Observations upon the treatment of chronic diseases of the stomach / by B.G.A. Moynihan.

Reprint from

SURGERY, GYNECOLOGY AND OBSTETRICS

January, 1908, pages 4-8

OBSERVATIONS UPON THE TREATMENT OF CHRONIC DISEASES OF THE STOMACH

By B. G. A. MOYNIHAN, Leeds, England

OBSERVATIONS UPON THE TREATMENT OF CHRONIC DISEASES OF THE STOMACH

By B. G. A. MOYNIHAN, Leeds, England

DURING the last few years there has been great surgical activity in the treatment of diseases of the stomach. The number of cases upon which I have operated, and the lapse of time since the earlier cases were treated, have enabled me to draw certain conclusions which now regulate my practice in respect of the simple, that is the non-malignant, diseases of the stomach and duodenum. I think all who have had any considerable experience in the surgery of chronic maladies of the stomach will agree with me when I say that the most serious, and the most difficult problem which now confronts us is the proper selection of cases for treatment by the surgeon. It is no doubt true that in the past a number, I think only a small number, of cases have been treated by operation, which would have been better left to the continued care of the physician. Surgery may not have done harm, but it has certainly not done good; and the purpose of surgery is not a merely negative one, some positive benefit should come to reward the patient for the risk and discomfort to which he has been subjected.

It is in the discovery of the appropriate case for the surgeon that our chief work now lies. If a consecutive series of, say, 100 cases of chronic simple disease of the stomach are seen by a surgeon, he will probably be able to say of at least 95, not only what the nature of the disease is, but what is the most apt method of treatment for it; but in the remaining five the task of deciding whether there is actual organic disease or not will be almost or quite insuperable without an exploration of the abdomen. There are cases that is to say, wherein the mimicry of the clinical picture of chronic ulcer is remarkably exact. Such patients are usually women, they have suffered long, and have suffered, by their own account, such agony and so great misery, that the prospect of even the gravest operation is hailed with thankfulness, if only relief may come from it. The investigations of the physician may have convinced him that organic disease is at the root of the matter, and an urgent call for the performance of gastro-enterostomy may be conveyed from him to the surgeon. The following case is an example: —

Case 1. Miss S. F. Aged 32. Since the age of 16 she has suffered much from "indigestion." Pain comes on, generally, within a very short time of taking food, sometimes after the first mouthful has been swallowed, so that occasionally she only eats a very small quantity before being compelled to get up and leave the table. At other times pain does not come on for an hour or more after food, and sometimes not for four hours. Whenever it comes it is relieved by vomiting. The pain is seated in the middle line of the abdomen on the left side of the chest, and extends up into the shoulders and the back of the neck. Flatulence is sometimes very distressing. Nine years ago she had hæmatemesis, but no great quantity of blood was lost. During the last few months the pain and vomiting have got worse, and now she vomits after every meal. When under observation in the Infirmary she vomited constantly after food, sometimes directly after taking a meal, sometimes an hour after. She has lost 3 stones in weight. The abdomen is thin; the stomach reached barely to the umbilicus on inflation. A few minutes after inflation with CO_2 the small intestine is seen to fill, and intestinal movements are visible. Test meals show no evidence of stasis, and no chemical alteration. The operation disclosed no abnormal condition. The patient after operation was better for about two weeks; then vomiting began again. The result of the operation was explained to the patient, and she was told that no visible disease was present. Her condition subsequently underwent a great improvement, and she now eats well and has regained most of her lost weight. It is interesting to remember that had gastro-enterostomy been done in this case bile would as always, have entered into the stomach. The material vomited

would have contained bile and a technical fault in the anastomosis have been considered responsible. The fault would, of course, have lain, not on the method in which the operation was effected, but in the performance of the operation when no indication for it was present.

