

ABSTRACTS OF CURRENT LITERATURE

MEDICINE

THE DIAGNOSIS OF PANCREATITIS.

(A. J. Ochsner, B. S., F. R. M. S., M. D., Surgery, Gynecology and Obstetrics, December, '08.)

After commending the brilliant work of Mayo-Robson for bringing the pancreas to the proper attention of the surgical profession, he reviews the Cammidge test, and concludes that the test is of value, but needs further development before it can be generally employed.

He says so large a proportion of patients suffering from gallstones and other infections of the biliary tract also suffer from pancreatitis, that the general symptoms of cholecystitis should make one suspicious of the probable presence of pancreatitis. The proportion of cases of gallstones complicated by pancreatitis is given from 6 to 30 per cent.

In a case of cholecystitis, if there is a distinct point of tenderness at Mayo-Robson point, half-way between the end of the ninth rib and umbilicus, and a second area of tenderness upon deep pressure for a distance of five to ten centimeters from a point a little to the right of the umbilicus upward over the right rectus muscle, you may safely make a diagnosis of pancreatitis in all cases where duodenal ulcer can be reasonably eliminated. Two symptoms of duodenal ulcer must be absent. First, hyperchlorhydria, with eructations; second, pain before meals when the stomach is empty.

Another common symptom is the pain radiating to the mid-scapular or the left scap-

ular region. This referred pain has been looked upon as indicative of gastric ulcer, but this seems true only when there is also pain upon deep pressure at a point half-way between the ensiform appendix of the sternum and the umbilicus.

Aside from the Cammidge test a number of authors have published other tests which are worthy of further study. Solomon claims that in giving von Noorden's oatmeal diet, patients suffering with pancreatitis have typical butter stools. He also stated that an abnormal large amount of lycethin is found in stools of patients suffering from pancreatitis. When they are placed on an egg diet, 0.4 to 1.2 gms. will be excreted in twenty-four hours, while under the same conditions if the pancreas is normal never more than 0.1 is excreted. Mueller's test is so simple that it must prove valuable if further test will establish its reliability.

The patient is given a test-meal, and two hours later a calomel purge. A few drops of the stool are sterilized by heating to a high temperature, then placed on an agar plate containing Loeffler's serum. This material is kept at a temperature of 131 to 141 degrees F. for twenty-four hours. If trypsin is present the serum shows pronounced depressions where the substance has been active; if inactive, the serum remains smooth.

The diagnosis of acute pancreatitis is extremely difficult, because so many other conditions have similar symptoms. Perforation of gallbladder, duodenum or posterior wall of the pylorus, renal colic, ectopic gestation and appendicitis have all been mistaken.

The pain is terrific in the right upper

quadrant of the abdomen, the patient is severely shocked, nausea and vomiting are present; tympanites develops rapidly, but is more marked in the upper right quadrant. The abdominal muscles are extremely tense. Sugar is sometimes present in the urine. Moynihan has found the muscles not rigid. He also directs attention to the steady rising of the pulse. There is generally an increase of temperature which rises high in the very acute cases. Elliott claims if a tumor mass can be felt, its surface is tympanic because of its location behind the duodenum and pylorus. Opie has observed cyanosis in several cases.

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TEMPORARY VENTRO-SUSPENSION OF THE UTERUS: ITS TECH- NIQUE INDICATIONS AND END RESULTS.

(By Edward H. Ochsner, M. D., Surg.,
Gyn. and Obstet., Jan., 1909.)

In reviewing the methods adopted for fixing the uterus, Dr. Ochsner says that both ventro-fixation and suspension are almost generally in disfavor because of unpleasant complications which they may produce. His principal objections are:

1. That they may seriously interfere with subsequent pregnancies.
2. That they may be a cause of intestinal obstruction.
3. That more suitable methods have been devised.
4. That he dislikes the idea of fixing organs that are normally movable.

He also says that none of the methods of suspension or shortening of round ligaments have been very satisfactory in preventing the recurrence of retroflexion and reformation of adhesions. He objects to the removal of the uterus in extensive disease of adnexa because of several reasons. Among them are: That it adds to shock; fresh areas are opened up for

absorption; the pelvic floor is weakened, and that it is opposed to the principle of conservatism now popular in reference to this organ. Because of the failure of the various methods, he has devised one which he feels is a useful and efficient measure. This method is a temporary suspension to be used in operations for diseased adnexa, such as pelvic abscesses and old extra-uterine pregnancies, or in any condition where a large raw area is left uncovered.

The technique of the operation is: In cases where you think it may be applicable let the skin incision extend down below fascial incision, and this below the peritoneum. Take a needle, armed with a double thread of 10-day catgut and carry it through the left rectus fascia one-half inch below end of incision; then carry through muscle and lastly through peritoneum one inch below end of its incision; the suture is then passed through the uterus one inch behind apex, and taking a good bite, is then carried up through opposite side. This suture is then tied only tight enough to bring uterus in contact with peritoneum, but not tight enough to cause absorption from pressure. Be very careful not to abrade peritoneal surface of uterus. The sigmoid is then placed behind uterus and omentum spread over all raw areas.

He especially emphasizes the point that in all our manipulation we should be very careful not to abrade peritoneum on bowel or omentum, if avoidable, because of the fact that where two raw surfaces come together then firm adhesions take place.

This operation, he believes, holds the uterus forward until most abraded surfaces have healed or have been protected by omentum. This procedure also allows the round ligaments to regain their tone so that later they may act as efficient supports. In this connection he remarks that it has been proven that where the ligaments can not act they soon atrophy, but where they are partially opposed they hypertrophy.