Cases requiring abdominal operations in the service of Dr. J.F.W. Ross at the Toronto General Hospital during the summer of 1891.

Contributors

Ross, James Frederick William, 1856-1911.
Doran, Alban H. G. 1849-1927
Royal College of Surgeons of England

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CASES REQUIRING

ABDOMINAL OPERATIONS

IN THE SERVICE OF

Dr. J. F. W. ROSS

AT THE TORONTO GENERAL HOSPITAL DURING THE SUMMER OF 1891.

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AT THE TORONTO GENERAL HOSPITAL DURING THE SUMMER OF 1891.[1]

In these days of sprays and batteries, and sterilizers and elegant operating rooms, the professional mind is, unfortunately, too apt to run off at a tangent. I began my surgical work under the vapor of the spray. The patients recovered, and I felt that it would be dangerous to operate without the horrid nuisance. But the spray taught its lesson, and even after I found that I could open an abdomen or take off a breast without it I clung tenaciously to the dressings of protective and gauze. After becoming a pupil of the much-abused Mr. Lawson Tait, I thought that Mr. Tait was wrong and that the surgeons on the other side were right. I was horrified when I saw him put a pad of cotton wrapped in gauze over the mouth of a drainage tube placed in the abdo-

[1] Read before the Toronto Medical Society, December 10th, 1891.

men. I felt sure that he was wrong when he lifted off the pads from his wounds as soon as they were a little soiled, and thus exposed the wounds to the terrible germ-laden air. I had been in the habit of using a piece of rubber dam and a sponge over my drainage tubes in the abdomen, but not over drainage tubes anywhere else. I used this dressing because Keith used it. I used cotton moistened with glycerin and carbolic acid over the wound because Keith used it. I agreed with Tait when he said that abdominal operations should not be done in a general hospital. I was a pupil in Germany when the operating room was almost flooded with water, when every one present was obliged to disrobe and dress in garments provided. And still the patients died. On my return I dared not follow Tait. Our hospital reeked with iodoform, and the populace became so accustomed to the smell that they did not seem to mind it. You met it in the street cars and on the street. Every fresh wound was now dusted with iodoform. A year before every fresh wound was buried beneath gauze and tow and layers of bandages. When necessity called for a change I operated in the General Hospital theatre and carried out the precautions enumerated below. I still wonder how many of these precautions were superfluous, but leave that question to be solved by some of my successors. At first every case was inquired for by many of my colleagues. They lived, and after seventeen lived I at least was assured that "something was wrong somewhere." My wounds were not dusted with iodoform, and yet they healed by first intention.

I do not claim to be a bacteriologist, but, as I said in discussing Prof. Kelly's paper on "Hand Disinfection," the bacteriologists are very confusing. One day one disinfectant is all-sufficient, and in a short time some one proves that this powder is full of germs itself. I do not spend much time in washing my hands, and do not intend to. I use frequently nothing but soap and water. It has been proven to be sufficient for Tait, and it is sufficient for me. But if my hands have been soiled by handling pathological material or by examining a puerperal woman, I use bichloride of mercury solution to cleanse them. Only a week ago I operated on a case two days after examining a woman in the last stage of puerperal fever. I felt uncomfortable as I pushed down my right

index finger into the abdomen, but the patient made an uninterrupted recovery.

The fact that certain operators with extreme views have certain results is no proof that the results are in any way due to the extreme views. With the same experience and dexterity, and less extreme views, I am certain that they would attain as great success without half the amount of fuss and hospital expenditure. German operators are wedded to their own ideas, and many of the younger men from England and America accept them as religiously correct, while the old and successful operators laugh at them as superfluous.

It is so easy to attribute results to the wrong cause. Extreme views are like eccentricities—they mark out the man who holds them. This eminence is valuable; it attracts and hypnotizes students and practitioners, and brings grist to the mill. A few years ago the surgeon who did not use the spray was soon tabooed and his clientèle fell away from him. Within our own memory the spray has come and gone again; the lightning fluid from heaven descended on us for a time, as it did in days long past, and it has left a "dream" of inaccurate observations behind it; the cure for tubercle has sunk into oblivion, and we are ready to grasp the next innovation, no matter how illogical.

The following is a *résumé* of my cases and methods:

Cystic ovaries and salpingitis, puerperal	3
" " " " tubercular	1
Pyo-salpinx, gonorrheal	6
" puerperal	1
Appendicitis	1
Ruptured tubal pregnancy	1
Porro's operation	1
Ovarian cyst (twisted pedicle)	1
Multilocular ovarian cyst	1
Encysted peritoneal abscess, puerperal	1
Salpingo-oöphorectomy for myoma of uterus	1
Exploratory	3
	21
Recovered	20
Died	1

Cause of death, septic peritonitis; source of sepsis unknown.

Place of Operation.—General theatre of a general hospital, owing to alterations in Woman's Pavilion.

Time of Operation.—Summer months. Washed out nine, drained sixteen; drained every case washed out. Fatal case not washed out, but drained.

Anesthetic.—Chloroform alone, nineteen; ether alone, not one; began chloroform, finished with ether, two.

Antiseptic used.—Iodoform powder in two (Porro's operation and appendicitis). Bichloride of mercury solution for the hands before operation.

Wound Dressing.—Ordinary fresh absorbent cotton in bichloride gauze in some cases, in plain gauze in others.

