A PLEA FOR THE HABITUAL PERFORMANCE OF AUTOPSIES IN GENERAL PRACTICE.*

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LEEDS.

[AFTER forecasting the ideal of scientific efficiency, professional co-operation, and public enlightenment which, *inter alia*, should render autopsies a matter of course, the subject was discussed as follows from the general practitioner's point of view:]

The great majority of us must surely often feel that as members of the scientific profession of medicine we at present often do let slip, from one cause or another, valuable and perhaps unique opportunities of adding to the knowledge of important facts upon which our science and art is built up. How frequently the practical difficulties—the sentimental opposition of the patients' relations, or our own lack of time, energy, or technical skill—condone us in abstaining from a task probably thankless and unpaid for! But let the general practitioners as a class realize that unless we march forward in efficiency, with the progress of knowledge we are doomed to practical extinction. Between the consultants and specialists on the one hand, and the prescribing druggist and amateur quack on the other, there will soon be little scope for us unless we maintain our position by thorough work, up to date of advancing science, and not a whit behind the best intelligence of an enlightened public, on whose patronage we subsist. I do not go so far as to say that the frequent performance of *post-mortem* examinations will at once ingratiate us in the minds of a grateful public, but I maintain that in the long run all that promotes our efficiency will do so. The new facilities for clinical research, and the special forms of new treatment may be helps—or hindrances if the public have learnt to expect them of us, and find us wanting. And in like manner the utilization of our opportunities for observing the morbid anatomy of many common diseases and the results of treatment, will be better appreciated by an intelligent public.

Some may say: There is abundant pathological material in our hospitals, and such as the general practitioner could furnish is not missed. In reply I would merely instance three diseases which he has the most frequent opportunity of observing, and of the morbid anatomy of which he could supply specimens very valuable to the pathologist. Others will no doubt occur to us, for do we not frequently note in textbooks a lamentable lack of trustworthy data of the actual lesions and their causes in studying the commoner diseases?

1. *Hemiplegia*.—If the injured brains in all these cases could be handed over to the skilled neurologist after death—whether occurring soon after the vascular breakdown, as in most hospital cases that reach the *post-mortem* room, or after months or years—together with notes of the symptoms, how much useful knowledge might be collected as to the localization of function, and the processes of repair in the brain! At the same time the examination of the vessels, heart, kidneys, livers, etc., that served these brains might shed light on prophylaxis against these terrible accidents.

2. *Cancer*.—Who knows but such specimens as the rank and file of us could contribute might materially hasten the solution of this problem?

3. *Tuberculosis*.—Even the general public, so apathetic in most medical matters, are now roused to take part in the battle against this other great scourge. Might not light be thrown upon the relative success or failure of various systems of treatment if there were more general and accurate record of *quiescent*, *cured*, and *latent* tuberculous lesions in various organs—for instance, where death takes place from other causes and, perhaps, no suspicion of tubercle was felt. I hope I have proved the desirability of progress in the direction spoken of; the practical point is "ways and means." What methods can be set on foot, for instance, by our Association, to forward this work? I venture to suggest:

(a) A recommendation might be adopted and sent down to all our rank and file commending the practice.

(b) A grant of money might be made to provide some payment for the making of autopsies, and reporting

records of the same under certain conditions. This might be more effective than the mere expression of a pious opinion.

(c) An organization for the collation of records and promotion of the work might be set on foot, something like that for the collective investigation of disease, perhaps.

(d) Co-operation and division of labour should be secured as far as possible. The help of specialists—pathologists, histologists and bacteriologists, should be enlisted. In urban centres a number of practitioners and hospital men might arrange to divide the chief fields of pathology between them. Thus, A might be observing the lesions of the alimentary canal, B, of the brain, C, cancer, etc.

Backed by such an organization, it should be possible for individual practitioners to secure many very valuable specimens of morbid anatomy and many useful pathological observations, and also to get them utilized by our scientific leaders instead of lying buried in their case records. The disagreeable duty would not be so hopeless to undertake, with prospect of practical fruit, and of some sort of a fee; whilst it would no longer cause any unpleasantness with the patient's relations to suggest it when the onus was shared by the whole profession; and I think we should not so frequently meet with a blank refusal, for we know that when the coroner orders an autopsy little is heard of the objection of the friends, and no animus attaches to the doctor who performs the duty.

TRAUMATIC RUPTURE OF THE LARGE INTESTINE: OPERATION: RECOVERY.

