Notes of cases of abdominal section for the relief of pain : read at the Medico-Chirurgical Society, Glasgow / by J. Crawford Renton.

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TUBERCULAR PERITONITIS.

Gentlemen,—A. B., aged seven years, was seen by me six years ago with Dr. McFadyen. She was suffering from an abdominal swelling of two months' duration; the temperature was 101° F. at night, the child was losing flesh and suffering pain, increased by pressure.

The abdomen was opened, assisted by Dr. McFadyen and Dr. Bryce, a large collection of purulent fluid was evacuated, the cavity washed out with 1 to 4000 corrosive sublimate solution, and a tube left in the abdomen. Child recovered, and has remained well since.

E. B., aged nine years, had complained of abdominal swelling for nine months, and as it was increasing he was brought to the Western Infirmary two years ago. In Professor Buchanan's absence I saw him, and found evidence of free fluid in the abdominal cavity. Abdomen was opened and the fluid was evacuated, when masses of tubercular material could be felt; the cavity was washed out and a tube inserted for four days. Boy did well, and remained well for eighteen months, when a hard swelling showed itself around the wound; this I dissected out, and he has remained well.

C. D., aged nine months, was seen with Dr. Thomson. The patient was suffering from acute tubercular peritonitis; the temperature was 104° F. at bedtime, the child was emaciating, and fluid was detected in the abdomen. No improvement had followed mercurial inunction and the other remedies employed. The abdomen was opened and the fluid was evacuated, when the peritoneum was found acutely diseased and the glands extensively affected. The temperature fell to normal, the child improved in appearance, and in five days was sitting up playing with toys; delusive improvement, for in another week the temperature was high and death followed quickly.

Why is it that in such acute cases our successes are so few?

R. B., aged eleven years, was seen with Dr. Macdonald, of Auchtermuchty, in February, 1897. She lived in a very small house, and suffered from subacute tubercular peritonitis with pain and abdominal swelling. There was a considerable amount of fluid with hardness. All remedies had failed to relieve her, so, assisted by Dr. Macdonald and Dr. Burnside Buchanan, I opened the abdomen and evacuated the fluid; large masses of tubercular swelling were found on both sides of the abdomen, and a small portion was removed for confirmatory examination, a glass tube being left

in the abdomen for four days. Her progress was uninterrupted, and by September she could walk three miles; she continues to be well, having gained in weight, and her doctor reports her at this date (March, 1899) to be quite well. All the masses have disappeared. The portion removed showed tubercle bacilli.

STOMACH ADHESIONS.

J. D., aged thirty years, was brought to me by Dr. Campbell, of Pollokshields, with the history that for six years she had been suffering from pain in the epigastrium, worst four hours after a meal, and always temporarily relieved by food. Dr. Campbell had tried all the usual remedies, aided by consultations with other physicians, but was disappointed that no improvement took place.

On examining the abdomen, it appeared normal except at a point midway between the xiphoid and umbilicus, where on the slightest pressure there was acute pain. She was otherwise healthy, and not being a nervous woman, I gave the opinion that probably there was some adhesion between the peritoneum and stomach, and that the adhesion dragged on the stomach when it was empty, causing pain. With this view I advised abdominal section, which the patient agreed to.

Assisted by Dr. Guthrie, Dr. Adamson, and Dr. Burnside Buchanan, Dr. Campbell being present, I opened the abdomen and found at the spot of pain a fine tube attached to the peritoneum, passing to the stomach and liver and surrounded by adhesions. This tube I removed along with the adhesions and closed the abdomen. In a fortnight, when I dressed the wound, I found it healed and the pain on pressure gone, the patient remarking, "There is no pain there; I am well." Since operation she has remained well.

The tube appeared to be the unobliterated umbilical vein, which had been intraperitoneal instead of, as usual, extraperitoneal.

GASTROSTOMY.

A. B., aged sixty-five, was sent into the Western Infirmary by Dr. Downie on account of malignant stricture of the œsophagus. Assisted by Dr. Downie and with Professor Buchanan's approval, I performed Albert's method of gastrostomy modified by Kocher, by which a small artificial œsophagus is made with a bridge of skin over the middle of it, and this prevents the contents of the stomach overflowing.

This patient did well and lived in comfort for five months.

ABSCESS IN THE LIVER.

R. B., aged fifty-three, was seen along with Dr. Bryce on account of an abdominal swelling, which at first looked as if it was connected with the colon, but gradually it enlarged, when it was evident that it was connected either with the liver or with the gall-bladder.

The patient was seen by Sir William Gairdner and Professor McCall Anderson, and we were all agreed that an operation to explore the swelling was essential, the more so that the patient was suffering severe pain controlled only by morphine.

Assisted by Dr. Bryce and Dr. Adamson, I opened the abdomen and found the swelling, which was an abscess in the liver with a hard swelling behind it, the whole being matted together so that it was impossible to say definitely what might be there. The abscess was opened and drained, and

the patient was much relieved and improved in strength and lived for five months in comfort. She died with gradual increase of the swelling behind the liver, which swelling on being examined by Dr. R. M. Buchanan after death, was found to be malignant, with a gall-stone in the gall-bladder.