Skin Cleansing.—Soap and water, turpentine, and then alcohol.

Suture Material.—Silkworm gut.

Ligature Material.—Best Chinese silk.

Room Preparation.—Sulphur fumigation in some when the room had previously been occupied by a suspicious case. Cases without drainage tubes were taken at once into the woman's ward.

Theatre Preparation.—Thoroughly cleansed and aired; occasionally fumigated. One case reopened in small emergency room without any preparation; rapid recovery.

Stitch-hole Abscesses.—One or two in case of hysterectomy; no others. Stitches removed on first appearance of irritation.

Time of Operation.—Morning, when theatre had been aired all night.

People Admitted.—No one from post-mortem or dissecting room. No one but immediate assistants admitted to floor of theatre.

Sponges used.—My own in most cases.

Instruments.—My own in all but one or two cases, and in all the severe cases; brought directly from my own house.

Preparation of Instruments.—Boiled for a few minutes and wrapped in clean towels.

Drainage Tubes and Suckers used.—My own in all cases.

Silk used.—My own.

You will thus see that I trust no one to prepare anything that is likely to go inside the abdomen. I keep the dirt out of the abdomen, and then feel easy when the peritoneum is closed. I felt very nervous of the results when I began this work forced upon me by circumstances, and determined to take extra precautions. I am satisfied that the danger does not lie in the room in which the operation is done or in the absence of this or that dressing from the wound, but in the use of sponges, instruments, drainage tubes and suckers, and silk not sufficiently clean before the peritoneum is closed. My fatal case was not washed out, although drained, and I regret this. I removed a pus tube, and some pus may have oozed out unobserved. The conditions of the operation were exactly similar to those of the others, except in this particular.

I mention these cases because they were done in a manner that we considered dangerous and experimental. The fad for special operating rooms for abdominal operations has been carried too far, as has the fad for special germ destroyers. A few years ago our surgeons were saturated with carbolic acid, and now they reek with iodoform. A fresh wound of the abdomen needs no antiseptic dressing. I have gone through all the stages, from the most rigid antiseptic precautions down to the method just related, and find that my wounds do just as well now as they ever did. I mention the cases seriatim to let you judge for yourselves, and also to prove to you that "pelvic cellulitis," as we have called it, though it may exist, does not exist as we were taught to believe. What we looked upon from the vagina and the post-mortem room as "pelvic cellulitis" is demonstrated by actual operation upon the living—the only time that the line of cleavage can be made out—to be in reality an intraperitoneal inflammation. This disease has puzzled me for years. I often felt "pelvic cellulitis" as recorded in the text books, that is, per vaginam, but have never been able to find it per abdominem.

Case I.—Left multilocular ovarian cyst and ascitic fluid. Vermiform appendix so adherent and bled so freely that it was removed; it was about five inches long. Adhesions of bowel and omentum. Subsequent collection of ascitic fluid in cul-de-sac of Douglas; punctured per vaginam. Other ovary left. Recovery.

Case II.—Salpingo-oöphorectomy for myoma. Recovery.

Case III.—Gonorrheal pyo-salpinx. One side only removed, owing to weak condition of patient and to severe hemorrhage. Tube cheesy and thickened (see Fig. 1). Mass felt per vaginam (pelvic cellulitis) was bowel fastened to the end of the Fallopian tube, and bowels all matted together. Recovery. Subsequent operation this month (December, 1891). Removed the left ovary, destroyed by an abscess, and left pus tube, with easy recovery.

Case IV.—Exploratory for salpingo-oöphorectomy for uterine myoma in a retroflexed uterus bound down by firm and impermeable adhesions. Recovery.

