NEW YORK SURGICAL SOCIETY.

Stated Meeting, February 28, 1894.

The President, ROBERT ABBE, M.D., in the Chair.

EXCISION OF GANGRENOUS APPENDIX FOLLOWED BY INTESTINAL OBSTRUCTION.

DR. ARPAD G. GERSTER presented a girl, aged nine years, whom he had subjected to operation for relief of gangrenous appendicitis, October 14 last.

On incision a large, somewhat turbid, odorless serous effusion, unencapsulated, was found around the colon, which, together with adjoining coils of small gut, was much injected, but not adherent. The root of the appendix was exposed, and it was found that the organ was reflected down into the small pelvis towards Douglas's pouch, where it lost itself in a hard mass. On further separation of some recent adhesions a cavity was opened, from which about two ounces of fetid pus were cautiously removed by sponging. Then the appendix, located in this cavity, was turned out. It was found nearly four inches long, was gangrenous and perforated near its apex, non-adherent, and containing some fecal concretions. Dissection of its mesentery was rather difficult on account of its density and shortness. For fear of injuring the colon, a ligature was not applied to one bleeding point, but an artery clamp was left in situ. The wound was drained and packed.

An immediate improvement of all symptoms followed. October 16 the dressings were changed in anesthesia. Deep packings renewed after removal of clamps. October 19 rather profuse arterial hemorrhage, apparently from artery which had not been tied, but it had stopped spontaneously by the time Dr. Gerster reached the patient, so nothing further was done.

October 22 it was noted that fever had set in, caused by retention in Douglas's pouch, from which fetid pus welled up through the wound on pressure from the rectum by the finger. A long drainage-tube was slipped into the bottom of this cavity, and immediately improvement followed.

About this time, after meals, severe colicky pains appeared, for which a dose of calomel was given, under the supposition that the colic was caused by retained solid feces. The colic disappeared for a few days, but set in again with increasing severity towards the end of the month, and became much aggravated by constipation and
continuous non-febrile vomiting, which finally became distinctly fecal on November 2. Characteristic distention of certain coils of gut was observed. These coils became very well defined during a spasm of colicky pain, when their squirming could be plainly seen through the abdominal walls. An internal obstruction was diagnosticated, and, as the child was apparently failing, laparotomy was decided on.

November 3, laparotomy. Fortunately the discharge from the appendicular abscess had become scanty and bland by this time. Nevertheless, the old sinus was first carefully scraped, wiped out, and packed with iodoform gauze. The old incision was then extended upward about three inches, well beyond the new adhesions to avoid injury to adherent gut.

On exposure, a much distended portion of congested small intestine came in view, behind which lay another flat, band-like, pale, and empty coil, the latter closely attached by recent adhesions to other similar coils and the parietal peritoneum of the small pelvis. These adhesions were all broken up. In fact, the small pelvis was emptied of its intestinal contents, and thus it was found that the collapsed intestine consisted of the ileum adjoining the cæcum, about three feet in length, its upper proximal portion crossing the median line to the left side diagonally at the navel. Finally, the place of constriction was found in the left hypochondrium. A band of inflammatory material was seen passing from the mesentery of this part of the ileum around the gut and to the other side of the mesentery, surrounding the intestine as a ligature would. On one side of this band lay the much-distended, on the other, the collapsed gut. After division of the band, intestinal contents were seen at once to enter the collapsed portion.

The wound was closed after irrigation of the abdominal cavity. The patient bore the operation excellently, and made an uninterrupted recovery. On November 4 there was a slight rise of temperature, but no distention, vomiting, or unfavorable change in the rate and quality of the pulse. November 5, the bowels were moved by a series of small doses of calomel. November 14, the patient was discharged cured.

Dr. McBurney suggested as to the origin of the obstructing band the following explanation: The inflammatory mass was broken up in the right iliac fossa. There were, of course, a large number of coils there. The adhesions were not limiting, and he supposed some
fibrin existed on the coils. Probably the coil which afterwards became adherent on the left side was one which had lain in the right iliac fossa, and when it became displaced or replaced, the adhesion band constricted it in its new position.

