Report of seven cases of abdominal surgery in which the Murphy button was applied / by A. Vander Veer.

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Publication/Creation

Louisville, Ky. : Printed by John P. Morton, 1896.

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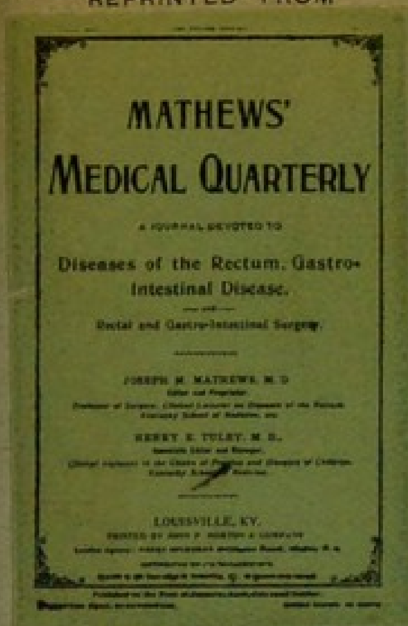
MATHEWS'
MEDICAL QUARTERLY

A JOURNAL DEVOTED TO

Diseases of the Rectum, Gastro-Intestinal Disease.

Rectal and Gastro-Intestinal Surgery.

JOSEPH M. MATHEWS, M.D.

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LOUISVILLE, KY.

JANUARY, 1896.

10.

REPORT OF SEVEN CASES OF ABDOMINAL SURGERY IN WHICH THE MURPHY BUTTON WAS APPLIED.

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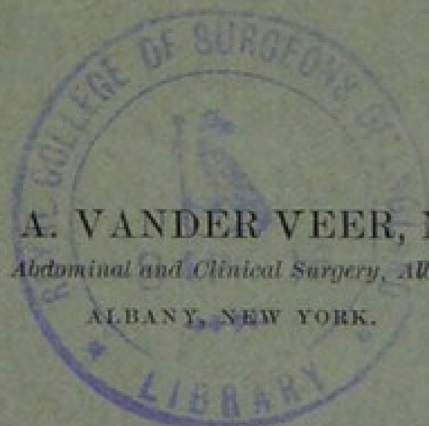
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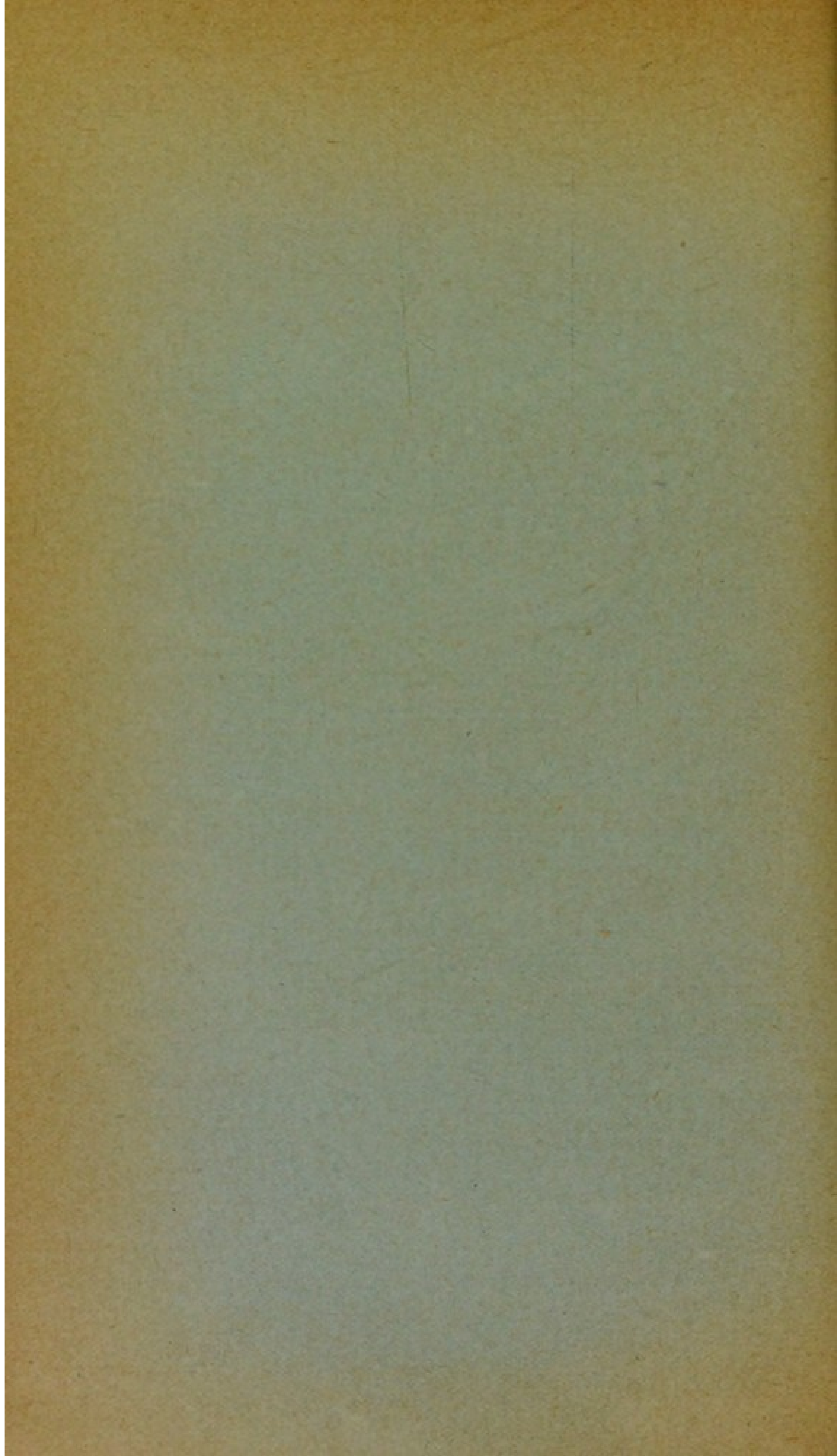