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TRAUMATIC rupture of the large intestine is such a rare injury that there were only 5 cases recorded in the surgical reports of St. Thomas's Hospital for the twenty years which preceded the date on which the following case was admitted. Of these, two recovered after operation, in both of which the lesion was found on the right side, once in the caecum, and once in the ascending colon, the bowel having given way directly into the peritoneal cavity. In a case of rupture of the transverse colon due to the kick of a horse, operation was not successful in saving life, for the patient died from collapse. Two patients died without operation from septic peritonitis; in these the lesions were in the sigmoid flexure and in the transverse colon respectively. Altogether 30 patients were admitted during the period mentioned, suffering from traumatic rupture of the intestines; of these, 5 died without operation, 6 recovered after operation, whilst in some others success was almost attained, life being considerably prolonged. The situation of the lesion was as follows: Duodenum 4, jejunum 10, ileum 11, large intestine 5.

A. L., a married woman, aged 33, was admitted on July 14th, 1907, at 12.15 a.m., having been run over by a horsed omnibus shortly before. It was stated that a wheel had passed over the abdomen at the level of the lower ribs, having struck the left side first.

Condition on Admission.

She was in a collapsed state with a feeble pulse, and complained of abdominal pain on the left side, where there was considerable tenderness. The urine was normal, and did not contain blood. She had not vomited. During the night she rallied from the condition of extreme shock, but complained greatly of pain, and vomited once. At 10 a.m. much of the shock had passed off, and the patient was lying somewhat propped up in bed, with quickened respiration (32) and pulse (100). She was complaining of pain on the left side of the abdomen, over the lower ribs, and the abdomen did not move well on respiration. There was rigidity, especially marked on the left side, with extensive tenderness towards the pelvis from the site of injury, following the line of the descending colon. She complained of some thirst. Urine had been passed, but nothing had come from the bowel. Temperature 98.6°.

The diagnosis of rupture of the large bowel with a commencing inflammation along the course of the descending colon was made, and operation performed as speedily as possible.

Operation.

A longitudinal incision was made through the outer part of the rectus sheath on the left side, and the peritoneum

* Abridged from a paper read at the annual meeting of the Yorkshire Branch of the British Medical Association at Bradford, 1906.

opened. At the first inspection there was little visible beyond a scratched appearance of the peritoneum over the situation of the splenic flexure. A bruised condition of the descending colon below this was apparent, but it was not extensive, and no abrasion or tear of the peritoneum was visible over it, nor was there any alteration in the consistency of the part. Some emphysema could be felt, however, in the descending mesocolon, and before this it had been found that a mounted sponge when passed into the splenic region, became soaked with dark fluid which was of small quantity but of a distinctly faecal odour. Gentle compression of the descending colon with the fingers whilst they were moved upwards forced some bubbles of gas and a little faecal fluid through the minute lacerations which had previously been noted. There was no doubt that a rupture of the gut behind the peritoneum was present with a communication directly into the peritoneum through these lacerations. A second incision was made backwards through the abdominal wall at a right angle to the primary cut just below the ribs, and further incision of the peritoneum to the outer side of the flexure gave access to a space containing soft faeces, which had escaped from a hole in the bowel the size of a penny at or below the splenic flexure of the colon; the space containing the extravasated faecal matter extended upwards into the retroperitoneal tissue behind the spleen and could hardly be cleansed, for the faecal matter was ground into the cellular tissue. The opening in the bowel was closed with interrupted silk sutures which did not enter the lumen, the torn edges being inverted. The peritoneum which had been packed off during the treatment of the bowel, was now cleansed, and some ounces of blood-stained offensive fluid removed from the pelvis. The wound was partly closed, the peritoneum being sutured off from the parts affected by the injury, a tube was passed into the splenic region, a plug placed over the sutured portion of bowel and brought out at the posterior extremity of the transverse incision. The operation was well borne.

After-History.

On the third day the evening temperature rose to 101.2°, and there was a thin discharge from the wound of a faecal smell and of a brown colour.

As the temperature was still above normal—100° to 101°—and the discharge offensive, an injection of antitoxin serum 25 c.cm. was given into the axilla on the 23rd.

On the 25th the stitches were removed, and the anterior part of the wound dressed with collodion and gauze. There was a definite faecal discharge. The amount of pus in proportion to the faecal matter appeared to have increased, and although the result of the serum injection had apparently lowered the temperature for a day still by the evening of the 26th it had reached 101.5°, and 25 c.cm. of polyvalent serum was given. Apparently as a result of this the temperature fell to 98.8°, rising to 100° on the following evening, when the dose was repeated. The temperature after this became normal, gradually falling, whilst the patient improved considerably in her general health, and the wound cleaned in a remarkable manner. On August 19th there was no longer any faecal discharge from the wound, which had quite closed on August 31st.

She left the hospital well on September 6th.

