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Cancer of the Breast

A Further Consideration of its Chemical Extirpation

C. W. STROBELL, M. D.

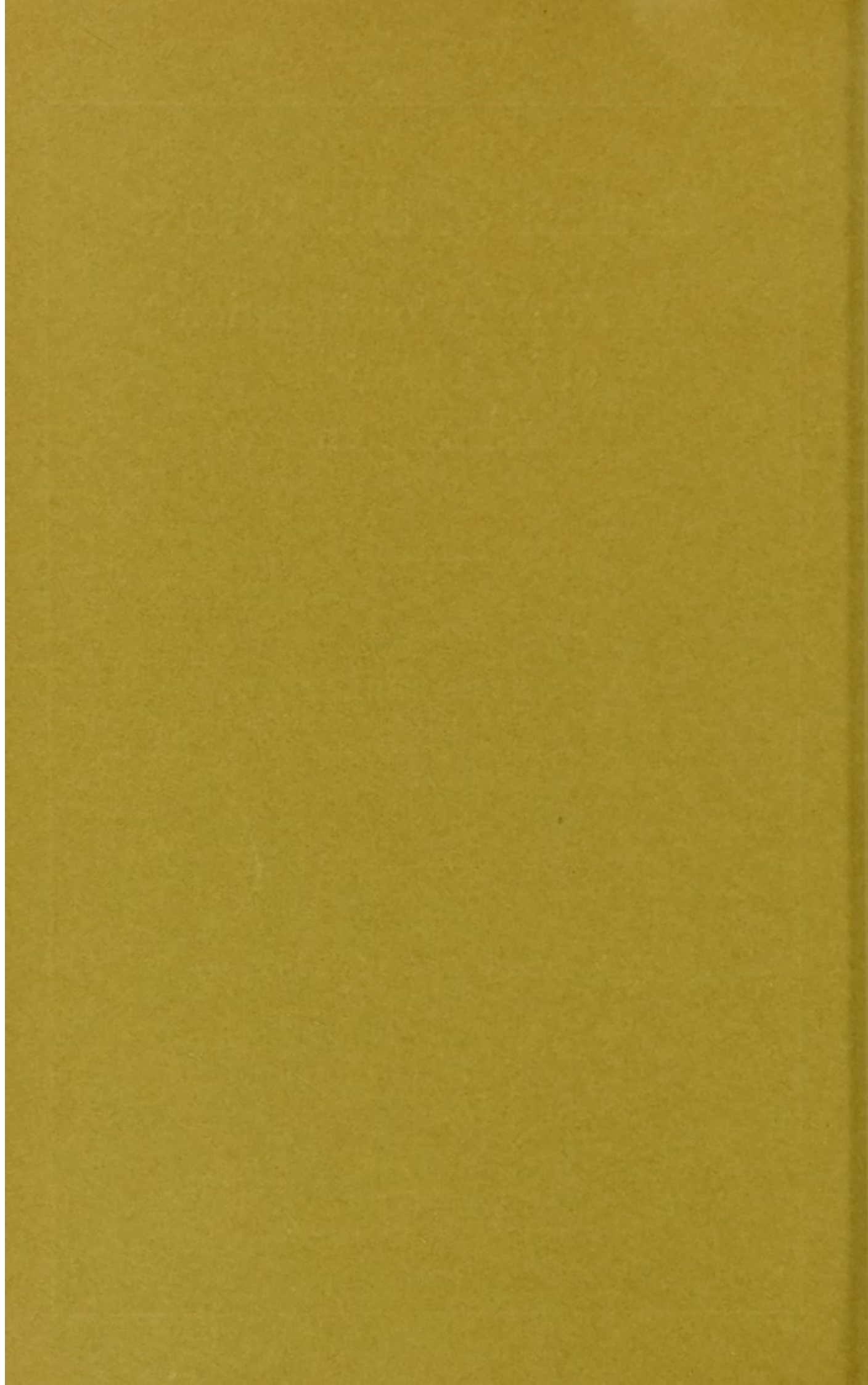
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CANCER OF THE BREAST.
A FURTHER CONSIDERATION OF ITS CHEMICAL
EXTIRPATION.*

BY

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Passing over the text-book classifications and descriptions of cancer of the breast familiar enough to all I shall plunge at once into the very heart of my theme and say a few words on its pathogenesis and treatment, as this alone will easily occupy all the time allotted to me. Moreover, I can say nothing new on the subject except to report some personal convictions based upon actual experiences and observations, and to demonstrate some of the results.

