AN ADDRESS ON THE DANGERS OF DELAY.

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MR. PRESIDENT,—When my old friend and your worthy colleague, Dr. Cattle, did me the honour on your behalf to ask me if I would give an address before the Nottingham Medico-Chirurgical Society, I decided somewhat hastily in the affirmative, trusting that some inspiration would come to me in the intervening period, which has, however, allowed me sufficient time to realise the difficulty of worthily fulfilling my promise. Fortunately Dr. Cattle helped me to a certain extent by suggesting that I should give something practical.

After casting about for a time it occurred to me that I might perhaps engage your attention most profitably by selecting a subject in which the physician, the surgeon, and the general practitioner of medicine are equally interested; the text of my address being *The Dangers of Delay*.

There are certain minds that seem to adopt as their motto, "Never do to-day what you can put off till to-morrow," which in legal quibbles and in many of the ordinary affairs of life may be a more or less useful maxim, but which in medical or surgical matters may frequently mean the difference between life and death. This procrastination, some of the evils of which I hope to consider to-night, is only occasionally to be laid at the door of the patient or the friends; for, as we all know, our clients, as a rule placing implicit confidence in our judgment, will in nearly every instance be guided by us if in consultation we are united.

I think the blame rather lies in the traditions of the past that we have not yet completely shaken off, in the reminiscences of the old days when an operation was a truly dreadful business to be avoided if possible, and possibly it lies a little in that *laissez faire* policy of the old school, for there are yet a good number of Micawbers in the world, and we know that they are sometimes encouraged by the unexpected turning up.

I will not trouble you with some of the more obvious dangers of delay in surgery, such as waiting for distinct fluctuation before venturing to incise the periosteum in a case of periostitis, or of waiting for the formation of pus before incising in a case of thecal whitlow, but will pass on to consider certain groups of cases in which I know by ample experience not only that delay in treatment is dangerous, but that serious delay, even in these enlightened days, is the rule rather than the exception.

First let us consider that large group of diseases that has been so much engaging the attention of the public recently. I refer to tuberculous affections, which are almost as common from a surgical as a medical point of view.

Perhaps there is no more fertile cause of serious joint disease ending in deformity or death than the delay which frequently occurs before absolute rest is advocated in the early stages of spinal or hip disease.

A child complains of a little pain on walking or on great exertion; the pain, being irregular at first and by no means constant, is put down to so-called "growing pain" or rheumatism, and no more is thought about it by the friends until a limp is noticed, and even then a night's rest will relieve it, and even if it should be mentioned to the doctor the best is made of the matter. And as there are probably no very obvious signs the poor victim is allowed to continue walking until the limp becomes so obvious that a careful physical examination is demanded, when stiffness of the joint, or even abscess is discovered, and the case has entered on its more serious stages.

From a large experience I am very firmly convinced that if complete rest were insisted on in the early stages of these tuberculous joint cases, whether spine, hip, knee, elbow, or other joint, a complete and permanent recovery would occur in a very large number, probably in 95 per cent. of the cases.

In nearly every case there is a history of injury or strain, maybe months before, which is almost forgotten until recalled by the questions of the surgeon; this is followed by a little local injury near to or at an epiphysis, which under rest would entirely clear up, and which may lie dormant for a longer or shorter time until some other cause, such as deteriorated health, imperfect feeding, exposure to infection, further injury, or some unknown cause leads to rarefying osteitis with pain on movement.

In this stage complete rest would obviate further trouble in the greater number of cases, but in the absence of proper treatment the inflamed area becomes the seat of tubercle, with its well-known sequelæ of abscess and destruction of bones and joints. Even in this stage much more can be done by the simple treatment of iodoform injection, if combined with judicious general treatment, including rest and fresh air, than is generally appreciated.

I can point to a considerable number of cases of advanced caries of spine with abscess treated in this way and now quite well, and of tuberculous joints, which years ago I should have excised, but which have completely recovered without any mutilation.

While I am a great advocate of the avoidance of delay in treatment, I would urge—even at the risk of being thought heterodox—the avoidance of excision, so long as there is any hope without it, in this class of joint disease, particularly in the lower extremities; for, at the best, excision inflicts a terrible mutilation, and the subsequent shortening owing to damaged epiphyses frequently means the saving of a practically useless member. So much am I impressed with the success of the iodoform treatment, even in advanced tuberculous abscesses and joint disease, that while the number of cases of tuberculous disease under treatment has not lessened, the number of excisions has markedly diminished in my own practice and in that of some of my colleagues in the Leeds Infirmary.

