

in making a resection of the stomach in a case of true diffuse phlegmonous gastritis, with recovery. This is the only case of recovery on record. There are a number of other cases of successful operations reported, as those of Hemmeter, Bovec,¹³ and others. In none of these, however, was a true phlegmon present, but on the other hand all were abscesses, or an infection extending into the tissue from an ulcer or cancer.

OVERLOOKED COMMON DUCT STONES*

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The object of this paper is to direct attention to two conditions, the existence of which is not sufficiently well known if we wish to lessen the number of recurrences following operations on the bile passages. These conditions are:

1. Calculi may be present in the common or hepatic ducts without giving rise to the symptoms which we have always considered pathognomonic of calculi in these locations.

2. Even at operation when the common duct is palpated to determine the presence of calculi, they may be found in a certain percentage of cases even if our usual methods of palpation yield negative results.

By the expression "usual methods" I refer to the fact that the segment of the common duct which is almost invariably palpated is the supraduodenal portion. Calculi lying in the retroduodenal division, that is, just above the ampulla, are not palpable through

the overlying duodenum unless they are of relatively large size or unless the mobilization incision of Kocher has been employed to expose the retroduodenal portion for direct palpation.

I became interested in the question of the "overlooking" of common and hepatic duct calculi at operation, after reading an article by Kehr.¹ In seventeen, or 46 per cent., of thirty-six cases in which palpation of the common duct was negative, he found calculi in either the hepatic or the retroduodenal portions of the common ducts. The reason such calculi are often overlooked or rather why they are not felt is that they swim in the stagnant bile or lie just above the ampulla in the retroduodenal

portion, which is not readily accessible to palpation. Kehr, in the paper referred to and in subsequent publications,² states that in about 20 per cent. of all of his cases the common duct calculi belonged to the latent class, that is, produced no symptoms, such as icterus, chills and fever, which we have always considered to be characteristic of such calculi.

During the past four years, in the course of a large number of operations on the biliary passages, I have explored the common and hepatic ducts in thirty cases in which palpation was negative. In ten (33.3 per cent.) of these, calculi³ were found on exploration in spite of negative palpation. None of these thirty patients died, and I am confident that the mortality will not be increased in the hands of other surgeons if a rapid technic⁴ for exploring the common and hepatic ducts is developed by the surgeon.

Of the four indications given by Kehr, three have seemed to me of especial importance, in the order named: (1) the presence of many small calculi in the gallbladder or cystic duct; (2) an enlarged, thick walled common duct; (3) the presence of chills, fever or icterus. To these I would add a fourth: recurrence of pain or symptoms of cholangitis (chills, fever, etc.) after previous operations, such as drainage or removal of the gallbladder, or even after previous choledochostomies. In two of my ten cases with positive findings (although even my palpation had been negative), operation had been performed by other surgeons (Fig. 1).

In one of these, the gallbladder had been explored without finding calculi and then drained. Eighteen months later the patient began to have pain in the right hypochondrium with icterus, and I operated on him. The gallbladder walls were thick, but no calculi were found. The common duct was of the size of two adult thumbs, thin walled and negative on palpation. On exploration of the common duct, a calculus the size of a navy bean was found just above the ampulla.

In a second case the greatly thickened gallbladder containing a large calculus impacted at its neck had been removed by one of my colleagues. Two years later the patient began to have pain in the epigastrium, icterus, chills and fever. I found the common duct greatly enlarged, and although palpation was negative, two faceted calculi, the size of a navy bean, were found just above the ampulla (Fig. 2). In neither of

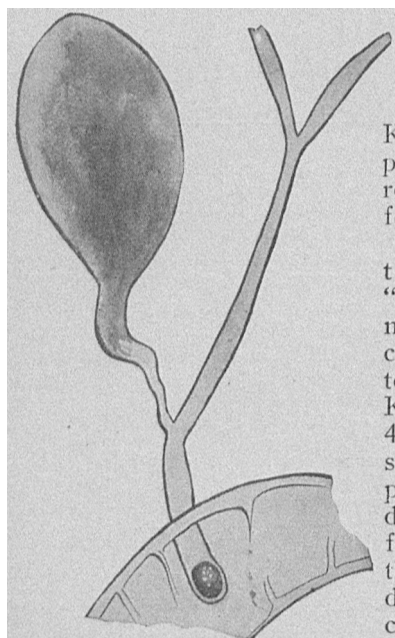


Fig. 1.—Removal of gallbladder with large calculus two years before by another surgeon. Recurrence of symptoms (pain with slight icterus) eighteen months later. Negative palpation of common duct but calculus size of navy bean found just above ampulla in retroduodenal portion of common duct at second operation.

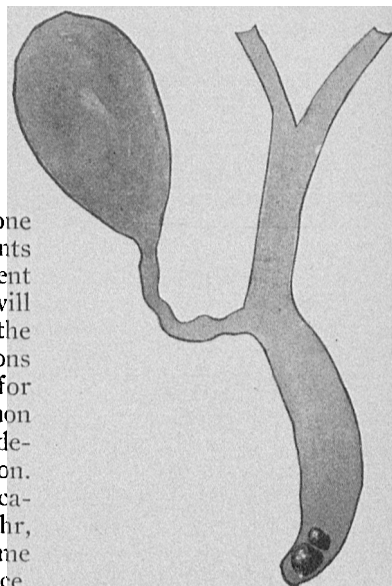


Fig. 2.—Cholecystostomy without finding calculi two years before by another surgeon. Recurrence of symptoms eighteen months later (pain, icterus, chills and fever). At second operation negative palpation of common duct, but two calculi the size of peas found at lower end (just above ampulla) of common duct.

