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AMPUTATION OF THE BREAST

BY MEANS OF THE ANTERIOR AXILLARY INCISION.

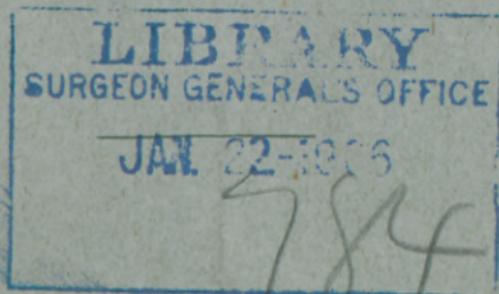
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COMPLIMENTS OF THE ASTOR
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Amputation of the breast in malignant disease is no longer regarded as a palliative operation in prolonging life; but should have for its purpose a permanent result, as verified by recent statistics. The operative technic of Halsted, which is simply a practical application of the profound anatomic research of Haidenhain in this region is certainly to be recommended. Of late, I have removed the breast, together with the axillary contents, without making an incision in the axilla.

The object of this short article is not to describe the radical operation for removal of the breast, which is only too well treated in all works on operative surgery, but to dwell on the value of the anterior axillary incision as a preliminary. The accompanying illustrations are more explicit than a detailed description of the operation. The breast is circumscribed by two curvilinear incisions which meet above at the border of the pectoralis major muscle. The incision is then continued slightly internal to the outer border of this muscle, in an upward direction, to a point about one inch above the apex of the axilla, where it takes an outward course in the deltoid region, forming a gradual curve, which terminates at the level of the apex of the axilla. (Fig. 1.)

Figure 2 shows the breast removed from the thoracic wall, but suspended by the axillary glands and adipose tissue, which are about to be enucleated en masse by blunt dissection. Figure 3 represents the operation completed.

I wish to lay stress on the following advantages of the anterior axillary incision:

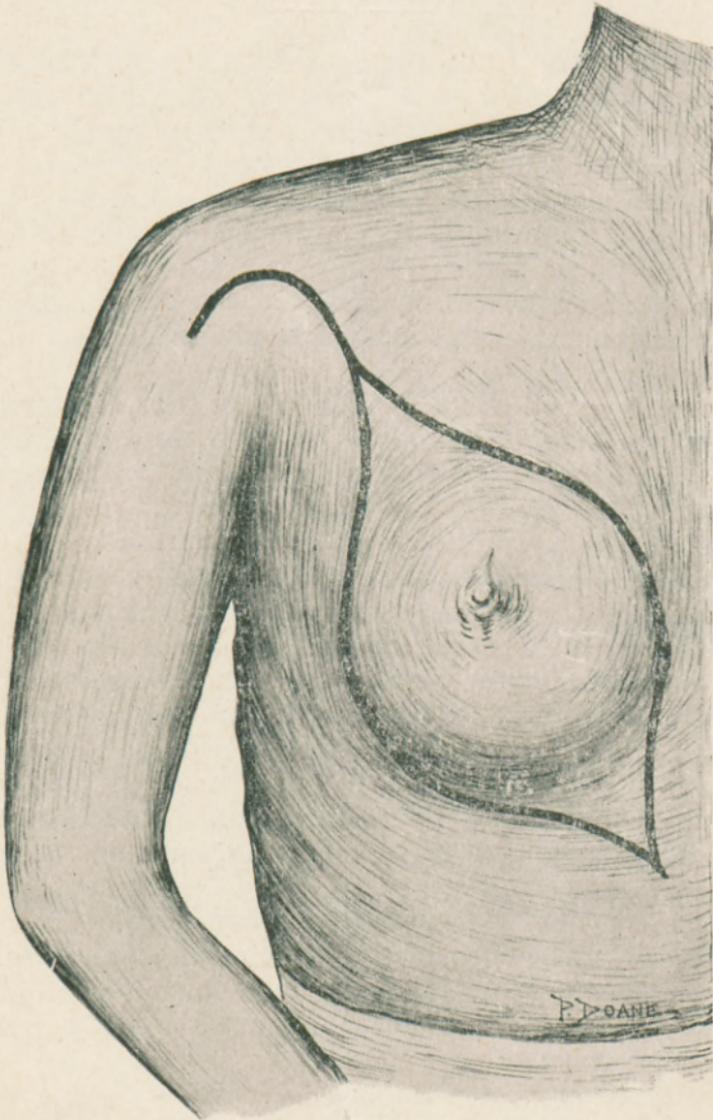
1. It exposes to the operator a larger field for radical work than the ordinary axillary incision.

