

Staff Meeting Bulletin
Hospitals of the . . .
University of Minnesota

Borderline
Breast Tumors

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

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William A. O'Brien, M.D.

I. TWO WEEKS AGO

Date: December 3, 1936
Place: Recreation Room
 Nurses' Hall
Time: 12:15 to 1:30 P.M.
Program: Movie: Behind the Shadows
Abstract: Gout
Present: 116
Discussion: I. J. Pass
 P. S. Hench
 H. S. Diehl
 M. Wetherby
 C. J. Watson

II. LAST WEEK

Date: December 10, 1936
Place: Recreation Room
 Nurses' Hall
Time: 12:15 to 1:15
Program: Minnesota Football Pictures
Present: 120
Note: No Bulletin issued.

III. ABSTRACTBORDERLINE BREAST TUMORS

R. W. Koucky

Scope

The following abstracts are limited to papers dealing with conditions of questionable malignancy of the breast. Certain paragraphs, i.e. those dealing with bleeding from the nipple and those on the choice of the type of biopsy while not dealing exclusively with borderline tumors, are nevertheless intimately

associated with this problem. In compiling the abstract, it was impossible to maintain an impersonal attitude. The favor shown certain papers has been influenced by our experience at the University of Minnesota Hospitals.

Fibroadenoma

Both carcinoma and sarcoma on rare occasions have been said to develop within this tumor. The experiences at the Johns Hopkins Hospital should make one investigate very closely any such diagnosis of malignancy.

From Johns Hopkins Hospital:

400 fibroadenomas (with sections now available)	
37 said to represent sarcomatous change	
27 of above cases show:	
Carcinoma	1
Sarcoma without evidence of preceding fibroadenoma	5
Fibroadenoma, cellular, but benign	17
Sarcoma in fibroadenoma	1
Sarcoma of questionable relationship to fibroadenoma	3

The authors state: "While we must still admit the possibility of a tendency on the part of these tumors to give rise to sarcoma, we are convinced that such a tendency, if it exists, has been tremendously overemphasized."

Fibrocystic DiseaseHistory

General historical reviews of this subject are well known and readily available and therefore need not be repeated here. In modern medical literature on this subject, there are two outstanding trends: Studies of the relationship of hormones to the genesis of the disease and the possibility of fibrocystic conditions of the breast

progressing into carcinoma.

Terminology

The wide range of terms applied to fibrocystic disease causes much confusion. In general, the various names given to simple cystic dilation of the glandular elements with fibrous hypertrophy of the stroma can be "indexed" in one's mind fairly easily: chronic cystic mastitis, benign cystic disease, Reclus' disease, Schimmelbusch's disease, mazoplasia, cystiphorous desquamative epithelial hyperplasia, etc., etc. On the other hand, the terms applied to fibrocystic disease complicated by tumor-like overgrowth of the epithelium are confusing: adenocystic disease, cystadenom (German), neoplastic epithelial hyperplasia, intraductal carcinoma, comedo-carcinoma, comedo-adenoma, etc., etc. Authors have chosen terms depending on how they have decided, in their own minds, the question of whether or not the condition is benign or malignant; hence, such terms as cystic adenoma and intraductal carcinoma.

Reduced to essentials, there are two types of lesions: the simple uncomplicated cystic disease of the breast which in this abstract will be designated as "fibrocystic disease" and cystic disease with various forms of hyperplasia of the epithelium which will be here designated as "fibrocystic disease with intraductal hyperplasia" with the addition of the adjective "benign" or "malignant" as deemed necessary.

Pathology

Evidence will be presented to show that all the lesions named above are stages of the same disease and in this paragraph, this impression will be followed.

Fibrocystic disease involves both the glandular elements of the breast and the fibrous tissue. In some cases, the epithelial changes are limited to the ducts; in others, the acinar hyperplasia is so marked that the picture suggests that of the breast during pregnancy.

The ducts are dilated and the lumina are often irregular in outline. The epithelium is flat or at the most low; often desquamation of the surface cells can be observed. The lumina contain granular debris and fragmented cells. The acini may be dilated. Often they are hyperplastic with cuboidal cells lining gland like spaces similar to the stages preparatory to lactation. Adjacent to both ducts and acini, there are collections of small lymphocytes. The fibrous stroma is definitely increased in amount. This fibrous tissue may be either compact and dense or loose as though it were edematous. Some lobules are more involved than others and the increased fibrous tissue, plus the dilation of the ducts, gives a nodular consistence to the breast. Cysts are formed by localized dilation of the ducts, ranging in diameter from 1 to 20 mm.