In private practice this treatment is specially successful, as the after-care and open-air treatment can be more efficiently carried out, but in hospital practice we are let down by the absence of suitable sanatoria for the after-treatment, and I would take this opportunity of pleading for the provision of such for the fresh-air treatment of surgical as well as medical tuberculoses.

There has of late been so much written on the subject of cancer of the breast that I will not take up much of your time in discussing it, though it is so very important both on account of its terrible effects and its frequency, as well as because of the distinctly beneficial effects of thorough surgery if adopted without delay. I think it is a good rule to advocate the removal of every tumour of the breast at an early stage, which I feel sure is at present not the general rule, though advocated by many surgeons. Over and over again I have removed a scirrhus of the breast from a patient who has had a simple adenoma for years, the removal of which at an early stage would have been the simplest matter in the world. You never know when the epithelium in a simple adenoma may overstep the basement membrane and become a carcinoma; therefore delay in advocating surgical treatment is, to my mind, extremely unwise, especially as the simple operation is devoid of risk. I operated on a case recently, in which a small tumour was pointed out to a medical man who pooh-poohed it, thinking it simple, and the patient, only too pleased to put off the evil day, sought no further advice for 9 months, when I had to do a most extensive operation in order to thoroughly remove the disease. Now in this case my medical friend with whom I saw the case thought to save his patient anxiety, but forgot all about looking at the little lump to see if it was increasing: until after that important interval his patient pointed out to him what was then obviously a scirrhus. I could furnish many similar examples were they necessary.

Nothing is becoming more clearly established than that the early and complete removal of cancer is curative and not simply palliative, and this is shown equally well in cancer of the cervix uteri and cancer of the rectum. How often do we operating surgeons have sent to us cases of carcinoma uteri too late for operation, and cancer of the rectum too advanced for anything but colotomy, yet if we had only seen these cases early, the patients might possibly have been cured; for

instance, I can at this moment point to a number of patients in good health from whom years ago I removed an epithelioma of the cervix, either by supravaginal amputation or by vaginal hysterectomy, and in the same way I can point to cancer of the rectum treated by proctectomy and well years later.

But it is quite useless to hope for a cure by operation or even prolonged relief, when the uterus is fixed and the broad ligaments and glands are involved in the disease. Sometimes the patients have themselves to blame for the delay, but very frequently I fear the medical adviser must take some of the responsibility, for alas! too often, time is lost in waiting for a positive diagnosis.

Intermenstrual hæmorrhage, or hæmorrhage after the menopause, should always demand careful and immediate attention, and an ulcer bleeding on touch should not be too long watched, but should be examined microscopically, and in case of doubt, freely removed, for it must be borne in mind that cancer is inevitably fatal, but that supravaginal amputation of the cervix is practically devoid of risk, and that even vaginal hysterectomy has only a mortality of 5 per cent., or even less.

Perhaps in no class of cases is delay in surgery attended with so much danger as in abdominal diseases, several of which from this point of view I will consider. First let me quote from Dr. Wm. Ewart's Harveian Lectures, 1898:

Not many years ago lives were sacrificed daily to the impossibility of establishing the diagnosis of actual suppuration in the abdominal cavity. To operate on an abdomen where an extensive abscess had not yet formed did not enter the professional mind in those days, and the idea of laparotomy for the sake of ascertaining that no abscess existed there was as foreign as are to us the thoughts of dwellers in distant planets. The whole anxiety was lest an operation should be attempted whilst pus had not been proved to exist. Most of the cases operated on died because gangrene and suppuration, though imperfectly revealed by physical signs, had proceeded too far.

What better testimony could we have of the dangers of delay?

TUBERCULOUS PERITONITIS.

Tuberculous peritonitis is in its earlier stages usually attended by effusion into the general peritoneal cavity, and in this stage is curable by abdominal section and drainage. Some of my most satisfactory cases have come under this category, and in several that I could relate operations performed on apparently hopeless invalids have been attended with excellent results. For instance, out of a considerable number of cases I will select two as examples:

My friend, Dr. Black, of Harrogate, sent a patient to me some years ago who was extremely ill with tuberculous dropsy in the abdomen and with doubtful phthisis. Simple drainage of the abdomen, though the peritoneum was covered with tubercle, led to recovery, and not long ago I had a letter to say that the patient is not only well but that she is now apparently the most robust and healthy member of an otherwise healthy family.