Broadly speaking, the rational treatment of cancer in any form is, and will continue to be, surgical, until the advent of a serum derived from its causative pathogenic germ. The rational surgical treatment of all forms of cancer should, so far as practicable, proceed upon the assumption that a wound freshly made in tissues adjacent to any cancerous focus is a wound almost invariably *swarming* (82½% of all cases) with pathogenic germ-infected cells. Further, that these specific germs—both within and without the cells—are most powerfully active, virulent and tenacious, in the presence of so favorable a culture medium as the living traumatized tissues of man; requiring nothing less than *total* eradication at the time of operation to remove from the patient the very real danger of recurrence. We find it increasingly difficult to believe that this so vital complete eradication can, with any degree of uniformity or certainty be accomplished by the method so universally in vogue. Far from it! Our failure thus far to deal successfully with this

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greatest scourge of the human race is known to all lands, and in all places. The intelligence which wields the scalpel cannot in any given case, with absolute certainty or precision remove *all* the diseased tissue, together with *all* the specific pathogenic organisms, nor *all* the straggling tail ends of tumor strands, *because of the manner of the traumatism.*

Traumatism I grant there must be in any method of removal of the cancerous breast, but, as compared with rapid extirpation with its uncertainties, and the utter lack of preparedness or defense on the part of contiguous structures,—*what about a traumatism that proceeds so leisurely from without inward as to accomplish the destruction, in situ, of all infected tissues, coincidentally affording nature ample opportunity to “wall off” and establish her own defenses by phagocytosis; two powerful forces co-operating and assuring for the infective organism silent, insidious, unescapable annihilation; and this without at any time severing the continuity of living tissues, i. e., opening fresh avenues of infection?* Such is chemical surgery—the *new* chemical surgery, (for the use of caustics in cancer is as old as the history of medicine, and has long been relegated to quackdom because of its unscientific employment). The *new* chemical surgery is along *purely scientific lines*, and is a powerful rival for surgical honors as against the present standard operations.

Let us compare a few of the advantages and disadvantages of the two methods,—i. e.,

Rapid Extirpation

vs.

Chemical Extirpation

All rapid extirpations, like the Halsted operation—favor reinfection and recurrence. Rapid extirpation has 62½% of recurrences within three years to its credit, in presumably “preferred” cases, as reported during the past decade by thirteen of our best surgeons. (See article, *Amer. Jour. Surg.*, Nov. 1912.

Rapid extirpation cannot always be employed in that large class of advanced cases, presenting broken-down conditions with coincident internal metastases.

Chemical extirpation absolutely does not favor recurrence. I confidently predict for my chemical method a reduction of these discouraging statistics to 10% or less for the same period, *in the same class of “preferred” cases.*

The chemical operation on the contrary may be employed in all these cases alike—being at all stages safe, insuring a longer subsequent lease of life, and increasing the possibility of permanent cure fully 50%.

Rapid extirpation must always be done under full chloroform or ether or gas anesthesia, and involves severe shock to the nerve centers.

Rapid extirpation traumatizes the remaining adjacent skin in various ways to cover defects, and for drainage purposes. This becomes apparent in recurrent cases in the appearance of nodules at the various sites of such traumatisms, more especially along the lines of incision and suture.

Rapid extirpation makes no provision in its program for recurrence, as it ablates to the limit all suspected tissues at the primary operation, and when recurrence comes, falls back upon re-excision and x-radiation, neither of which is effectual, as a rule.

Rapid extirpation knows no way of securing a pathological specimen for diagnosis in a suspicious case at any stage, *without exposing the patient to the danger of the open wound*; a danger which all surgeons freely admit.

The chemical operation, on the other hand, may, if desired, be begun, continued and ended *without* their use and with practically no pain or appreciable shock.

Chemical extirpation obviates all this, requires no punctures, stabs, tension or other sutures, in any way, and eventually covers the finely granulating surface with skin grafts from the thigh. These grafts soon insure a freely movable and normally functioning skin surface, which remains unaffected by recurrence.

Chemical extirpation however is highly competent when the standard operation has failed as evidenced by recurrence to immediately step in and "land" the patient "high and dry," after a safe and extensive destruction of the recurrent area, such as the scalpel alone could not accomplish. Finally it covers this granulating surface with functioning skin grafts, thus changing what has always been regarded as a badge of death, to a picture of health, and herald of hope.

Chemical surgery in doubtful non-cystic cases, proceeds with the removal of the tumor itself to the point where a specimen for diagnostic purposes can be obtained, following examination of which *either radical extirpation of the entire breast is at once proceeded with, or, the operation concludes then and there with the local removal of the growth*—as the case may be. (Notation:—A pathological diagnosis of such removed tumor tissues may be made with about the same facility as in the perfectly fresh specimen. Old broken down or far advanced cases present somewhat greater difficulties in this respect. However, in such cases a corroborative diagnosis is not required.)