No evidence has yet been offered to prove the commonly accepted idea that obstruction of the ducts causes these dilations.

In brief, the disease consists of an overgrowth of ducts and adjacent fibrous tissue with or without involvement of the acini. The epithelium growing from the lining of these structures dies as it is pushed up by the deeper newly formed cells much in the same fashion as epithelium is desquamated from the skin. Cysts form presumably from occlusion of the ducts by accumulated cellular debris and increased secretion.

Fibrocystic disease with intraductal hyperplasia is a much more complicated disease. Either in one focus, in multiple foci, or diffusely through one or more ducts, the epithelium manifests increased growth activity. Whereas, in simple fibrocystic disease, the older cells die and desquamate into the lumen; in this form, the new cells produced by the activated growth remain viable and attached to their point of origin. Single or multiple papillomata or a diffuse filling of the ducts with living growing cells is the result. The ducts become markedly dilated and they apparently develop numerous branches so that the total number of visible ducts is

greatly increased. When such a duct system is opened with sharp pointed scissors from 1 to 200 sessile and pedunculated papillomata may be found. They vary in size from 1 to 10 mm. Or, if the epithelial growth has caused a diffuse filling of the ducts, a cross section of the mass reveals a sponge-like structure from the openings of which can be expressed brownish, worm-like cylinders of cheesy material. Sometimes this material is semiliquid and then it can be readily mistaken for pus. Any amount of breast tissue may be involved: a single duct, a lobe, or all of the breast. It has been our experience, time and again, that the palpable border of the lesion, as determined clinically, does not mark the edge of the involved tissue as determined by pathological examination. It seems that only the center of the area of maximum change is perceptible by touch and the edge must be determined by inspection of serial (gross) sections.

At the University of Minnesota Hospitals (from the laboratory cross index), there are 420 breast tumors recorded. The types are as follows:

Carcinoma (scirrhous, adeno, Paget's, etc.)	231
Fibrocystic disease, simple	82
Intraductal hyperplasia (benign only)	13
Fibroadenoma	53
Inflammatory	19
Non-specific	
Tuberculosis	
Tuberculous adenitis	
Fat necrosis	8
"Chronic induration" - male breast	8
Neurofibroma	2
Lipoma	2
Hemangioma	1
Hematoma	1
Myoma	1
	<u>421</u>

Unfortunately, the carcinomata are not indexed in such a manner as to give the number associated with intraductal hyperplasia, i.e. a malignant papilloma is index as carcinoma rather than as papilloma.

Klingenstein, in 128 cases, found 96

of simple fibrocystic disease and 32 of intraductal hyperplasia.

Malignancy. The most important question regarding fibrocystic disease today is "at what stage shall this process be regarded as malignant"? In our own experience, the cases of outright, undeniable carcinoma present in conjunction with this disease have all the gross characteristics of malignancy when it is present independently. In one instance, a tiny scirrhous carcinoma less than 1 cm. in size projected out in a fan shape from the base of a papilloma. In another case, an equally typical carcinoma was embedded in the sponge-like mass described above. In the last case, the axillary nodes were involved. Microscopically, the carcinoma may be of any of the types designated by the descriptive terms - medullary, scirrhous, adenoid, etc.

Such outright malignancies offer no difficulty in recognition if they can be found within the mass of diseased ducts. In two instances in our own experience, a carcinoma was found some time after a diagnosis of a benign lesion had been made from the initial examination. It is fairly common for us to request that the patient be returned to her room to allow time to prepare numerous "paraffin" sections. The volume of the tumor is often so great that study of many sections is necessary for a satisfactory examination.

It is our custom to make a diagnosis of malignancy only when the growth has left the ducts and is demonstrable within the stroma of the breast.

As pointed out by one author, these cancer cells are not malignant simply because they are out in the stroma or nodes; they are just as malignant before they leave the duct. When, if ever, should the purely intraductal growths be considered malignant?