A few years ago I was asked to see a young lady in this county, who had been given up as beyond recovery by two able physicians who had seen her in consultation, and when I saw her lying in bed like a typhoid patient in the last stage of exhaustion, with sunken eyes, attenuated limbs, a hectic flush, extreme emaciation, a much enlarged abdomen, and dulness at the apex of the left lung, I almost felt inclined to say it was too late; but the simplest operation—an incision only large enough to admit a drainage tube—led to remarkable results, though the mesentery stood up stiff with tubercle and tuberculous nodules were scattered all over the peritoneum; for she began to recover at once, and four months after she wrote to tell me that she was so well as to be able to hunt and follow her usual country pursuits, and I have since heard of her in robust health.

If the patient be not operated on and survive the stage of effusion, we get matting of intestines and viscera generally, intestinal obstruction, caseation of glands, suppuration, and other troubles which frequently end fatally in one way or another. Moreover, the operation is of the simplest; an opening no bigger than to admit the finger and to allow of drainage is all that is required, and this can be done quite well under cocaine anaesthesia, the whole procedure not occupying more than a few minutes.

APPENDICITIS.

This is so very large a subject, and one of so much import

ance, that I could only touch the fringe of it even if I gave up the whole hour to its discussion.

It may sound somewhat radical, but I speak from conviction after considerable experience, when I say that I believe the early operation undertaken as soon as appendicitis is diagnosed, first advocated by Dr. McBurney, would lead to a far greater percentage of recoveries than the method of individualising which we in England still generally adopt.

I believe this, because I know that the removal of an appendix without delay—that is, before suppuration, perforation, or gangrene has occurred, or before firm adhesions have been formed, is practically unattended by risk, as shown by my own experience, and that of many other surgeons; moreover the operation can be accomplished through a small incision with separation rather than division of muscular fibres. In waiting for resolution we not infrequently land ourselves in serious difficulties, and have to operate under very unfavourable circumstances.

Catarrhal appendicitis furnishes the greater number of cases of recurrent appendicitis, and this is the variety which may, and usually does, recover without surgical treatment, though, while the first and second attacks may be catarrhal and end in resolution, the next seizure may assume the suppurative form and produce general peritonitis, demanding operative interference.

My friend, Dr. Macrae, has been kind enough to look through the notes of my cases in order to ascertain the proportion of cases of perforating or suppurative appendicitis which have been preceded by attacks of simple catarrhal appendicitis, and he finds that in the greater number one or more simple attacks have preceded the serious seizures.

The following case is an example:

I saw a young man of 19 with Dr. Scarth, of Leeds, on August 30th, 1896. The history showed that the attack was quite sudden, but he had had two slight attacks of catarrhal appendicitis within the year. When seen by me thirty-six hours after the onset of the attack, the rapid pulse, the absence of tumour, the sudden onset, the hard, tense abdomen, the presence of fluid in the flanks, the persistent vomiting, and the marked tenderness over McBurney's point, made me suspect perforation with extension of peritonitis, and I decided on immediate operation. The abdomen was opened by an incision 3 inches long over the cæcum. Suppurative peritonitis was found, with entire absence of adhesive peritonitis around the original seat of disease; 30 to 40 ozs. of thin, very offensive pus were evacuated from the iliac fossa and the cavity of the pelvis, the small intestines being bathed with offensive matter. The appendix, very large and gangrenous, was found perforated close to the cæcum, the opening being large enough to admit the tip of the little finger. It was removed where it joined the cæcum, and the stump was invaginated and closed by Lembert sutures. After the pus had been wiped away the abdomen was freely washed out with hot boracic lotion. Two large drainage tubes were inserted, one to the bottom of the pelvis and the other into the right kidney pouch. From the evening of the operation the pulse and temperature became and remained normal, and recovery was satisfactory in every respect.

Suppurative appendicitis may run an acute or a subacute course, but whatever form it assumes, whether with or without perforation, or with or without gangrene, it demands operation, which in my opinion should be advised at the earliest possible moment, that is, as soon as a probable diagnosis is arrived at.

I have never regretted operating, but I know of several calamitous cases where delay at the request of the patient or his family has led to a fatal termination, which might have been avoided had operation been more strongly urged.