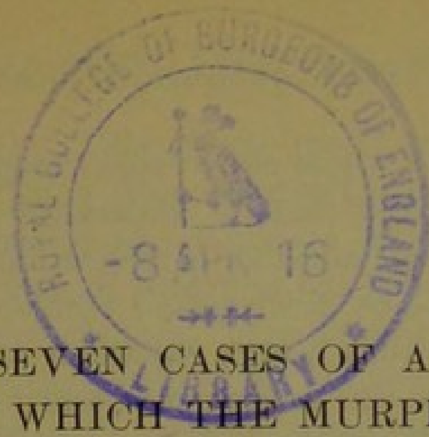

REPORT OF SEVEN CASES OF ABDOMINAL SURGERY IN WHICH THE MURPHY BUTTON WAS APPLIED.*

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[Published exclusively in MATHEWS' MEDICAL QUARTERLY.]

Mr. President and gentlemen: I am not unmindful of the fact that the reporting of clinical cases is not always the most interesting material to present at such a meeting as this. On the other hand, the seven cases here presented have a bearing upon the use of the Murphy button that is now receiving much attention not only in this country but abroad, and as a method of intestinal anastomosis is being placed thoroughly on its merits. It is difficult to understand some of the unfavorable reports made by English and German surgeons, when we contrast the very successful results indicated by so many of our American operators in the application in a practical way of this mechanical contrivance. Perhaps there is no part of surgery that, within the past quarter of a century, has presented so much in theory and in which there has been so much disappointment, when practical use has been made of the suggestions, as in the field of abdominal work with all its complications. In other words, how much we have changed from time to time our methods of treatment of many complications, and yet, withal, there have come certain reliable advances that have met all requirements for which they were indicated, leaving permanently in our possession the comforting thought that a grand progress in the sum total has been made; that we can treat all manner of pathological conditions, traumatisms, malformations, etc., of the intestinal tract and abdominal cavity with less embarrassment than perhaps in any other part of the body, and yet there are very few portions of the human system