Paget's Disease: Muir presents an extremely interesting discussion of Paget's disease which is of great value in estimating the malignancy of purely intraductal growths. There is a fairly general consensus of opinion that Paget's

disease is a carcinoma of the breast ducts which has spread externally to involve the skin of the nipple, i.e., a primary intraductal tumor of the breast rather than a carcinoma of the skin. The spread is by actual direct extension within the epithelium from the ducts in the interior into the external skin of the nipple. The "balloon cells" characteristic of the disease are cancer cells living within the otherwise normal epithelium. When the tumor breaks through the duct wall into the stroma, a characteristic carcinoma of the breast is produced. Paget's disease is notorious for the long periods of time in which it may stay limited to the ducts and epithelium without an apparent breast tumor or axillary involvement.

Muir presents the thesis that intraductal malignant growths may spread by way of the epithelium downward, away from the skin. In such cases, the "Paget cells" may be found growing in between the acinar or ductal epithelial cells. His illustrations demonstrate such cases.

Because of Muir's observation, our entire material is now being reviewed. In cases of intraductal tumors, large "balloon cells" can be easily found nested between the epithelium of the acini and ducts. However, cells having a similar appearance apparently can also be found in the acini of breasts involved only by simple fibrocystic disease. They apparently are degenerated cells or cells distended by secretion rather than cancer cells. From this study so far, it seems that Muir's findings cannot be used as a method to distinguish benign from malignant intraductal growths.

Nevertheless, Muir's studies suggest that intraductal hyperplasia, like Paget's disease, may be present for long periods of time before absolute evidences of malignancy make their appearance.

Statistical Studies

It is obvious that any statistical studies of the potential malignancy of intraductal lesions in humans are almost certainly doomed to failure.

One group of writers treat the subject as follows: A division is made between "pure" intraductal lesions and those associated with a carcinoma. The latter group are segregated and classified as malignancies. The results of the treatment of these are comparable to the results of treatment of any other type of cancer of the breast. The first group, i.e. the "pure" class, are those without malignancy. Treatment of these indicate that there are no deaths from carcinoma. Hence, the conclusion is drawn that intraductal lesions are benign (?).

In other studies, the separation of carcinoma, historically and pathologically, developing within or associated with a preceding intraductal lesion has also been done. Conclusions based on the end results of the surgical eradication of the remaining benign lesions cannot be accepted as applicable to the entire group of intraductal lesions. The fact that cancer does not develop after these tumors in their benign stages have been removed does not give any information regarding what would have ultimately taken place in the undisturbed tumor.

Cheatle has reversed these methods of study. He has attempted to study the "background" of cancer of the breast to define the lesion out of which or within which the malignancy developed. He has come to the conclusion that approximately 20% of carcinoma of the breast develops within intraductal hyperplasias. Simple fibrocystic disease (in accord with all other authors) is not a precursor of malignancy except insofar as it gives rise to intraductal hyperplasia.

The following are examples of the type of statistics which can be collected:

<u>Author</u>	<u>No. of Cases</u>	<u>Type of Cases</u>	<u>Criteria of Malignancy</u>	<u>% Malignancy</u>
Bloodgood (1921)	350	Fibrocystic	Follow-up	2.0
Bloodgood (1929)	100	Adenomata	"	0.
Bloodgood (1931)	?	"Borderline tumors"	"	0.
Campbell	233	Fibrocystic of which 43 showed adenocystic changes	"	0.5
Greenough & Simmons	83	Fibrocystic (all types)	"	4.8
Speese	295	" "	?	15.0
Semb	?	" "	?	24.0
Tietze	?	" "	?	10.0
Klingenstein	128	" "	Follow-up	3.8
Hart	128	Papillomata	Pathologic	19.0
Kaump & Ferreira	273	"	"	45.6
				(+19.3% considered "intermediate")
Lepper & Baker	11	"Intraductal cancer"	"	82.0

A new line of investigation has been opened within recent years--experimental production of fibrocystic disease and its complicated form, the intraductal hyperplasias.

Hormones

An extensive literature is being built regarding the changes in the breast after the use of various hormones alone, in combinations, and under varying experimental conditions. The results to date are not ready for final interpretation. The hormone injected may produce its effect directly on the breast; however, it may stimulate the animal's own organs of internal secretion and these stimulated hormones may be the active substances either alone or in combination with the injected substance.