One case of this kind in an otherwise healthy youth that I saw with my friend Dr. Lee, of Dewsbury, some years ago, made a very firm impression in my mind. We saw the patient on the third day of the attack, the tumour being well marked. The symptoms having apparently subsided somewhat, delay in operation was sanctioned in conformity with the wishes of the parents; the same night the abscess burst internally, and he died the following day, whereas had we operated I think there can be little doubt that we should have saved him.

In another case in an adult I saw the patient on the fourth day of his illness, and strongly advised operation, which was consented to, but when I went prepared to operate another consultant counselled delay. I never saw the case again, but I heard that a few days afterwards the abscess burst internally, and the patient died rapidly from general peritonitis. I could furnish many similar examples.

Dr. Willie Meyer, in the *Medical Record* of February 29th, 1896, remarked that "an appendix, once inflamed, has to be looked upon as a diseased organ, which is very apt to give

repeated and more serious, even fatal, trouble in the future." He therefore advocates the removal of the appendix in every case after a first attack, and I think this sound advice, though in England our practice is generally less radical.

I suppose we can all point to cases where a patient has had an attack of catarrhal appendicitis ending in complete recovery without recurrence, therefore those who advocate delay have reason on their side; but I do most strongly uphold that if after a first attack we should think it wise to wait, after a second attack operation should be decidedly urged, as repeated seizures will certainly recur, and from being catarrhal may become suppurative, and lead to other complications. I have operated on a considerable number of these cases in the quiescent period, and not only have not had a death but have never had any real anxiety with the cases subsequently.

Peritonitis is not the only danger, as shown by a case I saw about a fortnight after the onset of a third attack of appendicitis, the appendicitis having apparently subsided. Rigors, with tenderness and enlargement of the liver, pointed to pyelophlebitis, and although the appendix, which was perforated and surrounded with offensive pus, was then removed, the liver trouble continued, and ended fatally a month later, despite the employment of antistreptococcal serum, exploration, and all other treatment that could be thought of. I had been consulted about the patient after his former attack, and advised the removal of the appendix, which would have saved him the subsequent trouble had the advice been acted upon.

I had, in November, 1898, the curious experience of removing the appendix in three cases, all presenting the same dangers; in all there had been several recurrences, and each was adherent on its outer side to the external, internal, and common iliac veins respectively, and quite free on the inner side, each appendix being strictured and distended with muco-pus, so that there was probably no chance of a safe issue in any of these cases without operation, since if the perforation had occurred externally, embolic pyæmia must have ensued, and, if internally, general peritonitis. Here delay would in all probability have been fatal.

Only a few weeks ago I removed a tuberculous appendix, the disease having already extended to the adjoining part of the cæcum and to the omentum which was adherent over it. There had been numerous attacks of appendicitis within a period of three years, and doubtless the tubercle was of recent origin. The patient has made a good recovery, and from the course of another similar case that I operated on some time ago in all probability he will be cured, but had there been further delay I feel sure the tuberculous process must have extended, and not improbably ended fatally. Within the present month I have operated on two similar cases, in both of which there had been a number of previous attacks.

Not only do these and other dangers result from delay in operating, but the suffering, anxiety, uncertainty, and loss of time assume serious proportions, as in one case on which I operated where there had been nearly fifty attacks of inflammation.

CHOLELITHIASIS.

Cholelithiasis, until comparatively recent times, was looked upon as being a painful and inconvenient malady seldom or never attended by danger, the numerous serious or even fatal complications to which gall stones give rise being apparently ignored. I have operated over 300 times on the biliary tracts, and in many of the cases have had to perform extremely difficult and dangerous operations on patients in the last stages of illness from deep jaundice, infective cholangitis, persisting vomiting, or exhaustion, when, had the cases been operated on at an earlier stage, the operation would have been quite simple and the chances of recovery 99 per cent.; for under ordinary circumstances nothing can be simpler than to operate on a normal-sized or a distended gall bladder, before the gall stones have entered the common duct and before the normal anatomy of the parts has become completely disarranged by adhesions and contractions, but no class of operation presents more difficulty than those in which complications have supervened.

Among the dangers of delay in these cases not the least, though often long delayed, is that of malignant disease. I find that I have operated on 40 cases of malignant disease in-

volving the gall bladder or some part of the biliary apparatus, and I must have seen quite double the number of cases where I did not advise operation; so that if only from its frequency I consider the disease is one that merits consideration from a clinical and not merely pathological point of view. In by far the greater number of cases the disease is a sequence of gall stones.