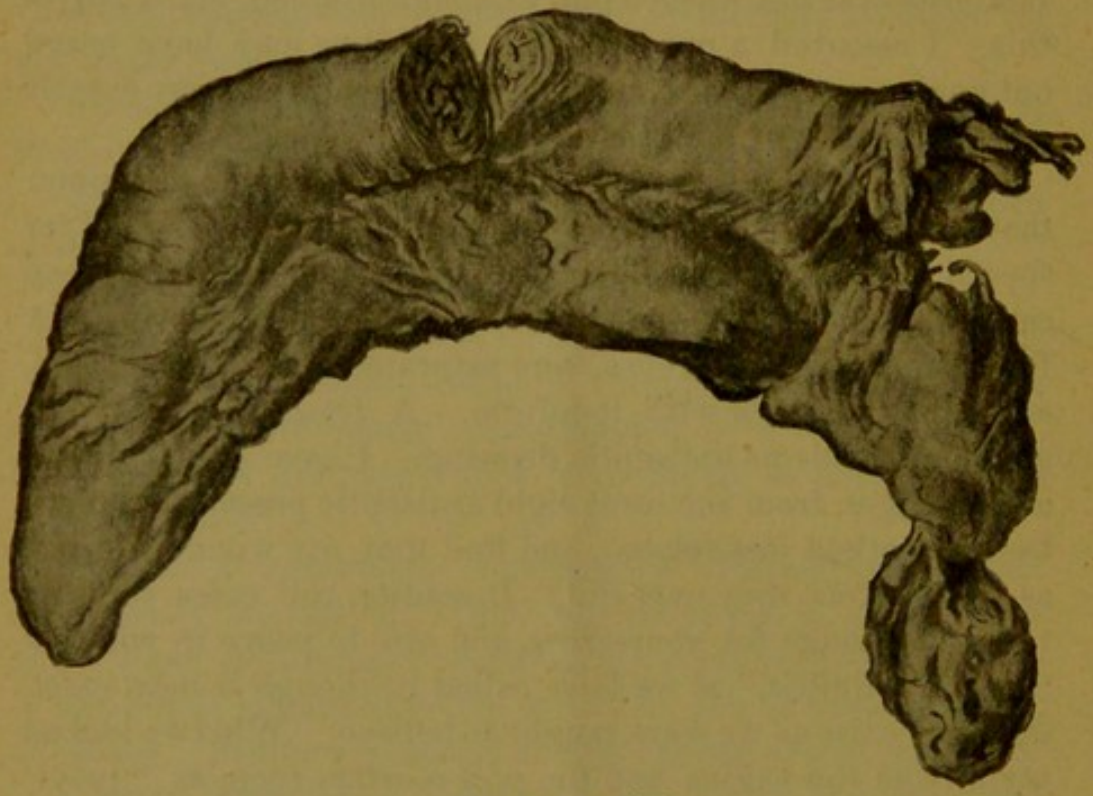


Fig. 1.—Pyo-salpinx.

Case V.—Encysted abscess of the peritoneum following puerperal fever, probably connected with a pus tube. Opened and drained in right iliac region. Recovery. Sinus still unhealed.

Case VI.—Ovarian cyst. Acute peritonitis. Diagnosis of a twisted pedicle. Tumor gangrenous at operation. Recovery.

Case VII.—Uterine myoma and pregnancy. Porro's operation, already reported (American Journal of Obstetrics, September, 1891). Recovery.

CASE VIII.—Exploratory tapping. Enlargement of liver and spleen with ascites. Done without an anesthetic. Ovaries and tubes, uterus, both kidneys, and liver and spleen felt with very little pain to patient. She said it was like a toothache. Went home, sixty or seventy miles, three days after, by a mistake; no inconvenience. This patient was weak and enormously distended.

CASE IX.—Cysts of both ovaries and salpingitis resulting from puerperal fever three years ago. Double salpingo-oöphorectomy. This case was seen by several, who failed to recognize the true condition. Recurrent attacks of pelvic inflammation. Mass on each side of uterus. Recovery.

October 29th, 1891: Saw her to-day; in splendid health and perfectly free from her old attacks.

CASE X.—Ruptured tubal pregnancy. Patient moving about with blood in her abdomen, or else rupture gave rise to no symptoms and intraperitoneal blood must have become treacly within a few hours. Operation. Recovery.

This is worth giving at greater length. Went for seven weeks without menstruating, then became unwell. Then went nearly a month (tenth week), and was taken with severe pains, like labor pains, and uterine hemorrhage. Thought she had a miscarriage. Became collapsed, cold perspiration, but not ill enough to send for a doctor. This was about June 9th, and she came to consult me June 30th owing to continuation of the uterine hemorrhage. On examination a pelvic mass could be felt, but I advised an examination under chloroform, and she decided to come back in two days to undergo it. The history as given above was not elicited from her at that time. She was not suffering any great inconvenience. Under chloroform a hard, movable mass was found to the right of the uterus and filling the pouch of Douglas. I advised exploration. She came back in two days; walked back and forth each time; walked around the wards for two days, waiting for operation (Saturday and Sunday). On Monday morning I found her abdomen full of treacly blood. Removed the tube. Washed out. Fetus not found, but membranes made out at end of tube. Inner end of tube about normal in size. Recovery. In splendid health since.

CASE XI.—Typical "pelvic cellulitis." Recent gonorrhea.

Pelvic peritonitis. Abnormally long omentum, rolled up and fixed in the cul-de-sac of Douglas. Intestines, Fallopian tubes, and ovaries fixed in a dense and impermeable mass. Patient was suffering with gonorrhea. When rising one morning she was seized with severe pain in the hypogastric region, and remained in bed for three days. Pain returned. Tender on pressure. At examination under chloroform a mass was felt to the right side of the pelvis, extending to within