13. Fovec: Suppurative Phlegmonous Gastritis, *Am. Jour. Med. Sc.*, May, 1908.

*Read before the Elkhart County, Indiana Medical Society, Nov. 2, 1916.

1. Kehr: When, During the Course of Gallbladder Operations, Shall We Open the Common Duct if Palpation is Negative? *Arch. f. klin. Chir.*, 1912, 97, 301.

2. Kehr: Monographs on surgery of bile passages, 1913.

3. In six cases the common duct calculi were of such size as to render it improbable that they would have passed into the duodenum spontaneously.

4. The author's technic and the later work on the surgical anatomy of the region will be given in a second paper, which will be furnished on request.

these cases were any symptoms referable to the common duct calculi present at the time of the primary operation, and there has been no recurrence since the secondary one.⁵

The chief indication for opening the common duct in eight cases in spite of negative palpation was the presence of many small calculi in the gallbladder. In all of the eight cases of positive exploration after negative palpation the number of calculi in the gallbladder varied from twenty to 300.

In three cases (Fig. 3) the common duct calculi were the size of a pea, faceted, and fifteen in number. In the majority of the ten cases the calculi were found in the retroduodenal portion of the duct. In two cases a number of small calculi of the same size (Fig. 4) and composition as those in the gallbladder and common duct were either found in the hepatic duct or escaped in a perfect shower from this duct while the edges of the opening in the common duct were retracted. In one of these patients there has been a recurrence of symptoms in spite of a cholecystectomy and choledochostomy with removal of calculi from the common duct.

The articles of Poore,⁶ Beer,⁷ and Lewisohn,⁸ have directed attention to the importance of intrahepatic cholelithiasis, and the three last cases are in all probability due to the formation of calculi in the intrahepatic bile passages and explain some of the cases of recurrence even after removal of calculi and drainage of the common and hepatic ducts.

In eight cases in which no previous operation had been performed, the principal symptoms were:

1. Pain, for months to years, not to be distinguished from that due to the gallbladder.

2. Icterus, slight and only during attacks of pain in three cases. In one case there had been distinct icterus during one attack. In the remaining four cases there was no icterus at any time.

3. Chills and fever, present in only one case of the eight. The common duct varied in size from a little finger to a thumb. The pancreas was hard and enlarged in only three of the ten cases.

The systematic exploration of the com-

5. Since reading this paper, I have removed three calculi, the size of a pea, from the common duct in a patient on whom a previous drainage and later re-

Fig. 3.—Typical findings in a case in which many small calculi were present in the gallbladder and palpation of the common duct was negative, but calculi the size of a pea were found embedded in thick bile at the lower end of the common duct (just above the ampulla).

moval of the gallbladder had been done by another surgeon. At the first operation a large number of small calculi were removed and the common duct found negative on palpation. The gallbladder was removed three months later on account of a biliary fistula due to a stone in the cystic duct. Jaundice and fever followed the second operation and three months later I found the common duct greatly dilated and one of the three calculi impacted in the ampulla of Vater.

6. Poore: Surg., Gynec. and Obst., 1912, 15, 634.

7. Beer: Arch. f. klin. Chir., 1904, 74, 301.

8. Lewisohn: Ann. Surg., 1916, 63, 535.

mon and hepatic ducts has not increased the mortality in my experience. The fact that symptoms pointing to common duct calculi were absent in the majority (six of ten cases) shows that we have a clinical group of silent or latent calculi which may escape palpation by the surgeon unless he is prepared to make a thorough exploration of the bile passages if the indications just given are present.

The finding of calculi in the hepatic and common ducts in ten of thirty cases after negative palpation of the common duct shows how easy it is for one to overlook such calculi. With more thorough search for calculi in the common and hepatic ducts, our percentage of recurrences must rapidly decrease.

It is my practice to open the gallbladder first, and after the calculi have been taken out to use it as a tractor while the common duct is opened in its supra-duodenal portion. After the common and hepatic ducts have been explored, the calculi removed and a T shaped drain inserted, a cholecystectomy is performed as the last step in suitable cases.



Fig. 4.—Case showing simultaneous presence of calculi in gallbladder, and the cystic, common and hepatic ducts; the last named illustrates how recurrences may be due to intrahepatic cholelithiasis. At operation, palpation of the common duct was negative but many calculi were found at the lower end and also many escaped in a shower from the direction of the liver.

CONCLUSIONS

1. In 20 per cent. of cases of calculi in the hepatic and common ducts, either no symptoms indicative of their presence are found or they are overshadowed by those of an accompanying gallbladder condition.

2. In the past four years calculi have been found at the lower end of the common duct in ten of thirty cases in which palpation was negative.

3. Exploration of the common duct does not increase the mortality, and should be done whenever one of the indications given above is present.

4. Recurrence following operations on the gallbladder and common duct may be due to overlooked or newly formed calculi in the intrahepatic bile passages.

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Danger of Quick Cure in Skin Diseases.—A cure, if possible, should be brought about as quickly as practicable. The belief of the laity that impurities are trying to get out, and that it is, therefore, dangerous to the general health to cure or to cure too rapidly, and which formerly found honest believers among physicians, is wholly without foundation. This view has been strongly supported purposely by advertising nostrums, and has likewise been a convenient cloak for medical advisers helplessly at sea in cutaneous therapeutics. On the contrary, the putting of the skin, an important organ and emunctory of the body, into a healthy state, will not only relieve the patient of an annoyance and worry, but conduce to his general well-being. The main difficulty, unfortunately, in many diseases is our inability to cure quickly enough.—Stelwagon, Diseases of the Skin, Ed. 8, 1916.