Again let me quote another case:—

Case 2. Miss M. R. Aged 33. Seen with my colleague Dr. T. Wardrop Griffith. The history was that 2½ years ago the patient began to have burning pain in the head, as though "something was running about." Later, she had pain in the body, in the epigastrium and left side. The pain was almost constantly present, but was accentuated by taking food. She felt, however, as if she could not leave off eating, though she felt very full. She constantly had a sensation of hunger. She was greatly troubled with wind; the body was distended, and she belched wind profusely. Sometimes she feels as though the stomach was working. The pain sometimes comes on at night time, and keeps her awake. She is not improved by rest, but has benefitted by restriction of the diet to fluids. Lately her symptoms have been more severe, and she has lost weight, from 8 st. 6 lbs. to 5 st. 4 lbs. There has never been any vomiting. Dr. Griffith thought that peristalsis was to be seen in the stomach, and my house surgeon agreed with him. I never saw this, though the abdominal wall was so thin, that the intestinal movements were clearly visible. At the operation nothing abnormal was discovered and the abdomen was therefore closed at once.

In both these cases I explored the abdomen, and found no evidence whatever of organic disease. The stomach was thin, the walls almost translucent, there was no ulcer, there were no adhesions, there was no displacement; the duodenum, the gall-bladder and the appendix were all quite natural in appearance. What was to be done for these patients? In looking through my cases of the last few years (SURGERY, GYNECOLOGY AND OBSTETRICS, 1907, i. 682) I have found 6 such cases and on them I performed gastro-enterostomy. Nowadays I should certainly not do so. When a stomach which shews no evidence of organic disease is discovered, there is no indication for gastro-enterostomy whatever the nature of the symptoms may have been. Even if haematemesis has been present this rule should still hold good. For, if dyspepsia of the chronic or recurrent kind is dependent for its existence upon a chronic ulcer of the stomach or the duodenum, that ulcer is a visible and a tangible thing. The ulcer that cannot be demonstrated to the entire conviction of the onlooker does not exist. No matter how urgent the recommendation for gastro-enterostomy may have been the surgeon should on no account perform it in the absence of a demonstrable need for it. It may be asked, "If the symptoms of so long a duration are not due to ulcer, what is the cause responsible for them?" To this question there is at present no satisfactory answer. The stomach in such cases is often, I think always, thin, membranous, almost translucent, as though deficient in its musculature. Yet stasis is not present, the stomach empties itself within the normal time. It may be that it empties its contents ill prepared, into an intestine whose rebellion at its improper supply is expressed in those symptoms of which the patient makes complaint. But this is mere hypothesis. The one clue, which, when followed up in these cases will lead, I think, to their discovery before operation, is the absence of an orderly arrangement of the symptoms. In all cases of chronic ulcer of the stomach or duodenum the symptoms are well-defined and are stated by the patient in terms of accuracy and precision. There may be intervals of perfect freedom from suffering, but when symptoms are present they are orderly in their appearance. In the absence of organic disease there is often a caprice in every aspect of the disease. Pain comes early or late, is now worse, now better, goes spontaneously and comes irrespective of food, solid or fluid. There is an erratic sensitiveness about the stomach. The story of one day's experience of symptoms is different from that of every other day. There is chaos where there should be order.

Another class of cases in which I have ceased to perform gastro-enterostomy is that in which the ulcer is seated on the lesser curvature close to the cardiac orifice, or within the cardiac half of the stomach. In three such cases I performed gastro-enterostomy when this condition was found. All the patients were better after the operation for a time, but this recovery was not to be compared with that easy, smooth and full return to health which would have occurred had the same ulcer been prepyloric or duodenal. One of the patients has lately relapsed, and is almost as ill as before the operation, in a second the symptoms have recurred to an extent which will probably lead me to advise the