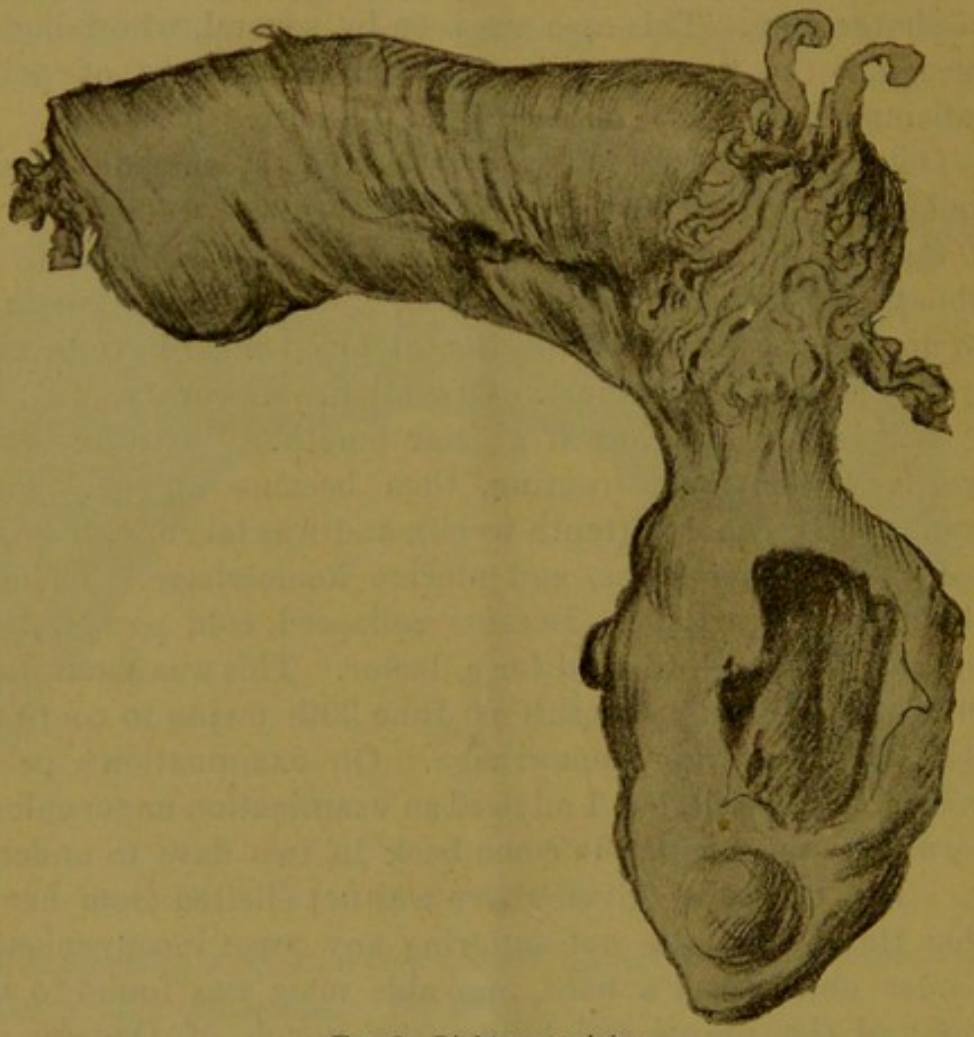


FIG. 2.—Right pyo salpinx.

one and one half inches of the crest of the ilium. An indefinite feeling, such as I never felt before, due, as was evinced at operation, to a tightening of the rolled and adherent omentum. Exploratory operation. Recovery.

December, 1891, patient is still suffering, and nothing but a desperate attempt to remove tubes and ovaries will cure her.

CASE XII.—Gonorrheal pyo-salpinx. Greatly thickened tube mistaken for uterine myoma and treated with electri-

city. Electricity of no use and advised salpingo-ophorectomy. At operation discovered that mass would peel out, and when cut across it proved to be an enormously thickened pus tube. (Reported in *Can. Pract.*, September 1st, 1891.) Several others examined this girl of 16 years and agreed with

