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The Problem in Local Recurrent Breast Cancer.

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COLLEGE OF SURGEONS
23 JUL 1913
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THE PROBLEM IN LOCAL RECURRENT BREAST CANCER.*

BY

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Attending Surgeon City Hospital.

As an unsolved problem, cancer easily distances its great rival, tuberculosis, in that it is not yet recognized or treated as of pathogenic germ origin.

My contribution to this important symposium on cancer is based upon the fact of practically no recurrence in fourteen years' experience with radical chemical extirpation, and should be regarded as supplemental to one recently published in the *American Journal of Surgery* for November, 1912, entitled, A New Method of Treatment of Cancer of the Breast based on the Nature and Causes of Recurrence. Certain seemingly apparent facts, unavoidable deductions, and tentative propositions recorded in that paper should have careful consideration, as a foundation for conclusions concerning the following.

That the question of recurrence in cancer of the breast is a very real and live problem needs no defence. Recurrence is of far greater concern to the surgeon than primary extirpation, because in the primary operation the case is, as a rule, in the preferred or so called "operable" class, and holds out a reasonable hope of ultimate cure; whereas, confronted with recurrence, the surgeon is quite helpless, in view of the well recognized fact that further excisions are usually but palliative measures. Did the patients in these recurrent cases more frequently recover as the result of single, or even successive, excisions, the subject would long ago have stimulated the consideration it deserves; the opposite being the case, however, there is only inclination to shift responsibility, and to forget as

*Read by invitation in the Symposium on Cancer, before the Medical Society of the County of New York, March 24, 1913.

quickly as possible the unpleasant episode. It therefore quite naturally follows that but little appears in the literature on the subject of recurrence, except in reports of unsuccessful cases. To be sure, the present day results, as regards both cure and recurrence, compared with those set forth by Gross in his *System of Surgery*, 1882 (vol. ii., pp. 982-3), show a very substantial improvement, thanks to the genius of our American surgeons. May I be pardoned if I digress for a moment to say that clinically speaking whatever has been accomplished in this direction, cannot justly be credited to either the accuracy or utility of Cohnheim's theory of the embryonic origin of tumors, *as applied to malignant disease*. On the contrary its failure to meet the test has insistently directed attention to the very obvious fact of a pathogenic germ origin. Therefore the Cohnheim theory, as applied to the embryonic origin of malignant tumors, must go; it has never been proved. According to Delafield and Prudden's *Pathological Anatomy and Physiology* (5th edition, p. 291), "no one has seen the strayed or delayed embryonic cells." Infection, as applied to the resumption of physiological activity of originally displaced, long dormant, and newly awakened embryonic cells, is a misnomer, and violates all rules of practical, hardheaded common sense. Nor can there be such a thing as a primarily germ infected, strayed, and coralled embryonic cell lying dormant for periods varying from fifteen to fifty years; to me it is unthinkable. Thus the proposition is: Either the misplaced cell was infected at the time of its "straying," or it was not. If infected, it must have been by a pathogenic germ; if by a pathogenic germ, pathogenic changes would soon have resulted. Life does not stand still save in *cold* storage. In the case of benign tumors, it probably is true that they are due to such an origin as heredity, or trauma, or displaced embryonic cells, but benign tumors neither recur nor metastasize; thus proving that they are in a class by themselves. Malignant tumors, however, do recur and metastasize, *and these attributes are characteristic of pathogenic germ infection*.

Recurrence, in cancer of the breast, implies a preceding radical extirpation. The rapidity of such a return depends upon many conditions, none of which are definite or absolute; so that even in a