Zenke found gall stones present in 85 per cent. of cases of cancer of the gall bladder.

Musser, in an analysis of 100 cases, gives the proportion as 69 per cent. Courvoisier found gall stones present in 74 out of 84 cases of primary cancer of the gall bladder, Brodowski in 100 per cent., Jale in 23 out of 30, Bertrand in 14 out of 15, and Siegert in 95 per cent. of primary, but only in 15 or 16 per cent. of secondary, carcinoma of the gall bladder.

Mr. Beales stated that out of 100 necropsies at the Cancer Hospital 4 were cases of primary carcinoma of the liver and all had calculi in the gall bladder; 36 had secondary carcinomatous growths in the liver, but there were no gall stones present in any of them. Of 9 cases of primary carcinoma of the liver at Colney Hatch gall stones were present in 7.

These facts, to my mind, support so strongly the theory of gall stone irritation producing primary cancer of the gall bladder and liver that I think it ought to have great weight with us in advising on the surgical treatment of cholelithiasis.

The following opinions express my views with regard to treatment:

1. Seeing that statistics from various countries and by many observers agree in showing the frequent association of gall stones and primary cancer of the gall bladder and liver, it is desirable that cases of cholelithiasis should be submitted to surgical treatment at an earlier stage than has hitherto been the custom.

2. In all cases of tumour of the gall bladder, even if unaccompanied by symptoms, an operation should be advised, and the obstruction, usually a calculus, should be removed.

3. If these rules were followed, primary cancer of the gall bladder and extension to the liver would probably be less frequent.

4. If early operation in cases of tumour of the gall bladder were followed out, even if cancer had commenced, it could be caught in an incipient stage, when a cure by cholecystectomy, or even partial hepatectomy, might be reasonably hoped for.

5. An exploratory operation, even in a patient seriously ill, with a localised tumour in the gall bladder region, is worth advocating, though malignant disease be feared, in the hope that the disease may be inflammatory, and so capable of relief.

6. If there are any secondary nodules in the liver, or if adjoining viscera are invaded, the operation had better be terminated as a simple exploratory one.

When I come to look through the notes of my cases, I find among the complications of gall stones for which I have operated:

- Infective and suppurative cholangitis.
- Acute cholecystitis with empyema of the gall bladder.
- Phlegmonous or gangrenous cholecystitis.
- Persistent jaundice leading to blood deterioration, loss of flesh, hæmorrhages, and other troubles.
- Dilatation of stomach owing to pyloric adhesion.
- Intestinal obstruction from localised peritonitis, volvulus, lymph bands, or obstruction of the lumen of the gut by concretions.
- Fistula into the stomach or bowels.
- Persistent and uncontrollable vomiting.
- General peritonitis owing to ulceration and perforation of the gall bladder or bile ducts.
- Rupture of a distended gall bladder for bile duct, and other troubles almost too numerous to mention.

I am therefore almost perforce driven to the conclusion that delay in advising operation in cases of cholelithiasis is responsible for the greater number of these troubles which so frequently lead to danger and not infrequently to death. Nor should it be forgotten that death may actually occur from the violence of the pain in an ordinary gall-stone attack, for I know of two such cases, and have heard of others.

I hope the time is not far distant when it will be more fully recognised that though cholelithiasis, so far as its course and early treatment are concerned, is distinctly a condition for medical treatment, it is both unjust to the patient and unfair to the surgeon to continue medical treatment until serious complications supervene, or the patient is almost, if not quite, past relief before surgical treatment is advised.

PERFORATED GASTRIC ULCER.

Here delay is inexcusable, for it is incontrovertibly proved that

the main factor in success is early operation; for instance, in my own experience, my last three cases all recovered from the operation, because I was able to operate within twelve hours of the rupture, and before the stomach contents poured into the peritoneal cavity had become septic, whereas in three previous operations, where there had been a delay of twenty-four to forty-eight hours, not only had the system become poisoned, but the peritoneal cavity was filled with putrefying fluid and general peritonitis was present, and in these operation failed to relieve.