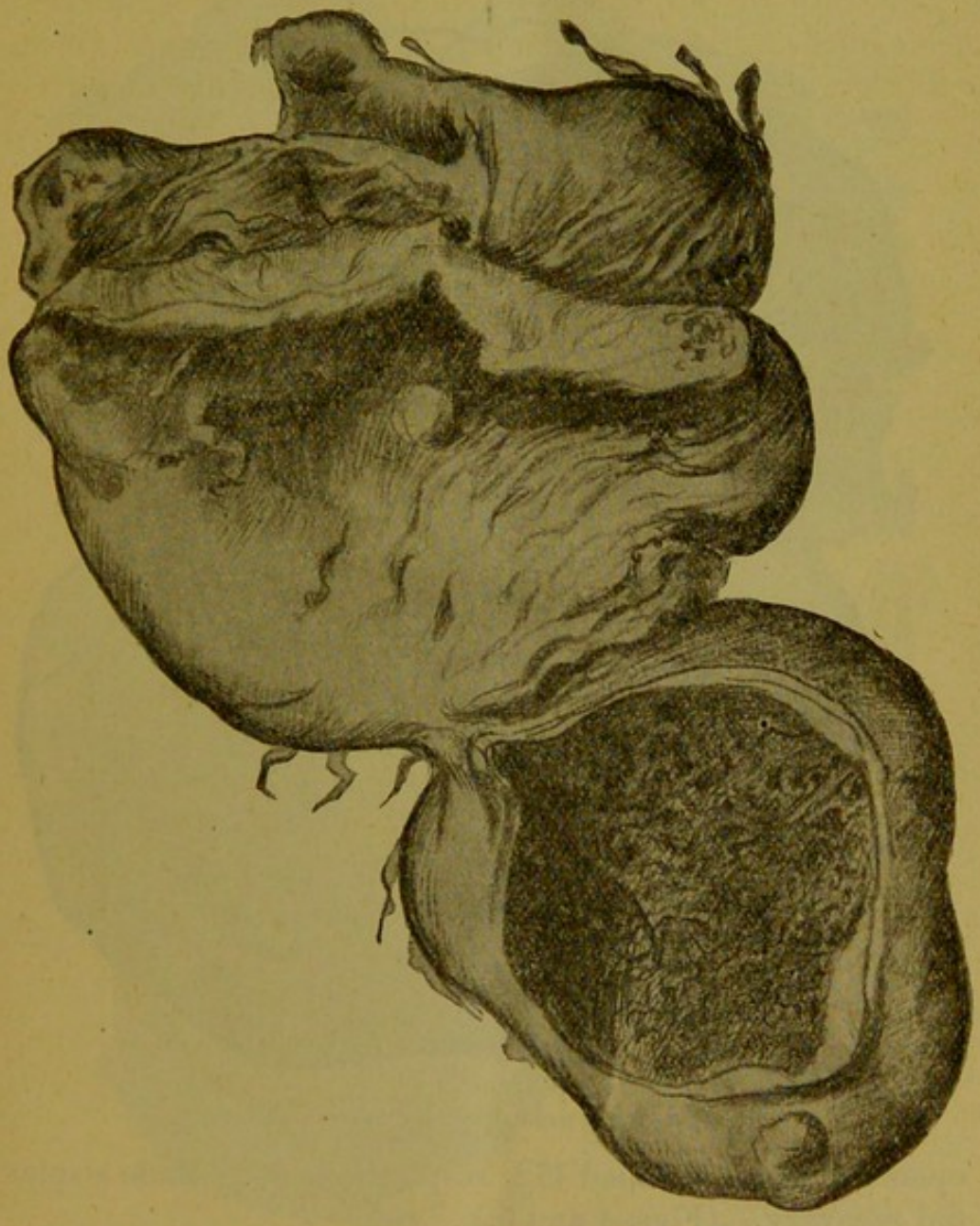


FIG. 3.—Left pyo-salpinx and ovarian cyst.

my diagnosis, but a positive diagnosis was not possible until after the removal of the tube and an incision across it. (Figs. 2 and 3.)

CASE XIII.—Cysts of both ovaries and salpingitis, resulting from pelvic inflammation following childbirth (five years

ago). A hunchback. Secondary hemorrhage from a small torn artery that did not bleed when abdomen was closed. Bleeding began with reaction, and was discovered by the drainage tube. Injection of solution of perchloride of iron through tube. Hemorrhage continuing, abdomen was re-

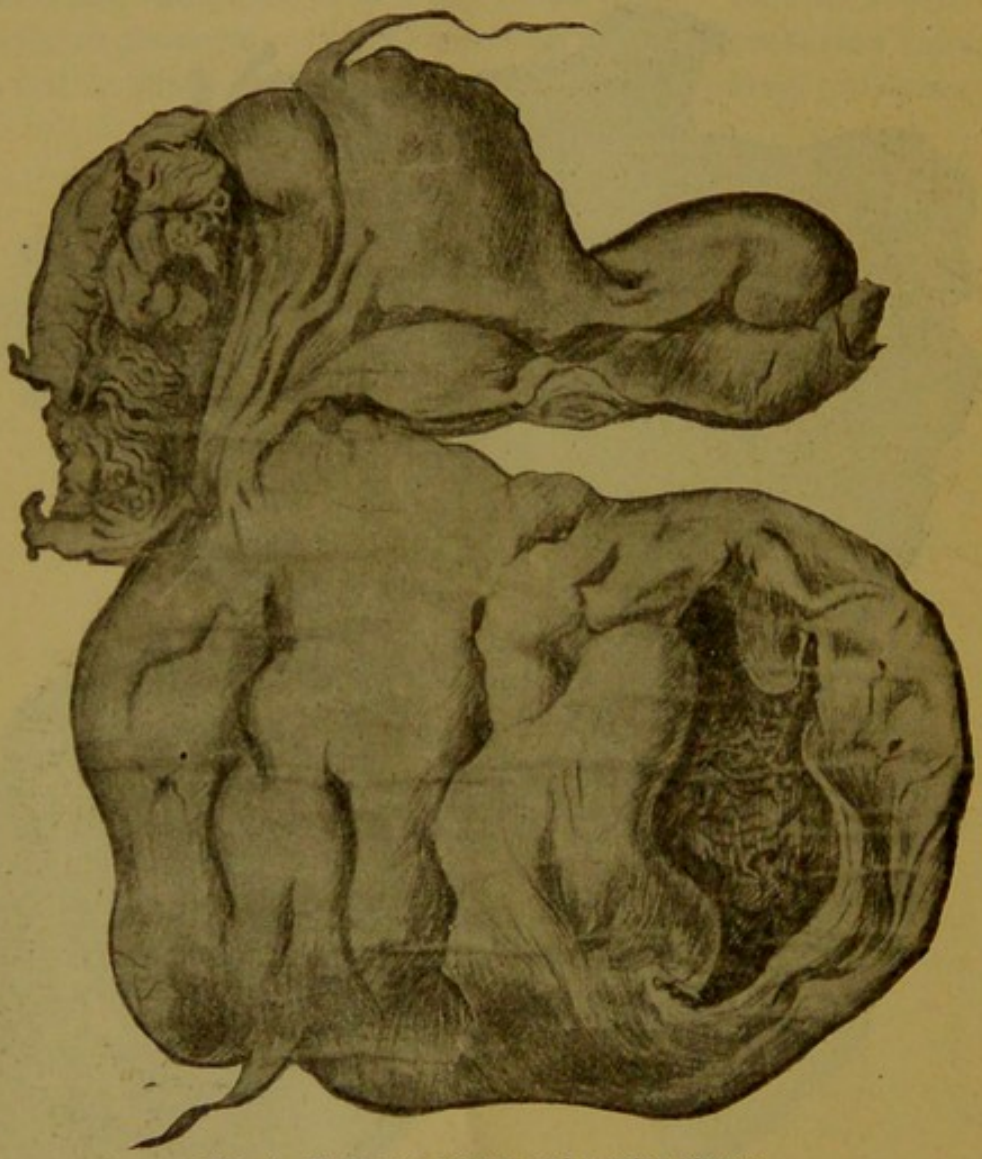


FIG. 4.—Right pyo-salpinx and ovarian abscess.

opened. Pulse reached 172, respirations 36. Made a splendid recovery. (Figs. 4 and 5.)