Even though the details are not clear, one feature is definite. The injection of excessive amounts of ovarian hormones (primarily estrin) produces a change in the breasts of animals which is indistinguishable from the fibrocystic changes seen in humans.

Malignancy in hormone induced tumors

In the past 2 to 3 years, it has been possible to produce carcinoma of the

breast in male mice by the injection of estrin (Lacassagne). Similar work is now being done with other animals. These experimentally produced tumors behave like those occurring spontaneously and they metastasize freely. It is of great interest and importance that the cycle of change in the breast in these experimental animals follows the sequence of simple cystic disease, intraductal hyperplasia and finally carcinoma. The photomicrographs of the hyperplastic stage in the animals are identical with the changes in the human breast described as intraductal hyperplasia. Verification and further study of these experimental tumors may yield the evidence necessary for proof of the contention that carcinoma frequently develop in this type of lesion.

Treatment

Fibroadenoma: The possibility of malignancy in this tumor is so small that it need not be considered. However, it should be remembered that the tumors are often lobulated with small tuber-like nodes on the surface. When the tumors are removed by dissection close to the capsule of the main mass, these small nodules may be left behind to give rise to so-called "recurrences."

Simple fibrocystic disease: It is the

consensus of opinion that this disease in its simple form (i.e. without hyperplasia of the epithelium) is not a neoplastic condition. Carcinoma does not develop in these breasts in any greater incidence than in normal breasts.

The use of ovarian hormone in the therapy of this condition must remain for the present as an open question in light of the experimental production and aggravation of the condition with ovarian hormones.

Cheatle states, "It would be a pity if its use in this condition were contraindicated, because it so often relieves the symptoms. I cannot conceive that it is dangerous."

Intraductal hyperplasia: In spite of the conflict of opinions regarding the potentiality of this lesion, the ideas regarding treatment are generally agreed upon.

1. When the condition involves a localized area, a single lobe or duct or group of acini, this area should be eradicated. The tumor should not be dissected out of the breast; instead, the entire segment should be removed with bold cuts with the knife. If the line of excision is carried through dilated ducts, or pus-like material (inspissated ductal secretion) appears in the wound, a new line of excision further from the tumor should be started. After the tumor has been removed, we frequently recommend one or two linear cuts through the adjacent breast tissue to further rule out the possibility of leaving behind any of the diseased tissue.

2. When it is probable, from palpation of the breast or by the appearance at the exploration, that the major part of the breast is involved, a simple mastectomy should be done. The skin and nipple may be preserved if this is thought to be of any value. However, all ducts leading into the nipple must be removed by careful coning-out of its interior. The possibility of a slough of the skin is to be considered.

3. Radical mastectomy is indicated

whenever the tumor is such that examination cannot rule out the possibility of malignancy. For example: Examination of 20 microscopic sections from a tumor, measuring 3 x 4 x 5 cm., still is an examination of an extremely small fraction of the entire mass. In one instance in our own experience, supposedly adequate examination of an intraductal papilloma showed no evidence of a carcinoma. Subsequently (and for an entirely different purpose), serial sections were cut from this block of tissue. In these sections, entirely by coincidence, a typical infiltrating carcinoma was found.

Therefore, when the intraductal hyperplasia is well developed and the mass is large, a radical mastectomy should be done.

4. When a carcinoma is found associated with intraductal hyperplasia, it should be treated as any other carcinoma of the breast.

5. The surgeon should advise his patient in such a way that he is prepared to reoperate, depending upon the pathologist's final impression. At least 4 to 5 days should be allowed for the pathologist's study and consultations.

Bleeding from the nipple

Surprisingly little statistical data can be collected regarding the causes of bleeding from the nipple. Most reports consist of studies of small series. Instead of statistical data, only a composite summary of the various opinions can be given.

1. Bleeding occasionally occurs in the following miscellaneous lesions: vicarious menstruation, trauma, fibrocystic disease, hemorrhagic diseases, hemangiomas, and fibroadenoma.

2. In three series of fibrocystic disease (including intraductal changes), bleeding occurred in 8%, 5.8%, and 5.7% (total 1,534 cases).

3. Carcinoma is accompanied by bleeding in "less than 1%" of cases (Bloodgood).

4. The most common cause is intraductal hyperplasia -- papillomata or solid intraductal masses, with or without associated malignancy.