An interesting series of 78 operations for gastric ulcer has been collected by Messrs. Keen and Tinke,¹ which furnishes a good example of the dangers of delay, for since 1896 in cases operated on within twelve hours of rupture there was only a mortality of 16.66 per cent., whereas of those submitted to operation in from twelve to twenty-four hours the mortality was 50 per cent., and within from twenty-four to forty-eight hours 55.58 per cent. But it may be argued that a diagnosis cannot always be made at once; then in a case of doubt it is much better to make a small incision in the middle line, and if a gastric ulcer has perforated, inodorous gas will escape on opening the peritoneum. The opening need not be larger than just sufficient to admit the finger, and the whole exploration need not occupy more than a few minutes, it being done under cocaine if there is an objection on the patient's part to a general anæsthetic, though of course general anæsthesia is to be preferred, so that in case it is necessary to proceed with operation there will be no further delay.

When the profession at large thoroughly grasps the fact that at least five out of six patients with perforated gastric ulcer can be saved by immediate operation, what a number of lives will be saved that are now needlessly sacrificed! I argue that in every case where perforation is in question a surgeon should be called in without delay to consult with the regular medical attendant or the physician in attendance, and he should come prepared to operate at once if there is a perforation, or to explore within the twelve hours if there is doubt.

PERFORATED TYPHOID ULCER.

Almost the same arguments may be applied to perforating typhoid ulcer, for although the rate of mortality after operation will necessarily, from the nature of the cases, be much greater, every life saved by operation is a life gained, since the outlook under medical treatment is extremely unpromising. Moreover, it is to be borne in mind that in this class of cases the perforation will probably be recognised early, for the patient will certainly be under medical supervision at the time, and either in a special institution or in a sick room with nurses in attendance, so that surgical treatment may be applied with very little delay and before the general peritoneal cavity has become invaded by escaping septic material.

Another thing to be remembered is, that as the perforation is usually in the neighbourhood of the cæcum, the seat of the disease can be reached at once by an incision there, and the dangers of a prolonged search and exposure of the abdominal contents are avoided, so that a rapid operation can usually be done if performed early. From the increasing number of successful operations it is becoming more manifest that even the severe general condition of a typhoid patient is not sufficient to warrant us in withholding surgical treatment from these desperate cases, and where the diagnosis of perforation is made, operation is indicated in almost every case.

We must not forget that delay in operating makes the difference between treating a perforating typhoid ulcer, at first a local matter, and operating at a later stage for general septic peritonitis following the perforation.

Again I will refer to statistics to prove the point. That able and philosophical physician, Dr. Osler, said in congratulating Dr. Cushing on his results in the surgical treatment of three cases of perforation in typhoid, "To save one case in three of perforation is much more than we can do on the medical side, for they all die with us except a few cases of appendical perforation." Probably, however, one in three is a greater number than at present has been saved, as Dr. Keen puts down the recoveries as 19.6 per cent., and Dr. Finney as 26.2 per cent., so that if we take the mean of these two figures as expressing the actual results, we may reasonably hope to

save from 22 to 23 per cent. of cases of typhoid where intestinal perforation has occurred.

Of the importance of this subject no doubt can be entertained, when the fact is grasped, that according to different authorities in America, England, Germany, and Australia, from 10 to 20 per cent. of the fatalities in enteric fever arise from perforation. I would therefore urge that the physician and surgeon should be more intimately associated in the treatment of typhoid cases, and that, when any abdominal symptoms occur in the course of the fever, especially if there be pain and tenderness in the right iliac region, a surgical consultation should be held, with a view to early treatment; for I believe it is only when this is fully realised that the mortality in these otherwise fatal cases can approach the low percentage now attained in acute perforative appendicitis.

DILATATION OF THE STOMACH AND STRICTURE OF THE PYLORUS.

It would be interesting to know how many invalids from stomach disorders are at the present time dosing themselves with patent medicines and being dosed for chronic dyspepsia, when they are really the victims of simple dilatation of the stomach or of dilatation associated with pyloric contraction, both of which troubles could be cured by operation.

Vomiting some little time after food, with thirst and rapid emaciation, should create the suspicion of, and lead to the examination for, dilated stomach, as shown by stomach splash and other well-known signs; if with this peristalsis from left to right is noticed, the chances are greatly in favour of narrowed or otherwise obstructed pylorus, which may, of course, be dependent on malignant disease, but which in many cases is due to some simple or removable cause.

I have myself published a number of cases of stenosed pylorus where complete cure has been established by pyloroplasty, and have done a further number of equally satisfactory cases which have not yet been reported. Before the Clinical Society of London, I pointed out some years ago how adhesions of the pylorus to the gall bladder or liver create a kink of the outlet from the stomach, thus leading to symptoms simulating stenosis, and I then referred to cases which had been cured by operation. Since that time not only have I added considerably to the number of such cases operated on with success, but the observation has been corroborated and acted on by other operators.

