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

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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.

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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

¹ Read in the Section of Surgery at the Annual Meeting of the British Medical Association held in Dublin, August, 1887.

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in bed, and for three months after that a Sayer's jacket was kept on; she went on favourably in every way, and not only was the Potts' spine cured, with, of course, deformity, but the abscess became eventually absorbed. I examined her with the greatest care on June 21st last, and the following state of things was observed: Her appearance was healthy, though not entirely free from wear and tear; her pulse, temperature, and respiration were natural; a fulness, which when first seen had existed in the left iliac fossa, had entirely disappeared. No trace whatever of the abscess could be found on palpation, or otherwise. A severe pain in the spine, from which she had also on the occasion of my first seeing her suffered, had likewise disappeared. There was some little pain across the hips after sitting, and the left leg was weaker than the right; the bowels were moved every second day. The appetite, urine, and sleep were natural; there was neither perspiration nor vomiting. She could stoop, work, and get jolted in a vehicle without pain or uneasiness. A prominent spine, the slight pain and weakness I have referred to, and menses which were almost *nil* from the start of the disease, comprised the total of the obverse side of the pleasing picture. Though it is quite possible that in this case the remains of a partially absorbed abscess, which might recrudesce hereafter, might still be pent up in parts inaccessible to the sight and touch, yet all the probabilities go the other way, and the case may, I think, be fairly cited as one of those exceptional ones in which spinal abscess gets cured, and the rule of not allowing spinal abscesses to get very large comes in for inconvenient question. Some similar cases have, of course, been reported, but unhappily they are *rari nantes in gurgite vasto*. No one ought, I think, to propose to sacrifice the overwhelming majority for a few chance cases, and therefore these abscesses should be opened, if only a way could be found to obviate the terrible danger arising out of the existence of a long and tortuous line of inaccessible fistulae. I often asked myself, Was it possible that nothing could be done for those sad cases? and it was therefore with no ordinary pleasure that I read Mr. Treves's proposal for dealing with some of them.

Mr. Treves proposed to cut down direct on the bodies of carious vertebrae associated with abscess. He proposed to attain by such an operation four objects:

1. He would come into direct contact with the diseased areas.
2. He would open the suppurative collections at their points of origin, and evacuate their contents by the shortest possible route.
3. He would be enabled thereby to remove pieces of diseased bone.
4. He would be enabled to apply treatment direct to the local tissues.

Mr. Treves, however, proposed to confine it to the lumbar and last dorsal, and he does not state at what period of the abscess he would cut down on the spine. Now, it appears to me that, if the surgeon should wait until the abscess becomes apparent at one of the usual sites, the mere tapping of it at the proximal end, while furnishing an exit for detritus—which, no doubt, now helps to keep the sinus discharging—would not of itself prove sufficient to agglutinate the walls, and therefore dry up such sinuses.

We every day witness the continued patency of long fistulous tracts long after the disease at the proximal end has been cured. I do not see, therefore, how cutting down on the vertebrae, where a large abscess has been allowed to form, can, in the majority of cases, at all events, effect all the good we desire. I do not see either why this operation should be confined, as Mr. Treves proposes to confine it, to the lumbar and last dorsal. Such a restriction seems to me calculated to limit within too narrow a field its sphere of usefulness. I would extend it to the dorsal vertebrae, where it is we find the great bulk of the disease.

I am not blind to the anatomical difficulties which would beset cutting down on the vertebrae here. I do not, however, think that they are either insuperable or indeed at all comparable to those which have been successfully mastered in other regions of surgery. We might expect, for instance, that the pleura would occasionally be perforated, and that pneumothorax would ensue; but we have now a sufficient number of cases of this to prove that it is a very much less formidable affection than it was once supposed to be. It is not to be denied that it is much less formidable than interminable fistulae, whose existence affords a too certain presage of the patient's destruction.