most carefully selected case, operated in under ideal conditions, there may be primary recurrence within two or three months; while on the other hand, recurrence may be surprisingly delayed, as notably in scirrhus conditions. "Of such recurrences," Pearsoll tells us, "eighty-five per cent. are in the chest wall and fifteen in the axilla." Recurrence following the radical standard extirpation is almost universally regarded as an external evidence of internal metastasis. I do not so regard it. To me it is simply the perceptible evidence of renewed activity of surviving specific pathogenic organisms. If internal metastasis to an abdominal or pelvic viscus exists at the time of recurrence, it so exists quite independently of the latter. Metastasis dating from a local recurrence is only by continuity through the chest wall to the pleura and lung, and thence to the general system. Whenever metastasis to any part of the abdominal or pelvic viscera manifests itself prior to, or coincident with, recurrence, it is certain that the primary operation was too late. This could not be known at the time of operation for the reason that the beginnings of all disease processes are microscopic rather than macroscopic, and that thus early they are also without appreciable symptoms. So that at the time of operation, the true extent of the disease must always be more or less problematical. To-day, for the first time in medical history, is there apparently something tangible at hand to hang our hopes upon; this consisting mainly of the very obvious fact of infection by a specific cancer germ, and the apparently corroborative results of the new chemical surgery. This new chemical surgery is based upon the assumed facts stated above and *upon scientific principles, questions altogether the expediency or safety of extirpation by excision through presumably healthy adjacent tissues.*

The foregoing facts should be accentuated in connection with the importance of a speedy and most radical secondary operation, upon the earliest indication of recurrence, such as can only be accomplished with any degree of scientific certainty by the new chemical technic. By the employment of this technic I regard recurrence, unaccompanied by internal metastasis, as a curable condition. May I again digress to call attention to the fact that of the seven radical chemical operations I have thus far reported, only one was

a really suitable case for the legitimate expectation of ultimate cure, all the others being far advanced. This will be seen by a study of that report; and yet in not one of that number is there, or has there been, any sign of local recurrence. One of the patients, with evident metastasis at the time of operation, returned, a year and three months later, with a tumor in the left breast, with accompanying bilaterally enlarged cervical lymphatics. Despite this development, however, and the ultimately fatal outcome (occurring subsequently to the publication of the report), *absolutely no sign of local recurrence was observed at any time at the site of the removed breast.* Surely my work deserves attention, if for no other reason than the fact that in all the patients the enlarged axillary lymphatics disappeared.

I desire here to submit the report of a recurrent case, with probably coincident internal metastasis, tentatively and palliatively operated in by the new chemical method. To my mind, it is a beautiful object lesson as to what may be done in even so hopeless a condition. The photographic plate of Fig. I was taken when the patient arrived. The black band about the infected field was done with the tincture of iodine, merely to mark the outermost boundary of involvement. It will be noted that recurrence was, as usual, along the line of "incision and suture," with secondarily infected trauma nodules studding the field above and below, which in similar cases are probably due to tension or other sutures, minute breaks in the skin from severe stretchings, or drainage punctures and stabs. The centre of the line exhibited an ulcerating aggregation of nodules. At the axillary end of the line was a larger mass as yet intact. About an inch superior to this mass and lying beneath the remaining portion of muscle was to be felt a large, freely movable lymph node, the size of a robin's egg. The tissue to be removed was firm, unyielding, cicatricial, and fixed to the chest wall. The involved area measured seven by nine inches in its transverse diameters; surely the picture of an extreme type of recurrence, in which few surgeons would have the disposition to employ re-excision.

The case was that of Mrs. P., aged seventy-two, an American, always in poor health. A radical standard extirpation of the breast had been performed in 1910, at Albany, N. Y. At the expiration