*Read at the meeting of the Southern Surgical and Gynecological Association, Washington, D. C., November 12, 1895.

upon which we operate where more rapid thought and best judgment is to be employed than in abdominal work. The best methods for meeting this and that complication must be adopted at once. There can be no great delay; temporary dressings can not be applied for the time being; expectant surgery has no field here. We must meet the emergencies, and I desire to emphasize that much is still wanting in discussions occurring in our special societies; we need less from a theoretical standpoint and more of practical experience. Therefore, in presenting the following cases, with such remarks as each one seems to call for, I am desirous simply of placing on record facts which may assist in future operations, and aid us in our final determination of certain procedures when conditions present that require their employment. It is seldom that so small a group of cases cover so wide a range of pathological conditions.

There can be no doubt but that the consensus of opinion today, among operating surgeons dealing with abdominal cases, is that when we come to intestinal anastomosis our patient is not infrequently in a serious condition as regards strength, and all things being equal, that method which will give the most rapid and safe manner of procedure is the one that is to claim our attention. Rapidity of action at such a time is absolutely necessary, and yet with it must be combined thorough safety.

If with carefully reported cases, when some new surgical procedure is on trial, we could have also a report of the same cases later on as to results, etc., we could then reach a more honest and clear conclusion than is sometimes accomplished.

Case 1: Gastro-intestinal anastomosis for carcinoma of the pyloric end of the stomach.

Mrs. J. C., aged sixty-five years; widow; six months' pronounced symptoms of carcinoma of the pyloric end of the stomach. Family history good; pretty continuous vomiting, at times in large quantities; emaciation very pronounced; much pain and suffering. Patient very desirous of an operation, although distinctly told that the chances were decidedly against her, as she had for some time realized. All other organs in a healthy condition.

An anastomosis made by means of the medium-sized Murphy button, between the upper end of the jejunum and greater curva-

ture of the stomach. Patient was really very comfortable after the operation, but died from exhaustion on the third day. On examination the button was found in excellent position, union quite pronounced, and all surroundings favorable.

These are the desperate cases that present at times to the surgeon for relief, with very little chance for recovery in any operation except they be reached early. It is yet a mooted question whether we ought to operate at this stage or not. I am of the opinion that the weight of argument and results is against doing any operation when the patient is so weak and emaciated.

Case 2: Carcinoma of the sigmoid flexure, removal and end-to-end anastomosis.

Mr. W. T., aged sixty-two; native of United States; machinist by occupation. Family history: mother died of consumption, also two maternal aunts; father died of some heart trouble, aged seventy-two; one sister living; one died in infancy, and one of consumption, aged sixteen.

Personal history: Patient well, save an attack of pleurisy thirty years ago. February, 1893, had attacks of pain and colic after eating, lasting only a few hours. At this time pain occurred at intervals of two and three weeks, but since has increased in frequency and severity until prior to operation when pain was almost constant. Bowels seldom moved voluntarily, injections being necessary, and tube passed to remove gas. Feces passed in small, hardened masses accompanied by pain, occasionally ribbon-shaped and clay-colored. Pain referred to lower portion of bowel in region of sigmoid flexure and up left side of abdomen.

Entered Albany Hospital February 1, 1894, and diagnosis made of stricture of intestine, lower portion descending colon, probably malignant. Operation performed February 3d, consisting of removal of mass in connection with sigmoid flexure, three inches in length, and an anastomosis of the large intestine by means of the Murphy button. Operation revealed cause of constriction to be carcinoma. Mass much adherent to the surrounding parts, which rendered the operation difficult. Wound closed by silk-worm gut sutures, with a tampon of iodoform gauze as drainage in most dependent portions, latter removed on second day and rubber drainage inserted. Patient presented on third day all the marked symptoms of obstruction of the bowels. Up

to this time he had been quite comfortable, passing more or less gas per rectum. He now began to vomit, and distension from intestinal gases was so great that I found it necessary to open the abdominal incision, bringing up a portion of the small intestine and attaching it to the edges of the wound. Very free discharge followed, the patient became more comfortable, but finally died from exhaustion on the eleventh day. On examination the ends of the intestine had united and the button was found loose in the lower portion of the rectum, about two inches within the anus. The patient was much exhausted and emaciated previous to the operation.

