REPORT OF CASES

A SURGICAL BLUNDER.

BY A. B. COOKE, A.M., M.D., NASHVILLE, TENN.

Happily for the sick and afflicted, success in the practice of medicine is the rule; failure and error the rare exceptions. But mistakes do occur, and, when not too quickly buried, are sometimes recognized and occasionally even admitted by the party responsible for them.

I am one of those who believe that, in our dealings with each other, the mistakes we make and the defeats we meet in our everyday experience should be discussed as freely as our successes. Certainly the lessons to be learned are equally valuable, and usually far more impressive. Personally, I should be glad to see one session of this society, each time it assembles, devoted to an experience meeting in which nothing but blunders should be mentioned. If we would all be as zealous in criticising our own work as we are in criticising that of others, I am convinced that such session would prove the most instructive as well as the most prolonged of the entire meeting.

In order to set a good example, and show the faith that is in me, I shall utilize this opportunity to briefly report a surgical blunder of which I was recently guilty, and from which I learned several valuable lessons.

Case.—Mr. K., aged, about 32, was brought to me from a Middle Tennessee county for relief from acute retention of urine. He had suffered from a urethral stricture for a number of years, and had experienced several similar attacks which required the use of the catheter for their relief. He denied ever having gonorrhœa or other venereal trouble. The following history of this attack was given by his physician:

The patient was just convalescent from a severe attack of double lobar pneumonia, which had left him in a greatly weakened condition. On the night before he was brought to the city his physician had been called to see him and found him suffering greatly with his bladder, having been unable to void more than a few drops of urine at a time for the previous six or eight hours, and that at the expense of intense pain and tenesmus. Hot applications and other local measures were employed without relief. After free incision of the stenosed meatus, the catheter, sounds, and bougies were in turn resorted to, in efforts to pass the stricture, but to no avail. Finally, after several hours of faithful effort, morphine was resorted to for the relief of the pain, which had become intolerable.

When I saw the patient on the following day, the pain, in spite of repeated hypodermics of morphine, was excruciating, and he begged most pitifully for relief. On account of the tenderness and muscular rigidity, examination of the abdomen was not as satisfactory as desired, but the clinical signs seemed to point unmistakably to a distended bladder. The penis was so swollen and painful from the prolonged manipulations of the previous night that it was deemed unwise to attempt further instrumentation at that time. The indications in the emergency seemed very clear for a suprapubic cystotomy and drainage, and this was quickly decided upon. On account of the patient's enfeebled condition, it was desirable, if possible, to avoid general anesthesia, and we determined to attempt the operation under cocaine.

The patient was sent to the hospital and

preparations for the work hurriedly made. Apparently very little pain from the incision was felt and no difficulty encountered except from the rigid abdominal muscles. When the deep fascia was incised a tense, glistening membrane immediately bulged into the wound. Thinking of no other possibility than that this was the bladder wall, it was at once punctured, when several inches of *omentum* unblushingly protruded. Recognizing what had occurred, a general anesthetic was at once administered, the incision lengthened, and the peritoneal opening closed with catgut. This area was then walled off with gauze and the operation proceeded with. After some little searching, the bladder was discovered deep in the pelvis, fully three inches from the anterior abdominal wall. Owing to its deep position it was reached with considerable difficulty, and, on being incised, proved to contain not exceeding *four ounces* of urine. The bladder wall was greatly thickened and contracted and the urine was thick, cloudy and offensive. The patient *had* retention and the bladder *was* distended—but—!

The operation was completed by suturing a drainage tube in the bladder, and the patient suffered no ill consequences of any kind from his experience. Ten days later a general anesthetic was again administered and an entrance per urethram effected, after which the abdominal wound rapidly closed, and the patient left the hospital three weeks from the date of the first operation, practically well, and *exceedingly grateful*!

The following points in this case are worthy of note: First, that the patient had a urethral stricture without a history of urethral inflammation, specific or otherwise; second, that he

had a severe case of chronic cystitis which had existed long enough to cause a contracted bladder, and yet had not suffered enough to seek regular treatment.

By way of extenuation (not justification) of the blunder above recorded, the following several points may be mentioned:

First—The length of time the attack had been on and the extreme abdominal tenderness and muscular rigidity which had resulted, thus masking the physical signs and rendering the abdominal examination misleading.

Second—The enfeebled state of the patient's general health, resulting from the pneumonia, which made it desirable to avoid general anesthesia.

Third—As a result of the two points mentioned, the impossibility of retracting the edges of the incision so as to clearly expose the underlying tissues.

Fourth—The fact that the tense peritoneum, closing, resembling a distended bladder, at once presented in the incision. This was probably due to increased intra-abdominal tension, caused in part by muscular contraction and in part by the flatulence resulting from the morphia exhibited during the preceding twelve hours.

Fifth—The haste which seemed to be necessitated by the conditions under which the operation was done.

In conclusion, I would emphasize two facts: First, that the diagnosis was correct—the patient *had* retention and he *had* a distended bladder; second, that the treatment instituted justifies itself to this extent at least—the patient made a speedy recovery, and remains well and happy.