

ly, in both, the loins were tympanitic on percussion, while there was dulness over the whole of the rest of the abdomen; and change of position did not change the percussion notes. This, in itself, is almost a certain sign of an ovarian cyst as against free fluid. Nevertheless, being led to suspect malignancy in the first case by the general bad condition of the patient, I tapped and drew off ascitic fluid. The second case I suspected to be tuberculosis on account of the age of the patient, (fourteen years), and therefore tapped, and got ascitic fluid. At the operations it was discovered that the disease in each case had puckered up the mesentery, and bound the intestines to the back of the abdominal cavity. For this reason the intestines were not free to float on the fluid; hence the tympanitic loins.

CASE XXIX. The patient was sent to me by Dr. W. E. Boardman, who had treated her for several years for chronic pelvic peritonitis. He thought the trouble was due to disease of the tubes, but was in doubt about the possibility of removing those organs in this case on account of long and severe peritonitis. The patient was in a deplorable condition, having been unable to earn her living for several years on account of attacks of peritonitis, and being deserted by her husband on account of vaginal tenderness. Her life was a burden, and she wanted to die. She had had two abscesses opened per vaginam, and had been in the City Hospital two or three times, where fluid had been aspirated from the pelvis. At the operation all the intestines and organs were found firmly glued together so that nearly three-quarters of an hour was consumed in tearing away adhesions to get down to the left ovary. The wall of a small cyst was found matted against the tube and intestine. The tube had become a cicatricial strand. After tearing away a piece of the cyst wall the operation was abandoned as impossible. After vomiting constantly for three days she died. At the autopsy no pus was found, but there was very extensive peritonitis. The ovaries and tubes had become cicatricial tissue, and could not be removed without tearing open the intestines at several points. I cite this case in full because it shows clearly one of the limitations of this operation. After a little successful experience in tearing out universally adherent ovaries or tubes, one is led to suppose that there are no limitations.

I am profoundly impressed by the fact that several of the worst cases recovered when there seemed to be little hope, and that all but one of the fatal cases would probably have recovered if they had been operated on earlier. This leads me to believe that there are still many lives lost for the want of prompt laparotomy. Unfortunately the general practitioner has been over-impressed by recent articles on the "laparotomy craze"; and it is undoubtedly true that ovaries and tubes have been unnecessarily removed by certain operators. I am sure, however, that this view has been greatly exaggerated and when we come to the more fatal class of diseases such as intestinal obstruction, perforation, purulent peritonitis, and the like, the situation is so difficult and appalling that there is no danger of the operations being lightly undertaken or overdone. Now that such operations are clearly established, what is wanted is a realization by the general practitioner of their value. No patient should be allowed to die of an abdominal affection without full consideration of the chances of relief offered by laparotomy.

My experience has made me enthusiastic about the operation, and it seems to me that the community is just beginning to get the full benefit of the fine work of the earlier operators. They have shown the possibility of these operations, and established the technique. And now the present generation has so reduced the mortality that the operation has become of the greatest practical value.

## ON SIMPLE EXTRACTION OF CATARACT.

BY HERMAN KNAPP, M.D., OF NEW YORK.

A FEW weeks ago, on February 23d, Dr. Hasket Derby published in the JOURNAL a paper on "The Dangers of Simple Extraction of Cataract."

The paper is a plea for the method of Von Gräfe. The dangers of simple extraction pointed out by Dr. Derby are real; but this is no sufficient reason to condemn an otherwise superior operation. If a sharp knife is more dangerous than a blunt one, it does not follow that we should prefer the latter, for with proper caution we may have the benefit of the former without its danger. That simple extraction yields the better results, results which, in the successful cases, Gräfe himself called ideal, is beyond controversy. The question for him and his time was: Shall we prefer inferior results in a greater number, or superior results in a smaller number? At the present day I believe this alternative is no longer before us. In simple extraction not only the visual results are better, but also the failures less frequent than in the combined method. Suppuration, owing to antisepsis, has become exceptional; and prolapse of the iris, owing to cocaine, eserine, and a perfected technique, becomes more and more rare, and is little to be dreaded; besides, an iris prolapse can always be removed. The occurrence of irido-cyclitis after Gräfe's operation, which insidiously destroys one eye, and occasionally both, weighs, in my opinion, more than all the dangers still adherent to the simple method.

This question can, however, not be decided by belief and argument, but by experience, experience so large that the element of chance disappears. We have, as Dr. Derby justly remarks, reliable and extensive statistics of the results of Gräfe's operation, but not yet of simple extraction. The Europeans, thus far, have given only general statements.

Dr. Derby in his communication, cites forty-eight simple extractions, the results of which, he correctly says, compare unfavorably with those of other methods. Dr. C. S. Bull, of New York, publishes,<sup>1</sup> in tabular arrangement, thirty-six simple extractions. His results were very good. Dr. Derby further quotes the present writer's report, at the last meeting of the the American Ophthalmological Society<sup>2</sup> (July, 1887), on sixty-eight extractions, with two total losses. This requires a correction, in so far as one of the losses marked in the *Transactions*  $\frac{1}{2}$  (mere perception of light) was converted by a subsequent discussion into a good result, namely,  $\bar{V}=\frac{2}{3}\%$ . Since June, 1886, I have practiced simple extraction, as a rule, combined extraction as the exception. Of 154 extractions, 132 were made without, 22 with iridectomy. Accidents during the operation have been less frequent than in

<sup>1</sup> Transactions of the American Ophthalmological Society, 1887, p. 413.

<sup>2</sup> Transactions, p. 419.

Gräfe's method. Prolapse of the iris occurred in 14 cases, in four it disappeared spontaneously, in four it was removed with scissors, in the others (except one) it was too small to require interference. In no case of prolapse was there any irritation, and the sight was good in all.

