

TRANSACTIONS OF THE CHICAGO SURGICAL SOCIETY.

Stated Meeting, February 1, 1904.

The President, E. WYLLYS ANDREWS, M.D., in the Chair.

APPENDICITIS.

DR. E. C. DUDLEY reported a case of appendicitis in a young woman, and showed the specimen. The appendix, which was about the size and length of one's finger, was very much constricted at its entrance to the bowel. After the removal of the appendix and squeezing it with considerable force, a drop or two of pus came out, which contained staphylococci. The lumen of the appendix was almost entirely shut off at its junction with the gut, and, in all probability, would have been soon shut off, and when this had occurred, if pus had continued to form, he thought gangrene of the appendix would result, with rupture of the organ before long.

ACCIDENTAL WOUNDING OF THE URETER IN VAGINAL HYSTERECTOMY; URETEROCYSTOTOMY.

DR. E. C. DUDLEY read a paper with the above title, for which see page 755.

DR. A. J. OCUSNER said that Dr. Dudley had made application of a principle which was not used enough by surgeons. In attaching a tube to any surface in surgical work the same principle could be employed to advantage. For instance, in attaching the trachea through a button-hole in a case of laryngectomy in this way it would not contract, while, if it was sutured to the skin directly, it would. In transplantation of the urethra into the perineum, by making a button-hole and carrying the urethra through and applying the same principle, there would be no stric-

ture at the end of the new urethra. Where one had occasion to attach a tube, which was lined with mucous membrane, as where a long portion of the lower part of the rectum had been excised and the bowel transplanted over the end of the sacrum, where one made the incision as in the Kraske operation, this principle of drawing the intestine through the skin would obviate the occurrence of stricture at the end of the rectum.

DR. JOHN B. MURPHY emphasized the point with reference to opening the bladder. The way in which bladder surgery in the female had been done in the past in the great majority of cases, with only a few exceptions, was through the urethra. Bladder surgery in the female should be done entirely through an artificial vesicovaginal slit, and the bladder opened without hesitation. In the last year and a half he had split the female bladder from the sphincter back towards the cervix of the uterus, turning the bladder out, exposing the ureters, doing any work that was necessary to be done, and sewing up the wound with horsehair sutures, securing primary union in every case except one, and this only required one secondary operation. For the treatment of ulcers of the bladder, papilloma, the removal of stones from the vesical end of the ureter, instead of removing them through an uretero-vaginal incision, as was formerly done, the bladder was opened, and its wall was divided in the direction of the bladder to remove the ureteral stones. The incision should be made through the vaginal wall, a probe or director passed into the ureter, and the ureter divided with scissors. Stones and tuberculosis of the lower end of the ureter are usually situated at that particular point in lower half-inch of ureter just outside the bladder. In one case he opened in the other direction and had some difficulty in closing the ureter. Where it was necessary to pull the bladder down with retractors, one could pull it clear out of the vulva and do any work that was necessary on the bladder or ureter through a vaginal incision. There was very little danger of a permanent fistula. The incision was clean-cut. In a case of vesicovaginal fistula following instrumentation in labor, there was necrosis from a crushing injury; hence there was a tendency towards the formation of a permanent fistula, while the tendency in the incision condition was prompt healing of the clean-cut incision.

DR. GUSTAV KOLISCHER said that when he saw the operation described by Dr. Dudley performed, he was impressed with its

feasibility. The operation was conceived in a minute and performed in a short time. That the method was practicable, there was no doubt; and he felt sure it would be employed in similar cases in the future, but whether it was absolutely necessary to operate by this method was another question, that is, fastening the ureter into the bladder after a special incision for this latter purpose was made. In 1898, when the speaker maintained that surgeons should not dilate the female urethra in order to perform endovesical operations, but should operate through an artificial, temporary vesicovaginal fistula, he was attacked rather fiercely, although he could show very good results. It was a personal satisfaction to him to see Murphy take up and recommend rather emphatically this way. The dilatation of the female urethra had been too long kept up, mostly due to the weight of authorities like Kelly and Saenger. He agreed with Dr. Murphy that the danger of a permanent fistula after such an incision hardly existed. There was no loss of substance, and no cicatricial contraction as in obstetrical vesicovaginal fistulas, and primary union after plastic operations would always take place if the lips of the wound could be approximated without any tension.