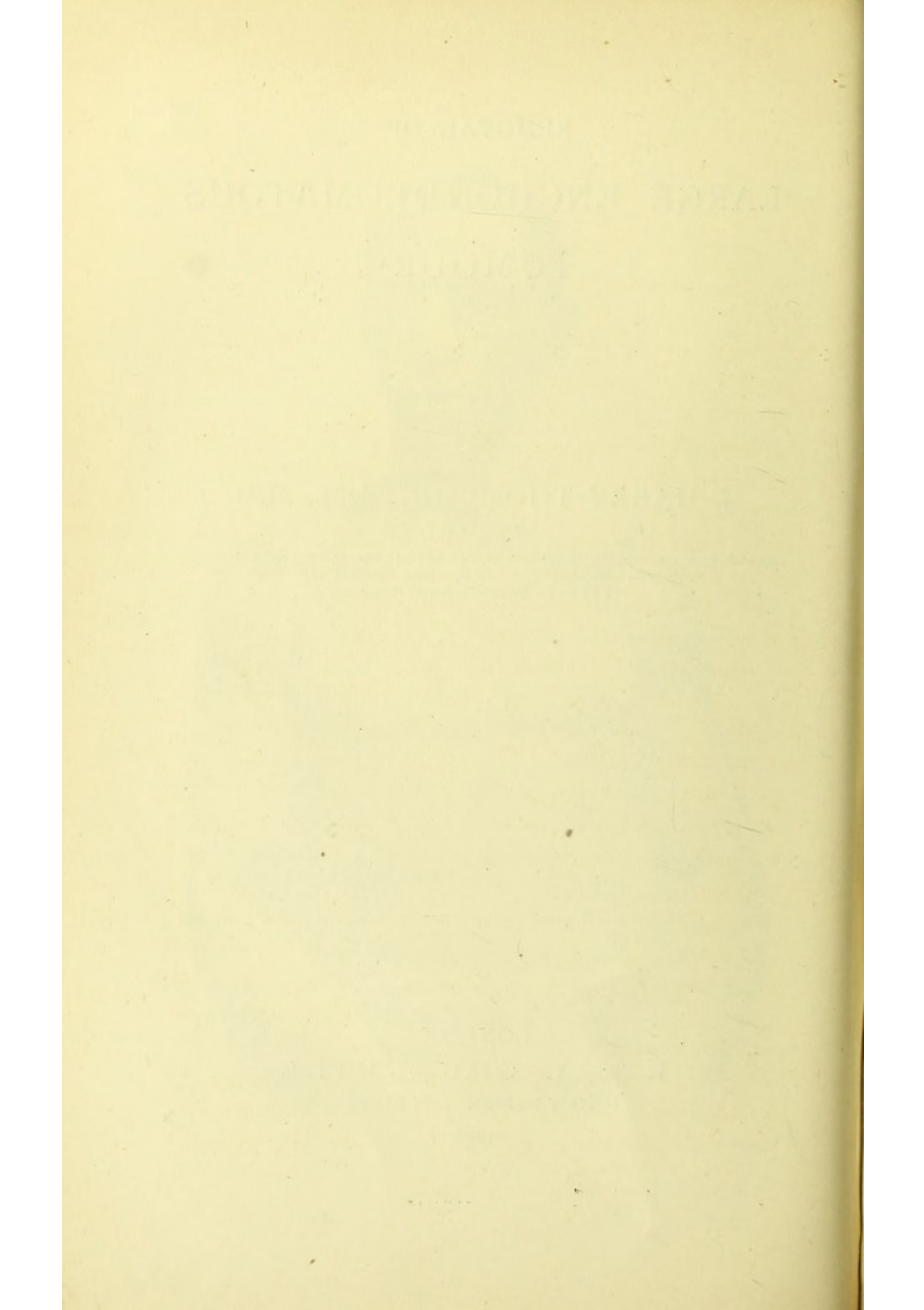
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1892





## REMOVAL OF LARGE ENCHONDROMATOUS TUMOUR.

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ANDREW LEE, aged 22, a bright mulatto, of remarkably fine muscular development, and in apparent good health, presented himself at the Clinic, October 4, 1887. He complained of a large tumour, which occupied the left side of the neck, extending from the trachea to the acromio-clavicular articulation, and completely covering the clavicle; posteriorly it lapped over the superior border of the scapula, anteriorly its most dependent part reached the margin of the second rib. It was hard, nodular at its borders, smooth on its upper surface and immovable, free manipulation produced no pain.