CASE XIV.—Gonorrheal pyo-salpinx. Gonorrheal infection when married. Pelvic peritonitis with pelvic matting per vaginam (pelvic cellulitis). Operation nine weeks after infection. Both tubes small, but filled with very nasty pus. Intestines, omentum, Fallopian tubes, and ovaries adhering in a conglomerate pelvic mass. Patient had gonorrhea for

four weeks before her first pelvic symptom. Aching came on in lower abdomen; could not touch it. Felt better and rose from bed. Took a chill and the pain returned. The peritonitis was evidently spreading at the time of the opera-

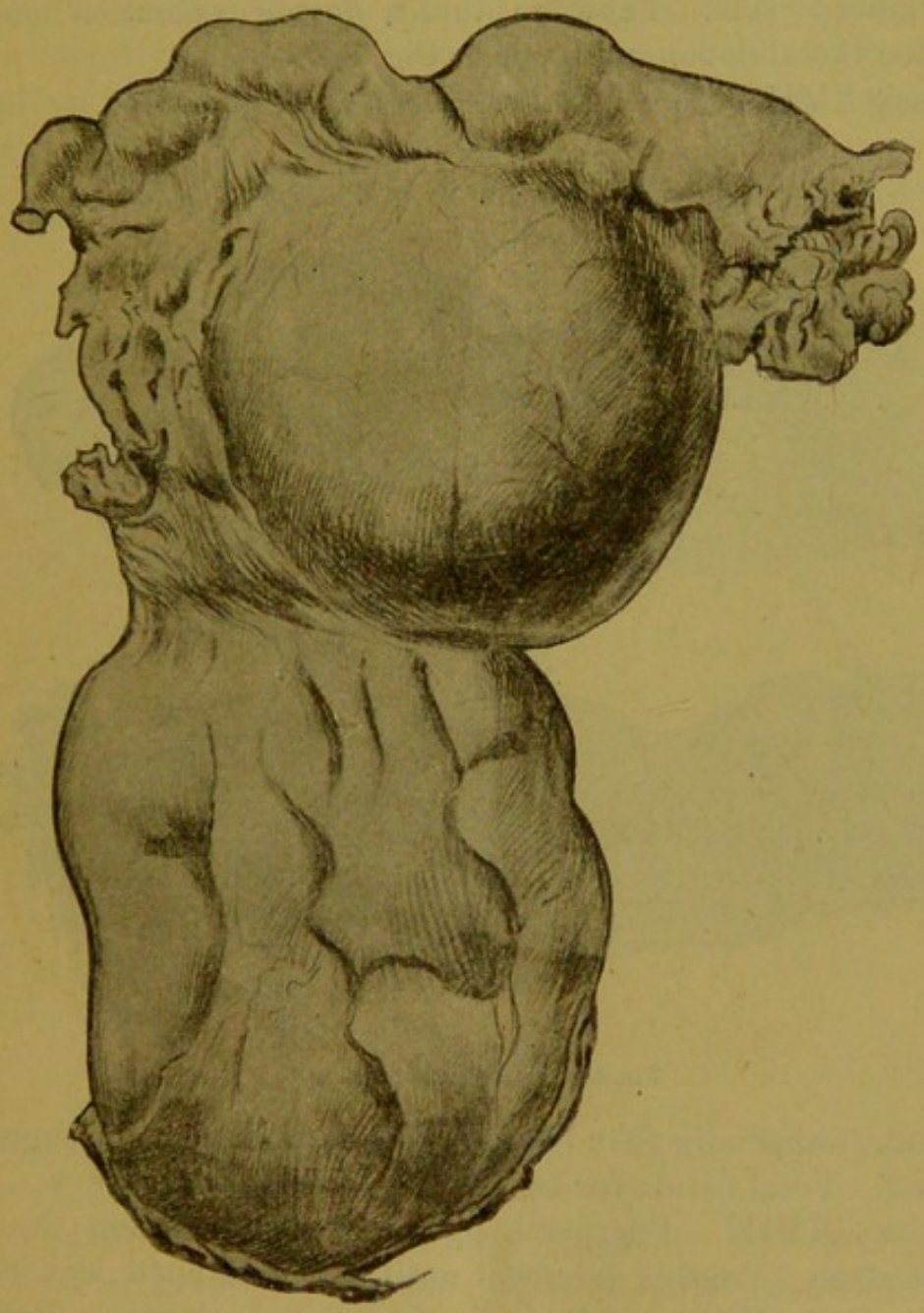


FIG. 5.—Left salpingitis and ovarian abscess.

tion, and became general immediately after. Both tubes and ovaries removed. Recovery. (Fig. 6.)

CASE XV.—Gonorrheal pyo-salpinx. Operation three years after infection. One year ago trachelorrhaphy was performed

by some surgeon. Double salpingo-oöphorectomy. Recovery. In good health since. (Fig. 7.)

