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A SIMPLE AND SUCCESSFUL MEASURE FOR THE PERFORATION OF A GASTRIC OR DUODENAL ULCER.

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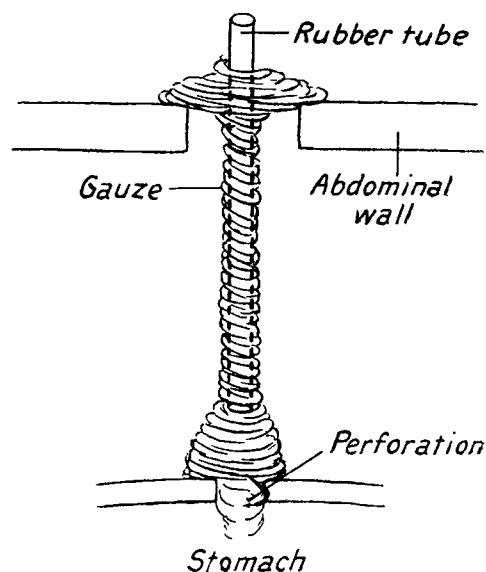
ABOUT a year ago, in a paper contributed to the Surgical Section of the Royal Society of Medicine upon the results of operation for the perforation of a gastric or duodenal ulcer and published in THE LANCET,¹ I mentioned a method of dealing with perforation by tamponade. This can be done without any time being spent in attempting to close the perforation by suture. The method is of easy application and can quickly and simply be used by those less experienced in surgery, a very important point nowadays, as so many men practise the art of surgery. Thus it is within easy attainment of the comparatively inexperienced surgeon attached to a minor provincial hospital. Most medical men may be suddenly called upon to operate for the perforation of a gastric ulcer, as, with the cussedness of things in general, the perforations will not occur when a skilled surgeon is about. It is wrong to await the arrival of such a man and so jeopardise the patient's chance of recovery. Last year (1912) a great example of this passed through my hands, an experience which a long journey back to town compelled me to dwell upon, so fixing it in my memory.

One morning I received a warning from Boston in Lincolnshire to hold myself in readiness to depart on a sudden journey there. Later in the day I was asked to come, and arrived in the late afternoon. The patient was a young man, recently married, who had suffered from his "stomach" for some years. About four years ago a gastro-enterostomy had been done by Sir Berkeley Moynihan, of Leeds. This had relieved him for a time. Then came a sudden attack of pain and great collapse. I saw him within 24 hours of the perforation. The abdomen was tightly distended with extravasated gas. There was no liver or any other abdominal dulness. To be short, there was no doubt of the diagnosis. But no operation was allowed by the friends until the surgeon arrived from London. When I arrived the poor man scarcely had any pulse at the wrist. Still, within 24 hours of the perforation so young a man could not be allowed to die without an effort being made to prevent it. So a hurried operation was done whilst the patient was infused with saline. It seems almost needless to add that the patient died after rallying for a time.

After the operation one of the medical men who were so kind as to have assisted me said, "Were not the patient's chances of life lessened by the delay in operation? Would not a less perfect operation which was not delayed be preferable to a more perfect but delayed operation?" Undoubtedly the delay had greatly lessened the patient's chances of recovery. And I must answer the second question by showing that a comparatively simple operation, well within the powers of most to do, is all

that is necessary to enable such a patient to live. Also I must thank my professional colleague for his courtesy for referring to my work as a "more perfect but delayed operation." Indeed, I hope to show in this paper that there is no need to use the adjectives "less" and "more" perfect in connexion with an operation for the perforation of a gastric ulcer.

Such an operation must be carried out quickly, and should be shortly described. 1. Open the abdomen below the umbilicus. Examine the appendix and the pelvic viscera. Place a gauze packing in each loin and in the pelvis and leave them there. Free gas may or may not be seen, but odourless greenish-yellow fluid always is. 2. Open the abdomen above the umbilicus—e.g., through the inner part of the right rectus. Find the perforation, mop out any extravasation above and below the liver or round the spleen. Place one end of a gauze "plug" in the perforation to "cork it." Pack a layer or two of gauze plug over the ulcer and wind the rest round a rubber tube which leads out of the wound. (See figure.) 3. Partially close



Diagrammatic representation of the tamponade of a gastric perforation. This method is applicable to any perforation.

wounds after removing the gauze (draining the pelvis if there is much extravasation).

In the convalescence do not withhold morphia, but do not use it heedlessly. At first withhold liquids by mouth except water in ounce doses. It will wash the interior of the stomach. A patient on "rectal saline" is in no great want of food by mouth. In 48 hours the drains or "plugs" are removed under an anæsthetic and replaced in part. A gastro-enterostomy is not often needed, and no time is wasted in closing the perforation by suture. So frequently is the tissue round an ulcer too soft to hold stitches that, unless the ulcer can be excised, it is better not to attempt to close the perforation. It is very doubtful how long such stitching lasts, and though apparently secure at the operation it may be loose ten minutes after. Therefore there should always be a drain to the site of the perforation. Indeed, it might be said that the success which has followed the (apparent) suture of a perforation has probably more often been due to the gauze drain than to the suture. So that even better results may be expected when time is no longer wasted in "suturing" the perforation.

In my communication I mentioned that this proceeding had been done many times. Since that date I have done it several times more, proving again its

¹ THE LANCET, March 1st, 1913, p. 600.

efficiency. Two instances only will I quote, because they impressed themselves on me by being done in one night and because they bear on the theoretical suggestion that the non-suture of a perforation must lead to the formation of a gastric fistula. This I may say hardly ever occurs, and when it does is only temporary.

