ACUTE INTESTINAL OBSTRUCTION*

BY

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General practitioners are often blamed for failure to recognize intestinal obstruction in its early stage. They are blamed most unjustly. In the early stage there is nothing more difficult to diagnose; in the later stages the diagnosis is so easy that he who runs may read. I propose very briefly to mention a few only of the points which are of importance.

Early diagnosis is the key to success. Severe pain of sudden onset unaccompanied by rigidity or marked tenderness should always raise a suspicion of intestinal obstruction. When the pain is accompanied by rigidity the symptoms may suggest the perforation of a hollow viscus. We are told in our textbooks that the rigidity of intestinal colic is superficial and less marked than in cases of perforation. This is not strictly true. The rigidity of intestinal colic may be board-like in its intensity, but there is an important difference. In intestinal colic, gentle massage with a warm hand will gradually overcome the rigidity; in perforation, no coaxing will induce the muscles to relax their protective spasm. If, in addition to pain, there is inability to pass flatus or faeces, surgical treatment is indicated. A person who is passing neither wind nor faeces is a dying person. If this cannot be ascertained from the history of the illness the administration of two enemata at intervals of one hour, as indicated by Sir Henry Newland, will settle this point and confirm or negative the diagnosis.

The suggestion that radiography should be employed in the diagnosis of intestinal obstruction is one which should be condemned whole-heartedly. Sir Henry Newland has stressed the value of the "seeing eye," and I am in most cordial agreement with him. At the present time, there is a tendency to rely too much on laboratory-made diagnoses. I prefer the "seeing eye" of a living clinician to the scientific eye of a dead machine. Even if the diagnostic value of radiography in intestinal obstruction were more than problematical, the unfortunate patient, by the time his examination and preparation are completed, has had quite sufficient test of his patience and endurance. In dealing with intestinal obstruction, the surgeon should have the courage of his convictions and get on with his job. I began my professional life as an anaesthetist, and my experience during the years I was resident at St. Bartholomew's Hospital taught me three important lessons. First, the importance to the patient of a short period of rest after the preparation for operation is completed—when the patient has been prepared, a small dose of morphine should be administered and the patient allowed to rest for at least half an hour. Secondly, the importance of keeping the patient warm. In more senses than one, a cold slab is the death-bed of the acute abdomen—a heated operation table is a vital necessity, and the patient's extremities should be bandaged in cotton-wool. Thirdly, that patients who are acutely ill will not stand prolonged operations. After half an hour the pulse begins to fail, and after forty-five minutes this failure becomes very pronounced.

The aim of treatment should thus be the relief of obstruction by the simplest method and in the shortest time possible. Two great principles should be observed: (1) no form of anastomosis or resection is permissible in cases of acute intestinal obstruction; and (2) drainage of the bowel should be established wherever necessary. I

am aware that at the present time drainage is not fashionable; indeed, by some it is regarded as a confession of ignorance on the part of a stagnant and indecisive mind. This heresy is a heritage of the war, when claims were made as to the success of excision and primary suture of wounds which were not confirmed by those who witnessed the ultimate results of this method of treatment. If the obstruction cannot be removed, or if, after its removal, the intestine is too paralysed to empty itself, drainage of the bowel is imperative. In the statistics so admirably presented by Mr. Vick, resection was performed in 10 per cent. of the cases, and I think less heroic measures would result in a diminished mortality rate.

To sum up, the important points are: (a) early diagnosis and early operation; (b) preparation of the patient followed by a short period of rest; (c) a heated operation table; (d) no resection or anastomosis; (e) drainage of the bowel when necessary—sepsis demands drainage; surely this is one of the eternal verities of surgery.

STATISTICS OF ACUTE INTESTINAL
OBSTRUCTION*

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In 1925, at a meeting of this Section of the Association at Bath, a very useful and interesting discussion took place on the subject of acute intestinal obstruction, and it was suggested that after the lapse of a few years the discussion should be repeated in order that all our ideas might be ventilated again and our knowledge brought up to date. Unlike most really useful suggestions this one has been carried out, and the stage is now set for another full-dress discussion on the diagnosis, treatment, and prognosis of the many conditions, all of them potentially serious, which are included under the wide term "acute intestinal obstruction."

In 1925 Mr. Souttar presented a carefully prepared set of figures showing the results of treatment of cases of acute obstruction at seven large London hospitals during the years 1920 to 1925. At the invitation of the officers of this Section I have prepared another series for the years 1925 to 1930, and I have to thank Mr. Souttar for the use of all his available material and for his help. It has been my deliberate endeavour to adhere to the classification and arrangement adopted in 1925, in order that we may be enabled the better to compare the two sets of figures. This has worked out so satisfactorily that it would be possible, if it is considered advisable, for the two sets of figures to be fused together and thus give us records with a considerable amount of clinical detail of nearly 10,000 cases. I have introduced certain modifications and elaborations: my period is six years instead of five, and I have widened the scope of the investigation by collecting from twelve hospitals in London, eight in the provinces, and one in Scotland, making twenty-one in all. Although this return does not include any of the hundreds of cases operated upon in cottage hospitals or in private practice, it must be admitted to be a very representative statistical return.

I have listened far too often to the dreary recapitulation of statistics ever to wish to condemn even my greatest enemy to so unkind a fate, and I will communicate the figures to you as quickly and as painlessly as I can. First of all, I would call your attention to the graph which I have prepared. There, in diagrammatic form, I have set forth the facts. The number of cases is 6,892. They

* Paper read in the discussion in the Section of Surgery at the Centenary Meeting of the British Medical Association, London, 1932.

* Communicated to the Section of Surgery at the Centenary Meeting of the British Medical Association, London, 1932.