Remarks

ON

SOME CASES IN GENERAL SURGERY.

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I HOPE that the following brief notes of cases, which have been more or less recently under my care in the Cheltenham Hospital, may be considered of sufficient interest to justify their publication.

CASE I.

Gastrostomy for Cancer of the Lower Part of the Oesophagus.

W. D., aged 66, was admitted at the beginning of May, 1901. His appetite had begun to fail one year previously. Vomiting began six months before his admission and had been occasional ever since.

Three months ago he noticed that he was getting thinner.

About two months before his admission he found that he could no longer swallow solids, and when he was admitted he could hardly swallow liquids. No growth was palpable, though a probang was arrested near the stomach. About two months previously he began to feel a pain in the lower part of his chest, a pain that was always worse at night, but was not made worse by food. For several weeks the little solid food which he had apparently swallowed regurgitated soon afterwards.

Not many days after his admission into the hospital, where he was sent by Dr. Searancke of Mitcheldean, all power of swallowing was lost, and accordingly a Frank's (or Albert's) operation was done. This is too well known to need description, though I may add that I allowed at least 1 in. of the stomach to project through the second skin incision, which was made over the cartilages of the ribs. In this projecting portion a small hole was made, through which a No. 10 indiarubber catheter was passed. The catheter entirely filling the hole there was no leaking of the contents of the stomach. This projection at first of the stomach is distinctly advisable, as great retraction occurs later. No fever or attempted vomiting followed the operation. On the contrary, he improved rapidly and continuously and every two hours enjoyed his meals, which were at first of peptonized milk 1 oz., beef tea $\frac{1}{2}$ oz., and champagne $\frac{1}{2}$ oz.

There is nothing further to remark, save that he put on flesh, returned home in very tolerable comfort and was kept alive, thanks to his gastric fistula, till the progress of the malignant disease destroyed his life eight months afterwards.

We have done one or two previous gastrostomies in the Cheltenham Hospital, but the case narrated is our first fortunate one. The operation is not more difficult than an inguinal colotomy, and would not, I believe, be much less successful, were it only practised, as it too seldom is, before the patient is almost sinking. We must not forget, however, how much greater is the shock resulting from operations on the stomach, which is closely connected with the solar plexus. The inferior mesenteric plexus, with which the descending colon and sigmoid flexure are connected is a nerve centre of vastly less importance. I believe a small gastric opening to be a very important point. At first the catheter should be kept in continuously. Later it should be passed only when needed.

CASE II.

Amputation at Hip-joint: Use of Wyeth's Needles.

H. P., aged 19, sent in by Mr. G. A. Cardew. Here the original disease was a round-celled sarcoma growing from the periosteum of the upper part of the tibia. For it a Stephen Smith's amputation had been done ten months previously, but the disease had returned in the lower part of the femur.

I then advised amputation after Furneaux Jordan's method, through the hip-joint. This was done on May 7th, 1899, and I am mentioning the case chiefly to illustrate the comfort and security afforded by Wyeth's needles. They are a vast improvement on the abdominal tourniquet and rectal lever. These needles, as is well known, are 10 in. long by $\frac{3}{8}$ in. in diameter. One of them, entering just below the anterior

superior spine of the ilium, is thrust through the superficial structures of the outer and upper part of the thigh at right angles to the latter; the other one, embracing the tendon of the adductor longus, is passed through the skin of the inner part of the thigh, emerging finally below the tuber ischii. Slipping of the elastic bandage, which is applied above these needles, is quite impossible, and consequently little or no blood is lost. In the case referred to I am sure the loss did not exceed 1 oz. Being anxious to secure healing by first intention, and being a Listerian by example and conviction, I practised a plan which I have found to be safe and infallible. I thoroughly washed the large wound with 1 in 20 carbolic lotion, and soon afterwards washed away the latter with 1 in 2,000 sublimate lotion. I have found by comparative experiment that 1 in 40 carbolic lotion, even when followed by sublimate, is a less certain preventive of suppuration than the 1 in 20 lotion is, and I would claim a special virtue for the usage above narrated.

The wound, which was drained for a few days, healed at once, and he left the hospital about five weeks afterwards, in excellent health. But our efforts were of no permanent benefit. There was no local recurrence, but he died about fourteen months later of sarcoma of the lung.