Cancer of the sigmoid flexure is one of the most difficult conditions in intestinal surgery that we have to deal with. At the time of the operation I was fearful, and said to my assistant that there was great danger of the button impinging too much upon the crest of the sacrum, and I believe that this was really the after-condition that caused the obstruction. I scarcely think I would use the button again when doing the same kind of an operation, and yet I have been equally disappointed in doing an end-to-end anastomosis in similar cases by other methods, and must say that the use of the button saves an immense amount of time and anxiety.

Mathews says that the prognosis in cancer of the sigmoid flexure is very bad, and that there are but two operative procedures: (1) Colotomy, (2) Extirpation. In the former operation he thinks the question of operative procedure should be decided rather by the patient than the physician. In dealing with the subject of excising the sigmoid flexure for cancer he would be inclined to class it as a piece of unjustifiable surgery, except that in several reported cases excision has been practiced successfully, notably the one reported by Dr. W. T. Bull, of New York.

Case 3: Removal of gall-stones from the gall-bladder, using the long drainage-tube button.

Mrs. H. J. D., aged thirty; excellent history in every respect; had suffered seriously from attacks of gall-stone colic for a period of five years or more. Had had a great variety of treatment from many sources with little benefit. Never jaundiced, and not infrequently received the opinion that her case was probably not one of gall-stones. I had advised an operation in 1892, but patient

was reluctant to have it done. Her sufferings became so great, however, that she consented, and operation was done November 13, 1894. Gall-bladder easily reached in the usual manner and several calculi could be felt. The long Murphy button was made use of and the operation was then exceedingly simple. Three gall-stones were removed at once and wound closed without any difficulty whatever. A rise of temperature on the second day to 101°, but on the morning of the third day it became normal and remained so through her entire sickness. The button came away on the eleventh day, wound healed without difficulty, although patient vomited very freely from effects of ether for a period of thirty-six hours. After removal of the button two more gall-stones were removed through the sinus; wound completely healed at the end of third week, or about twenty-second day.

This patient has been absolutely healthy since, has had no return of her trouble whatever, has gained in flesh, and feels very happy in her recovery.

In all my operations upon the gall-bladder (cholecystotomy and otherwise) in no single instance was the operation done with such absolute ease, and done so quickly as this. When once it is shown that the gall-stones are confined to the gall-bladder, that they are yet outside of the common duct, surely this operation is the easiest of any yet devised. I believe it is much quicker and much easier of performance than the operation of removal of the gall-stones and immediate suture of the gall-bladder, and I have no doubt that the results will prove equally as good.

Case 4: Removal of eight inches of the small intestine with papillomatous ovarian cyst. End-to-end anastomosis.

Mrs. A. S., aged forty; widow; history of a rapidly developing abdominal tumor during a period of six months. Patient also gave a history of epileptic seizures extending over a period of ten years, more or less.

Operation January 14, 1895. Multilocular ovarian cyst connected with the left ovary, papillomatous in character, with very many adhesions. Unilocular ovarian cyst on right side removed with very little trouble. On removing the tumor on left side a coil of the small intestine, about eight inches, was so completely imbedded in the growth that it became necessary to do an intestinal resection. More than eight inches of the ileum were removed

and the ends brought together by the Murphy button, making the operation exceedingly simple. Patient was very nervous for some time after the operation; no vomiting; catheter was necessary, and the hypodermic use of morphia, as she had been accustomed to it before. On the third day there was a free movement of gas, and on the eighteenth day a well-formed movement of the bowels. Patient two days after this had two very decided convulsions, and then remained partially delirious for more than a week. Stools were watched carefully for appearance of the button. On the nineteenth day, while in care of her daughter, she had three movements of the bowels, which were thrown away without being examined, and it is very likely that the button passed at that time, as it was never found in stools passed afterward. This patient made a most remarkable recovery and is now in absolute health, having gained more than twenty pounds in flesh. She has had no convulsions since the few immediately after the operation, her abdomen seems soft and in good condition, and she apparently has made a perfect recovery.