Rapid extirpation always requires the most extensive and complete removal of all enlarged axillary glands on the generally conceded assumption or ground, that all such enlarged glands are cancerous.

Chemical extirpation does *not* include the removal of all such enlarged axillary glands, it having developed in the course of the pioneer work that *they subside and resume their normal function*. Why this is so cannot yet be definitely stated. The most plausible view is that a *sufficient proportion of the active agents employed in the devitalization is absorbed by the lymphatics, and thus destroys the cancerous elements lodged therein—these glands thereafter undergoing resolution*. For many reasons this may easily be the solution, as it explains among other things the melting away of glands frankly cancerous and far advanced beyond the stage of a possible benign pre-metastatic enlargement.

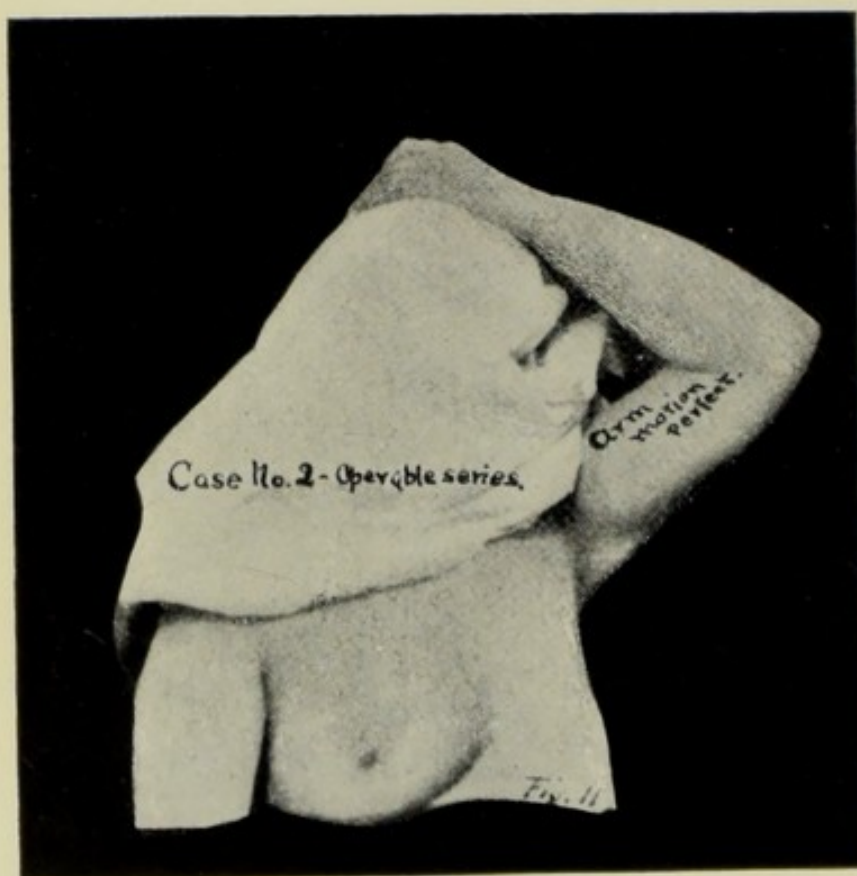
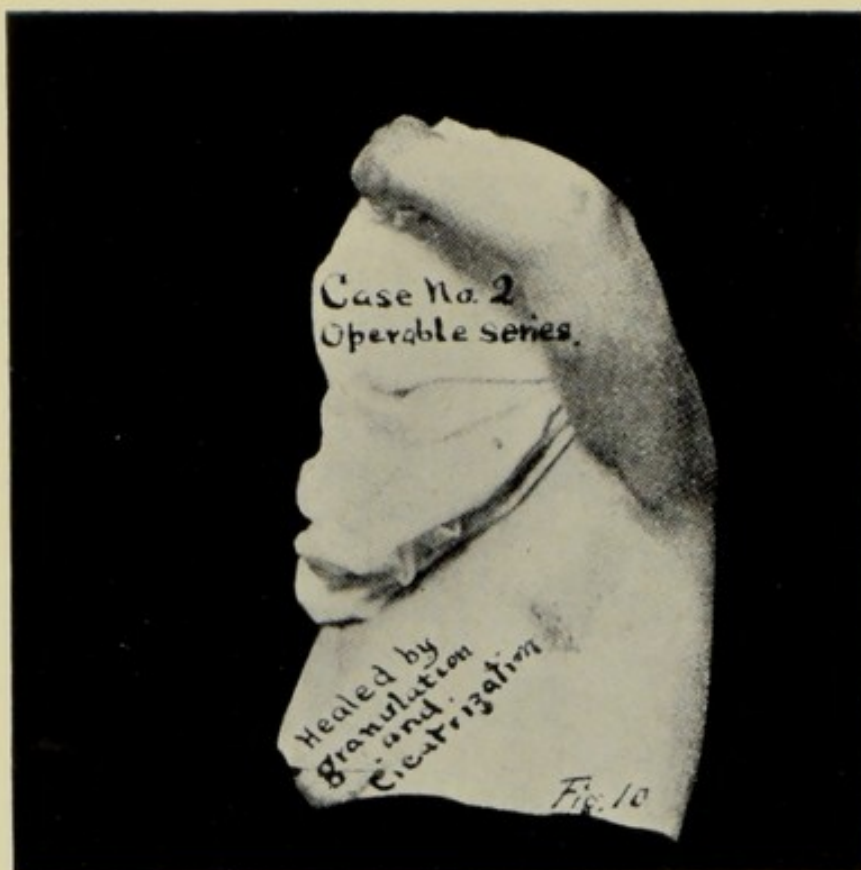
In well advanced cases with septic absorption, the coincident intravenous employment of arsenical preparations;—the iodides and chlorides generally;—and, more particularly, the use of iodoform in ether, as adjuvant treatment, is under observation, and bids fair to prove of definite value.