Case XVI.—Gonorrheal pyo-salpinx. One side of pelvis filled by a large mass—a pus tube. Other side apparently healthy and not removed. Recovery. Is now suffering from unremoved side. Tube ruptured during operation and flooded the abdomen with pus. (Fig. 8.)

Case XVII.—Appendicitis. Deep abscess covered by in-

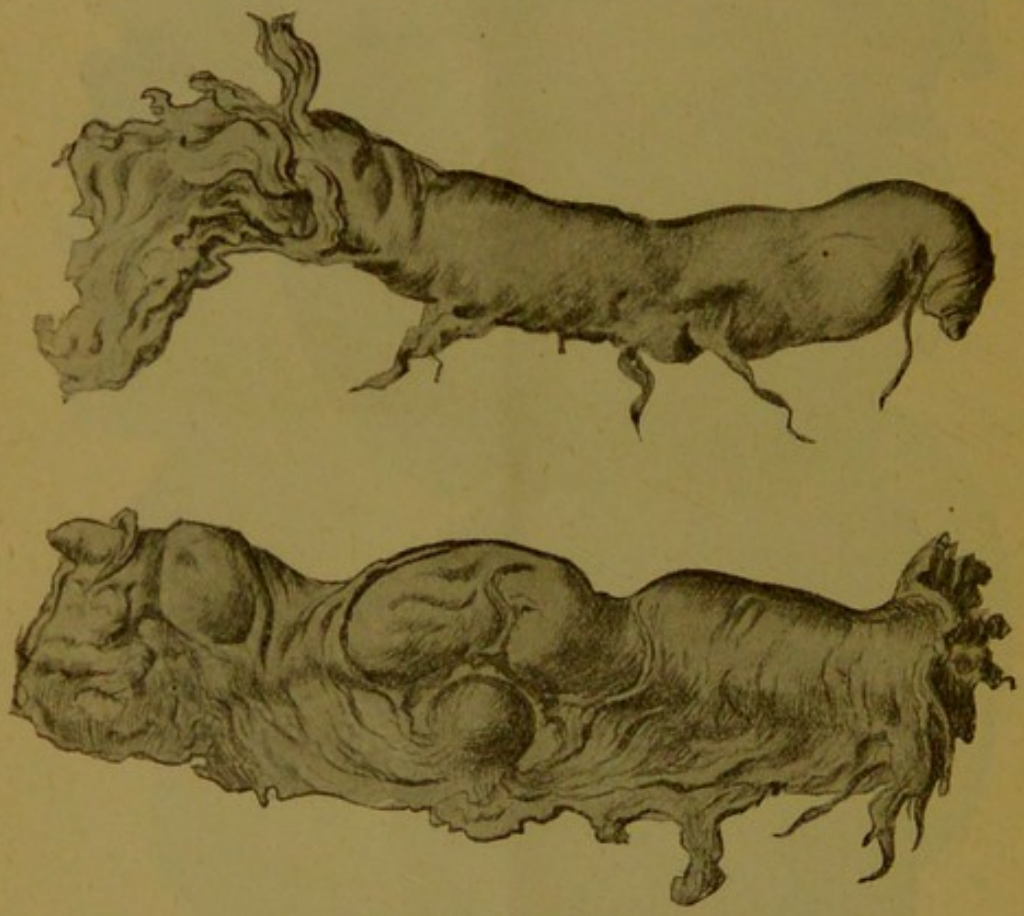


Fig. 6.—Acute pyo-salpinx.

testine. Appendix found at the bottom of abscess and unremoved. Fecal fistula for two weeks; closed. Recovery.

Case XVIII.—Puerperal pyo-salpinx. Operation three years after. Trouble quiescent until patient slipped and fell on her back. Was unable to rise for several minutes. Next day had pain over lower abdomen. Walked to the hospital, but was compelled to remain in bed after arrival. Temperature 101°; pulse 100. A nodule noticed on examination near the crest of the ilium on the right side proved to be an adherent vermiform appendix fastened to the right tube.

Death in sixty hours, probably from septic peritonitis. No post-mortem.

CASE XIX.—Inflamed myoma in the left broad ligament, the inflammation following a miscarriage. Obstruction of the rectum. Typical "pelvic cellulitis." Exploration. Non-removal of tumor, owing to its impaction in the pelvis and the density of the adhesions. Recovery. Still under observation. (Reported Trans. Amer. Ass'n Obstet. and Gynec., 1891.)

CASE XX.—Cysts of both ovaries, salpingitis, tubercular.