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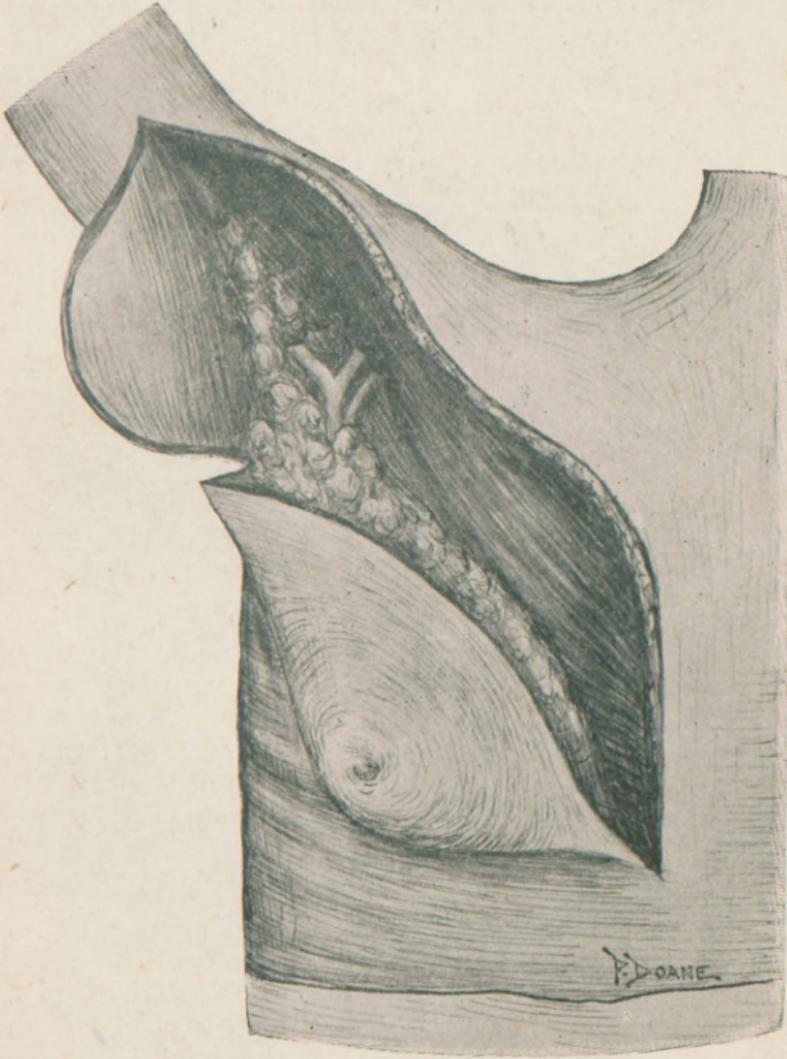
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2. By making traction on the axillary flap, it is easily freed from the subcutaneous tissues with a few strokes of the knife, exposing at once the position of the axillary vein.



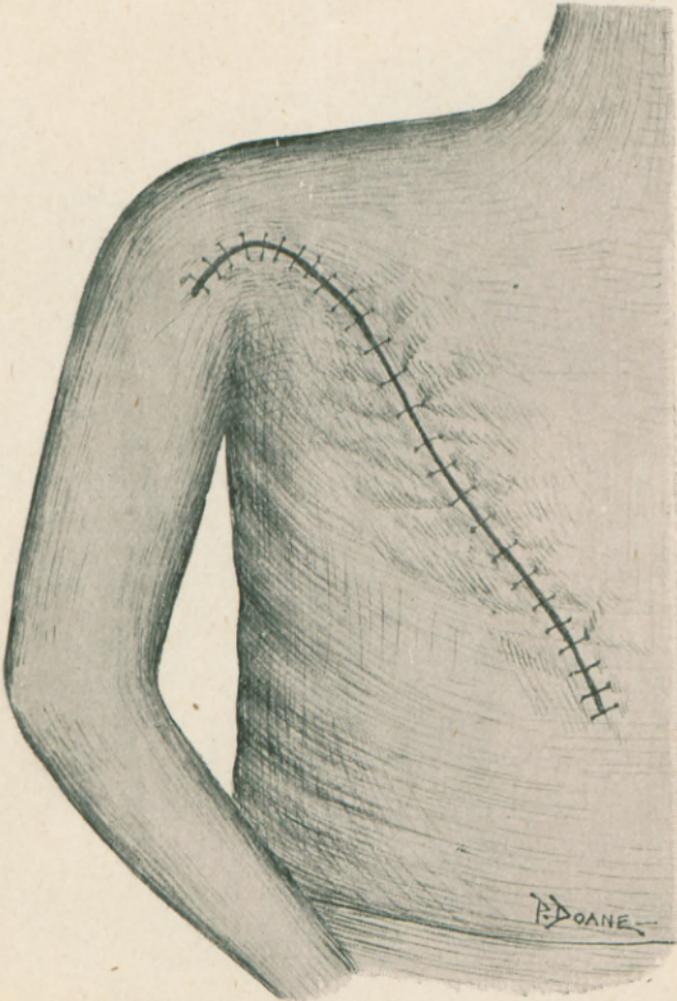
3. Injury to the vein is greatly diminished, because the incision bares all the surrounding muscular land-

marks to this important structure. Moreover, dissection is done away from the vein instead of toward the vein, as must be done through an incision in the axilla.



4. The axillary space is unfavorable to primary wound healing, being often the seat of a fistula long after the rest of the wound has healed intact. It is a region difficult to render aseptic; hence the advantage of access to this region from without.

5. The incision is so situated that it does not impede free motion of the arm, the patient being able to extend the arm to the head at the first dressing. There is no subsequent cicatricial contraction, as in an axillary scar, to interfere with the physiologic function of the arm.



6. The cicatrix is not dragged upon by motion of the arm, consequently scar tissue is little exposed to trauma through mechanic stretching; hence the diminished liability of recurrence of the disease.

