

A TECHNIC FOR PERFORMING A SHOCKLESS SUPRAPUBIC PROSTATECTOMY.

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THE shock-producing factors of a prostatectomy are first, the effect of the anæsthetic; second, the *amount* of painful traumatism; and third, the hemorrhage. In so far as any of these factors can be minimized, post-operative shock will be lessened; if they can be eliminated then the operation becomes shockless and may be performed without hesitancy upon patients who, because of their age or because of diminished vitality from any cause, have been considered bad operative risks.

After a considerable experience and the trial of many different methods to diminish the dangers of this operation, the following technic has been evolved. Patients undergoing a prostatectomy performed by this technic are not only free from shock but are in splendid condition to combat any other untoward influence that may arise during convalescence.

TECHNIC.

1. An hour before the operation the patient is given a hypodermic injection of morphine and scopolamine, the size of the dose depending upon his age and condition.

2. Immediately before the operation the bladder is irrigated and 60 to 90 c.c. of a 5 per cent. solution of alapin is injected through a catheter, the catheter is clamped, and both catheter and solution are allowed to remain.

3. Nitrous oxide-oxygen is administered by an expert anæsthetist; this anæsthetic when administered by one trained in its use being safer than ether and to some extent in itself a preventive of shock.

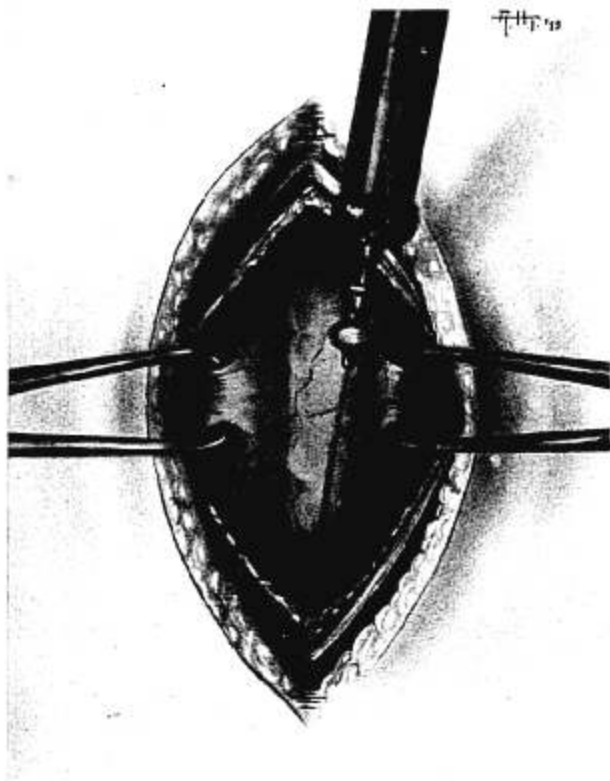
4. The bladder is approached in the usual way, except that the skin incision and every division of tissue is preceded by a thorough infiltration with novocaine in 1-400 solution (Fig. 1).

FIG. 1.



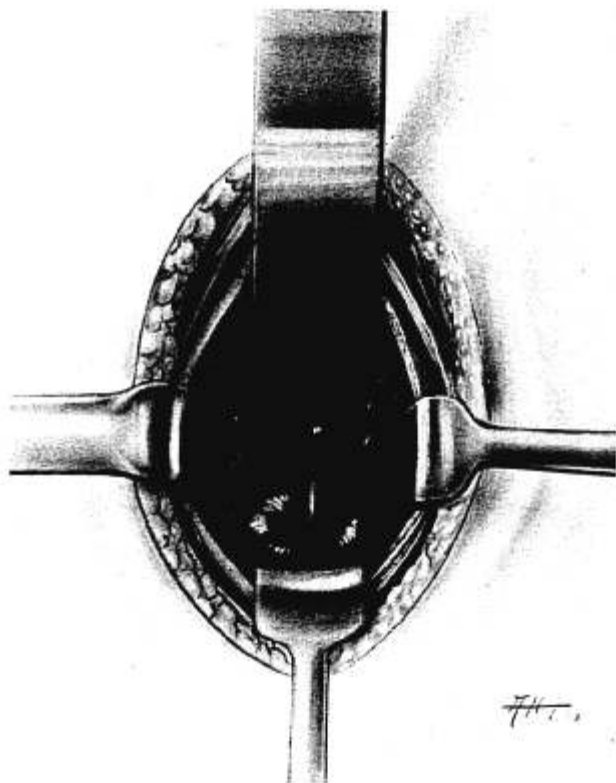
Infiltration of skin and fascia with novocaine.

