The Murphy button : with a report of an unsuccessful cholecystduodenostomy / by Aug. Schachner.

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THE MURPHY BUTTON; WITH A REPORT OF AN UNSUCCESSFUL CHOLECYSTDUODENOSTOMY.

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THE MURPHY BUTTON; WITH A REPORT OF AN UNSUCCESSFUL CHOLECYSTDUODENOSTOMY.*

By AUG. SCHACHNER, M.D., Ph.G.,

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THE history of every well-accepted operation in surgery can be divided into three stages:

First.—The creative stage, in which the operation is being conceived and completed within the mind of the originator.

Second.—The probatory stage, or that period in which it is given to the world, and is subjected to the test of actual use.

Third.—The stage of limitation, or in which we begin, after an experience with the operation, to add to, to subtract from, as well as to modify it that the maximum of success can be obtained from its application; for past experiences have abundantly proven that operations at first entirely acceptable have, after passing through a period of actual use, had their scope of usefulness limited and their method of performance modified.

The operation of anastomosis, as devised by Dr. Murphy, is well into the third and final stage of its existence, and as to the limitations and modifications, if any at all, to which it will be subjected, time and ex-

* A paper read before the Louisville Academy of Medicine.

perience alone can tell. So far a number of objections have been raised against this device.

Among these might be mentioned:

First.—The contraction of the opening, especially in a side-to-side anastomosis.

Second.—The button acting injuriously by assuming the role of a foreign body.

Third.—The possibility of the button causing trouble by becoming arrested at the ileo-caecal valve.

Fourth.—The chances of the button dropping in the wrong direction—i.e., into the stomach in a gastro-enterostomy, or into the isolated loop of intestine in an intestinal anastomosis.

Fifth.—The possibility of the button not disengaging itself or of becoming arrested in some part of the intestinal tract.

Sixth.—"It makes the patient dependent upon the craft of the cutler, rather than the skill of the surgeon."

As to the first objection, i.e., the subsequent contraction of the anastomotic opening, Dr. Murphy distinctly expresses himself that this does not occur, and, from some cases embodied in his last report, it seems that even the reverse condition may take place. If this be true, why not cut down the size of some of the larger buttons? If we can accomplish the desired end with the ordinary sized round button or a smaller sized oblong button, it seems illogical to use such extremely large buttons which might create trouble by their size and weight.

So far as the second objection is concerned, there can be no room for doubting that, under certain conditions, the button

can create harm by acting as a foreign body. This is illustrated by the case reported by Dr. F. H. Wiggin ("N. Y. Med. Jour.," December 1, 1894), in which the weight of the button anchored the bowel in a flexed position, causing a fatal obstruction. Another case, an ileo-colostomy reported by Dr. Abbe, in which the cylinder of the button became plugged with hardened feces, resulted in a fatal obstruction. Dr. Murphy says that this can easily be avoided by the use of a mild cathartic immediately after the operation. But if this has happened in an ileo-colostomy, how much more liable is it to occur in a colo-colostomy, where the contents of the large intestine are not to be compared in density to those of the small intestine?

In the case above mentioned both salines and high enemas were resorted to without effect, but not until the second or third day. The possibility of the third objection, i.e., the button becoming arrested at the ileo-caecal valve, has been pointed to by Dr. Keen soon after the appearance of the button. This surgeon in his article upon an ileo-colostomy ("Annals of Surgery," Vol. XVII, p. 661) writes thus: "We all know, on the one hand, that a considerable number of cases have been reported in which the plates of artificial dentures, with several teeth attached, have been swallowed, have passed the ileo-caecal valve, and have been voided without difficulty. But certainly a much larger number of cases of intestinal obstruction from gall-stones have been reported. Pouzet has collected twenty-seven operations for such

obstructing gall-stones, to say nothing of the cases which have died without operation. Gall-stones are less irregular than the artificial dentures, and more nearly approximate in shape and size the Murphy buttons, and yet are capable of producing serious and even fatal intestinal obstruction. Moreover, in the seven cases so far reported by Murphy, no such difficulty was encountered, though it was uncertain in at least one case whether the button had ever escaped. It is curious to note that in one of his cholecystenterostomies gall-stones of the same size as the button escaped on the eighth day, while the button was not passed till the eighteenth day."