One Sunday afternoon I was called to see a lady whose medical adviser, Dr. Ross, had diagnosed the perforation of a gastric ulcer. When I saw her there was nothing except a history of "neuralgic dyspepsia" and tenderness in the epigastric region to suggest that the abdominal calamity originated in the upper abdomen. All the physical signs—distension, rigidity, dulness, immobility, &c.—were in the lower abdomen. On opening the peritoneal cavity nothing of note was found in the lower abdomen. Nothing being found, the upper abdomen was opened, and a perforation found near the lesser curvature on the anterior wall of the stomach. The perforation was large, surrounded by a sodden area of inflamed tissue, and much fluid was issuing from it. The perforation was tamponed in the way described above. Forty-eight hours after the operation the "gastric" gauze was changed, when gas and fluid escaped from the stomach. The issuing fluid smelt like gastric juice, and was more copious when fluid was taken by mouth. It was only mildly septic and interfered little with the healing of the wound. This fistula was present for about ten days, when it healed spontaneously. On my return home, as I opened the front door of my house the telephone rang from Colney Hatch Asylum, where Dr. S. J. Gilfillan told me a nurse was suffering from the perforation of a gastric ulcer. In her case, also, the diagnosis was simple. The operation was also, and was carried out substantially as narrated above. The perforation was much smaller than in the lady just mentioned. Her recovery was very prompt. Her indigestion vanished and her general health has improved very greatly. In neither case was a gastro-enterostomy necessary at the time or has proved to be so later. Indeed, I suspect that in the absence of (narrowing the stomach by) suture, a gastro-enterostomy is less often required than if the perforation is sutured.

These two reported instances are specially selected only because they happened to take place on the same night, and by preventing my getting to bed stamped themselves on my memory as possible examples of results of tamponading the ulcer. Its advantages I will briefly summarise. 1. The operation is simpler for the operator to do. 2. The operation is quicker, particularly in less experienced hands. 3. In consequence of being simpler and quicker, the patient more easily gets over it—that is to say, the mortality is lower. It certainly is so amongst my own figures. 4. A gastro-enterostomy, primary (at the time of the operation for the perforation) or secondary (at a later period), appears to be less frequently required. 5. Complications—e.g., pelvic abscess, subdiaphragmatic abscess, &c.—are in my experience less frequent. Fears of more than a temporary and brief gastric fistula may be dismissed.

If such a summary is in its turn summarised it may be said that such an operation offers the patient more chance of recovery, particularly in the hands of an operator of no great experience. Of course, in the hands of experienced and facile operators the excision of the ulcer, followed by suture of the wound, and perhaps gastro-enterostomy, may be better and result in the

recovery of the patient. But for more ordinary patients, surgeons, and circumstances the method of tamponade is better.

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NOTE ON THE TREATMENT OF SCIATICA.

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IN view of the great and, I believe, increasing prevalence of sciatica, and the often comparatively poor results obtained from treatment by rest, injections of various kinds, and internal medicine, I think it may be of interest to report the results attained by me during the past year by physical measures—namely, by the use of the 500 candle-power lamp and static electricity. Nine cases have been treated by these methods, eight of which made a complete recovery, but only six of them deserve special mention, as the other three were early acute cases, and the probability is that they would have recovered promptly with rest, drugs, ionisation, or other treatment.

The short history of the six cases is as follows:—

CASE 1.—The patient, aged 53, had lumbago some four weeks previously, but this had got better. He now had cramp in calf and thigh muscles, and severe pain on certain unguarded movements ran down the back of the thigh and was worst at the knee. Knee-jerks present. A patch of anæsthesia, described by him as a "dead patch," on the outer and lower part of the leg, down to the ankle. This patient showed improvement after two or three treatments, but was slow in making a complete recovery. The interesting point was that the "dead patch," which he had had for years, apparently completely recovered.

CASE 2.—The patient, aged 53, who was referred to me for electrical treatment by Dr. T. J. Horder, had had sciatica for two years; had been treated by ionisation, been to the Riviera and Harrogate, &c. Was never very bad, but only exceptionally free from pain for a whole day. He improved very much at first, and then seemed to stick, and just as I was about to despair he recovered completely. This patient was taking medicine as well as having the treatment given by me.

CASE 3.—The patient, aged 64, had sciatica 18 months ago. He went to Vernet-les-Bains and was cured; returned to England and was exposed to cold, with the result that his sciatica returned 13 months ago. The pain was not severe, but always bothered him when he got up in the morning. Slight tenderness over the sciatic nerve between the great trochanter and tuberosity. This patient showed no improvement whatever. His pains became less marked in the region of his sciatic nerve, and increased in the lumbar region and in the anterior part of the thigh. I took a skiagram of the hip-joint, and as there was some evidence of osteo-arthritis in the joint I thought it of little use to continue the treatment. I understand that now, six months later, he still has the pain.

CASE 4.—The patient, aged 57, who was referred to me for electrical treatment by Dr. H. W. McClure, had had sciatica for three months; at first very severe pain night and day; now very severe at times, but not continuous. Always worse at night so that sleep was prevented. There were marked wasting and fibrillary contractions of the muscles of the thigh, less wasting of the calf. Knee-jerks equal. Tender point situated over the sacro-sciatic notch, the internal popliteal, and in the outer side of the calf. Could walk only with the aid of two sticks. After three treatments this patient was having good nights, and after 18 treatments was completely cured.

CASE 5.—The patient, who had had two bad attacks of sciatica lasting for months, came to me complaining of lumbago, but next day said he had cramps in the calves of his legs, and that his previous attack of sciatica had begun in the same way. There was a definite tender point