There is no malignancy like that of round-celled sarcoma. I have met with it twice in 76 amputations of the whole breast, and can only add that repeated operations were perfectly futile in both of those cases. The mortality of those 76 Listerian operations was one only, and that patient was a diabetic. Fatal coma supervened soon after the operation. I mention this fact of a low mortality as showing that, whatever may be claimed for asepsis, Listerism is still safe and good. I may here refer to a case of round-celled sarcoma of the upper part of the humerus, seen not long ago by me. Here disarticulation was declined when it might have been helpful, though it was requested when it would have been useless, owing to the extension of the disease to the thorax. The patient, also a young man, went to the Middlesex Hospital, but there also they declined to operate. In three months the tumour was nearly as large as his body. It was soft though brittle, and almost exsanguine, and on one occasion, without serious consequences, he himself pulled away a large portion of the weighty mass. In about four months from its first appearance it destroyed his life.

CASE III.

Removal of Superior Maxilla.

Notwithstanding the foregoing remarks, there are instances in which even round-celled sarcomas have been extirpated with permanently good results. I may cite a case under my own care nine years ago.

J. H., aged 18, suffered from such a growth, originating in the inside of the right superior maxilla. It had penetrated the hard palate and was projecting into the mouth. As a minor measure I completely scooped away the whole of the growth, leaving little more than a shell of bone, and afterwards mopped out the interior of the maxilla with a strong solution of chloride of zinc. Needless to add that the growth soon reappeared. He then desired, and I effected, what I had advised at first, the removal of the whole bone, including the orbital plate.

He made a good recovery, and the point of the case is that he still, after the long period of nine years, remains in excellent health and free from any recurrence. This operation—which, once the division of the bone is begun, cannot be finished too quickly—is to me one of the most repellent in surgery. I have seen a patient die of haemorrhage before it was finished; and in this respect I would bracket it with Kraske's removal of the rectum.

CASE IV.

Acute Appendicitis.

Rose S., aged 15, originally under the care of Dr. Lloyd Davies, was admitted on July 8th, 1899. She became much worse soon after her admission, and accordingly the abdomen was opened in the middle line on July 10th. Some offensive pus escaped at once, but the intestines were all matted together, and it was evident that there was deeper-seated mischief—in fact, it could be felt per vaginam. By working mainly with the finger a large and deep collection was

reached, which was found to extend into Douglas's pouch. This collection had probably originated in the neighbourhood of the appendix, which, however, could neither be seen nor felt. The point which is somewhat exceptional is that I determined to drain through the vagina, into which a large tube was passed from above. This tube was retained there for one week. Anterior drainage was also practised.

Her convalescence was somewhat lengthy, as a puncture of the small intestine was made whilst burrowing for the deep-seated pus; and a second and much larger opening resulted from the partial sloughing of the necrotic caecum. The drainage was afterwards supplemented by frequent syringing with boiled boric lotion. Serious and unpromising as her case looked for a long while, it is encouraging to add that within six months her fistula and skin wound had perfectly healed, and she is now in admirable health, and apparently not suffering at all from the former adhesion almost *en masse* of all her bowels. I may add the gratifying fact that all the fecal fistulae I have met with have healed, sooner or later, spontaneously.

CASE V.

Ovariectomy during General Peritonitis due to the Bursting of a Secondary Cyst.

E. B., aged 50, like the last patient, was admitted at first under the care of my colleague, Dr. Trevithick. This patient was married, though childless. She had had a swelling of the lower part of the abdomen for three or four years, but it had grown rapidly during the last six months. The whole abdomen was extremely tender.

She was evidently suffering from peritonitis, and as her temperature was high and she was rapidly becoming weaker the abdomen was opened on April 29th, 1901. The whole abdomen was full of mucoid fluid, from which it was evident that an ovarian cyst had burst. The great omentum was closely adherent to the principal cyst, and it was necessary to divide the former to reach the latter. Even then the mesentery and small intestine and the sigmoid flexure were found to be closely adherent to the tumour. After some delay the intestines were separated from the cyst wall, though not without the sacrifice of much of their peritoneal covering. The main cyst, whose thick contents could not be evacuated by tapping, was removed entire, the peritoneal cavity was flushed with sterilized hot water, a Keith's tube was inserted, and the abdomen was closed in the ordinary way.

The tube was removed on the eighth day, and the patient's subsequent course would have been quite uneventful but for a large faecal fistula which formed after ten days. From the direction of this fistula it was evident that it proceeded from the sigmoid flexure; but, just as in the previous case, it healed up after a few weeks, and the patient is now in perfect health.

Of course the best way in the case of intestine adhering to a cyst is to dissect off the peritoneal covering of the cyst; but, if it be the lower part of the sigmoid flexure or rectum which is adherent, it may be difficult to do this; and it is consequently often omitted, with, perhaps, such a result as the one just described.