The chief symptoms on which the diagnosis of a rupture of the large intestine following injury are based are, as a rule, the same as those which accompany a similar injury to the small intestine. It is true that emphysema of the abdominal wall is occasionally met with both in rupture of the large bowel and in rupture of some parts of the duodenum. This, however, is not a symptom on which any reliance can be placed, and arises mostly when the rupture is behind the peritoneum and not into the cavity of the peritoneum. In more than one instance the mesentery of the colon has been felt at the operation to contain some gas; but our object should be to operate before this can be dispersed in the cellular tissue or felt outside. The excessive tenderness along the line of the descending colon was regarded as an important sign, and from the description of the operation there can be no doubt that it was an indication of the irritating character and passage of the fluid which was removed from the pelvis. The principle of the operation had to be somewhat changed from the usual one, for we could not depend on primary union of the contused wound in the muscular wall of the bowel, and therefore it was necessary to provide as far as possible that the faecal matter should escape externally if the stitches gave even to a limited extent. The effect of the antitoxins is worthy of attention.

THE Swedish National League against Tuberculosis raised £12,500 during the year 1905-6 by the sale of badges of benevolence.

THE late Mr. Francis Abel Smith, of Ashby-de-la-Zouch, whose will has now been proved, left £1,000 to the Nottingham General Hospital.

PERFORATED GASTRIC ULCER: OPERATION: RECOVERY.

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THE following case appears worthy of record, since it presents several points of interest with regard to diagnosis and the treatment adopted:

History.

A woman, aged 40, unmarried, had for some years suffered occasionally from indigestion, but had never shown symptoms suggestive of gastric ulcer.

On September 16th, 1907, she complained of slight indigestion, which passed off. On September 21st, at 8 p.m., she had supper, consisting of meat and potato pie; at 1.30 a.m. she complained of acute abdominal pain situated around the umbilicus. When seen at 6 a.m. she was still in acute pain, referred to the umbilicus and the left iliac fossa; there was slight pain on palpation in the epigastrium, but it was more severe in the left iliac region. The liver dullness was present, and the left iliac fossa appeared less resonant than the rest of the abdomen. With combined auscultation and percussion the stomach appeared normal. She appeared to be decidedly ill, and the facies suggested acute abdominal trouble. She was given liq. morph. hydrochl., m x, every three hours, and was seen again at 6 p.m. Evidence of general peritonitis was then present, and there was considerable more resistance in the right iliac fossa than in other regions of the abdomen; that region was also dull on percussion.

Operation.

At 8.30 p.m., under chloroform, the abdomen was opened by a mesial incision, with its centre at the umbilicus. There was a quantity of serum present, which escaped on opening the peritoneum; the appendix, tubes, and ovaries were all normal. The incision was extended upwards; large flakes of lymph were present over the stomach, and a perforated gastric ulcer was discovered. The ulcer was situated at the cardiac end of the stomach on the anterior surface of the lesser curvature; it extended up to the commencement of the oesophagus and was about 2½ in. in diameter, the perforation being about the size of a pea. The parts were carefully swabbed and attempts were made to close the ulcer, but each time the sutures tore through. Looping up the healthy stomach over the ulcer or excision seemed to be impossible on account of its large size, in consequence the great omentum was folded up and stitched rather inadequately over the ulcer. A large drainage tube was inserted and the abdominal wall hastily sutured owing to threatened collapse of the patient.

Progress.

Olive oil, a pint, followed later by a turpentine enema were given each day by the rectum, with no result, until September 25th, when the bowels moved well. From that date nutrient enemata were given every six hours. On October 1st she was allowed one teaspoonful of water by the mouth. On October 4th she had meat juice by the mouth, and the quantity was gradually increased. On October 10th she was taking beef tea, 3ij, every six hours, and on October 16th she was given milk, 3j, with barley water, 3ij, every four hours, and Benger's food; from then onwards the food was gradually increased until on November 14th she commenced ordinary diet; the wound had then quite healed.

The case presents the following interesting features:

1. *The movable dullness on percussion* noted at one time in the left iliac fossa, and at another time in the right iliac fossa, making the diagnosis difficult, but Sargeant has called attention to this point in cases of perforation of the stomach.
2. *The size and situation of the ulcer.*—According to Osler the largest ulcer recorded is that reported by Peabody, which measured 19 by 10 cm.
3. *Closure of the perforation.*—The imitation of nature in closing the perforation by means of an omental graft has been previously recorded by H. S. Clogg in the BRITISH MEDICAL JOURNAL, 1905, and in cases similar to the above seems to be the most rational method.
4. *After-treatment.*—During the first week, when no food was given by the mouth, the patient exhibited the greatest endurance, and at the end of that time she stated that if food was injurious to her she could manage quite well without it for a few days.