The inflammatory conditions favorable for the formation of bands were often present, and the wonder was that they did not occur more frequently. One often saw a coil of intestine with a mass of lymph about it and all the conditions pointing to the probable formation of a band, but the subsequent history did not point to constriction of any kind. The adhesions disappeared in some way. In this particular case a band remained and became organized. Probably all had observed at second laparotomies entire absence of adhesions where at the first operation lymph was observed in abundance.

Dr. Gerster said that in this particular case sufficient time had not elapsed since the first operation for the fresh adhesions to have disappeared, yet the vast fresh adhesions in the small pelvis where he might have expected obstruction had caused no obstruction whatever, and it was not until he had broken up the adhesions of about three feet of intestine in this neighborhood that he discovered the real cause of the obstruction above. Dr. Gerster accepted Dr. McBurney's explanation of the manner in which the obstructing band had formed as probably the correct one.

VARICOSE ANEURISM OF THE HAND.

Dr. John A. Wyeth presented a boy, two years and eight months old, with a dilated condition of the vessels, beginning with the subclavian artery of the right side, involving the axillary, brachial, radial, and ulnar arteries, and evidently anastomosing with the veins at the hand and wrist, forming varicose aneurism with a distinct bruit. The boy's home was at a high altitude in Nevada, and during his stay at the sea level there had been considerable diminution in the size of the hand. At Dr. Wyeth's request several surgeons of the city had seen the patient, and they were not yet decided whether the innominate was involved, but it was Dr. Wyeth's opinion that it was not. The carotid on that side did not pulsate more than that of the left. The affected hand felt much warmer than the other. As to treatment, it had been concluded not to operate upon this patient at present. Should unusual activity in the varicose vessels supervene at any period, operative measures, such as partial amputation or deligation of vessels, or occlusion by Roser's method, would be indicated.
Dr. Abbe referred, in connection with Dr. Wyeth's case, to one, which he had shown about ten weeks before, of aneurismal varix of the hand of considerable extent. The boy had been under treatment ever since. The radial artery had been ligated, and the tumor had been traversed in various directions by over a hundred silk threads dipped in a styptic solution and left in for two weeks. The result had been marked reduction in size, and numerous cord-like masses could be felt where the threads had penetrated the tissues.

Dr. Gerster had seen good results in the treatment of such cases by various methods, and he thought we should not limit ourselves to any single one where a combination might do better. Deligation of the chief afferent vessel seemed to him one of the conditions of success. Then the diffuse part of the malady could be treated by excision of wedge-shaped portions, and the parts united by deep sutures. The method suggested by Dr. Abbe could also be applied in the superficial or cutaneous portions, although he did not believe they alone would bring about lasting improvement in deeply-affected parts. Percutaneous ligatures could also be employed. He had had the pleasure last year of seeing Dr. Mynter, of Buffalo, demonstrate brilliant results gained by percutaneous ligature, ten or fifteen being used with the result of nearly curing the case. Aseptic surgery, which did not attempt too much, would accomplish a great deal in these cases.

BRAIN TUMOR; DOUBLE TREPHINING FOR RELIEF OF PRESSURE.

Dr. Kammerer presented an adult woman with the following history:

She has never been ill; admits, however, the possibility of venereal infection, although she has had no symptoms of syphilis; has had no children. Her present illness began about a year ago with violent headaches on the right side, and vomiting. Fourteen days later, on awakening one morning, she experienced an unusual sensation on the right side of the head, and on closing the left eye, she for the first time became aware that she could not see with right eye; gradually hemi-anæsthesia, and then about five months later a hemiparesis of the whole right side of the body developed. The diagnosis of specific lesion was made, and the patient was put on large doses of iodide of potassium—300 to 400 grains a day—for a long time, with no marked result. The attacks of headache and vomiting became
more severe every time they came on, and during the last three weeks before the first operation the patient vomited everything that she took.