FIG. 2.



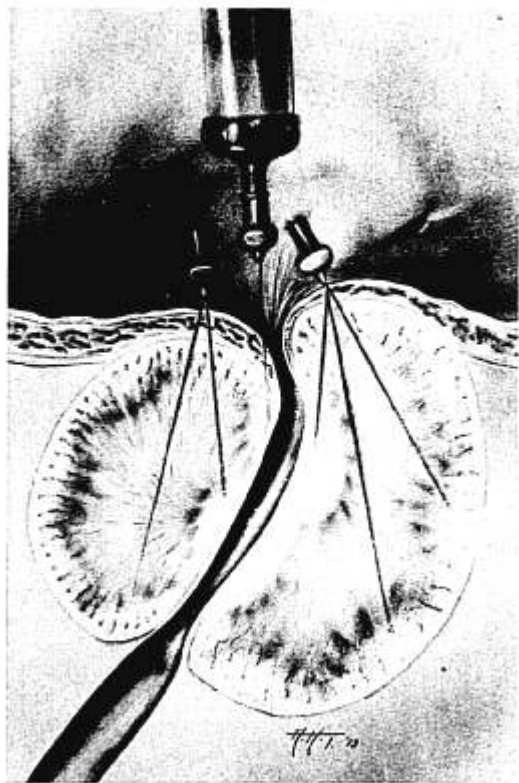
Infiltration of bladder wall with novocaine.

FIG. 3.



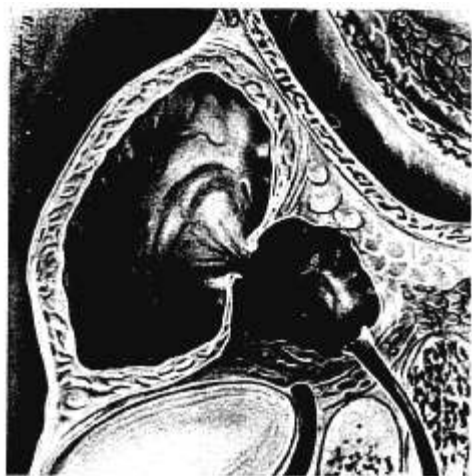
Intravesical exposure of prostate.

FIG. 4.



Deep infiltration along edge of capsule of prostate before removal.

FIG. 5.



Cavity left after enucleation of prostate.

FIG. 6.



Gauze packing by which the raw surfaces of capsule are brought in apposition.

5. When the bladder is exposed, it is elevated with curved bladder hooks and the bladder wall is thoroughly infiltrated with the novocaine solution (Fig. 2).

6. By gentle retraction and without injuring the cut edges of the bladder wall, the prostate is exposed intravesically (Fig. 3).

7. The bladder mucosa on the projecting prostate is infiltrated with novocaine, and along the edge of the capsule a deep infiltration is made (Fig. 4).

8. With careful and most gentle manipulations the prostate is enucleated with the finger (Fig. 5).

9. Narrow strips of gauze are packed along the side of the catheter on top of the mucous membrane so that the raw surfaces of the capsule are brought in apposition, a procedure which effectively prevents hemorrhage (Fig. 6). The two ends of the urethra are thus brought together, so that a continuous funnel-shaped mucous membrane is produced—a most important factor.

At the close of this operation the color of the patient will be good; the pulse and respiration will not be increased, in fact, may be even lower than before the operation. The patient will rest comfortably, will be free from nausea and mucus, can take water early, and a speedy, uninterrupted convalescence may be looked for.