There is a class of cases of ulceration of the pylorus or of the stomach near the pylorus producing a very distressing form of chronic dyspepsia, and very apt to be mistaken for malignant disease. Within the past year I have operated on two of these cases; the first in consultation with Dr. Johnstone, of Ilkley, with whom I hope to publish it in detail.

The patient, a middle-aged lady who had been a complete invalid for many months and ailing for years with so-called chronic dyspepsia and with well-marked dilatation of the stomach, and who had been submitted to the Weir-Mitchell and various other forms of treatment, when operated on was found to have the pylorus firmly adherent to the under surface of the liver, and on separating the two, an ulcer with its base in the liver was found, the aperture in the pylorus being about the size of a sixpence. The passage through the pylorus was contracted so as only to permit the passage of a No. 10 catheter; separation of the adhesions and pyloroplasty completely cured the patient, who rapidly gained weight, and is now well.

In another case in which I was associated with my colleague, Dr. Barrs, a young medical man was worn to the last stage of exhaustion, and had lost flesh until every bone showed prominently through his skin, the prominent physical signs being dilatation of the stomach with a doubtful tumour under the liver. On exposing the stomach, the tumour had every appearance of malignancy, and extended from the pylorus along the lesser curvature of the stomach to the entrance to the œsophagus, so that excision was out of the question and gastro-enterostomy was done, with the result that the patient has gained over 2 stone in weight, is now quite well, and carrying on a large general practice. From the result, it is highly probable that what appeared to be growth was in reality inflammatory exudation around an extensive ulceration in the stomach.

In both of these cases delay nearly led to loss of life, and the operations should have been performed before the patients were so far reduced, especially as the symptoms had been so well marked for some time before; the patients consulted the physicians, who diagnosed the conditions and advised efficient treatment.

I could relate many other cases did time permit, but these will serve to point out the fact that many cases treated for months or years as chronic dyspepsia are really suffering from dilated stomach, and some of them from pyloric obstruction, and that the former condition may be relieved by

gastrorrhaphy, and the latter by pyloroplasty or by gastroenterostomy.

INTESTINAL OBSTRUCTION.

I hold that every case of intestinal obstruction is a case for consultation, and should be seen at an early stage by a surgeon, not necessarily for operation, but that he may be prepared to interfere as soon as ordinary remedies have failed, and before the system has become poisoned by the fermenting contents of the gut above the seat of obstruction; moreover, in an early stage, the diagnosis of the nature and seat of the obstruction can be more easily made out, and, if the obstruction be a mechanical one, such as an internal hernia, a band or a volvulus, the less delay in operating the better for the patient, for nothing short of operation is likely to afford any relief. How frequently is the surgeon called in to relieve obstruction when the patient is moribund from septicæmia, and when all that he can do is to bring up a loop of bowel and drain it, the result being some slight relief, but in a great number of cases only for a short period. Then, unfortunately, surgery is blamed for the death, whereas the blame should be on the delay in applying surgical treatment. I have seen some of the most simple operations, such as the simple division of a band or the reduction of an internal hernia, to fail, not because of the technique or because of the failure to relieve the obstruction, but because the distended bowel had become paralysed and the mucous membrane necrosed before relief had been sought by the only means possible. This was very well demonstrated by Professor Kocher in a paper he gave before the British Medical Association in Edinburgh, on the Causes of Death in Acute Intestinal Obstruction, in which he showed photographs of the ulcerated and gangrenous mucous membrane in the gut above the seat of obstruction.

The dangers of delay in this class of cases could be illustrated by very many examples, but as we doubtless all know of cases in point I will not take up more of your time, but would simply urge that we should strive to avoid these dangers by an early surgical consultation, and, if needful, operation.

OVARIAN TUMOURS.

I have operated some hundreds of times for large ovarian tumours, and the question has often crossed my mind during the operation, Why should these cases have been allowed to go on so long before being submitted to operation, when by bimanual examination they can be recognised in their infancy and removed with almost absolute certainty of recovery before any complications have supervened? Sometimes, of course, it is owing to the patient having failed to seek advice, but I know that in many cases it is due to that *laissez faire* policy of not interfering until the tumour is producing distress, which frequently means waiting until some complications have supervened demanding early operation, when the dangers of ovariectomy are decidedly increased; in fact, in this case we may put down the dangers of delay as 4 or 5 per cent. as compared with the almost complete absence of danger in early operation, to say nothing of all the discomfort and inconveniences which have to be borne.