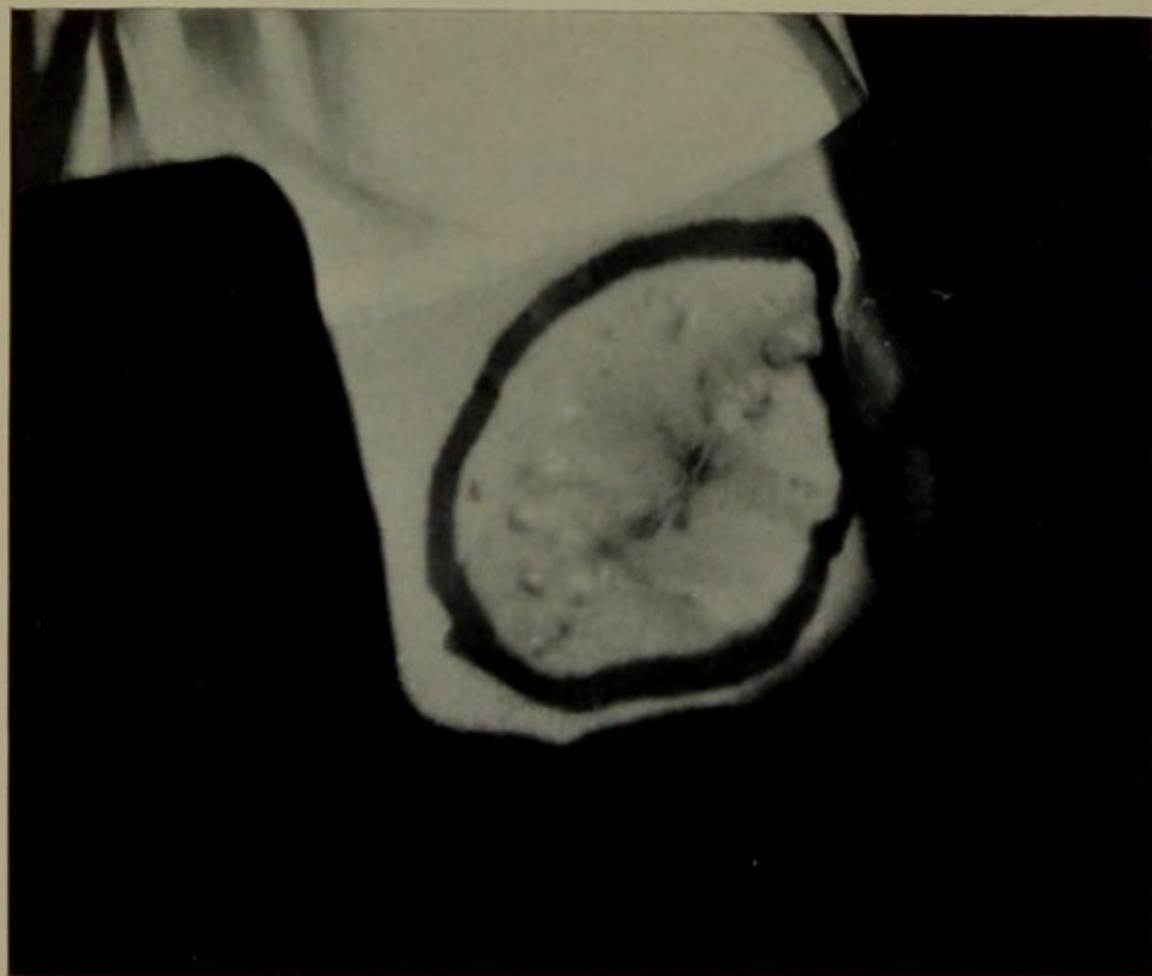
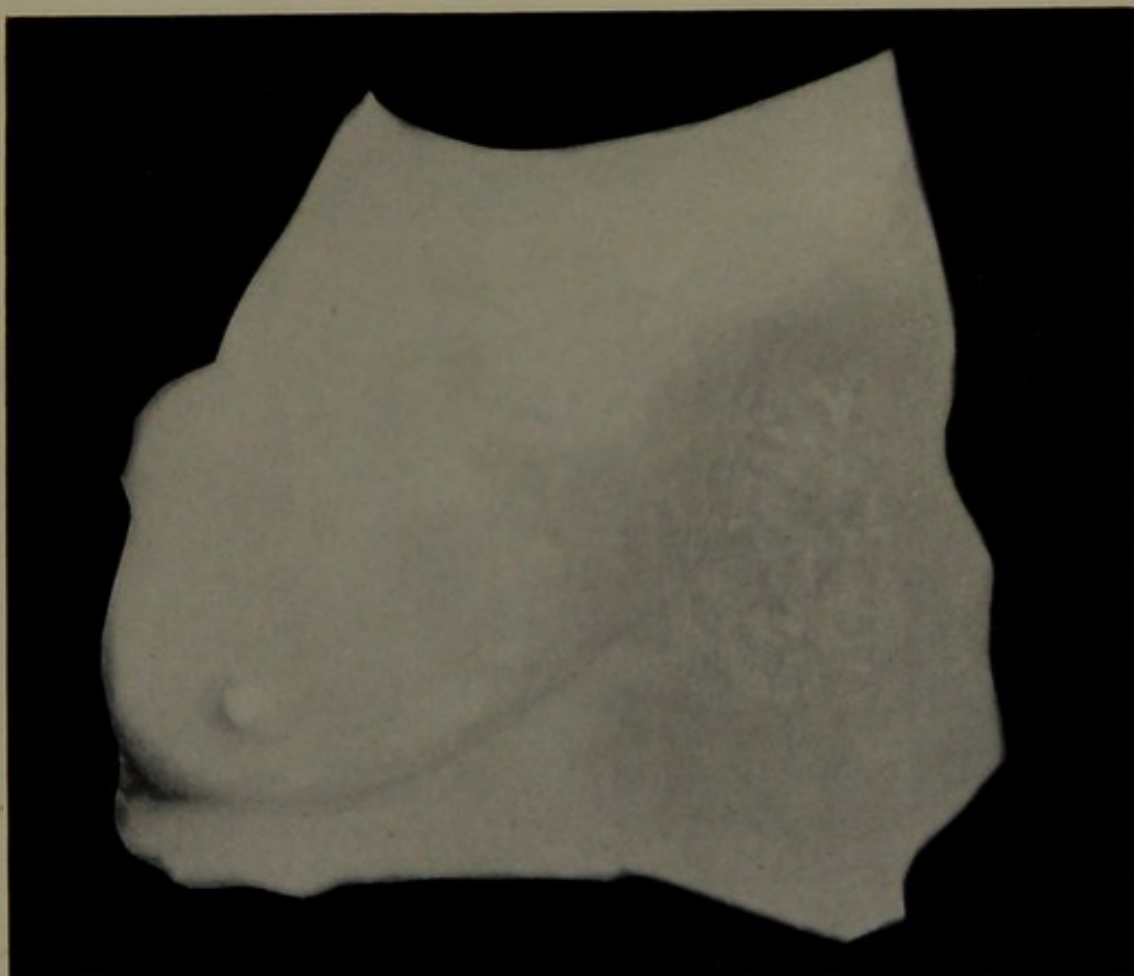