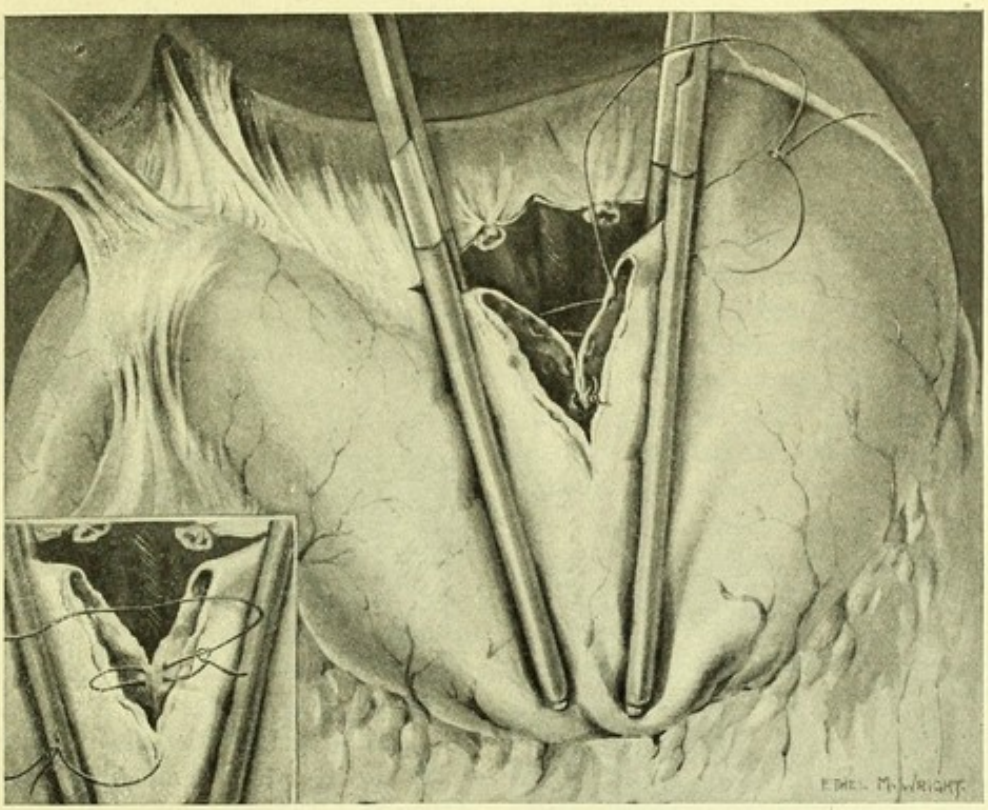

Fig. 1. Excision of an ulcer on or near the lesser curvature of the stomach. The clamps are applied to include the ulcer which is excised after separation of the gastro-hepatic omentum. In the small figure the first stitch is shewn.

excision of the ulcer; the third case is still troubled with pain but not severely. What then is to be done for such ulcers? In my opinion they should be excised. If the ulcer be near the cardia and adherent, possibly to the pancreas, the task of excision is no light one. The technical difficulties are then far greater than in an ordinary case of partial gastrectomy for carcinoma. But excision must be practiced if at all possible, if relief is to be given. I have excised five such ulcers and the result, in all cases, has been completely satisfactory. Happily all the ulcers were solitary. If such an ulcer had been complicated by the existence of a second ulcer at the pylorus, then excision and gastro-enterostomy would both have been necessary. The technique of this operation of excision is shown in the accompanying figure.

When a chronic ulcer is seated at the pylorus along the lesser curvature close to the pylorus ("prepyloric") or, in the duodenum, gastro-enterostomy should be done. In the proper case no operation in all surgery is so completely satisfactory as this. The bad results of this operation are due, I feel sure, almost without exception to an improper selection of cases. If the ulcer is causing obstruction, or if in its later healing it is likely so to do, then gastro-enterostomy will surely effect complete relief.

The form of gastro-enterostomy I adopt is that described in "Abdominal Operations." The no-loop operation, with clamps and two rows of suture is performed, as I there depict it. Indeed, the only question which now seems open is concerned with the direction of the jejunal application to the stomach. As I originally described it the jejunum was placed so that from the flexure it ran downwards and slightly to the right, as if it were tending towards the appendix. Dr. W. J. Mayo suggested that the anastomosis should be directed downwards and to the left, following what he described as the natural direction of the jejunum. I am not at all sure that the anatomy he describes is accurate, for the position of the jejunum as the patient lies on the operation table may not be the same as it is when the patient is erect. We find the jejunum tending from the flexure towards the upper part of the kidney merely, I think, because that is the position it must