CHOLECYSTOTOMIES.

C. D., aged thirty-two, was sent to me two years ago by Dr. Sneddon, Cupar-Fife, suffering from intense pain and recurrent attacks of jaundice. I opened her abdomen and took out twelve stones from the gall-bladder. One large one was troublesome in the cystic duct, and as a precaution I put a tube both in the abdomen and gall-bladder. I was glad I did so, as the duct gave way and considerable discharge of bile took place from the abdominal tube as well as from the gall-bladder. After some anxiety she made an excellent recovery and is now well.

A. B, aged forty-seven, sent by Dr. Oastler, with a history of attacks of intense pain and recurring jaundice, had twenty-seven stones removed from the gall-bladder. She has remained well for two years.

C. S., aged forty-nine, sent by Dr. Westwood, with history as in above case. Seven stones removed with recovery.

R. O., sent by Dr. Oastler, with exactly same symptoms, the jaundice being well marked. Abdomen opened and no stones found, but adhesions between gall-bladder and duodenum, which were freed.

This relieved the pain, and she has remained well for two years.

D. G., aged fifty-seven, sent by Dr. McKinnon, of Drymen, with history of pain and jaundice. Abdomen was opened. No stones were found in the gall-bladder, but adhesions were present between the gall-bladder and the colon; the whole were freed, and after two months the patient was well. The duodenum and colon naturally take some time to get out of the habit of contracting spasmodically, hence the delay in complete relief being obtained.

R. A., aged twenty-seven, was seen with Dr. Alice Maclaren in October, 1896, with acute hepatic colic and high fever, which is often noted with gall-stones; there was tenderness over the gall-bladder region. The abdomen was opened, assisted by Drs. Maclaren and Pace, within two hours of seeing the patient, and fifty-seven gall-stones were removed along with a small discharge of pus from the gall-bladder. The patient made an excellent recovery, and has had no recurrence of any former trouble.

COLOTOMY.

I wish to mention only two out of a number of cases which have come under observation and operation for rectal obstruction by inguinal colotomy, as it relieves the pain with speed.

C. S., aged seventy, was seen by Dr. Adamson in October, 1896, with urgent obstruction of the bowels due to rectal cancer.

Dr. Beatson kindly saw the case also, and agreed as to the urgency for inguinal colotomy, which I performed on the left side, raising the bowel on a glass rod passed through the mesentery, which insures a satisfactory opening and prevents any movement passing into the bowel below.

The patient lived in comfort for a year.

R. H., aged forty-five, sent by Dr. Duff, of Helensburgh, with acute obstruction from a tumor in the rectum. The same operation was carried out as in the case above mentioned with great relief to the patient, and, although the ulceration spread and I had to do another operation to prevent

contraction of the opening, she lived for three years and was able to attend to business.

When coming near her end she sent a message of gratitude for the relief given her.

REMARKS.

I have selected the above cases as they illustrate fairly well the variety of abdominal conditions for which we can afford relief from pain by abdominal section.

I have avoided any reference to conditions of the appendix and cæcum, as that region requires a paper to itself, and I have also not referred to cases involving the uterus and its appendages, as I hope to read a paper bearing on that subject in the future.

The cases of tubercular peritonitis are instructive as showing the value of a simple incision with evacuation of fluid, either accompanied by washing out of the abdomen or not.

Three of the cases did well, and I purposely mentioned the case of the baby as instructive and possibly as a warning to you and me not to open the abdomen in so acute a case; at the same time I was impressed by the striking improvement for a week, showing that possibly there may be something additional required in very acute cases to insure permanent benefit. In all the cases the usual remedies had been tried before operation, and this should always be so, as excellent results are obtained in many instances from recognised medicinal treatment.

Why is it that a simple incision causes the hard masses to disappear? In Dr. Macdonald's case it was most striking how they seemed gradually to dissolve. We have much to learn yet about the tubercle bacillus, its effects in different regions, and still more about its treatment.

The case of J. D., with umbilical vein adherent to the stomach and liver, is one of the most interesting I have seen, and it impresses me with the importance of considering such possibilities in obstinate cases, the more so that we frequently find adhesions giving rise to symptoms indicative of more serious disease.

The case of gastrostomy was done early in the patient recommended by Dr. Downie, for the earlier the operation the more likelihood there is of longer relief from pain and quiescence of the serious disease which is present.

The cases of cholecystotomy were of the usual class, presenting no specially difficult features, and the usual plan of operating was adopted, the gall-bladder being stitched to the fascia and drained.

In from six to eight weeks the fistula closes, as a rule, but in one case an opening has remained, and will require an operation to obliterate it.

The cases with adhesions are specially interesting as presenting symptoms of gall-stones and recovering after operation.

The two cases of colotomy are mentioned, as no disease of the bowel obtains such relief from pain as disease of the rectum by colotomy, and that relief ought to be given much earlier than it is often afforded. Some surgeons do not advise it early, and many patients will not agree to it soon enough, and the disease is often far advanced before the operation is performed. The propriety of doing the operation ought to be considered at the first indications of difficulty in obtaining a satisfactory movement, when, of course, it is already settled that no other operation is advisable.