The technic of chemical extirpation of the cancerous breast has been, and still is, undergoing important modifications. Radical chemical extirpation of the cancerous breast is a most deliberate procedure, requiring patience, and a thorough knowledge of details, and would best not be undertaken without special training. Also it is pertinent to say that such cases should be treated in a specially equipped institution.

Naturally the question uppermost in our minds at this moment is,—what are the clinical results? Anticipating this I have much pleasure in presenting Mrs. B., who has consented to a demonstration. Mrs. B.'s is one of the seven pioneer cases reported in the *AMERICAN JOURNAL OF SURGERY*: Nov. 1912.

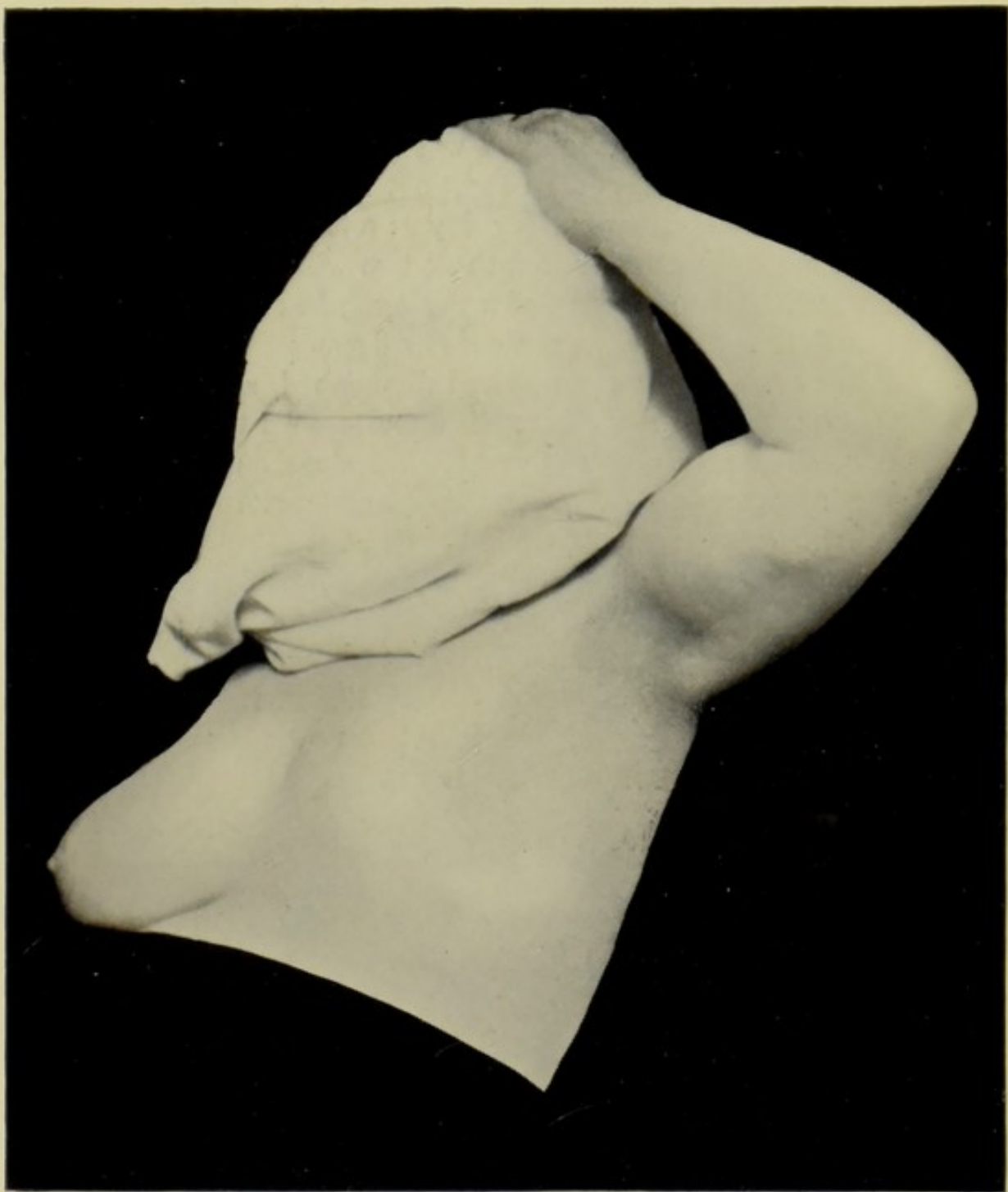
See reproduced photographs, figs. 10, 11.