It is also interesting to note that Dr. Keen's report of this case seems to indicate that even the opening may undergo subsequent contraction. He expresses himself as follows: "The size of the button by which the opening was made is one inch in diameter, showing that the aperture, in the forty-seven days since the operation, had contracted to one-half of its original diameter." Again, Dr. W. Koerte has reported (in "Verhandl. d. deutsch. Gesells. f. Chir.," XXII. Congress, 1893) four cases of intestinal obstruction from gall-stones. Three were operated upon, of which two recovered; a fourth case not operated upon died of peritonitis, which was caused by a stone lodged in the valvula Bauhini.

In regard to the button dropping in the wrong direction, this seems to have occurred principally in the gastro-enterostomies, and it has happened in this operation with such frequency that there is a ten-

dency to dismiss the button entirely in this procedure. At first it was thought that the button dropped into the stomach, owing to the anterior fixation (or Woelfler's technique); and the Von Hacker operation, or posterior approximation, was urged as a solution of this difficulty, but with no better success. Dr. Murphy still thinks that the buttons which were retained in these operations would have eventually found their way out after the subjects had gotten up and gone about some time, but these opportunities were not presented.

The retention of the button, however, is not confined to the gastro-enterostomies alone. In a colo-colostomy operated upon by Dr. Abbe ("Annals of Surgery," February, 1895) the button was removed by means of a second celiotomy from the wrong or proximal side of the anastomosis after it had been there for six weeks; recovery. Another case, in which Dr. Fred Kammerer performed an entero-enterostomy by the end-to-end method, is discussed in the same number. Here death occurred after the lapse of twelve weeks; the button had not passed in the mean time. At the autopsy the button was found upon the wrong or proximal side of the anastomosis. In this case the question has been raised as to whether the button had anything to do with exciting the peritonitis which caused the death of the patient.

The possibility of the button not disengaging itself or of becoming arrested in some part of the intestinal tract has not been considered of much importance by Dr. Murphy. In fact, the button seems

to have liberated itself so far in every case without any difficulty. As for becoming arrested in some other part of the intestinal canal, Dr. Murphy, in his answer to the objections raised by Dr. Wiggin, says: "It has been retained by a fibrous band in the hepatic flexure of the colon; it produced no symptoms of obstruction, but was found there in the post-mortem."

Another case, in which it was retained, there was a secondary carcinomatous growth of the sigmoid flexure where anastomosis had been performed higher up; here also there were no symptoms of obstruction. We believe that there are many, however, who are as yet unwilling to consider such fears as groundless.

The last objection, that it makes the patient dependent upon the craft of the cutler rather than the skill of the surgeon, has been raised by Dr. Wiggin in his paper already alluded to. There can be very little room for trouble from this source if the button is properly constructed, and Dr. Murphy, in answering this objection, has displayed a very liberal and commendable spirit in volunteering to examine all buttons submitted to him. He also offers a timely warning that care should be taken in the purchase of the button, as the market contains defective specimens. I have seen a set of buttons from a certain house in which the cylinders of the female halves were some two or three lines shorter than those of others made by a well-known Chicago house; in addition, the catch-spring of one of these buttons snapped off by the first manipulation. A difference of a few

lines in the length of the cylinder will make a considerable difference in the ease with which the operation can be performed, and I am confident that some of the feeling against the device has had its origin in some of the defective buttons.

These objections have been reviewed not with the intention of waging a war against the button, nor does the raising of objections against a new departure necessarily indicate a weakening of the same. But since they have been made, it becomes our duty to consider them impartially and to act cautiously. If the Murphy button is capable, under certain conditions, of creating harm, we are anxious to know just what the conditions are and their chances of occurrence, and then the rest will be plain sailing.