5. Malignancy of same type accounts for slightly over 50% of all cases.

6. Bleeding may be the first sign of this condition, i.e. may be present before the tumor has been observed by the patient.

7. Bleeding may be present before the tumor is palpable to the physician. Transillumination may be of value in localizing the mass. The age of the patient and her inclinations undoubtedly are factors in determining the method of treatment when the mass cannot be localized. Simple mastectomy is advocated by several authors.

Biopsy of the breast: Interesting discussions can be found on the technique of a biopsy of the breast.

Aspiration biopsy: Cysts may be aspirated and the examination of the sediment theoretically might be considered as a biopsy. In the same manner, trocars or needles may be inserted into solid tumors and a study made of cells torn from the mass. The originators of these ideas advocate them highly without meeting with much support from others.

It has been our custom for some time to make smears from the interior of surgically removed tumors. It is our impression from study of this material that the malignant cell has a typical nuclear pattern but it is not distinguishable from the pattern seen in other rapidly dividing but benign cells. Such cells as pleural or peritoneal endothelial cells stimulated to activity by some irritant have an appearance similar to many tumor cells. Similarly, smears of crushed intraductal papillomata cannot be distinguished from those made from malignant tumors. Our own experiences, therefore, confirm the numerous objections to this type of biopsy.

Incisional biopsy: The discussions

regarding the merits of the surgical knife and the electrical knife do not seem to contain more than personal preferences.

Certain other features of this biopsy should be considered by the surgeon. It is the responsibility of the pathologist to make a diagnosis as to the nature of the lesion contained within the mass of excised tissue. In case of breast tumors, any incision or mutilation of that tissue increases the difficulties of the examination. Cysts are collapsed; papillomata are torn from their base; ducts are bisected; small carcinomata are divided so that the fragments are hard to find. The pathologist should be given the entire mass intact so that he can orient the gross relationships and choose his material for examination from the undisturbed tumor.

In addition to these factors, there is a good possibility that the cells within malignant tumors and intraductal masses may be transplantable. The surgeon should avoid cutting into these tumors in order to prevent contamination of hands and instruments by these cells.

Conclusions

1. The diagnosis of malignancy arising in a fibroadenoma is to be questioned very critically. Usually such tumors are rapidly growing but benign.
2. Fibrocystic disease appears to be a functional disease and may be produced in animals by injection of excessive amounts of ovarian hormone (especially estrin).
3. Intraductal hyperplasia apparently is a secondary and complicating change in a preceding simple fibrocystic disease.
4. The hyperplasia takes the form of papillomata or a diffuse growth filling the ducts.
5. In spite of studies to the contrary, the opinion that carcinoma develops in these areas of hyperplasia is

gaining favor.

6. Paget's disease, a recognized malignant state, is considered to be an intraductal tumor with extension of the growth into the skin of the nipple.

7. Treatment of these intraductal lesions necessitates complete eradication of the involved areas. If the size of the mass is such that carcinoma cannot be ruled out, radical mastectomy is indicated.

8. Bleeding from the nipple in most cases is due to this intraductal type of lesion.

9. Aspiration biopsies are of no value other than as evidence of fluid within the palpable mass.

10. Since the responsibility for the diagnosis of the nature of the lesion within a segment of excised tissue rests on the pathologist, the surgeon should not interfere by making preliminary cuts through the specimen.

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IV. CASE REPORTS

1. _____, 65 years of age.
Hospital No. 618025.

Tumor of breast

6-1-33 - Observed lump in right breast about 2 x 3 cm. Lump grew rapidly. No symptoms. No discharge from nipple.

Admitted for biopsy - one month duration

7-11-33 - Admitted to University of Minnesota Hospitals. Physical examination: smooth, movable, cystic mass, 2 x 2 x 5 cm., in outer and upper quadrant of right breast; examination otherwise of no significance in relation to the breast tumor.

Operation - local excision

7-12-33 - "Blunt dissection was used to remove the tumor. Fairly wide excision was done, although in the middle portion the tumor extended up to the line of excision."

Pathological report

7-12-33 - "Gross: Tumor of breast. About 30 grams of breast tissue presented for examination and consists chiefly of an irregular, soft, friable mass in which are innumerable yellowish spots of about

1 to 2 mm. in diameter. Pressure on these areas causes an exudation of yellow, caseous material. Microscopic: There is enormous hyperplasia of the ductal structure. The ducts are dilated, their lumina are filled throughout with epithelium. A few mitotic figures are present in this epithelium. At no point in several sections is there any infiltration of the stroma with the epithelial cells. Conclusions: Intraductal hyperplasia of breast."

