

ABSTRACT

OF A

Clinical Lecture

ON A

CASE IN WHICH NUMEROUS GALL-STONES
WERE DISCHARGED THROUGH A
FISTULOUS OPENING IN THE
ABDOMINAL WALL.

Delivered in King's College Hospital, May 11th, 1880,

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GENTLEMEN,—I have enumerated the various ways in which biliary concretions may escape from the gall-bladder and the biliary passages, and the case to which I now wish especially to direct your attention is one in which the gall-stones have been discharged in a somewhat unusual manner—viz., through a fistulous opening in the abdominal wall. I show you here between seventy and eighty gall-stones which have been discharged by my patient in this way. Over a hundred have been discharged altogether; twenty-five of these, however, were removed by an operation the particulars of which I shall immediately detail. You will observe that these concretions are faceted as gall-stones usually are when they are numerous. They vary in size from that of a hemp-seed to that of a large pea; they are of a brownish-yellow colour, and on section they display the ordinary structure of gall-stones—viz., a dark, almost black, nucleus, surrounded by a light brown “body” and an external crust.

This patient, a married woman, a dressmaker, fifty-six years of age, was admitted into the hospital on the 24th of last October. She had occasionally come under observation from time to time as an out-patient during the previous five years, and was looked upon as a rather troublesome nervous woman, with dyspeptic symptoms. She used to complain of pain and flatulence after food, with occasional vomiting, but had never, while attending as an out-patient, presented any signs of jaundice, nor had she ever complained of attacks of acute pain such as occur during the passage of gall-stones. She states now, however, that she remembers an attack of sudden pain in the hepatic region so long ago as 1873, and that this was associated with slight jaundice of the conjunctivæ and skin. She also states that in February of last year she had a severe attack of jaundice, during which she kept her bed for two months. For the first fortnight of this attack she suffered great pain, and the motions were quite white, then the pains diminished and disappeared, but the discoloration of the skin remained for some months, so that this patient may have discharged gall-stones in the ordinary way for some years. Last August she first noticed a swelling in the lower part of the abdomen on the right side, which she was ordered to poultice. She had suffered much pain while it was forming. In September this broke, and discharged “blood and matter,” and the day after four gall-stones came away through the opening, their passage being attended with much suffering; *fifty-one* concretions came away in one week, and as many as *twenty-one* in one day. She had passed, on her admission, *sixty-one* gall-stones altogether, and she passed *seventeen* more during the first fortnight of her stay in the hospital. On analysis, they were found to be composed of cholesterin and bile-pigment.

On examination of the abdomen, on her admission, an external opening low down on the right side in the abdominal wall was found, situated in the hypogastric region, about three-quarters of an inch from the median line, and about five inches below the umbilicus. It was discharging a considerable quantity of glairy mucus, not unlike the white of egg. A deep inflammatory blush, at this time extended for a considerable distance around the opening. A probe introduced into the opening passed readily for six or seven inches upwards and to the right, where it apparently came against and was arrested by a hard mass, which could be felt through the abdominal walls, and grasped, as if it were the fundus of a displaced and distended gall-bladder; while,

extending downwards from this, and following the course of the sinus, was an extensive mass of inflammatory induration.

No discharge of anything like bile had ever been observed from the external opening of the sinus. The few biliary calculi that were passed soon after her admission were passed without any suffering; and with rest in bed and appropriate treatment the inflammatory condition of the integuments around the sinus rapidly subsided. Her constitutional condition was good; tongue clean; appetite fair; some tendency to constipation; urine normal. There was no enlargement or tenderness over the liver, or in the natural situation of the gall-bladder.

On Nov. 7th Mr. Lister was good enough to see the patient with me, and, as we thought there might be many more calculi accumulated in the hard mass at the end of the sinus, and which might possibly be the displaced gall-bladder, Mr. Lister proceeded to dilate the passage rapidly by means of large-sized metallic urethral dilators. This was done twice, but without any marked result; one or two small calculi continued to be passed at intervals.

The patient continued without much change until the middle of February. Several weeks had elapsed without the passage of any more calculi, and, as the sinus still continued to discharge a considerable quantity of the glairy mucus I have before described, it was determined, after consultation with Mr. Lister, that he should slit up and explore the sinus.