When I consider the ease with which this operation was performed compared with some others in which I have done anastomosis by the older methods, I must express myself as feeling exceedingly grateful to Dr. Murphy for his valuable contribution to intestinal anastomosis. There are few more trying positions for the abdominal surgeon than to come in contact with an abdominal tumor that necessitates resection of a portion of the small intestine. The operation is generally ong and tedious and patient much exhausted when the point is reached of spending one half or an hour in some other method of bringing together the ends of the intestine. The saving of the strength of the patient is here the great necessity.

Case 5: Anastomosis of gall-bladder with small intestine.

Mrs. O., aged fifty-four; good family history, and patient in good health up to the summer of 1894, when, during July and August, she suffered some distress, supposing it to be due to her menopause. Last menstruation August, 1894. In September she had some attacks of gastric disturbance supposed to be simple congestion of the liver. Never had any severe colic; no attacks like that of passing biliary calculi. The early part of September she developed quite a severe attack of sciatica, left side, from

which she gradually recovered, but the second week in October began to develop a condition of jaundice which became very severe. I saw her first April 10, 1895. She had suffered greatly during the winter from itching and nausea, loss of appetite, loss of strength and emaciation. Her pulse was feeble, and she had many ecchymotic spots, the entire body so jaundiced it had almost the appearance of mahogany. Urine was loaded with bile; kidneys otherwise apparently healthy; movements of the bowels were very light in color and had been so for months. She had been recently earnestly advised by her physician not to have any operation, and yet no positive diagnosis given except that of jaundice. I was in doubt as to this being a simple case of catarrhal stenosis of the common duct, or a case of cancer of the liver. Gall-bladder was somewhat distended. I advised an immediate exploration, which was consented to at once by herself and family. Usual incision. Gall-bladder found distended, and twelve ounces of bile carefully withdrawn by means of the aspirator. Thorough search failed to find any nodule, cancer of the liver or stomach, or gall-stones present. An immediate anastomosis was made between the gall-bladder and lower end of the duodenum, or upper portion of jejunum, by small-sized Murphy button. This patient did nicely after the operation. Full movement of the bowels on the third day and afterward by aid of oil enemas. Button passed on twelfth day, after she had had several good movements of the bowels. Soon after this a marked change was apparent in the passages, being yellow and dark in color, her appetite returned, and in every way she continued to improve. At the present time she is in good health, has gained in flesh, is much stronger and able to move about. She is practically well as regards her appetite, digestion, and general condition.

Case 6. Mrs. J. J., aged thirty-four; three children; family history indefinite; patient not strong; general appearance good; menstruated at thirteen; regular but painful. Hernia at umbilicus presented at first confinement; never reduced; pain more or less constant. Two confinements since, natural in every respect. Bowels constipated. October 3, 1895, while straining at stool, suddenly taken ill; tumor increased in size; vomiting and much pain. Was called to see her on Monday, October 7th, at her home some fifty miles distant. Learned that on the previous Saturday