One case of the 154 was a *failure*. It referred to a patient suffering from diabetes (6% sugar) and chronic purulent dacryocystitis. In all the others good vision was restored. The ominous symptom  $\frac{1}{2}$  does no longer appear in the record; there was no case of irido-cyclitis.

The *visual results* of the first 100 cases, which I have just compiled for a detailed communication in the *Archives of Ophthalmology*, were as follows:

V = $\frac{3}{10}$ . . in 21 cases	V = $\frac{2}{10}$ . . in 12 cases
V = $\frac{2}{10}$ . . in 18 cases	V = $\frac{1}{10}$ . . in 10 cases
V = $\frac{1}{10}$ . . in 11 cases	V = $\frac{1}{20}$ . . in 2 cases
V = $\frac{1}{20}$ . . in 8 cases	V = $\frac{1}{30}$ . . in 1 case
V = $\frac{1}{30}$ . . in 16 cases	V = 0 . . in 1 case

I may add that the cases were in no way selected, and that V represents the visual acuteness of the last record entered in the case book.

To obtain high degrees of V, a *subsequent division of the capsule* is necessary in the majority of cases. In these first 100 cases 54 dissections have been made thus far. They were all successful.

If, in conclusion, I may *formulate my opinion* on this subject, it is as follows: Gräfe's method can neither in excellence nor safety compete with simple extraction; it deserves no longer to be the general method, but it will, in a certain number of cases, be the preferable operation, in some the only operation possible.

## REPORT ON PROGRESS IN SURGERY.<sup>1</sup>

BY H. L. BURRELL, M.D., AND H. W. CUSHING, M.D.

### LAPAROTOMY FOR INJURY.

SIR WILLIAM MACCORMACK, in the annual oration in May to the Medical Society, spoke on this subject, and advocated an early and more general application of the operation of laparotomy to all intra-peritoneal injuries endangering life, and of exploration of the abdomen in penetrating wounds of the abdomen, gunshot wounds, and traumatic rupture of the abdominal contents without external wounds. Reference was made on this occasion to several cases that had been successfully treated by London surgeons, but it is to Parkes, Morton, Kinloch, and other surgeons of the United States, that we are indebted to the fullest and most recent information on this subject.

Farquhar Curtis has sounded a warning note against the indiscriminate application of laparotomy to this class of cases, and has endeavored to point out the indications for operation, and also the contra-indications. He has pointed out that if the operation is performed while the patient is in a state of collapse, that the result will almost inevitably be fatal, and will bring discredit not only upon the operative procedure, but also on the operator. That a serious injury of any abdominal viscus may be successfully treated by laparotomy has been shown by Burckhardt, of Stuttgart,

who early in the year reported a case in which death from hæmorrhage was averted by exposing and plugging a deep incised wound of the liver.

### LAPAROTOMY IN CASES OF PERITONITIS WITH PERFORATION OF INTESTINE.

Dr. Th. Eschar reports in detail<sup>87</sup> five cases of perforation, two of which recovered, although purulent peritonitis was present at the time of operation. In both the perforation was closed at the operation. Eschar discusses at length the question, in case of perforation or necrosis requiring resection, of whether immediate closure of the intestine by suture, as advocated by Krönlein and Mikulicz, is indicated in all cases. His conclusions are that in *traumatic* cases of peritonitis with perforation, laparotomy and intestinal suture, with resection, if necessary, should be the rule; but for *pathological* cases, the extent of operative interference justifiable depends on the conditions of each individual case, and that the treatment of these cases is closely analogous to that for gangrenous herniæ. Eschar also states that the collection of free gas in the abdomen, which has frequently been designated as one of the most certain signs of "perforation-peritonitis," is occasionally absent. In two autopsies the injury was in the jejunum, in one a double complete transverse separation of the intestine; and the writer believes that in cases of perforation where free gas is absent, or where the appearance of symptoms denoting its presence are delayed, one can assume with certainty that the jejunum is the seat of the lesion.

### LAPAROTOMY FOR SUPPURATIVE PERITONITIS.

Mr. Barwell has recently reported a case<sup>88</sup> of recovery from a suppurative peritonitis in a man who had been struck on the abdomen, but who seemed but little hurt. Five days afterwards, while stooping, he felt a severe pain in the abdomen, vomited, and passed a little dark-colored urine. The next day he entered the Charing-Cross Hospital, and a laparotomy was done, the abdomen being washed out with ten pints of distilled water at a temperature of 99°. A quantity of pus was evacuated, and the abdomen was closed completely, no drainage-tube being used. Mr. Barwell points out that the operation has been performed fourteen times, though not always done for the same trouble. The precise circumstances of the case have been, various ulcers, ruptures of the intestinal tract or of an ovarian cyst. He considers that to attempt to drain the back of an abdomen through a drainage-tube in the anterior wall is an absurdity, and may be a source of direct injury. He considers, if there is much distension following an operation, or if it is thought necessary to drain the abdomen of collected fluid, that it is better to remove the lower stitches and allow the fluid to escape in the male; in the female, he thinks that vaginal drainage would be indicated. Mr. Barwell claims for Mr. Hauck the credit of opening the abdomen for suppurative peritonitis.

### LAPAROTOMY IN PERITYPHLITIC ABSCESS, WITH ESPECIAL REFERENCE TO PERFORATION OF THE APPENDIX VERMIFORMIS.

This paper by R. F. Weir consists<sup>89</sup> of a critical an-

<sup>87</sup> Wien. Med. Wochenschr., 1887, Bd. xxxvii, s. 18-22.

<sup>88</sup> Lancet, November 5, 1887.

<sup>89</sup> N. Y. Med. Rec., June 11, 1887.

<sup>1</sup> Continued from page 320.