She also complained of excruciating pain on the right side of the head, over the entire frontal lobe, whereas the left side was entirely free from pain. All external applications for relief—also mercury and iodide internally—having again proved useless, it was decided to operate to relieve intracranial pressure. The following was the condition of the patient before first operation:

Complete hemi-anæsthesia on right side.
Hemiparesis on the same side.
Partial paralysis of the right oculomotorius,—raising and lowering of eye impossible.
Complete paralysis of right olfactory.
Complete paralysis of right abducent.
Sense of taste is destroyed on anterior and posterior right half of tongue.
Sense of touch, temperature, and pain are much reduced on right side.
Right bulbus oculi protrudes slightly, and the iris on this side does not react to light, but does contract synchronously with the left iris.

Slight increase of tendon reflexes on right side.
The diagnosis was made of a tumor of the brain.

It was assumed that at least two foci were present, one in the left hemisphere, and the other on the right side at the base of the brain. Any radical operative measure being out of question, he trephined by the omega incision for the relief of pressure over the right parietal region, and removed a piece of bone three and a quarter inches long and two and a half inches wide, with Hartley’s chisels, described by him for the operation of intracranial neurectomy. Leaving the bone in connection with the flap, he fractured its base with the intention of simply raising it at its upper margin, and thus increasing the capacity of the cranium, a method previously employed by Dr. McBurney. He found some difficulty in retaining it in this position, and feeling that great freedom would be afforded the brain if the bone was entirely removed, did so. There was primary union. After the operation—June, 1893—the pain on right side entirely disappeared, and there was no vomiting for several weeks, then occa-
BRAIN TUMOR.

Ventricles, believing some reduction as regards paresis on right side, the patient being able to walk much better, and having more power in right arm and leg. There was also some sensation on pushing a pin into the deep tissues. The patient began to complain of pain on the left side, vomiting was more frequent towards September. Imagining, from the bulging out of the brain on the right side, that the former was perhaps due to mechanical causes set up by the first operation, he decided to do the same operation on the left side, and again removed a piece of bone in like fashion, measuring two and a half by two and a half inches. The effects of this operation, although also very apparent, were not as marked as the first time, but even now, nine months after the first operation, her condition is much better than before that time. Lately she has more pain on right side again, but rather at the back of the right eye. The latter protrudes very much now, being evidently pushed forward by the neoplasm, which, of whatever nature, has invaded the orbital space. At the time of the operation the dura was not incised, and in this way a prolapse of the brain avoided, as the large openings in the bone were deemed sufficient for, at least, some reduction of pressure. A few months ago, although the patient was fairly comfortable, he again anaesthetized her, and punctured both ventricles, believing that some fluid might be present. On the right side he withdrew several drachms of clear yellow fluid; on the left side, though several punctures were made, only blood. No change in the patient's condition resulted from this.

There is now considerable bulging of the brain on both sides, although the dura was not incised; and the object of the operation has been realized, perhaps not to so great an extent as if the brain had been allowed to protrude from the cranial cavity.

Dr. Wyeth remarked that he had trephined in two cases with symptoms of brain tumor, and finding no tumor had sewed up the dura, but had not replaced the bone, improvement had followed relief of pressure, as it had in Dr. Kammerer's case. One of the patients had been comatose about two weeks. He had not made a will, but after removal of the piece of bone consciousness returned, the man was able to attend to his business for seven months, wrote a will which afterwards stood, and finally, at his death, the tumor of the brain was discovered to have been beyond the reach of the surgeon's knife. The other patient also became conscious after the exploratory operation.
REMOVAL OF EXTENSIVE OSTEO-SARCOMA OF UPPER JAW; NON-RECURRENCE.

Dr. Charles McBurney, in connection with the case shown Nov. 22, 1893 (see page 241), presented a young man to further illustrate the possibilities of non-recurrence after removal of extensive osteo-sarcoma of the upper jaw. The patient was operated upon a little over four years ago for sarcoma of the superior maxilla of nine months' duration. When he came under the reporter's notice the cheek was very prominent, the eye was bulging, the malar bone was somewhat elevated. The operation was the usual one for complete resection of the left upper jaw, the floor of the orbit and malar bone being also taken away. The healing was rapid. The patient has a plate to fill in the cavity, but, unlike most patients, finds it somewhat uncomfortable, and prefers to put in gauze, which he changes frequently. Dr. Hodenpyl, after microscopic examination, reported the tumor to be a small spindle-celled sarcoma. There is as yet no evidence of recurrence to be found. In reply to a question, he stated further that in his opinion the wearing of an artificial plate for filling in the defect in the roof of the mouth was to be preferred to any plastic operation.