Now for my second point. It will not, I maintain, do to cut down on vertebrae where an abscess can be seen and felt. The diagnosis of spinal caries having been once made, I would anticipate the external appearance of the abscess by cutting down upon the vertebrae at once, and maintain a direct opening with the diseased bodies. If disease should be really present, we might count on the presence of a considerable effusion around the bodies of the vertebrae; and this thicken-

ing might be counted on as a sufficient protection against the premature admission of air to the carious mass. The case of Potts' disease without abscess, if there be any such, would present a difficulty; but the thickening already referred to might here, as in the last case, afford sufficient protection against atmospheric action. On the other hand, if the diagnosis should be incorrect, and no spinal caries should be found to exist, no possible mischief could accrue to the healthy vertebrae themselves.

In conclusion I submit the above note to the Section with a profound conviction that for a disease which is but too often indeed the opprobrium of our art bold remedies offer the only resource.

Dr. ILLINGWORTH deprecated in the strongest possible terms the procedure recommended. The formation of any wound meant the incurring of new dangers. Aspiration, when the pus was fully formed, offered the safest means of prevention of septic processes. Spinal support during the process of aspiration was essential.—Mr. WALSHAM said that he considered Dr. Laffan's a very grave proposal. He understood Dr. Laffan to advocate cutting down on the dorsal vertebrae in cases of spinal caries, for the purpose of preventing the formation of an abscess as well as for the early evacuation of the pus, should such form. Such a procedure appeared to Mr. Walsham fraught with danger, as a deep wound would have to be made, probably a portion of a rib or two would have to be excised, and the pleura might easily be opened. On the other hand, if spinal caries was treated early by recumbency combined with some efficient support, the great majority of cases recovered without any suppuration. In the lumbar region cutting down on the vertebrae, as suggested by Mr. Treves, was no doubt, in suitable cases, of service, but Mr. Walsham would hesitate to attempt such an operation for caries in the upper dorsal region, even when pus had been formed.—Mr. EDWARD L. FREER (Birmingham) was in favour of aspiration where possible; when impossible, recourse should be had to free incision, with antiseptic dressings, weak iodine injections, and free drainage. Some disappeared altogether if the spondylitic vertebrae were kept at rest, so he did not advocate early operative interference of any kind.—Dr. GIBNEY (New York) advocated the directing of treatment to the bones diseased, and claimed that, when sufficient mechanical support, long continued, was provided, it was quite unimportant to give any attention to the spinal abscess. The cases thus managed, in New York city at least, gave satisfactory results. He was convinced that orthopaedic surgeons, as a rule, aimed to fix the spine and seldom treated the abscess.—Dr. LAFFAN, in replying, expressed his astonishment at the amazing number of cures which the speakers had had, and he invited them to authenticate them by publishing them. As for him, he had had no such success; and as far as he could gather, and he had inquired in several quarters since the commencement of the meeting, his experience was not unique. If the disease, therefore, was so fatal, he maintained that for it the remedy he advocated was the proper one. Some of the speakers had talked about the antiseptic treatment, but its advocates asked too much from it. He had tried it in these cases, and it had not saved them. He aimed at two objects in bringing that paper before the Section: the first one was to bring once again under public notice a line of treatment which should recommend itself, if for no other reason, because it had been suggested by so able a surgeon as Mr. Treves; and next, because he desired to extend and develop an operation which, he repeated, alone held out any rational prospects to patients.

TWO RARE GROWTHS OF THE SOFT PALATE.

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THE two cases which are described at length below present a certain amount of interest, on account of their uncommon occurrence, and this reason, I consider, justifies their publication.

CASE I.—Mr. S., aged 20, a student, came to the Heidelberg throat clinic (Professor Jurasz) to seek advice about his throat. On examination, he was found to be suffering from granular pharyngitis. Moreover, during the exploration of the pharynx, a small tumour was noticed lying somewhat to the right of the uvula, and partially concealed by the same; in length it measured about three and a half centimetres, was elongated in shape, and in colour agreed with the surrounding mucous membrane. To obtain a good view of it, it was necessary to seize it and draw it forward. The tumour was mobile, slightly narrowed at the base, of a soft consistency, and quite painless when manipulated. Its general appearance gave one at first the im-