

Correspondence.

Modern Hospital Asepsis from an Interne's Viewpoint.

CHICAGO, Dec. 21, 1904.

To the Editor:—It seems almost superfluous and uncalled for to try to bring out anything more relative to asepsis in the modern hospital and operating room of to-day, but with the exception of a hint of them now and then to be seen in various articles in some of the later journals, no one has touched on two or three points that should be strongly emphasized and criticised, and the causes of which should be eliminated in order to get better aseptic surgical results.

One would think on close examination of one of the newer operating rooms that every precaution had been taken, that every means known to bacteriology had been or was constantly being employed to destroy the bacteria that had already gained entrance to the operative field and its environment and to prevent any further contamination. The room as a whole is built so that every square inch of its floor, walls and ceiling can be cleaned. There are no corners or ledges for dust or dirt to lodge or which are inaccessible to the frequently appearing scrubbing brush. Marble, iron, stone, tiling, enamel, glass and nickel are used exclusively in the make-up of the room and its necessary furnishings, not so much for the durability of such materials, but in order to obtain smooth surfaces which can be easily cleaned—surgically cleaned.

Everything that is brought into the room is surgically clean. The tables are scrubbed, washed with antiseptic solutions and covered with covers that have been sterilized. The basins, towels, sponges and instruments have all been baked, steamed or boiled. Only nurses specially trained in asepsis and antiseptics and in the reasons and necessity for the same, make the operating room ready for an operation and assist during it. In the dressing rooms are to be found scientifically arranged wash basins where hot and cold sterile water, sterile soap, sterile brushes and antiseptic solutions can be used without the necessity of touching anything that is not clean. Sterile gowns are put on, sterile gloves are at hand to cover the hands and sterile masks are ready to protect the open wound from the pathogenic bacteria that are present in such large numbers in our mouths and nostrils.

It certainly would seem improbable, yes, almost impossible, for clean wounds to become unclean in such an operating room, fitted with every appliance known to prevent it. But they do become unclean, wounds do become infected, clean hernias frequently must be "dressed" for days after the operation, single iridectomies do occasionally result in suppurating panophthalmias, ventral "suspensions" do become "fixations" after weeks of irrigation of purulent sinuses leading down to peri-uterine abscesses. Stitch abscesses do only too frequently occur. "Oosings" which are "only serum" do appear after interval, clean appendectomies. Redness and induration do occur even after the much abused poor, innocent catgut has been really and truly sterile.

And why?

It is not always due to some error in aseptic technic done behind the screen in the ward by the usually extremely careful nurse during the preparation of the patient, nor is it always due to the junior interne who, fresh from books on asepsis, is anxious to be known as a careful man in his preparation of the patient. It is not always because the bandage slipped up while the patient was being transported to the operating room from the bed. It is not always because the senior assistant interne has become careless because he is soon to leave the hospital. It is not always due to the fact that this or that unscrubbed nurse "touched things" about the sterile field. It is not always due to any peculiar affinity between bacteria and catgut, and it is not always because the "fool patient stuck his finger under the eye-pad to stop the itching."

But such unnecessary and inexcusable infections do occur and often, too, in our best hospitals and in our most carefully

managed operating rooms. It seems to me that the real cause lies not with the hospital operating room, internes or nurse, but with the surgeon himself, the operator, the teacher and professor of aseptic surgery, and simply because he does not really do what he teaches others to do, what he believes should be done, and what he doubtless for the most part thinks he does do.

He says to the class, "Scrub hard for fifteen or twenty minutes," and then he comes hurriedly to the clinic and scrubs but two or three, in spite of the fact that he knows very well that he can not put on sterile gloves with unclean hands. He says, "To obtain aseptic surgical results you must not only make clean, but you must keep clean," and within a few moments he has literally removed his glasses with his sterile glove, or has traced a drawing on a blackboard and then, with not so much as a dip into the bichlorid solution, takes up the iridectomy knife to remove the cataract.

He says to the assistant, "While you are in my service do not go to the autopsy room," and yet he will come directly to an operation from the dissecting room himself.

Teachers of surgery—leading clinicians of to-day—can be seen daily grossly breaking the fundamental rules of asepsis in all our leading clinics and hospitals. They are very exacting about others and then very careless about their own behavior. The first is excellent, the last is unpardonable. The more strict with nurse and interne they are the better, but they must not expect the nurse and interne to remain enthusiastic about absolute surgical cleanliness when they see him—just because he is late or in a hurry, or for no reason whatever—neglect to do what he demands of them.

It is not necessary to go more into detail. Scores of such instances of aseptic lying are noticed by an interne during his year or two of service relative to some of our best operators. The same operator should know he is constantly watched, looked up to, listened to and gladly followed just so far as he is true to surgery and to himself, and criticised and ridiculed just so far as he blames nurse, interne or catgut when it is only too evident that he himself has been the cause for failure of primary union.

JOHN C. HOLLISTER.

Urination in the Dorsal Position.

LANCASTER, PA., Jan. 3, 1905.

To the Editor:—The inability to void urine lying down is common to many people even in health. By practice this may be overcome; rather easily when the half reclining position may be assumed, and the ability to urinate in the dorsal position gradually acquired. The patient usually has the joy of learning the technic of dorsal urination with added zest from postoperative pain and ether nausea.

I have found it of distinct advantage to have all patients who will have to void in the dorsal position practice this often before the position is necessitated, when time permits. In obstetric cases I order the morning urination on the douche pan during the last month of pregnancy until the knack is thoroughly acquired. In operative cases advantage is taken of every opportunity during preparatory treatment. I have had no patient who learned to void before operation who could not void afterward, excluding, of course, obstetric cases in which there had been much pressure on the urethra, and operative cases involving the region of the urethra or rectum.

Where the physician is so situated that he must either catheterize the patient himself or must trust to untrained assistants any help to make a patient void is of great value. Under the best surroundings there is danger in catheterizing. Patients readily see the value of this practice and are glad to adopt it. I have found that the procedure saved me a very great deal of trouble.

JOHN L. ATLEE.

Sarcoma of Intestines.

RIVERSIDE, CAL., Dec. 30, 1904.

To the Editor:—Five years ago I removed from Harold S. a small round-celled sarcoma with several inches of intestine, from which it originated. The case was reported in THE