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MODERN OVARIOTOMY.

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THE great mortality which formerly attended this operation has become a thing of the past in the hands of certain operators. Unfortunately for us, however, a large percentage of fatality still discourages the surgeon in this community. This is more especially true of New England, and above all of Boston, than of other parts of America. For in Philadelphia and New York, Atlee, Sims, Peaslee and Thomas have attained many favorable results, while here we can only infer the amount of success of ovariatomists by their reticence from publishing any detailed statistics of their cases.

But it is to England that we must look for the successful revival of this operation; and the wonderful percentage of recoveries attained by Mr. T. Spencer Wells have attracted to him patients from all parts of Europe; while his hospital is attended by physicians from the whole civilized world.

While in London, during the past summer, I enjoyed, through the courtesy of Mr. Wells, unusual facilities for seeing his operations and the after-treatment of his cases. I have, therefore, thought that an abstract of some notes taken on the spot might be of interest to the profession here.

While I was in London, Mr. Wells completed his five hundredth case, and the mortality had steadily declined, until in the fifth hundred, 80 per cent. recovered and only 20 per cent. died. A ratio of recovery of *four-fifths* is far above that of most other capital operations, amputation of the thigh being followed by a mortality of about 50 per cent.; strangulated hernia, 45 per cent.; and some being even larger.

So far as I observed, Mr. Wells's operations had the following peculiarities:

*First*—In diagnosis, established, in cases of doubt, by tentative tappings, microscopical and chemical examination of cyst contents, &c.

*Second*—In the least amount of handling of the patient possible; no one touching the abdomen but the operator.

*Third*—Celerity and decision in operating. This was very noticea-

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ble; the time consumed, the period of exposure of the abdominal cavity, and the proportionate shock being much less than in other operations I had seen.

*Fourth*—Personal care in subsequent dressing and nursing. In this the operator was much aided by a corps of nurses, trained under his own eye in his hospital.

The Samaritan Hospital, for women and children, of which Mr. Wells is surgeon, is an ordinary London dwelling house of brick, five stories high. The stairway is in the centre, and the rooms, front and rear. Each room has an open soft-coal fire, a ventilator over the outer windows, and one opening into the central stairway. The latter has a ventilator at the head of the stairs. The hospital has been in use for twelve years. Sometimes there have been cases of septicæmia, when it was necessary to clear it out and whitewash. After operation the patient always has a room to herself.

During the year 1871 *fifty-six* operations of ovariectomy were performed here. The first successful operation was performed in 1858. Ovariectomy had been very fatal in the other London hospitals, thus: at St. Bartholomew's, 12 cases, 8 deaths; Middlesex, 8 cases, 7 deaths; King's College, 7 cases, 6 deaths; St. George's, 7 cases, 5 deaths; University College, 5 cases, 4 deaths; Guy's, 44 cases, 21 deaths; total, 83 cases, 51 deaths. At the Samaritan Hospital, 106 operations, 30 deaths. In other words:

In five large hospitals,	mortality, 76 per cent.
Guy's Hospital,	" 47 per cent.
Samaritan Hospital,	" 27 per cent.

These results show what can be done in smaller hospitals in comparison with the larger ones.

CASE I. The patient was about 40 years old, not excessively large, and in good condition. She was placed on her back on a table, with the head and shoulders a little raised. She was strapped down by a broad webbing over the knees, and wristlets fastened to a strap, which passed under the table. The whole body was covered with a sheet of rubber cloth, with an oval cut out over the abdomen. The edges of this oval were made to adhere to the abdomen by adhesive plaster.

Bi-chloride of methylene was the anæsthetic used. About 3 v. were consumed in half an hour. It was given cautiously with an atomizer. Mr. Wells has used no other anæsthetic for four years; he thinks it less likely to be followed by nausea. In about eight minutes the patient was asleep.

The first incision was about four inches long, from below the umbilicus to the pubes. He cut down rapidly to the peritoneum. Bleeding was checked by forceps left on. On opening the peritoneum the uterus presented itself below, and above this was the white cyst. A very large trocar, with clamps and tube attached, was at once plunged into the cyst, and as it collapsed it was seized with a

peculiar vulsellum and drawn up under the hooked clamps. This cyst was of moderate size; another, and larger one, immediately appeared above it. The external wound was now slit up above the umbilicus. The first cyst was seized with strong forceps, and the opening pinched up. The trocar was then plunged into the second cyst, from which a large quantity of fluid escaped. This also was dragged up under the hooked clamps, and by strong traction pulled out of the abdomen. There were no adhesions.

The second cyst was now dragged entirely out, the clamp put on and the pedicle cut, without hæmorrhage. The first cyst was then easily dragged out, clamped and cut in the same way.

Thus double ovarian disease was removed; both ovaries extirpated, and both broad ligaments clamped. The sides of the wound were held together by an assistant.

Mr. Wells now passed a large soft sponge into the abdomen, and left it. He then rapidly passed sutures of silk, with two needles, from within outwards; taking stitches alternately at either end. The sponge was withdrawn the last thing, and the wound closed with eight sutures. There was very little hæmorrhage, and no fluid escaped into the abdomen.

Not satisfied with the large protruding pedicles and two clamps, he now passed a large needle through the pedicles, and tied them up around it with hemp twine. Finally he took away the clamps, and cut away the projections of the pedicle. The wound was padded around with bits of sheet lint; and strips of plaster drawn across; higher up, a large wad of fine cotton, and more adhesives. The patient was then immediately removed, dry, to bed.

She was on the table about half an hour, owing to the delay for the final arrangement of the pedicles. She retained a good color, pulse and warmth; there was no vomiting. The temperature of the room was about 80°; a warm June day, with the windows open. No disinfectants were used. The urine was to be drawn every 6 hours. A little opium given to relieve pain, if needed. The sutures to be removed the fourth day. The clamp to be left to come away of itself, usually about the seventh day. The wound to be dressed dry; no moist applications. Lint to be changed when soiled.

