

THE ABDOMINAL INCISION—THE REMOVAL OF THE WEDGE OF SKIN AND FAT TO FACILITATE INTRA-ABDOMINAL OPERATIONS.

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IN an article on "Excision of the Fat of the Abdominal Wall—Lipectomy,"¹ I recommended large excision of skin and fat from the overweighted abdominal wall in obese women. Such an operation serves the purpose of reducing their avoirdupois, and at the same time renders the patient less unwieldy by taking some pounds of fat from a part of the body where it is most awkward to carry it. It is also cosmetic and serves the purpose of cleanliness. This operation, to which I gave the name "lipectomy," bids fair to be extensively used in this country as well as abroad. It has been considered by Weinhold² and by A. E. Maylard.³

Dr. Maylard, of Glasgow, in a most interesting and thoughtful article on the "Direction of Abdominal Incisions," describes two cases in which abdominal walls were resected, removing ten pounds and eleven ounces, and six pounds and two ounces, respectively, the incision in each case being 21 inches in length.

A number of surgeons also in our own country, without having specially reported their cases, have relieved excessively obese patients by a similar procedure.

The matter I now wish to speak of, though bearing a superficial resemblance to the operation of lipectomy, is rather an adaptation of the same idea to another field and for quite another purpose.

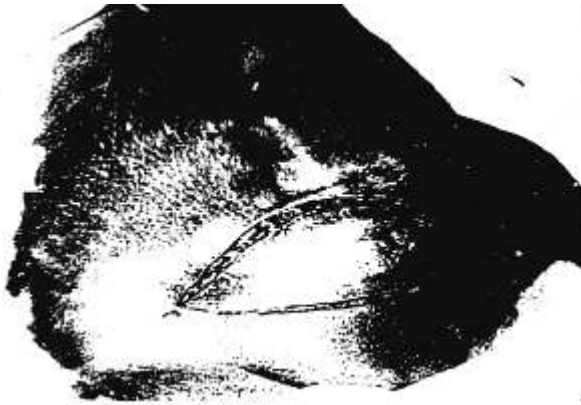
Every surgeon knows well how the difficulties of intra-

¹ Surgery, Gynecology, and Obstetrics, March, 1910.

² Cent. f. Gyn., No. 38, Sept. 18, 1909, p. 1332.

³ Brit. Med. Jour., Oct. 5, 1907, p. 895.

FIG. 1



Oval incision for the removal of a sector of skin and fat to get the embarrassing superficial tissues out of the way in operating upon the deeper abdominal structures. The dark color of the abdomen is due to the tincture of iodine.

FIG. 2.



The wedge of skin and fat being lifted away, the upper part of the incision is hauled up, showing the extent of the linea alba, which is accessible for a vertical incision into the abdomen even when the skin and fat are removed transversely.

abdominal operations in a stout patient are often greatly enhanced by thick abdominal walls which increase the distance of the tissues to be treated from the surface, compelling the operator to work, as it were, through a long funnel. On the other hand, almost all abdominal operations, however difficult, if they could be transported onto the surface of the body, would become comparatively easy. Any one, for example, could cut into a common duct and sew it up or lay bare a pelvic ureter without injury if these structures were disposed, for example, close to the surface of the body. The more distant the structure is from the superficial plane of the body the more difficult those delicate operations become, just on account of the remoteness and for no other reason. In some cases actual suturing is made impossible by nothing else than these vexing mechanical difficulties of the situation, the unget-ativeness of the parts, so to speak. This awkwardness I have been able to obviate in most instances by a large oval excision of the skin and fat down to the abdominal wall, removing a skin section either in a transverse or in a vertical direction, corresponding to or at right angles with the incision, about 8 or 10 inches in length by 3 or 4 inches in width. This does away with the thickness of the wall down to the fascia, while from the fascia inwards the difference between different abdomens is not great. If the patient is excessively fat, one will then naturally do a regular lipectomy operation, such as I have described in my previous article. This serves the same purpose and is done the same as the lesser procedure here described. I wish, however, here to emphasize the value of removing wedges of skin and fat in patients who are not troubled with obesity, but simply and solely for getting rid of a part of the thickness of the abdominal wall and making the field of the operation more accessible.

An oval or an elliptical excision is made such as that figured (Figs. 1 and 2), cutting right down to the strong fascia overlying the rectus and oblique muscles. All bleeding vessels ought to be carefully tied. It is a good plan, I think, to slope the edges of the incision a little inwards. When this

piece of skin and fat is removed the operator then finds it much easier to open the abdominal wall and operate than in a similar case where he has to retract this embarrassing mass of tissue as well.

I like to close such a wound with a fine catgut suture, catching a distinct layer of fascia about the middle of the fat, silkworm gut sutures uniting both skin and fat.