she had vomited contents of stomach, and had had a slight movement of the bowels, but none since. Vomited once on Sunday, and once at twelve o'clock on Monday, a yellowish substance, also some portions quite dark in color; had passed some gas from bowels during past forty-eight hours. There was a strong inclination to eructation of gas; able to take very little food; was not thirsty, and drunk but little. Had had three compound cathartic pills without causing a positive movement of bowels; required a moderate amount of morphia to get rest and relief from pain. Her condition of pulse was 88; temperature had been 101°, but now normal; tongue moist and clean; eyes had a sunken appearance, and there was rather an anxious expression of countenance; abdomen soft, except in immediate vicinity of umbilicus. Tumor greatly inflamed and presenting signs not unlike an acute abscess. Amount and condition of urine normal. There was no distension of abdomen nor the appearance of complete obstruction. I ordered the patient removed to Albany Hospital on midnight train on account of her surroundings. She entered the hospital on the morning of the 8th of October, at three o'clock, and operation done at 10 A. M. Tumor, size of cocoanut, in immediate vicinity of umbilicus; portion, size of a silver dollar, implicating umbilicus, in a gangrenous condition. On making an incision there was found a strangulated hernia; many old and firm adhesions. Peritoneum intensely congested, very dark in color. Loop of small intestines included in tumor gangrenous for space of ten inches. Vessels in mesentery secured, and this portion of intestine excised. Murphy button used for end-to-end anastomosis. Two Lembert sutures made use of outside of button. Gangrenous intestine, large portion omentum, some mesentery and peritoneum removed with mass. Wound closed by silk-worm gut sutures; no drainage. After operation patient vomited dark, greenish fluid, and complained of severe pain in the back. Secretion of urine continued normal. Complained of considerable nausea, and continued to vomit at intervals a greenish fluid, from two to six ounces in quantity. At 3:15 P. M. on the 9th she had a large movement from bowels, evidently from that portion below the point of anastomosis. After this vomited a small quantity of clear fluid, still complaining of distress in stomach. At 7:15 P. M. of the 9th had another small move-

ment, and again at 10:20 P. M. No vomiting after this. Was given only hot water and rectal enemata of whisky and hot milk, at intervals of about four hours. At 12:30 A. M. on the 10th had a large fluid movement from bowels, and another at 3 A. M. After this rested very comfortably and in every way feeling nicely. Was allowed some coffee, milk, beef extract, chicken broth, etc., from this time on. At 8 A. M. on the 10th she had another small movement of bowels, and one at 11 A. M., natural in form and color; 2:25 P. M. had a large movement, a small one at 6:15, and then several in succession. Patient now tolerated various kinds of nourishment; her bowels continued to move two, three, and even four times in twenty-four hours, passing gas freely. At 5:30 P. M. the 21st, thirteen days after operation, the button was passed, followed by a large movement of the bowels. On the 24th she had several movements of the bowels, and after this her bowels acted in a normal manner.

This patient made an uninterrupted recovery, and returned home in excellent condition.

This case illustrates the position that the abdominal surgeon is sometimes placed in. One could hardly believe from examination and symptoms that there was present such a gangrenous condition of the small intestines. I really had concluded that the tumor was made up mostly of omentum, and that the gangrenous spot to be observed on the surface would be found to be connected with gangrenous omentum, but, as soon as the sac was opened and the real condition presented, the necessity for prompt, immediate action was upon us.

Most of us will remember that it was but a few years ago when a very able paper was presented at one of our surgical associations in which, regarding the treatment of these cases, it was advocated that the better way was to leave the exposed gangrenous portion of the gut to slough away and a fecal fistula to form, which was opened later if necessary. One can not help feeling grateful for any method that will facilitate and do quickly the work required and save precious time, as was done in this case.

Case 7. Mrs. B., aged sixty-seven; generous, active, cheerful woman, having large interests to look after; much nerve strain at times, and suffering greatly from nervous prostration, being under the care of Dr. Weir Mitchell and other specialists. I was

called to see her three years ago by her family physician, Dr. Caverly, when she was suffering from attacks of pain and of colic, in which I made the diagnosis of biliary calculi. A careful, thorough course of treatment was followed out by the use of large doses of olive oil, then smaller doses, also phosphate of soda and other preparations, with some relief, so that for a year she was very much better. However, during the summer and fall of 1894 she suffered several severe attacks of pain, latter increasing in severity during the spring of 1895, and when I saw her again, October 16, 1895, she had suffered two very severe attacks, was slightly jaundiced in one, the only time that she had had this appearance. The pain was so severe that large doses of morphia were required, and at times the administration of chloroform had been necessary to afford relief. Her kidneys were found to be in very good condition, although her general strength was not such as would encourage any one to do a very severe surgical operation; however, the patient was suffering so much that it was decided, if the pain returned, she was to have the benefit of an operation.