On the 16th February the patient was put under chloroform, and a large probe being passed along the sinus as far as it could go—viz., between five or six inches,—the thickness of the abdominal wall between the surface and the sinus was cautiously divided, the cut extending from the orifice of the sinus upwards and outwards towards the somewhat globular mass situated about midway between the costal margin and the crest of the ilium. In doing this a considerable thickness of the abdominal wall had to be divided, the wound extending nearly down to the peritoneum. About twenty calculi were dislodged from along the tract of this sinus, and the round mass before described appeared, so far as we could judge, not to be the gall-bladder, but merely the result of inflammatory induration. On carefully examining the sinus now it was exposed, a small diverticulum to the right admitted of the passage of the probe for about an inch and a half. This was slit up, and five more calculi discovered, so that five-and-twenty biliary concretions in all were found infiltrated, as it were, in the abdominal wall, and were removed by this operation.

The wound, which was a large one, was dressed with glycerine and carbolic acid, and the patient removed to bed. The patient bore the operation extremely well. The next day the temperature rose about one degree, soon to fall again to normal. A faint putrid odour was given off by the wound for a few days, but this disappeared and the wound steadily filled up. It is now nearly quite healed. There has been no further discharge of gall-stones and no complaint of pain, and the sinus appears completely closed.

There are many cases on record of the passage of gall-stones through fistulous openings in the abdominal walls, and they have nearly all occurred in the persons of women of middle or advanced age, like our patient, who is aged fifty-six. The process which leads to the formation of these fistulæ is usually as follows:—The ulcerative inflammation set up in the gall-bladder leads to adhesion of the superjacent abdominal wall, and the ulcerative process “eats its way through the adherent abdominal wall till it reaches the surface.”

We may suppose that in this case the gall-bladder had become distended by a vast accumulation of biliary calculi. Some of these had from time to time escaped in the usual manner, along the common bile-duct into the intestine; the passage of the smaller ones giving rise to no suffering, the passage of the larger ones being attended with the symptoms of biliary colic, which this patient appears to have suffered at least twice, at long intervals. Then, probably, one larger than its predecessors became impacted in the cystic duct, and set up inflammation which led to the closure of the duct. Subsequently the inflammatory and ulcerative action extended through the coats of the gall-bladder and the adherent portion of the abdominal wall. A number of gall-stones then made their escape, and became as it were infiltrated into the abdominal wall, working their way downwards between its layers, and giving rise to fistulous tracts, and setting up a great amount of inflammatory thickening

and induration around, and finally discharging at a point low down on the abdominal surface, no doubt quite remote from the seat of the original opening in the gall-bladder, which may have become completely closed before the formation of an external wound. So that in this case, as in most others of the kind on record, the cystic duct must certainly have become closed before the formation of the fistula in the abdominal walls.

The discharge, after the first rupture of the superficial abscess, has always been that of white, glairy mucus. We thought, for some time, that this discharge proceeded from the mucous membrane of the gall-bladder itself, which we imagined was in direct communication with the fistulous tract, and on that account we hesitated long before having recourse to any operative procedure, for we thought that if we were to divide the fistula as high up as we could go we should still have remaining behind the discharging inner surface of the gall-bladder. But as the discharge still continued undiminished in quantity, and as it was a perpetual nuisance to the patient, and as it seemed probable, if she were allowed to leave the hospital, inflammation would again set in around the sinus and its opening, and as we considered that if we divided the sinus as far as we could we should certainly leave a less extent of discharging surface, and bring the external opening much nearer the source of the gall-stones, if there were any more to pass, as seemed most likely, and as the patient herself was very anxious that something should be done, Mr. Lister divided the sinus, as I have told you. It was an operation of some importance, for the sinus ran for some distance five or six inches, and was deeply situated in the abdominal wall about an inch and a half from the surface, and was, therefore, very near the peritoneum. A gall-stone was found impacted at the end of the main sinus, and then beyond this several more; five and twenty, and some fragments, altogether being removed from the main sinus and a diverticulum from it. The success of the operation has been complete. No further gall-stone has been passed, and there is now no more secretion, the wound appearing completely healed, so that we hope to be able to discharge the patient from the hospital in a few days.

The issue of the case has been a very fortunate one. The patient is not likely to have any further trouble from biliary calculi, and the operation has relieved her from what was, though not a painful, yet a very distressing, state of affairs—viz., a constant and profuse discharge from a fistulous opening in the abdominal walls.

