Sims in store for us. This young practitioner's results are very remarkable indeed, considering the operations were done under such difficulties, and his work deserves our commendation. He has done successful surgery under conditions which would seem to some of us to be appalling. I do not agree with the author of the paper regarding hospitals. While he has done operations outside of hospitals and has been successful in obtaining satisfactory results, I think the chances of patients are much better where they can be taken to a hospital and be operated upon there. A hospital is more convenient, and I think our statistics will show that the chances of these patients are better where they can be taken to a modern hospital and operated upon. But when we consider the point that was made by the essayist that he could not get some of these patients to a hospital; that he had to operate in a turpentine camp; his results are remarkable indeed."

Dr. John A. Gaines, Nashville.—"I congratulate the author of this paper on his beautiful results. I agree also with the previous speaker, Dr. Crook, in regard to hospitals, and I may be a little enthusiastic about them, but if possible I always like to have patients I am to operate upon taken to a hospital, as I think it adds very much to the prognosis in all cases of major surgery; yet we all know surgeons in the city have many calls to the country and have

practically to undergo the same ordeal, but usually, however, with certain modifications. Personally, I always have the sterilizing done at the hospital before I start. I go equipped with sheets to make the immediate surroundings sterile. I must say that my results from operating in country practice have been good. It is hard work; it has increased responsibilities, and I always feel it is much safer to have the patient in a hospital. The essayist is to be congratulated on the report of these cases, and on the result he has obtained. I certainly feel very grateful and proud of some of his work, and if I can get such results even in a splendidly equipped hospital, with favorable surroundings, conducting to proper results, I should be satisfied. At the same time, under ordinary circumstances, I would prefer to have my patients taken to a hospital to be operated on."

Dr. Alsbrook (closing the discussion).—"I do not discourage carrying patients to a hospital except where the danger is greater than if they were kept at home. Every young man who does country work ought to be equipped under the present methods of teaching and the present hospital advantages to do operative surgery. He should be capable of and competent to do this work, and if the necessity arises he ought to be able to take care of his own patients rather than refer them to others. There is no excuse for the young practitioners with the teaching of to-day not being able to do this work."

REPORT OF SURGICAL CASES

By R. R. KIME,

Gynecologist and Abdominal Surgeon to Tabernacle Infirmary.

Atlanta, Ga.

Case 1—Chylous Cyst of Mesentery of Ileum with Appendicitis.

Case 2—Extensive Abscess of Abdominal Wall with Complications.

Case 3—Cholecystectomy with Complications.

Case 4—Large Multilocular Cyst with Complications.

REPORT.

CASE 1—Mr. C. D. M., age 28 years, married. Previous health good. Worked in express office lifting heavy packages. No previous history of lymphatic disease.

History.—Some four weeks previous had some pain and tenderness in right iliac region, disturbance of digestion, torpidity in action of bowels, but continued to work for

two weeks, then quit with a hope of getting better.

Pain, tenderness and enlargement in right side increased, accompanied with elevation of pulse and temperature. On investigation it was decided that operation was indicated and case was referred to me by Dr. J. J. Foster. Patient came to my office with Dr. Foster for examination, with elevation of pulse and temperature, pain, tenderness and enlargement in right iliac region, the pain and tenderness over region of appendix, but the character and location of swelling led me to believe we had an abscess involving right rectus muscle, possibly resulting from appendicitis. Advised operative measures. Patient went immediately to the Tabernacle Infirmary.

*Read before Fulton Co., Ga., Medical Society, January, 1911.

ary and operation was performed the next day. Urine examined.

Incision made at border of right rectus muscle, wall thickened, congested, bled freely, no pus, entered abdominal cavity and found tumor beneath muscle in mesentery of ileum, tip of appendix adherent to tumor, both inflamed; separated and removed appendix, cyst wall so thin and adherent to posterior wall of abdominal cavity that decided removal was not safe.

Opened and drained cyst of one pint or more of good rich yellow chyle, sponged out cavity, which bled so freely had to use gauze pack to stop bleeding; stitched sack wall to parietal peritoneum and closed abdomen.

I left city two days later for Chicago and Rochester on my summer vacation and Dr. E. C. Davis attended the case during my absence. Gauze was removed on the ninth day, cyst cavity gradually filled up and patient made uneventful recovery. Specimen of fluid from cyst was examined by Dr. E. C. Trash and pronounced pure chyle.