tend to assume when the patient is supine. Even then it does not always so lie, for I have found it vertical, or tending to the right in a certain number of cases. I am now investigating this point by altering the position of the abdomen, by placing a rubber cushion under the back, by turning the patient on to the right side, and so forth before the incision is made, and I propose in a few months to disclose the results. At present my opinion is that the position described by Mayo is not the best for the anastomosis to take. In deference to his opinion, than which none more strongly appeals to me, I performed a series of operations making the anastomosis along "Mayo's line," but adopting every other part of the technique of the operation as I described it in my book. I was not pleased with the results. Three of the cases suffered more from bilious vomiting than any I had seen since my early experience. My friend, Mr. Rutherford Morison says the same. He writes me: "I noted with special interest the fact that you had had vomiting after adopting the 'Mayo turn' of the jejunum. My experience was the same. In two cases, after a series of about 50 successes and with practically no vomiting, I adopted Mayo's suggestion. Both cases were more sick than of late years I have been accustomed to see." I have reverted to my original plan of the operation and now place the jejunum almost vertical with a slight, usually an extremely slight inclination to the right. My friend Dr. W. L. Rodman, who honoured me with a visit in August 1907, told me that the operation as I now practise it is the same as that I performed when he was here in 1902, except that I place the jejunum more nearly vertical now than I did then. The results of the operations so performed are quite satisfactory. The mortality now is less than 1 per cent; the after-complications are rarely encountered. Regurgitant vomiting, or the late vomiting of bile, I have certainly not met with in over 200 cases performed by the method I describe. Peptic ulcer has occurred once in a case of duodenal ulcer with intense hyperacidity. My own opinion therefore upon the question of the best form of gastro-enterostomy is in favour of the posterior no-loop method with the almost vertical application of the jejunum to the stomach. But though I firmly hold to this opinion I do not hesitate to say that many of the ill results of gastro-enterostomy, and especially that concerned with the vicious circle, are due not so much to the method practised, as to the absence of any sufficient indication for the operation itself. If the case is a proper one for gastro-enterostomy, the result may possibly be good with any one of several operations, but with the operation I describe and practise the result approaches to certainty.

In duodenal ulcer surgical treatment should always be adopted. The outlook of the patient otherwise is hazardous; the risks of perforation and lethal hæmorrhage, are far more imminent than in cases of chronic gastric ulcer. I have recently operated upon several cases where the ulcer was in an early stage; in three cases in my last 20 it was no bigger than the end of a lead pencil. I have excised one such ulcer, which had bled profusely, and I exposed a "kissing ulcer" on the posterior wall of the duodenum at an exactly opposing point. I therefore removed a part of the duodenum and closing the distal end, I mobilized the duodenum and implanted into the front of the descending portion the anterior proximal end immediately beyond the pylorus. The appearance of the anastomosis did not please me, and I therefore at once performed gastro-enterostomy as well. But there are I feel sure early cases of duodenal ulcer, where the ulcer is solitary, of small size, and not causing stenosis in which this operation might with advantage be tried. If beyond the pylorus there is half an inch of healthy duodenum before the ulcer is reached, then after removal of the ulcer and closure of the distal cut end, the implantation of the proximal end, with the side of the duodenum rendered mobile by Kocher's method, would leave the action of the pyloric sphincter, unimpaired. The proximal section of the duodenum might be made in such manner that a wide anastomosis with the second portion would result. (See figure.)

I find that I have only twice performed Rodman's operation of excision of the ulcer bearing area of the stomach. I have found gastro-enterostomy to be so simple, easy and safe an operation that I have hesitated to inflict a more