The fact that a certain accident has occurred once forever settles any doubt that may have existed as to the possibility of its occurrence, and forever places it within, not only the possible, but also the probable, range of reoccurrence, and the question then resolves itself into: What are the chances for this accident to occur? In the single clinical case, a report of which is appended, in which I have used the button, I was satisfied that the operation is not always the simple procedure that many would have us believe, and I am convinced that much harm has been done the device by floating the impression that any novice, and even the busy practitioner, as one enterprising manufacturing firm would have us believe, could safely use the button. The truth is just as Dr. Murphy expressed

it: "While the button is easily inserted, the pathologic condition requiring the operation may demand the greatest surgical skill to secure a favorable result." I am also convinced that a large number have yielded too readily to the temptation of using the button and have met with failure, and these failures have never been recorded.

Since using the button it occurred to me that conditions necessitating an anastomosis might arise in which the draw-string could with advantage be replaced by another method of inserting the button. This method, which I offer merely as a suggestion, and which might become advantageous in selected conditions, consists of making an opening in the gut some distance above the proposed site of anastomosis; then pushing the half of the button, which is mounted upon a suitable forceps, down the intestine to the proposed anastomotic site; by means of the forceps, the button can then be pushed against the intestinal wall, making the overlying structures tense and easily definable; these are now divided to the extent of one-half the diameter of the presenting cylinder and the stem forcibly pushed through. This insures an absolutely firm grasp of the wall around the cylinder, and all the manipulation can be done from the handle of the forceps without any further injury to the intestinal wall.

It has been observed by others that the pushing together and other manipulation have sometimes been carried out at the expense of some additional violence to the intestine. When the buttons are locked the

forceps can be withdrawn and the additional opening safely and quickly closed with a double Lembert stitch. This suggestion might be used when the structures tear readily or where the part can be reached with difficulty only.

Report of Case.—F. B., bookkeeper, aged thirty-four years.—Was first seen by me somewhat more than a year ago. At that time he was suffering intensely from what appeared to be a biliary colic, and which readily subsided under the influence of a hypodermic injection of morphine and atropine. He informed me that these attacks have been common occurrences for the two preceding summers, and that various medical measures were tried by two medical attendants without any success. From this time and continuing for several months thereafter, I carefully tried such medical measures as are supposed to be efficacious in the treatment of the gallstones, but without success. Such had not only been my diagnosis, but also the diagnosis of the attendants who preceded me, as well as that of Dr. A. Muench, who also saw the case with me. In addition, I might add that for a long time he was treated by another attendant for gastro-intestinal catarrh, without any effect whatever. At times he became jaundiced, his urine containing considerable bile pigment and his stools of a light color. He complained of a dull pain in the region of the liver, which at times became extremely sensitive to the effect of heat and cold. Seeing that he was daily losing ground, as he expressed it, he finally consented to surgical measures, these

having been suggested some time previously.

He was removed to an infirmary and an exploratory opening made directly over the gall-bladder. The liver was enlarged and felt abnormally hard. The gall bladder was full, but hardly distended. Palpitation and examination revealed nothing. The gall-bladder was aspirated, drawing off about three ounces of healthy-looking bile. The interior of the bladder was now explored with a probe, with negative result. The gall-bladder was incised and the duct examined, but only with partial satisfaction. Everything being in readiness, and taking his past history in consideration, I concluded that the most logical course would be to drain the bladder into the intestine, thereby hoping to effectually relieve those rapidly increasing colics and arresting his downward tendency.

In performing the operation the chief difficulty experienced was the hemorrhage from both the intestinal and hepatic side. The intestines had also become a source of annoyance by continually coming into the field of operation. Finally the anastomosis was completed and, after carefully cleansing the parts preparatory to closing the abdomen, a small leak was suddenly discovered at the upper edge. This was due to a slight tear of the intestinal wall, which, owing to its friable condition, had been a source of trouble. It was closed by a running Lembert stitch, which extended two-thirds of the way around. The patient was removed in good condition. His course for the succeeding thirty-six hours

was perfect, notwithstanding his behavior, which was indiscreet and disobedient.

Although the case ended unfavorably, it goes for nothing so far as the button is concerned, for no operation would have had a fair test under such circumstances.

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