Dr. Gerster agreed with Dr. McBurney, for while the defect could be closed easily by a plastic operation, yet it would obscure any point of recurrence should this take place, and prevent early removal or other method of treatment.

Dr. McBurney rejoined that in one instance he had operated fourteen or fifteen times for recurrence in the back part of the pharynx, usually with the cautery, through the aperture left after the first operation for removal of the upper jaw. Had the cavity been filled by a plastic operation the seat of recurrence would have been concealed from view.

Dr. Abbe also thought the advantages of leaving the cavity open very great, and he had done so in a recent case of fibro-sarcoma of the posterior pharyngeal wall, in which he had resected the upper jaw. He thought, however, that where there had been no relapse for four years it might be permissible to close the cavity by a plastic operation.

SPLENECTOMY.

Dr. F. Kammerer presented a spleen from a man of forty-five, who had been treated for malaria for the past three years, during which time a large tumor of the spleen had developed. Patient has taken
arsenic, iron, and strychnine in large amounts. During the past half a year he had been unable to do anything, suffering pain, and especially inconvenience from the rapidly-increasing size of his tumor, which reached on admission to the hospital beyond the median line to the right and down on the left side to the brim of the pelvis. It seemed fairly movable, and on standing it distinctly changed its position, sinking down somewhat towards the pelvis.

The ratio of white to red blood-corpuscles in many examinations showed such differences that the number are of no value. The number of red corpuscles was normal. There were no glandular enlargements. The post-mortem examination gave distinct evidence of the existence of leukæmia of the splenetic variety. The general conditions being good, after refusing to operate at first, he was finally persuaded by the urgent request of the patient to undertake extirpation of the spleen. An incision was made transversely, reaching from the lumbar region on the left to the outer border of the right rectus muscle, separating all the parts, including the peritoneum. A small incision was then carried, about three or four inches long, from the first in a downward direction along the outer border of the left rectus. Thus the lower border of the tumor was well exposed. Some of the omentum lying over it was ligated and severed. Then the lower border was raised and an attempt was made to reach the pedicle, separating the adhesions of the omentum as he worked on. The hæmorrhage from the original incision, and at this stage, was rather free, but was easily controlled; but this was otherwise when the large veins entering the spleen were reached. These were exceedingly brittle. He tore a small opening into one of them, although proceeding with the utmost care, and in trying to apply an artery forceps to it the entire vessel gave way, necessitating compression to prevent serious hæmorrhage during the greater part of the operation. Finally, he was able to ligate the vessels at this point by passing an aneurism-needle behind them, fortunately without injuring them, and to divide them between two sutures. He now began to separate the adhesions to the diaphragm. These were very firm and necessitated the application of much force, but he finally succeeded in developing the tumor from under the ribs and holding it over. It was attached to the stomach, pancreas, and colon. There was considerable, but not alarming, hæmorrhage from the adhesions to the diaphragm, which were immediately controlled by a tampon of sterilized gauze. It was now seen that only half the pedicle had been ligated, and that another
strand of vessels entered the spleen at a higher point than that which they had been able to reach from below. They were ligated and the spleen removed. The patient was in a fair condition considering the heavy loss of blood. Suddenly, after having tamponned the wound cavity, sutured the parietes and applied a dressing, the respiration began to fail and the pulse began to intermit; the anaesthetic (ether) had been stopped half an hour previously. Although stimulation of every kind and transfusion were resorted to, the patient did not rally, but died from shock. The spleen weighed seven and a half pounds.

The case demonstrated the dangers of splenectomy for leukaemia from hæmorrhages, and the many adhesions which one may expect to find in such large tumors.

RESECTION OF GUT FOR GANGRENOUS STRANGULATED HERNIA.

Dr. A. J. McCosh read a paper on the above subject, for which see page 647.

RUPTURE OF THE KIDNEY.

Dr. Charles K. Briddon read a paper on this subject, for which see page 641.