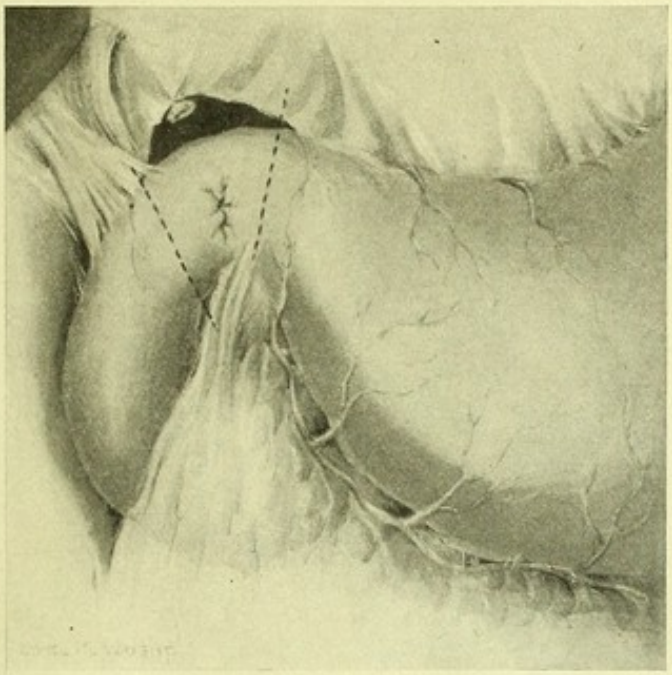

Fig. 2. Ulcer of the duodenum. Excision of the ulcer.

serious operation upon these patients. But in all cases where there is doubt as to the simple or malignant nature of the ulcer, and in some where the ulcers are multiple, Rodman's operation is imperatively indicated. I am confident that I ought to have done this operation oftener than I have done; for three cases of what at the time I supposed to be simple ulcer died eventually of malignant disease and the interval between operation and death was such that there is, to say the least, no denying the likelihood of a malignant change having occurred in an ulcer that was simple in its early stage.

If an ulcer occur in the body of the stomach causing an hour-glass condition it may be excised, or gastro-enterostomy may be done on the proximal side of it. The leaving of an undrained pyloric cavity provided the pouch be small in size, does not seem to matter. I have found gastroplasty an unsatisfactory operation on the whole. I performed it 7 times in 30 cases of hour-glass stomach, and two of these cases have needed secondary operations.

When small indurated ulcers are found in the stomach or duodenum I always infold them in exactly the same manner as if they had perforated. In doing so I make a point in my first line of suture of securing the vessels of supply. As was, I think, first shewn by Mitchell of Belfast, the infolding of an ulcer is equivalent to its excision.

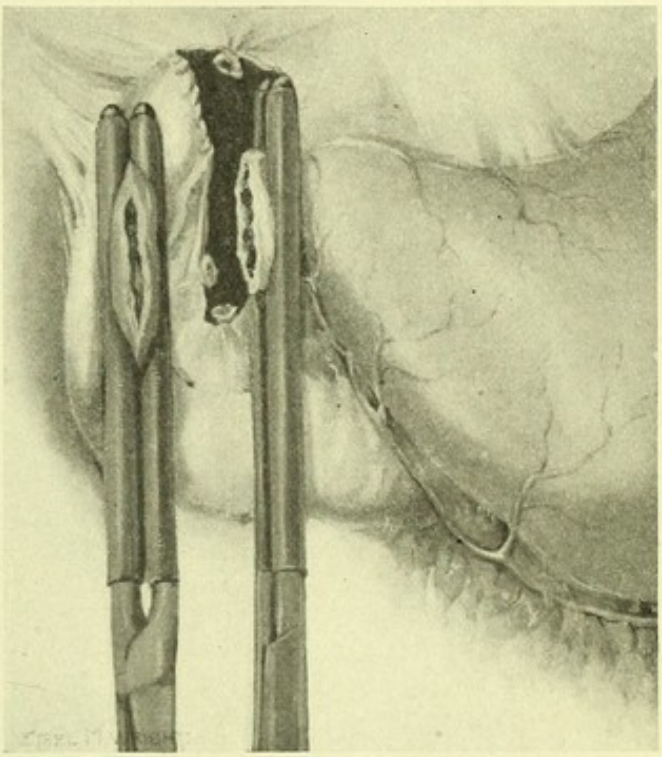

Fig. 3. End to side anastomosis of duodenum after excision of the cylinder bearing the ulcer.