A CASE OF CHOLECYSTOTOMY FOR GALL-STONES, WITH REMARKS ON THE TREATMENT OF THE IMPACTED CALCULUS.¹

By JOHN W. TAYLOR, F.R.C.S.,

Surgeon to the Birmingham and Midland Hospital for Women.

EVERYONE who has any practical knowledge of the operation of cholecystotomy, or is *au courant* with its literature, must have recognised the fact that the one occasional important difficulty of the operation is the removal of the obstructing calculus from the cystic or common duct. Sometimes this difficulty is almost insurmountable, and under such circumstances, as is well known, Mr. Tait has practised crushing the stone from outside the duct, either at the time of the original, or at a subsequent, operation. When the stone is very hard, this proceeding may be risky, or, at all events, may appear to the operator to be specially dangerous. Some alternative method is a desideratum.

Perhaps the narration of the following case may help to point out the direction in which we may seek for such an alternative treatment with the greatest probability of success.

Mrs. K., aged 42, was sent to me by my old friend and colleague, Dr. Woollett, of Monmouth, on March 21st, 1887, with the following history. For four or five years she had noticed a swelling on the right side of the abdomen. This grew suddenly larger about eight months previous to the date already given, and although unattended with special pain or tenderness, showed no signs of any subsidence or diminution, and caused her considerable uneasiness and anxiety. She had had eleven children, nine of whom were living; her last confinement occurred about twenty months before her visit. Menstruation was regular. There had not been at any time the slightest history of jaundice or even of acute colic.

On examination a large, rounded tumour was found in the right hypochondriac and umbilical regions, extending some distance below and to the left of the umbilicus. It was very freely movable, and careful palpation elicited a vibratory thrill. There was no true fluctuation. I diagnosed the case to be one of distension of the gall-bladder, and this diagnosis was subsequently confirmed by the opinion of my colleagues, Dr. Savage and Mr. Tait; Dr. Savage noticing the fact, which had at first escaped my observation, that the edge of the liver was to be felt overlapping and covering the tumour, except at its most extreme limit.

The patient was admitted into the Birmingham and Midland Hospital for Women at Spark Hill, and on April 2nd I opened the abdomen on the outer side of the right rectus muscle immediately over the most prominent part of the tumour. On dividing the peritoneum, liver substance was seen lying immediately underneath the incision. This appeared to have been dragged down by the enlarging tumour, and formed a thin covering to it. By pressing the tumour from the opposite or left side of the abdomen upwards and towards the right, a small portion of the tumour was found uncovered by the liver, and seen to be the rounded end of a largely distended gall-bladder. This was tapped, and fully a pint of clear, somewhat glutinous fluid evacuated. The puncture was then enlarged with a tenotomy knife, and the index finger introduced within the gall-bladder. Several large stones were felt lying loosely in its cavity, and these, four in number, were removed with scoop and forceps. One remained, wedged into the cystic duct, which it seemed impossible to move. There was no space for the application of any of the forceps at my command, and after repeated attempts to extract the stone I could only succeed in breaking off some portions of its upper surface.

As all the gall-stones were hard, and very considerable force was necessary in order to break them, I was afraid to attempt the crushing of the stone from outside the duct, and therefore determined to complete the operation in such a manner as to afford the best means for any subsequent treatment of the impacted calculus that might be necessary. I sewed the incision in the gall-bladder to the abdominal wound by several stitches, so as to leave a large external opening, and placed within this a short piece of large-sized rubber tubing. The nurse was directed to syringe out the gall-bladder with warm water every night and morning through the drainage-tube. No disturbance followed the operation, and by the fourth day it was noticed that the water returning from the gall-bladder on the use of the syringe was tinged with bile, indicating that the passage of the duct was becoming free. No alteration was made in this regular treatment of the case for more than two weeks after the operation. The large drainage-

tube was kept within the external opening, being only removed temporarily for cleaning, and the gall-bladder well syringed out twice each day.

On April 18th, sixteen days after the cholecystotomy, I examined the gall-bladder for the impacted stone with Lister's sinus-forceps. I found that the stone was loose, and that it was soft. It broke into pieces on being grasped by the forceps, and the fragments were extracted without any difficulty from the opening in the gall-bladder. The latter was syringed out a few times after this to ensure its being thoroughly cleaned out from any *débris* of the broken calculus. The tube was removed, and the abdominal opening allowed to contract and close. The patient left the hospital for her house on April 26th, quite convalescent, and with gall-bladder and ducts patent and free from any calculus.

REMARKS.—1. The power possessed by a current of water, when wisely and patiently employed, for the dislodgment of foreign bodies or wax from the auditory meatus suggested its use in the present case. It appears to have been largely responsible for the successful result. 2. There is probably, in addition to this, some time in the history of a biliary calculus retained after operation, when a considerable amount of softening occurs due to the inflammatory changes and discharge set up by the operation. If so, it is of some importance that the best time for any secondary interference should be ascertained. 3. In difficult cases, whether at the time of the cholecystotomy or afterwards, it is probable that an impacted calculus may be divided by delicate forceps similar to those utilised in the present case, when no other forceps could be employed with advantage from within the gall-bladder.

These three points—the regular daily use of the syringe after operation, the taking advantage of a time when the stone becomes softer, and the use of proper forceps, will, I believe, be of use in bringing difficult cases of cholecystotomy for gall-stone to a successful termination.

✓ A NOTE ON THE TREATMENT OF SPINAL ABSCESS.

By THOMAS LAFFAN, M.K.Q.C.P.I., Cashel.

I HAVE, in common, I suppose, with most surgeons, met with a good many of those melancholy cases of abscess dependent on diseased spine, most of which at least have but one end—death. I have witnessed several of these where death ensued notwithstanding the cure of the spinal affection. In these the fatal end was brought about by the discharge from an extensive fistula, which was without the reach of surgical art. It is not possible to bring pressure to bear on the walls of such fistulae; still less is it possible to slit them open and allow them to granulate from the bottom. We are told that spinal abscesses should not be opened hastily, inasmuch as they may become absorbed, and on the other hand we are directed not to allow them to enlarge to any considerable extent without opening them, as the constitutional disturbance that would follow on their being opened would be attended by risk proportioned to their size. These two rules will be found in practice to be more or less contradictory. If we act on the advice not to open them hastily, we too often give time for very considerable though not always apparent enlargement. If, on the other hand, we do open them early, we, in my experience, all but invariably ensure the death of the patient, and we also deprive him of the chance that the abscess might become absorbed. This seldom happens, but that it does sometimes happen is evident from a careful collation of writers on the subject. I have had myself one such, but only one, out of all my cases; it occurred in a girl aged 30; she was the daughter of a farmer, of healthy appearance, and with a family history which was good, though not wholly free from some suspicion of scrofula. About May, 1875, she strained her back whilst jumping off a ditch, and after more or less medical treatment she came under my care in the following November. At that time she had an abscess in the left iliac fossa, which was about the size of the two hands clenched. She had disease of the tenth and at least two adjacent dorsal vertebrae. The spine of the tenth was very prominent, and those of the two adjacent ones were also prominent, but very much less so. She had had several rigors; the pulse, appetite, perspiration, and the menses were what obtain in a hectic case. She was placed in the horizontal position, and such remedies as suggested themselves, the enumeration of which would but occupy time without communicating any fresh information, employed. She was kept for four months

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