Remarks—I find but little written on the subject of chylous cysts of the mesentery. Most writers simply mention that such conditions may occur. Lexner (Bevan's Surgery, page 995) states: "Nothing definite is known concerning the developmental history of the large chylous cysts which are occasionally found in the mesentery." It is not a process of degeneration, but one of extravasation.

We have tumors or enlargements of various parts of the body due to extravasation from obstruction, blocking, or rupture of the lymph channels and designated by names indicating location and method of extravasation. One of the chief causes is filaria, especially in tropical countries, producing a condition known as filariasis, often accompanied by chylous urine.

CASE 2—A. B., girl, age 7 years.

History—Taken with convulsions due to intestinal toxæmia April 3, 1909. Had three convulsions, high temperature and pulse with severe constitutional disturbance, which under

treatment by Dr. W. N. Brawner subsided in a few days, which was then followed by lobar pneumonia, with complete consolidation, and ran the usual course. Following pneumonia typhoid fever developed, which cleared up in about two months. Patient convalescing, clear of fever, up and about for two weeks, when suddenly she was seized with pain in the abdomen. Collapse with severe constitutional symptoms, abdomen distended, tense, tender, followed by elevation of pulse and temperature, with symptoms of peritonitis. Desperately ill for two or three weeks, then localized, abscess formed and discharged at umbilicus, which continued to discharge pus and occasionally fecal matter until I first saw patient.

The little patient was now a mere skeleton, so weak and anaemic that we feared she could not stand an anaesthetic or operative shock, but decided that she would die unless something was done for relief.

Patient was anaesthetized July 28, 1910, and as hurriedly as possible opening at umbilicus was enlarged to admit finger to find direction of channel. A large metal catheter was introduced down into the ilea-caecal region, a counter opening made, fecal matter discharged, a good sized rubber tube carried through and left protruding at each opening. Patient rallied and improved for two weeks, when the tube could not be replaced after cleansing and patient then became worse.

I was called again by Dr. Brawner and we decided to anaesthetize patient and secure better drainage with a hope of getting sufficient improvement for a more radical operation later.

Under anaesthesia, as rapidly as possible, we enlarged opening in right inguinal region sufficient to explore with finger. Found the fecal fistulous tract close to opening, also that whole abdominal wall had been separated from parietal peritoneum by burrowing of abscess. All except a space two inches in diameter at left of umbilicus in which was a small abscess which we opened with finger.

A large metal female catheter was carried up to liver on right side, over to region of spleen on left side, also down low in left inguinal region from original opening in right inguinal region, counter opening being made at splenic and left inguinal regions. Large soft rubber drainage tubes were carried from opening in right side to both upper and lower openings in left side; also extra tube from upper to lower opening in left side. Believing this was all the shock the patient was able to stand, no search was made for other fecal fistulae.

Patient rallied well from operation and soon began to improve. Pus and fecal discharge gradually lessened after the first week, and later it was noticed there was also some fecal discharge from vagina. At present there is very little fecal discharge, but it is aggravated and slightly increased by coughing, due to an attack of la grippe, which occurred about the middle of December, 1910, and followed by broncho-pneumonia, from which the patient seems to be gradually recovering.

Remarks—At no time have tubercle bacilli been found. Colon bacilli were plentiful. This case is reported because of the extensive abscess of the abdominal wall, the various severe complications and as an illustration of the wonderful vitality and resisting power of some patients.

CASE 3—Mrs. B., age 38 years, widow, mother of four children.

History—Mrs. B. was operated on by the writer Nov. 23, 1907, for tubercular appendicitis, husband having died of tuberculosis about two years previously. At that time there were extensive adhesions. I removed part of omentum, separated ileum from tubercular mass, cleansing intestine with dioxogen; applied pure carbolic acid, then neutralized with alcohol and closed over surface with sutures. The tubercular mass of appendix was curetted from caecum, swabbed with dioxogen followed with pure carbolic acid, then alcohol, and covered over with stitches and abdomen closed without drainage. Patient made uneventful recovery, gained rapidly in

flesh and strength, and seemed to be completely restored to health. The diagnosis of tubercular appendicitis was confirmed by microscopic examination of tissue removed.

