TRANSACTIONS

OF THE

PHILADELPHIA ACADEMY OF SURGERY

Stated Meeting, Monday evening, October 5, 1914

The President, DR. JOHN H. GIBBON, in the Chair

MOWING MACHINE CUT OF LEGS

DR. EDWARD B. HODGE presented a boy of three and a half years whose right leg had been nearly severed by the blade of a mowing machine. Both bones and the anterior tibial vessels and nerve, with the extensor muscles, were entirely divided. There was some laceration of the calf muscles next to the bones, but the posterior tibial vessels were not injured. Circulation in the foot was good. Under iodine sterilization the anterior tibial vessels were tied, the nerve sutured, and the ends of the divided muscles united as accurately as possible without unduly enlarging the incision and prolonging the operation. The child had lost much blood. The wound was dressed in a fracture box without drainage. Healing took place with slight discharge of serum, but no infection, and the boy has a perfectly useful leg. There is slight toe-drop and later it is probable that some further work will be needed on the muscles. There is a slight amount of sensation on the dorsum of the foot.

SARCOMA OF TONSIL

DR. GINSBURG presented a man who had developed a growth in the right tonsil, the condition dating back to April of the present year. He had operated upon it in two stages; in the first operation, he removed the anterior palatine arch and the tonsil. Three weeks later, he made a dissection of the neck, removing the right submaxillary salivary gland, and all visible lymphoid tissue, finally ligating the external carotid artery at the bifurcation of the common carotid. A rapid recurrence has followed, and at present he is receiving daily treatments with radium, holding the tube containing the radium in his mouth for five hours at each sitting. Thus far he has received six radium treatments, and there is evidence of beginning resolution of the pathological overgrowth. The diagnosis is sarcoma of the right tonsil.

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AN ANALYSIS OF TWO HUNDRED AND TWENTY-SIX CASES OF ACUTE INTESTINAL OBSTRUCTION

DR. GEORGE G. ROSS read a paper with the above title, for which see page 198.

DR. CHARLES H. FRAZIER said that one of the most important life-saving factors in the management of cases of intestinal obstruction is the avoidance of a general anæsthetic, particularly ether. These patients are intensely toxic and do not stand an anæsthetic well. The greater part of the operation can almost always be conducted under a local anæsthetic, and at most a few whiffs of nitrous oxide may be required to allay pain.

DR. JOHN H. GIBBON said that there are two elements in the mortality of strangulated hernia or intestinal obstruction: One is the anæsthetic, already mentioned by the authors and in discussion. General anæsthesia should be avoided whenever possible, in the hernia cases especially. If a general anæsthetic is used, it should be as short a period of general anæsthesia as possible. Not only because of the bad effect of the anæsthetic upon the patient, but because the man who is operating under a general anæsthetic is tempted to do a great deal more than if operating with a local anæsthetic. It is trying to complete an operation that often results in the death of these patients. This is particularly true in regard to colonic obstruction. When the patient is anæsthetized it is easy to make the mistake of trying to do too much instead of simply trying to relieve the obstruction, and doing the radical operation at a later stage.

Another point is that of post-operative obstruction—a condition the frequency of which has greatly diminished in recent years. This difference is due to the fact that we are not packing abdomens full of gauze, and that drains are covered with rubber to prevent adhesions.

DR. ROSS, in closing, said that the technic carried out is a very simple one. As a rule, a general anæsthetic is used; infrequently, a local anæsthetic. The anæsthetic is given to the degree that obstetricians give it, enough to dull the patient's sensibilities. The abdomen is rapidly opened with a liberal incision and evisceration done at once. No attempt is made to locate the obstruction. The entire small bowel is delivered and laid upon a wet towel. At once the obstruction comes into view, and it is dealt with according to the condition of the bowel and condition of the patient. If the patient is profoundly toxic, enterostomy is done and the wound sewed up. If the patient's condition warrants it, resection is attempted when the bowel is badly damaged, but as a rule the intestines are put back at once, salt solution used, drainage instituted,

TRAUMATIC RUPTURE OF THE DEEP URETHRA

and the wound sewed up. Paul's tubes we rarely use to drain the bowel. Occasionally, but rarely, the bowel is fastened to the anterior abdominal wall for the purpose of permanent drainage.