I last saw this patient on the *sixth* day, doing well; the sutures were out, and the pedicle partially sloughed away. She was eating quail. I afterwards learned that she recovered.

CASE II. Patient older, tumor larger, marks of two tappings. Four drachms of bi-chloride of methylene. Incision of four inches. On opening the peritoneum an ascitic fluid ran out. The hand was passed in between the abdominal parietes and the cyst, and adhesions were broken down. The cyst was tapped; the trocar clamps hooked on, and an attempt made to deliver the cyst, but in vain. The cyst was then slit open with a knife, and the two cut sides seized with forceps and held open. The hand was passed into the

cyst, and numerous others broken down and evacuated. The cyst was then dragged out, and an attachment to the omentum torn away. Near the pedicle, the cyst was found to be attached to the side of the uterus, by inflammatory adhesion. The pedicle was clamped and cut. Then the large adhesion was transfixed with a needle and ligatured, and divided. There was a good deal of hæmorrhage. This was checked with silk ligatures. These were cut short off, and returned into the abdomen. The pedicle was finally secured with silk ligatures, and the clamp taken off. The pedicle was dropped back into the abdomen. The omentum was ligatured at several bleeding points, and the thread cut short off. The ragged omentum was trimmed, and the whole returned into the abdomen. The wound was closed by nine silk sutures. *Nothing was left outside.* The abdominal cavity was freely sponged out, and the omentum left out fifteen minutes. The patient had to be stimulated a little. I saw this patient on the *fifth* day, doing perfectly well. The sutures were out, and the wound closed by first intention. On returning to London in September, I learned that she had recovered.

CASE III. Patient was middle-aged, somewhat reduced, abdomen large. From first incision to clamping and cutting pedicle, only eight minutes. The abdomen was open fifteen minutes. The patient was back in bed in thirty minutes. No vomiting; good color; gentle, warm perspiration when put to bed. Anæsthesia not very profound. The cyst was very thin, and was punctured with the knife on opening the peritoneum. No trocar was used. Other cysts within it were punctured, broken down and emptied. The mother cyst was a little adherent to the omentum and the peritoneum. The cyst was separated from the abdominal walls, by the hand inside of the cyst; Mr. Wells considering this the best way, as there is thus no risk of stripping off the peritoneum. The pedicle was small, and was clamped. I saw this patient on the fourth day, doing well. She recovered.

CASE IV. Mr. Wells stated this to be a doubtful case. An exploratory incision revealed a large, solid, vascular, uterine tumor, and a cyst above it and adherent to it. This cyst, when tapped, gave exit to a bloody fluid, in large quantity, but when tapped before the operation, it had shown a pure ovarian fluid. The cyst could neither be removed nor brought to the surface to drain, so it was emptied, and the abdomen sewed up. This patient recovered from the operation.

Three of these operations were in private houses. Mr. Wells selects a room at the top of the house, and has a soft-coal open fire. The sponges are cleansed with sulphurous acid, and warmed at the fire. He gives a good diet as soon as the patient wants it. The urine is drawn every six hours. The bowels moved after the 7th day. No one dresses the patient but Mr. Wells. He relies a good deal on the temperature, which is taken frequently. He says it is the little things that tell. He does not believe the operation is followed

by any more shock than an amputation. The absence of shock, in the cases I saw, was one of the most remarkable peculiarities.

He says the ligatures, cut short and dropped in, take care of themselves. No carbolized ligatures are used; plain silk, or hemp.

His assistant told me that he made an autopsy a year after the operation, where the ligatures were left in, and he could barely find a trace of them.

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## IN-FLESHED TOE-NAIL.

### A NEW OPERATION FOR RADICAL RELIEF.

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THE selection of a suitable name for this extremely painful and persistent affection seems to have puzzled authors almost as much as has its etiology and proper treatment. It is called by them In-growing, In-grown, Incarcerated, and Incarnated Toe-nail—all misnomers except the last, if the term is intended to indicate the cause and nature of the malady. *In-fleshed Toe-nail* may not be thought an improvement, but it does not involve a theory, and sufficiently describes the condition as usually presented to the practitioner.

The affection has been known and appreciated from time immemorial, yet still remains one of the minor opprobria of our art. It is not necessary, however, to go over its history or to recount the numerous expedients for its relief, as the object of the present paper is to call the attention of the profession to a new, and, it is believed, an effective operation for the complete removal of the disease, applicable alike to all varieties and stages of its development. Any one who wishes it may learn how thoroughly the ancients understood such matters in *Paulus Ægineta* (Translation and Commentaries by Adams, Syd. Soc. Ed.) vol. ii. pp. 414-415; can find an elaborate essay on the causes, varieties, and treatment of the disease in *Dupuytren's Clinique Chirurgicale*, vol. iv. pp. 379-413; can obtain an analysis of the doctrines of later writers in *Chelius's Surgery*, by South, vol. i. pp. 221-229, and of the practice of fifteen of the foremost French surgeons in *Table Anal. du Journal de Méd. et Chir. Pratiques*, 1850-69, p. 337; can get an authoritative sketch in *Holmes's Surgery*, vol. iv. pp. 795-6, an account of the practice in different London Hospitals in the *Lancet*, May 29, 1869, pp. 747-8, and the last dictum in Gross's great work, vol. ii. pp. 1042-3, revised and issued from the press in 1872. Moreover, most text-books and manuals have a word to say about it; and many reports of cases, and special projects in superabundance, have lately appeared in Medical Periodicals at home and abroad—indicating the still un-