I was called Nov. 18, 1910, three years after previous operation, and found patient suffering from pain in region of gall bladder, some tenderness, elevation of pulse and temperature, no marked jaundice, slight distension of abdomen, fullness, induration and enlargement in region of gall bladder, with indistinct outlines. Gave history of repeated attacks of pain in that region during last eighteen months or two years, with indigestion, constipation, loss of flesh and strength. Nov. 26 temperature reached 105 degrees F. Under medium doses of urotropin, salol, diuretics, calomel and phosphate of soda with large doses of quinine once daily in rectum, temperature rapidly subsided to nearly normal. Operated at Tabernacle Infirmary Dec. 2.

Incision near border of right rectus muscle. Found transverse colon adherent to liver over gall bladder, covered in with extensive adhesions. At first thought it would be impossible to operate, but after separating adhesions found a line of cleavage between gall bladder and colon. It required considerable force to push the intestine loose from gall bladder with gauze until we could reach cystic duct. Gall bladder being so indurated, thickened and diseased, decided to remove it. Clamped cystic duct and dissected up gall bladder from below about half distance, then tore into gall bladder, removed sixty gall stones from lower portion and cystic duct. Adhesions and inflammatory deposits so dense and firm that we could not proceed farther from below, so we hurriedly cut gall bladder loose from liver from above and stitched wound in liver to check bleeding. No bile found in gall bladder, cystic duct occluded. Tied it off, placed drainage and closed abdomen with layer of catgut suture.

Some little discharge of bile for ten days. Incision now healed, patient improving rapidly.

ly, appetite and digestion good, pulse and temperature soon reached normal and remained so.

Patient requested not to know if any malignant or tubercular condition existed, so microscopical examination of diseased tissue has not been made. You can see from the specimen the thickened, diseased wall, and evidences of extensive adhesions.

Remarks—I recognize that it is not best to remove gall bladder when it can be avoided. It is a safety valve, preventing pancreatic disease. In this case it was so diseased, duct occluded, walls thickened, that it was a menace to patient, and her previous history made me apprehensive.

CASE 4—Mrs. L., age 29 years. Married eleven years and had never been pregnant. Flows regular until present condition. Last flow occurred March, 1910, and considering herself pregnant she engaged the services of a leading surgeon of the city so as to get special attention and care during pregnancy and confinement. At the expected time for labor the engaged surgeon was out of the city on vacation. Dr. Kelly and I were called Jan. 2, 1911, to see her, and recognizing at once the serious condition of the patient, had her removed to the Tabernacle Infirmary.

Pulse ranged from 110 to 130 and temperature 99 to 102 degrees F. There was immense distension of abdomen, very difficult breathing and severe constitutional disturbance. Three or four distinct cysts were outlined, indurated masses could be felt, uterus could not be outlined on account of distension and pressure. As soon as elimination could be established and patient prepared operation was performed, Jan. 8, 1911.

Ether anaesthesia, incision in median line, at first large enough to admit hand for exploration, later had to be extended from near pubes almost to easiform cartilage to facilitate breaking up adhesions and removal of tumor. There was over one gallon of free

fluid in abdominal cavity. The omentum was adherent to parietal peritoneum at pubic arch, also to bladder, and being fixed the nodules of the cyst by pressure had riddled it so that it had to be tied off in bands at different points; the tumor was universally adherent to parietal peritoneum, intestines, stomach, etc., adhesions of recent origin, and easily separated with hand, but was accompanied by free bleeding. Very broad pedicle with a nodule of tumor running down in base of broad ligament which could not be closed up, bled freely and had to be packed with gauze, the part exposed to intestines covered with rubber tissue, pedicle tied off in sections. Serous coat of intestines universally eroded, raw, with extensive adhesions, flakes of plastic lymph, also bands of adhesions. Where adhesions were separated had free capillary bleeding, even from wall of stomach. Additional drain of split soft rubber tube, covered with rubber tissue, was placed in Douglas pouch and incision closed. Patient placed in Fowler's position and protoclipsis used.

As you will see from specimen it was a multilocular cyst, originating in right ovary. Cyst and fluid weighed approximately forty or fifty pounds. The patient had lost about thirty pounds in weight and now weighed about 100 pounds. The hard substances felt before operation were the thickened, indurated bands uniting the cysts, being on tension and the lobules separated by the free fluid in the abdomen. The patient has recovered and gained twenty pounds in weight.

Remarks—This case illustrates the necessity of a careful examination of patient by physician when engaged to attend a primipara, and especially when patient has been married several years without becoming pregnant. In early months this operation would have been comparatively safe, but in the condition in which we found her it was extremely hazardous even to give an anaesthetic.