Lectures

ON

THE RELATIONS OF SARCOMA TO CARCINOMA.

Delivered at the Royal College of Surgeons in June, 1880,

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LECTURE I.—PART I. TUMOURS OF THE TESTIS.

MR. PRESIDENT AND GENTLEMEN,—As the first Erasmus Wilson Professor of Pathology under the new conditions of the trust, the duty devolves on me, which I cannot but regard with pleasure, of expressing, so far as I can do so in words, the feeling of gratitude which must animate all those who are working in the great field of pathology towards the founder of this chair.

The act, generous in itself, is rendered yet more graceful by his permission to deflect the endowment from the purpose to which it was at first devoted to one which cannot in the nature of things be so dear to him as the encouragement of his own favourite study of dermatology. I trust, however, that Mr. Wilson may be in some sort repaid by the impetus which will certainly be communicated to the study

of pathology and by the knowledge that through his means this impetus has been conveyed.

A classification of tumours may be based either on their anatomical or clinical characters. At the present time the former is nearly exclusively employed and the clinical classification has fallen almost entirely into disuse. Nor is this, I imagine, solely due to the influence of fashion, although I am aware she exercises even in pathology considerable sway. But the anatomical classification is preferred because it is more scientific and is more in accordance with the methods which are adopted in arranging plants and animals, methods from which the best results have been obtained, and by which our knowledge of these things has probably been much increased. It cannot, of course, be maintained that the anatomical classification is perfect, or that it fulfils every purpose for which it was designed. To judge justly of its merits, however, it must be compared, not with some ideal method, but with the method it has succeeded in replacing. I think it will be admitted that a classification, on whatever basis arranged, should be consistent or should at least be capable of being made consistent; and, as a corollary of this, that classification must be the best of which every part is in harmony with every other part, and all whose parts are in harmony with the principle on which the classification is arranged.

In the "Nomenclature of Diseases" drawn up by a Joint Committee of the College of Physicians in 1869, tumours are arranged according to what is understood as the clinical method. The great primary division is of all tumours into malignant and non-malignant. Of the malignant growths the scirrhus and medullary varieties are so formed on the ground of their clinical characters; but the definition of the variety epithelial cancer admits that the cancer is "characterised by the resemblance of its cells to those of epithelium." So slight a deviation from the guiding principle, however, might be pardoned, but the non-malignant tumours are subdivided according to the likeness each presents to some natural texture of the body, as fibrous, fatty, osseous. And among these, with an inconsistency more striking still, are found varieties which depend upon their microscopic structure, the fibro-plastic and fibro-nucleated tumours, which, clinically, are more than half-malignant, and anatomically cannot be distinguished with the naked eye. I say "cannot be distinguished with the naked eye" not on my own authority, but on that of Dr. Bennett,¹ who, speaking of the fibro-nucleated canceroid growth, uses these words, "I know of no means of distinguishing it except by a microscopic examination, as sometimes the growth exactly resembles scirrhus, at others encephaloma." And Sir James Paget,² describing the recurring-fibroid tumours, which are included with the fibro-plastic, makes one of their chief characteristics the resemblance of their general aspect to that of the common fibrous tumours.

Here, then, is a classification purporting to be clinical but of which more than half the classes are based upon other than clinical grounds, some of them upon the gross or rough anatomical appearances, others of them upon the microscopic characters. I should not deem it necessary thus to criticise a method of arrangement which was most valuable thirty years ago, and under which, or perhaps in spite of which, the study of oncology made rapid strides, but the loss of it has been made a subject of deep and wide-spread lamentation, exceeded only by the indignant scorn with which its successor was received.

Now, whatever may be said against the anatomical classification on the ground of imperfection or of uselessness at the bedside, it cannot be reproached with being generally inconsistent. Its inconsistencies are few, and those which yet remain are gradually yielding before a wider knowledge of the subject and clearer insight into the nature of certain doubtful groups. Most of the groups of non-malignant tumours have been transferred unchanged to corresponding groups in the new system, but the difficulties experienced in arranging the malignant and semi-malignant tumours have not yet been wholly overcome. Virchow,³ discerning certain structural characters common to the fibro-plastic,

¹ On Cancerous and Canceroid Growths (Edin.), 1849, p. 176.

² Lectures on Surgical Pathology (London, 1853), p. 155.

³ Krankhaften Geschwülste, Band ii.