Post-operative adhesions are diminishing in frequency. It used to be, five, six or seven years ago, that one patient out of eleven coming to the German Hospital with appendiceal abscess and drained with the method employed at that time, of large folds of iodoform gauze, had post-operative obstruction. This is not so to-day, because a different method is used. Rubber tissue is used to protect the capillary drains and prevents adhesions.

TRAUMATIC RUPTURE OF THE DEEP URETHRA

DR. GEORGE G. ROSS presented a boy, aged eleven, who was run over by a heavy wagon, the wheels passing diagonally over the right lower abdomen, pelvis and left hip, at 7.30 P.M., April 21, 1914.

On admission the boy was shocked and in great pain; temperature remained subnormal until the following morning. Pulse was weak and thready and rose to 144 by the following noon. Examination revealed a bruised abdomen and hip, and in addition a fracture of the left tibia in the upper third. The patient's chief complaint was rectal pain. No urine was voided from 7.30 P.M. until the following day. Shortly before noon the day after the accident the patient was catheterized. Before this had been done some blood was noted at the meatus. The first use of the catheter brought a few drops of blood and later one-half ounce of bloody urine. There was great abdominal and perineal tenderness and swelling in the perineum. At 2.15 P.M., on April 22, hypodermoclysis was given and strychnine ordered. Dr. Ross saw the patient at 4 P.M. and concluded that operation was inadvisable because of the patient's general condition.

In the next few days the abdominal rigidity lessened and catheterization was possible. A retention catheter could not be employed because of the discomfort caused. The patient's general condition improved, the pulse, however, remaining very weak and there being always much abdominal pain and tenderness. An X-ray showed a fracture of the descending ramus of the left pubic bone. The patient began to void urine fairly well four or five days after the accident, often involuntarily, and had involuntary bowel movements.

On April 27, the sixth day, he became very restless and began to run a septic temperature. Examination revealed a lower abdominal resistance with tenderness suggesting urinary extravasation, and operation was decided upon. On April 28, 1914, one week after the accident, a

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suprapubic incision was made and the space of Retzius opened. A large quantity of ammoniacal urine was evacuated. The broken portion of the pubis could be easily felt, but evidently had sprung back partly into place. A catheter (silver) introduced showed its tip through a rent in the bladder just at the site of the urethral junction—or the site of the urethral avulsion—and could not be introduced into the bladder proper. Drainage tubes were introduced and allowed to remain a number of days. The temperature was septic for a week, and mildly febrile for a week, and then from the third to sixth week septic, but not severely so. All urine came through the suprapubic wound. Several attempts at catheterization were failures. On May 27 a deep gluteal abscess was opened by his assistant, Dr. Mencke. It was a hard abscess with little pus that had been extremely painful and evidently caused by deeply burrowing urine. The suprapubic wound showed great tendency to close and the discharge of urine was impeded. This gave the patient great pain. The incision was again enlarged on May 27, but an attempt to pass the catheter was unsuccessful.

Finally, these closures exhausted the patient so much that on June 9 under ether anæsthesia he attempted catheterization, and was successful in introducing first a silver catheter and then a 10 English woven catheter, which was sewn in and remained five days. The suprapubic incision was cleaned of old granulations. The former bladder rent was not felt. The catheter remained in five days and since then the patient voids naturally. No urine has come out above since the last operation.

DR. GWILYM G. DAVIS said that, in cases of rupture of the urethra in the membranous portion or in close connection with the bladder, difficulty is often experienced, as in this case, of passing the catheter into the bladder. Some years ago he was visiting in the country and he was asked to see a man who had sustained a rupture of the urethra from falling astride a board. There was no external wound at all, and the endeavor to introduce a catheter by the usual method was a failure. He therefore injected warm water into the urethra through the meatus, which distended the urethra and also the parts at the site of the injury. He then took up a large metallic catheter and with ease passed it across the broken part into the bladder. He suggested the method as worthy of trial in such cases.