Its history was given by the patient as follows: about five years previously he was struck on the clavicle with a stick; the blow was hard, but did not break the skin; for a few days the part was bruised and tender, but he soon forgot the circumstance.

A few months afterwards he noticed a lump, about the size of a bullet, at the spot where he had been struck; it was hard but not painful, and kept gradually increasing in size, but gave him no trouble until within the last few months, during which time its increase had been very rapid.

He now suffered great inconvenience from its presence; he was unable to move his head freely, being compelled to keep it over the right side; by its pressure on the trachea it



interfered with respiration, and the venous circulation on the left side of the head was impeded, the pressure on the subclavian and first portion of the axillary vein prevented the free return of blood from the arm, and caused a varicose condition of the vein of the forearm, as will be observed in the accompanying engraving, which was copied from a photograph taken immediately before the operation.

A consultation was held, Doctors Ritchie, Newman, Holstein, and Reybur being present. There was a unanimity of opinion as to the propriety of its immediate removal, but quite a difference of opinion as to the character of the tumour.

From the history of the case, the general good health of the patient, his age, and the fact that all the inconvenience he suffered was attributable to the mechanical pressure alone, I was fully satisfied that it was not an osteo-sarcoma, but an enchondroma springing from the periosteum of the clavicle, and hoped to be able to remove the mass without sacrificing the bone.

The patient being fully etherized, an incision was made across the centre of the tumour,  $8\frac{1}{2}$  inches long, extending from the edge of the sterno-cleido-mastoid muscle on the right to the acromion process on the left side; another was made antero-posteriorly from the spine of the scapula to the margin of the third rib. The dissecting up of the flaps was tedious, the skin being intimately adherent to the tumour, and the fibres of the platysma myoides incorporated with the mass, the external jugular vein was obliterated.

The lower portion of the tumour anteriorly was adherent to the thin layer of fascia covering the axillary vessels, processes of the growth having insinuated themselves between the fibres of the pectoral muscles. Upon liberating this



portion and slightly elevating it, it became evident that the tumour had grown downwards beneath the clavicle on either side—that bone occupying about the middle of the mass—and that its attachments extended to the deep portions of the neck.

The attachments posteriorly and on the left extremity were next separated, and strong traction being made upwards I continued the dissection, working from the front downwards and backwards; the subclavian vein and artery were both adherent. This portion of the dissection, and liberating the phrenic nerve, which lay in a sulcus between two lobules, was the most difficult part of the operation. In separating the adhesions formed with the pleura, I unfortunately wounded that membrane; and although but a small quantity of air entered the cavity (the opening being immediately closed with the finger), the effect upon the respiration was immediate and alarming; the breathing became very laboured and almost stopped, the pulse fluttered and for a moment was lost. The operation was suspended, the tongue drawn forward, and artificial respiration resorted to. It was some minutes before there was sufficient reaction to justify me in continuing the operation. The deep attachments anteriorly having been separated, a strong short-bladed bistoury was laid flat on the finger, and passed under the tumour up to the superior surface of the clavicle. Keeping the edge in close contact with the bone, it was carried from right to left, dividing the strong attachments by which the mass was held down. Thus partially liberated, its posterior deep adhesions were exposed, and the sheath of the common carotid dissected off, as also the strong attachments which bound it to the trachea; a few strokes of the knife completed its removal.

A small portion of the clavicle was necrosed. This was removed with the chisel.



The chasm was filled with pieces of sponge soaked in a weak solution of carbolic acid; brandy and ether administered hypodermically to assist in bringing on reaction, which was not yet well established, and the parts covered with warm flannels.

At the end of two hours the pulse was full, the patient conscious, breathing naturally, and the surface warm.

The sponges were removed, and all oozing having stopped, the flaps were accurately adjusted, and the entire surface covered with lint soaked in carbolized glycerine, compresses were carefully arranged so as to bring the flaps in contact with the deep tissues, and the whole covered with several thicknesses of raw cotton—my fear being that the flaps might slough, as they were very large and thin, hence poorly supplied with blood. If I could succeed in getting adhesions to the deep tissues, it would materially assist in maintaining their vitality.