CASE VI.

Burst Ovarian Cyst.

M. T., aged 40, was a patient of Dr. Prance, from whose notes I am quoting. She was first seen on November 7th, 1901, when a hard, non-fluctuating tumour was discovered in the hypogastric region. On December 5th the tumour was larger. On January 1st she suffered great pain, and when seen soon afterwards the tumour had disappeared. Ascites supervened, and she was admitted into the hospital on January 14th, 1902. She was not seriously ill at first, though her temperature varied from 100° to 101.5° F., and her pulse remained steady at about 100. On consultation opinions differed much, but the majority considered the case to be one of peritonitis with effusion, and, as her life was not in danger, it was decided to temporize.

But she got worse instead of better, and so an exploratory operation was done on January 22nd, 1902. By that time the effusion was completely circumscribed, and it was necessary to cut through a layer of lymph half an inch thick before the peritoneal cavity could be reached. The cause of her trouble was then disclosed in a collapsed ovarian cyst, which

was forthwith separated and removed. She made a good and quick recovery, but there can be no doubt that it would have been better for her if she had been operated on eighteen days sooner. I was the less inclined myself to hurry on the operation as I have known good recovery to follow the rupture of a parovarian cyst. I was doubtful as to the best course to follow with the great lymph cyst which lined the abdominal walls and covered the intestines, but finding it easily detachable without much bleeding, and fearing that, if left, it might break down into pus, I stripped off all the parietal part and most of that over the intestines. I wish I might elicit an opinion on this practice from one of the great ovari-otomists.

CASE VII.

Cyst: probably Pancreatic.

L. G., aged 44, admitted on February 16th, 1902. She had previously enjoyed good health, though she had latterly noticed a swelling in the middle of the abdomen. Recently the swelling had become very tender, and her temperature and pulse had risen. The tumour was central, slightly movable laterally, and distinctly fluctuating. Nothing of it could be felt on vaginal examination. The general impression was in favour of its being a mesenteric cyst.

On operation (February 19th) the cyst, which was as large as a young child's head, was found to lie between the stomach above and the transverse colon below, the mesocolon being incorporated with it, while the omentum was pushed over to the left. Its origin passed upwards and backwards to the spine, and it had evidently originated either in the pancreas or in its immediate vicinity. On tapping, the contents were found to be dark and semipurulent. In consequence of its deep connexions I elected to drain and not to attempt removal. As much of the cyst as possible was accordingly drawn out and fixed externally, and the patient has made a good recovery, though there is still a slight discharge. There is now retraction in the place of protrusion at the site of the incision.

Though albumen was not digested by the discharge from the cyst, I still believe the latter to have originated in the pancreas, a view which is corroborated by the present discharge being distinctly amylolytic and by the microscopic examination of the fluid, in which were found streptococci in abundance, with at least two other kinds of bacteria, probable entrants through the duct of Wirsung. I believe I may congratulate myself on not having attempted removal, as whatever may be the case now, it was certainly true in 1897 that such cysts had been successfully removed 8 times only, whereas 70 cases of drainage had been followed by 65 recoveries.

Mr. Doran's learned and characteristic paper in vol. ii of the BRITISH MEDICAL JOURNAL for 1897 will be found to be a veritable mine of information on the subject.

CASE VIII.

Epithelioma of the Tongue.

My eighth and last case may be very shortly described. J. S., aged 83, admitted on September 14th, 1897, with epithelioma of the left side of the tongue. The latter was split and the left half removed after the admirable method of my friend, Mr. Walter Whitehead. The patient is still living and in excellent health at the age of 88. The truth is, that the aged are extremely good subjects for operative surgery and should not be debarred its benefits. No one radically unsound and deficient in vitality or resisting power ever becomes aged. Thus, nearly all the very old persons I have known operated on for strangulated hernia have recovered, including a patient of my own, aged 91. In selecting these cases for publication I have been at pains to exclude any of ordinary character.

In conclusion I wish to express my obligations to the House-Surgeons, Messrs. Armitage and Curtis, and to the Sisters of Wards 5, 7 and 8 for their unremitting care.

A HOME FOR INDIGENT DOCTORS.—The late Russian Privy Councillor, A. P. Raszfelloff, has bequeathed to the city of Moscow a sum of 8,000,000 roubles for the erection and maintenance of a home for indigent members of the medical profession. It is probable that part of the capital will be applied for the provision of pensions for the widows of medical practitioners.