

SPLENECTOMY FOR GUNSHOT WOUND OF THE SPLEEN.

BY EDWIN H. FISKE, M.D.,

OF BROOKLYN, N. Y.,

Assistant Surgeon to the Kings County Hospital.

R. B., aged 25 years, a bartender by occupation, was admitted to Kings County Hospital at 6.30 p.m. August 28, 1907, with the following history: One hour before admission to hospital, patient was shot in the back, during an altercation. Examination showed a wound about $\frac{3}{8}$ inch in diameter, in left posterior axillary line, at tenth intercostal space.

General condition fair, conscious, but restless; face somewhat blanched, expression anxious; respirations rapid, but regular; 26 per minute. Conjunctivæ slightly pale, mucous membranes likewise anæmic, though not markedly so. He complained only of pain beginning posteriorly over subscapular region, and extending into left epigastric and left hypochondriac regions. Pulse 108, regular, of only fair volume. Temperature 99° F. Heart and lungs negative; no dulness at base of left lung, respiratory sounds normal.

Abdomen somewhat distended; tenderness general, but marked in left epigastric and particularly so on deep pressure under chondral borders over splenic area; slight rigidity of left rectus; no tumefaction. Percussion showed flatness in left lumbar region in recumbent position; in lateral recumbent flatness gave place to tympany. During examination patient complained of thirst, and pulse increased to 115, and seemed of less volume.

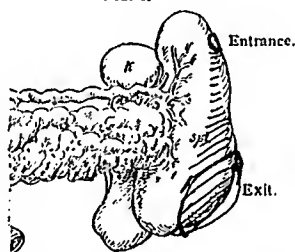
A diagnosis of intra-abdominal hemorrhage, with possible splenic injury was made; the patient was quickly prepared for operation and brought to operating room.

Operation.—Dr. Fiske, assisted by Dr. Canna and house staff. Under ether narcosis, with large pointed probe, the wound of entrance was probed; the course was directed downward and forward and inward to upper border of eleventh rib, where the probe was arrested and not pursued further.

An incision over outer border of left rectus was made, extending from costal margin down to a point midway between

umbilicus and symphysis. On opening peritoneum about one pint and a half of blood escaped, followed by several small clots, but without gas, faeces, or gastric contents; the stomach and intestines were carefully examined without result, excepting a punctured wound of transverse mesocolon, a short distance (1 inch) from gut. This wound was repaired and as blood continued to well up, the spleen was rendered more accessible by a transverse incision running outward at right angle to the one parallel to outer border of rectus, from about its centre. The hand was then able to grasp the spleen in which a wound admitting two (2) fingers could be felt. It was impossible to expose spleen to field of vision because of incomplete anaesthesia and intestinal disten-

FIG. 1.



Showing course of bullet through spleen entering above, emerging below. Extensive destruction of splenic substance.

tion. The ligaments of spleen were separated by dissection with fingers, and spleen brought up into wound; it was now evident that the injury was one necessitating removal of the organ. The pedicle was ligated en masse, being previously clamped; and the spleen then removed. The individual vessels in the pedicle were ligated separately. Bleeding having ceased, the stump was returned to the cavity and the abdomen flushed with normal saline solution; a small iodoform drain was inserted down to the pedicle, and the wound closed by through-and-through silkworm gut sutures excepting at the upper end where only enough space was left to allow the exit of the drain.

The patient was given 1 pint of normal saline solution, containing oz.i of sol. adrenalin intravenously, the wound dressed and patient returned to the ward in good condition.

On the following day the patient complained of slight pain

in the operative region, no other abdominal tenderness, no rigidity, no vomiting. Pulse 115, but of good volume; temperature 100; respiration 30.

Patient made thereafter an uneventful recovery. On September 2nd the drain was removed; the wound was clean, and the dressings were reapplied without drain.

September 5th, several stitches removed; wound healed primarily.

September 7th, all sutures removed.

September 11th, patient out of bed.

September 22nd, patient left hospital, completely recovered.

Radiograph taken shortly before discharge from hospital, showed the bullet in the pelvis.