To give examples of suppurating cysts, cysts with twisted pedicles, cysts with numerous and firm adhesions, general peritonitis owing to ruptured cysts and other complications, all of which might be avoided by early operation, is unnecessary, and I think everyone will agree that here delay is most undesirable.

UTERINE TUMOURS.

Here we are entering on more debatable ground, but I think it is becoming more generally recognised that myoma uteri is not the harmless growth that it was once considered to be; for though at first it is usually benign, it not infrequently undergoes sarcomatous or carcinomatous degeneration.

It is usually thought that these tumours disappear at the menopause, and that therefore waiting may be counselled; but how often are we disappointed to find that the climacteric brings no amelioration, but that the growth and hæmorrhage persist long after a change has been expected. Moreover, in many of the cases where such amelioration does occur, how often does it come to a patient so worn down by hæmorrhage and pain that she remains a permanent invalid for the rest of her existence.

Apart from myomata breaking down and sloughing, and so giving rise to septic troubles, other complications arise from

pressure on nerves, ureters, kidneys, and rectum, leading to complications of various kinds; so that the simple myoma is by no means the harmless disease that it was conveniently considered when its surgical treatment was so unsatisfactory and fraught with so much danger.

The mortality from removal of the appendages, myomectomy or hysterectomy, has been reduced to such a low figure that we may now venture to consider the question as to whether every myoma should not be treated like an ovarian cyst, and operated on at an early stage. My own feeling is, if causing no trouble, we may be content to wait; but as soon as it causes inconvenience or tends to grow, especially if in a young person or if in a woman who has to work for her living, it should be operated on without waiting for all the dangers and inconveniences which we know that delay will entail.

REFERENCE.

¹ *Phil. Med. Journ.*, June 14th, 1898.

THE PROGNOSIS AND TREATMENT OF ACUTE INTUSSUSCEPTION.*

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THE frequency of intussusception as a cause of acute obstruction of the bowels and death was, until quite recent years, not sufficiently recognised, and in my own student days we were accustomed to look upon the disease as one of extreme rarity. The explanation of this probably lies in the fact that as the trouble is particularly common in young children, and in them is apt to terminate fatally very quickly, its presence was in many cases overlooked.

Leichtenstein's statistics would seem to show that it forms quite 40 per cent. of all the cases of acute intestinal obstruction, and two or three such cases are seen almost every year at most of our large general and children's hospitals.

DIAGNOSIS.

The diagnosis of intussusception is not, as a rule, a matter of any great difficulty unless the main symptoms be masked or otherwise obscure. Fifty per cent. of the cases occur, according to Treves, in children under 10 years of age, and it seems to be slightly commoner among boys than girls. The main symptoms are a sudden onset of abdominal trouble with vomiting, the presence of blood and mucus in the rectum, tenesmus, and the presence of an abdominal tumour.

1. Of all the classical symptoms, the presence of bloody mucus in the rectum or its passage *per anum* is of such frequent occurrence as to be almost pathognomonic of the disease. It is present in more than 80 per cent., and its presence in a young child who has been taken suddenly ill with acute abdominal trouble should make us strongly suspect an intussusception.

2. The onset of the illness is usually sudden, and is often attended with collapse. The pain, as is usual in intestinal obstruction, is generally referred to the umbilicus, and is colicky in character. Actual vomiting is a very variable symptom, and may be absent from first to last. In about a quarter of the cases it is persistent, and becomes fæculent. It is commonest—as one might expect—in intussusceptions occurring in the small intestine. It generally becomes more persistent towards the fatal termination of a case, and is then probably due to the peritonitis which has supervened.

Straining or tenesmus was a marked symptom in three of my cases, but it not so constant a symptom as either vomiting or the passage of blood. It would seem to be most marked in intussusceptions of the large intestine, or when the intussusception, beginning in the small intestine, has reached the rectum.

The presence of a sausage-shaped tumour in addition to the symptoms enumerated above would make the diagnosis almost a matter of certainty. But in 50 per cent. of the cases no such tumour can be made out. The tumour is somewhat elongated, often easily movable, and owing to the fact that intussusceptions most frequently commence at the ileo-cæcal

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