Recurrence

1-9-35 - For past few weeks has observed another nodule in the region of the previous operation. Examination: hard nodule, .5 cm. in size, attached to skin and fixed to adjacent breast.

Operation: radical mastectomy

1-11-35 - Biopsy. Pathological report: areas again show typical intraductal hyperplasia of a marked degree. In addition, there is an infiltrating carcinoma of the scirrhous type. Radical mastectomy done. Examination of axillary nodes (3) shows no tumor infiltration.

1-17-36 - Discharged.

4-15-36 - Failed to appear for further follow-up.

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2. Female, 31 years of age.

Breast tumor - 7 years duration

11-27-36 - Admitted to hospital for biopsy of a breast tumor of 7 years duration. Pain had appeared one month prior to admission. Examination: triangular tumor with apex near nipple; edges discrete; movable; has nodular consistence; base occupies approximately one-fifth of circumference of breasts; soft nodes palpable in axilla; no discharge from nipple. Biopsy: excision of entire wedge of involved tissue.

Pathological examination

Gross: The tumor is a triangular

mass with the apex extending into the nipple and the base at the edge of the breast. It is composed of a solid mass of twisted dilated ducts which are filled with yellowish material. Pressure on the tumor causes this substance to ooze from the ducts. Embedded in approximately the center of the mass, on its deep surface, is a typical scirrhous carcinoma characterized by the usual appearance of these tumors. Microscopic: all the ducts are packed solidly with hyperplastic epithelium. In these areas, a diagnosis of malignancy cannot be made. In the area of the carcinoma, the appearance is that of a typical scirrhous type.

Radical Mastectomy

Dissection of the subclavicular and axillary areas revealed a large number of nodes. Pathological examination of these nodes (total of 14) shows heavy infiltration by carcinoma.

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V. MOVIES

Title: "When Fish Fight"

Released by: Vitaphone

Title: "Symphony in Sight"

Released by: Universal

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VI. CHRISTMAS MESSAGE

Herold S. Diehl, Dean of Medical Sciences, expresses his personal wish that each staff member has a most pleasant holiday and a good New Year. The following editorial (Minneapolis Journal, Dec. 6, 1936) is reprinted in part by permission of the publishers, through the courtesy of Dr. Diehl.

THE HUMAN TOUCH

"Have you never noticed how readily everyone in the world responds to a "human" attitude in the casual contacts of life? The waitress, the cashier, the elevator man, the butcher, the grocer, the bank teller become "just folks" at a friendly remark, a little jest, a comment on current happenings or the weather. It is said that Matthew Arnold resented this attitude in America. He complained that the cab driver and the waiter acted as if they thought they were his equals. But then Stevenson, you remember, remarked, when Arnold died, "Poor Matthew - he won't like God!" There are snobs elsewhere than in England, and they deserve what they get. Even the freest American is capable of respect for genuine dignity and worth.

But the point that strikes us is not the matter of "equality." It is rather the common humanity of us all, which reveals itself when it gets a chance. After all, in the important matters, we all share a common experience. We were all born, were boys and girls with fathers and mothers, we all work for a living, we all have loved ones and friends; we have known sickness, and hardship, and disappointment, and grief. The "things that are common to everybody," as Chesterton pointed out, "are more important than the things that are peculiar to anybody."

We are all busy and hard pressed, and it is natural for us, as we go about the day's work, to be absorbed in our own thoughts, and to take the day's contacts as a matter of course. The other fellow is doing the same thing. But when, out of a clear sky, our neighbor ventures a neighborly remark, there is not one of us who does not feel his heart warmed. We are lifted for a moment out of our preoccupation with ourselves, we forget our worries, we respond in kind to his advances. It is touch and go, the next instant we are on our way, but we shall have gone half

a block before the smile fades from our lips and the warmth from our heart.

No small part of the value of Christmas to the world is the awakening of this spirit of human kinship which it brings with it. It is just that we are a little more human than usual, that is all. But how it brightens the world while it lasts, and how much simpler life would be if we should never forget!"