The pain continued so severe that on Monday, October 28th, patient having taken ether, I made the usual incision for exploration of the gall-bladder, found it containing about two ounces of bile, and through the walls and down into the cystic duct could be felt a number of small calculi. There were some adhesions, but not serious. Desirous of making the operation as short as possible, the patient's condition being such that we were not warranted in doing a long one if it could be avoided, I made use of the long drainage-tube button to the fundus of the bladder, and closed the wound after a careful examination for any possible cancerous mass, which was not found, then placed patient in bed. She vomited some after the operation, but had no unpleasant complications, aside from the fact that her pulse remained in the neighborhood of 90 to 96, and not very strong. Stomach presented a constant condition of nausea, and was not able to take food readily. Kumyss and other preparations were tried, but she was mostly nourished by rectal enemata. Not very large doses of morphia required to afford relief, in fact it was given up for a couple of nights. Patient's bowels moved thoroughly well on the third day, and each day after that. Tem-

perature, first night morphia was discontinued, reached 101°, after that it was absolutely normal; wound healed without any disturbance whatever, and button came away on November 6th, eleventh day, when I visited her for the first time after the operation. I also removed a small calculus at this time, but refrained from using the small forceps or scoop until the parts had had a chance to form more firm adhesions. Secretion of bile had been fairly free, the dressings at times quite decidedly saturated. Aside from the nausea and condition of the pulse patient was in every respect doing well. I believe that this was the best method of treating this case. The clinical history was in the direction of the gall-stones being confined entirely to the gall-bladder, and though the stools had been watched with great care there was no evidence of her ever having passed any through the common duct. Had I attempted a more prolonged operation I am sure that the patient's chances for immediate recovery would have been seriously jeopardized, and that the use of the button in this instance was a saving of time, leaving the patient in good condition for removal of the gall-stones later.

On November 7th her physician removed five of the very irregularly-shaped calculi, which I here present; but at this time she began to show more marked symptoms of cerebral anemia, with delirium, which continued, patient finally passing into a comatose state, and died Friday, November 8th, at 10:30 P. M., temperature just before her death going up to 104° and 105.5°. At no time since the operation had her stomach willingly accepted nourishment, but during that time she vomited but twice.

Autopsy by Dr. Caverly, twenty-four hours after death. Stomach in fair condition, possibly somewhat dilated; liver normal in size but quite fatty. Kidneys also presented a condition of fatty degeneration; but no evidence from gross appearance of nephritis. The doctor states: "The heart was the most decidedly fatty of any I have ever seen. There was no color or appearance of muscle. Heart weighed twelve ounces. Intestines and omentum were loaded with fat; walls of the abdominal cavity were almost entirely fat, the muscular layers very thin. There did not seem to be any other pathological condition, so far as the organs of the chest and abdomen were concerned. Brain not examined. The only remnant of gall-stones found was a

small one about as large as a grape seed. Gall ducts were patent and unobstructed. Adhesions left by the button were very nicely observed. From all appearances we concluded her death was probably due to a fatty heart."

This case is one that puts the surgeon in a most marked position of anxiety: a not very strong patient; a patient evidently suffering from marked cholemia; one who had suffered most severe and agonizing pain, and had not been able to take her usual exercise, carriage drives, etc., in more than six months. I do not believe that any method of treatment could have been accomplished more rapidly, and yet it was a plain case in which her strength was not equal to the demands made upon it.

At the meeting of the New York State Medical Society, in February, 1894, I gave indorsement to the use of the Murphy button, believing that it was a mechanical contrivance of value, that it would supplant all other devices of its kind for the present, and be a great saving of time to the surgeon in certain operations about the abdomen. Possibly something still better will be suggested in the near future, yet, for the present, this is certainly worthy our acceptance and use.

Although the cases I have reported are not many, yet they cover the field in which the device may be made use of so readily and easily, and the result so satisfactory, that I have considered them worthy your attention as having a bearing upon statistics. I believe I have given a just criticism of the accumulation of facts so that we can reach and determine definitely as to the value and usefulness of this contrivance.

It will not answer for every lesion about the intestinal tract, but it surely has its sphere of usefulness, being clean, easily handled, and saves the patient from a much longer operation, when time alone is the great desideratum, which can not be secured by some of the other methods.

28 Eagle Street.