10 P.M. : Five hours after the completion of the operation, patient restless; pulse 100, and full; tinct. opii, 10 drops, to be given every two hours until the general irritability was reduced or the patient slept.

October 5.—8 A.M. : Passed a moderately quiet night; has taken the drops three times; complains of great thirst; pain in left shoulder, extending down the arm; pulse 100, and hard; the drops to be continued every three hours, ice *ad libitum*.

2 P.M. : Thirst less troublesome, pulse no better, temperature 100; had passed no urine; spts. ether. nit., 3j, tinct. opii, gtt. x, to be given in two ounces of water every three hours.

10 P.M. : Pulse 90, and softer; has passed twelve ounces of urine; less pain in the arm and shoulder. Medicine to be



given every six hours; milk alternating with beef jelly every three hours.

October 6.—9 A.M.: Has slept six hours; tongue furred, but moist; respiration normal; pulse 85, soft; passed urine freely during the night; same treatment continued.

8 P.M.: Pulse 80; skin moist; respiration normal; tongue furred; medicine to be discontinued; an enema of salt water to be given as the bowels have not moved since the operation.

October 7.—11 A.M.: Patient bright and comfortable; said he had no pain unless he turned or moved his head to the right side; felt a little hungry. Examined the wound, and found a suspicious blush about the centre of the flaps where they were the thinnest, and hence death of the tissue most likely to occur; removed the compresses, and covered the parts with a thick poultice of flaxseed meal, and painted all the discoloured tissue with pure carbolic acid; the poultice to be renewed every two hours. As the pulse was good and the man's general condition all that could be desired, and every part appeared to have united by first intention, I apprehended that the threatened destruction of tissue was confined to the epidermis. Beef essence to be given freely, and one grain of quinia every hour.

10 P.M.: Discoloration spreading; every other symptom was as favourable as could be desired.

October 8.—10 A.M.: Patient sitting up in bed; pulse and respiration normal; no constitutional disturbance whatever; bowels had opened early in the morning; urine normal in quantity and appearance; temperature in the axilla 97. The discoloration had spread, and at the point where the incisions crossed each other over the clavicle the skin was black. This gave me no anxiety, as I was quite satisfied the cutis vera was not implicated.



October 9: Every part involved in the discoloration had turned black, but the line of demarcation was as sharply marked as if drawn with ink on yellow paper, which would not have been the case if the true skin had been involved. Removed every alternate suture, and applied a few strips of adhesive plaster to guard against traction. The condition of the patient was in every way satisfactory. There was nothing about him to indicate that he had recently been subjected to so severe an operation.

October 10.—5 P.M.: The epidermis had partly separated and revealed sound tissue beneath. All the sutures were removed, and it was found that there was union by first intention in every part. Poultices discontinued, and carbolic ointment applied.

October 13: The point of union in the antero-posterior incision, immediately over that part of the clavicle of which a portion had been removed, had given way to the extent of half an inch, and the space was filled with healthy granulations.

October 20: Cicatrization perfect in every part; no further attendance required.

On the 10th of December I saw him loading a cart with sand, handling the shovel as well as those with whom he was labouring. He informed me that he had commenced work the day previous, and felt no inconvenience or pain, but thought he was as good a man as he had ever been. Microscopical examination showed that the larger portion of the tumour corresponded to the chondroma of Billroth, but the upper part lying immediately beneath the skin answered nearer to his description of spindle-celled sarcoma; it weighed twenty-two ounces.

The absence of pleuritis, which we had every right to



expect would follow the wounding of the membrane and introduction of air into the pleural cavity; the union by first intention of so large a surface; and the almost entire immunity from severe constitutional disturbance, was in my opinion due to the free administration of opium.

I have for many years followed the practice of giving opium freely after all severe operations, not waiting for inflammation and irritative fever as indications, but anticipating them, and, by getting the nervous system well under control, succeeded in preventing them; rarely failing to obtain union by first intention, however severe the operation.

I was strongly advised before commencing the operation to remove the clavicle in its entirety, but decided, as the man was a labourer, to give him the benefit of a doubt as to the probable return of the growth, urging that in case of necessity the bone could be removed at any time.

Five years have now passed since the operation, and there has been no return of the disease.