Fig. 1. Reappearance of Breast Carcinoma in fifteen months, following the radical standard extirpation of HALSTED.



* The same case five weeks subsequent to skin grafting, following the radical chemical extirpation of the author.

of a year and three months evidence of recurrence was noted. Two months later the patient was referred to me for chemical surgery in a final attempt to save her. The problem was most difficult, as the devitalization had to be very carefully gaged and guarded on account of the near proximity of the pleura to the overlying affected area and the close relationship existing between the axillary vessels and the large node under the pectoral stump. The tissues lying within the circumscribed area down to, but not involving, the periosteum of the ribs, together with the enlarged node, were chemically removed; a fine granulating surface eventually presenting. This granulating surface was then covered with Ochsner skin grafts, every graft "taking." The photograph of the completed condition was taken about five weeks after the grafting operation. *Under the influence of important modifications in the previously described technic, the discomforts attendant upon previous operations were almost wholly abolished.*

Fig. 2 shows the healed site of the operated area, the outlines of the larger grafts being easily traced. These grafts have gradually taken on the natural pale flesh color with the accumulation of subcutaneous fat, and have the same appearance in their central portions as that of the surrounding skin. At the end of three months, in an uncomplicated early case of recurrence, the same result would obtain as is shown in plate XIV of my previous article. The skin should then be quite freely movable, possessed of the normal glandular secretions, and would need no care different from that of the surrounding skin. Subsequent to the taking of the photograph, some small flat, lentil-like papules, discovered well outside the operated area, were devitalized from time to time. The operation was done in November, 1912, and at this reading the patient is in fine condition.

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