Quoting from that report: "March 20, 1907, Mrs. B., American, age 45, nullipara; carcinoma of left breast size of small hen's egg. Lancinating pains for months; retracted nipple, tumor adherent; enlarged lymphatics. Had been *x*-rayed for three months. No material progress; began enlarging again. The modified chemical operation was done. Lymphatics disappeared, and healing took place quite rapidly . . . The aponeurosis of the pectoralis major was removed." I am here presenting the same case six years and two months after the operation. You will note that the patient is in fine physical condition and appears perfectly well. Also that the operated site is covered with a soft, white, movable, perfectly flexible, cicatricial substitute for the normal skin. This being next to the earliest case, the skin grafting idea had not suggested itself. Much dryness and discomfort follows this method of closure resulting from lack of the natural glandular secretions. As a result closure by skin grafting is now an essential part of the present technic, and assures an ideal result in every way.



*Breast removed by author's chemical operation, March 20, 1907
and healed by cicatrization*

*Reproduced Figs. 11 and 12; Case No. 2 of
Operable Series, reported in American Journal of Surgery, Nov., 1912*



Photograph of Case No. 2 of Operable Series (see reproduced illustration on opposite page) taken June 20th, '13, six years and three months subsequent to the removal of the cancerous breast by the author's chemical extirpation, showing well the present condition

An interesting coincidence in relation to the above case may with fairness be cited here to illustrate the striking advantage of the new over the old or standard operation. At about the same time that Mrs. B. began having her *x*-ray treatments another patient, whose name shall be Mrs. X, came, also with an indurated irregular tumor of fair size in her left breast, having all the earmarks of carcinoma. This patient, a multipara, whose age was 32, (13 years younger than Mrs. B.) was in good physical condition, and even rosy cheeked, feeling fine, and was working every day at a local bakery. Side by side almost, figuratively speaking, these two women underwent, for three months, the same degree of *x*-raying. In each, on four separate occasions, a good therapeutic *x*-ray dermatitis was produced. In each the tumor and symptoms had diminished, and in each also at about the end of the third month of treatment the growth and axillary glands began again to enlarge, coincidently with the return of pressure symptoms. At this point *x*-ray treatment was abandoned and the alternative presented to both patients, of undergoing either the radical Halsted excision, or the chemical devitalization of the author. Mrs. B. chose the latter, with the foregoing results; while Mrs. X. disappeared, and, as I later learned, had gone to Burlington, Vt., where she had undergone the radical Halsted operation. Several months later I learned that there was recurrence, and nine months from the time of operation news came that Mrs. X. had died of recurrent carcinoma.

Apropos of the specific cancer germ question, those interested should be familiar with the recently published work of Prof. Irwin F. Smith, Plant Pathologist, U. S. Bureau of Agriculture, Washington, D. C. Prof. Smith has discovered the specific plant cancer microorganism (*bacterium tumefaciens*). Those so inclined will do well to send to Prof. Smith for a reprint of his article "On some resemblances of Crown Gall to Human Cancer," also bulletins No. 213 and No. 255. These bulletins beautifully illustrate this important work. Prof. Smith was able to obtain, in rapidly growing young plants 100 per cent. of infections, with the speedy production of plant carcinoma.

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