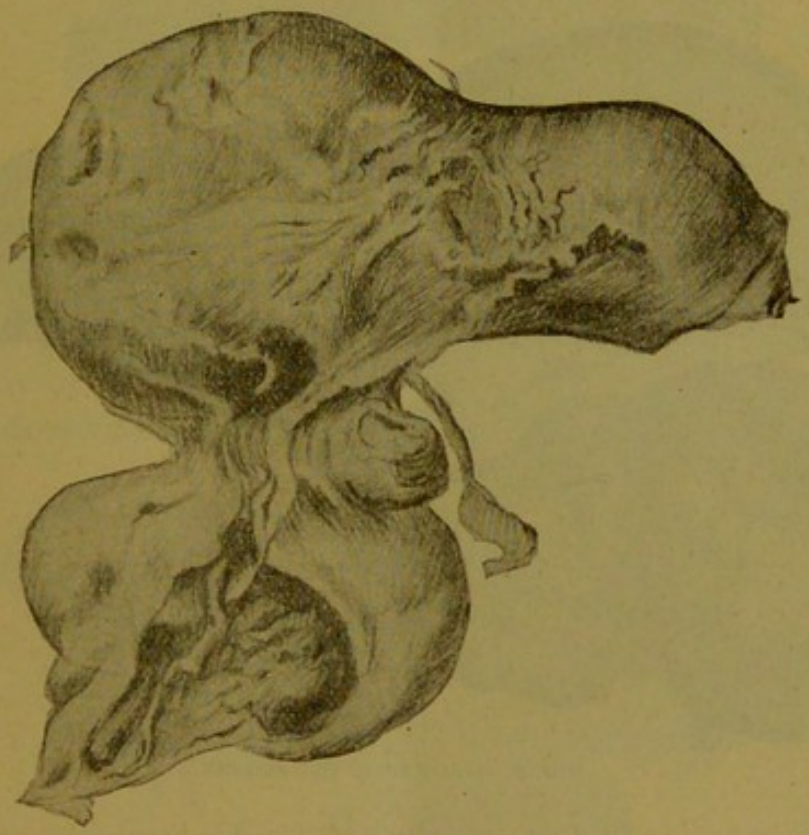


FIG. 7.—Gonorrheal pyo salpinx.

Salpingo-oöphorectomy. Recovery. Family history tubercular. (Figs. 9 and 10.)

CASE XXI.—Cyst of left broad ligament. Left hemato-salpinx with concretion in tube. Disease following miscarriage at the fourth month five years ago. Never well since. Sent for trachelorrhaphy. Double salpingo-oöphorectomy. Cysts of both ovaries and disease of both tubes. (Figs. 11 and 12.)

These cases have been epitomized from my case books and they are accurate. Hearing so much about the unnecessary removal of ovaries and tubes, I carefully preserved the speci

mens and engaged a young artist to make the accompanying drawings. The actual specimens have been examined by several of those who are extremely conservative, and the verdict has been that nothing but radical operation would have cured the patients. I am glad to say that in Canada many of our older men are open to conviction and do not make surgical obstructionists of themselves. In days gone by they have used all the so-called conservative methods of treatment on such cases without effecting cures. We all respect these men who have been our teachers. A son cannot accept as

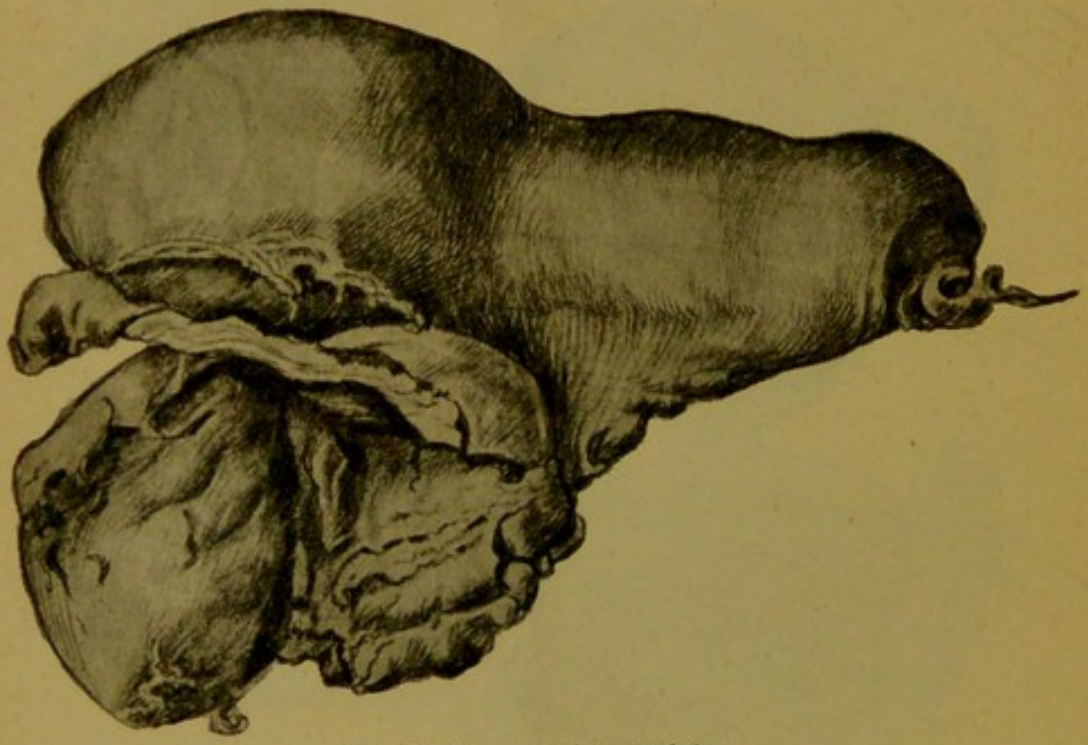


FIG. 8.—Gonorrheal pyo-salpinx.

gospel all that his father tells him, and we cannot accept as gospel all that our teachers tell us. The time comes when the pupil becomes in his turn a teacher. I often wondered how the pelvic cellular tissue became so rapidly inflamed and edematous. Cases of gonorrheal and puerperal pelvic inflammation present, very soon after the attack, this peculiar edematous condition, as if the pelvis was filled with plaster of Paris. The foregoing cases demonstrate, to my mind at least, the nature of this swelling. The inflammation is in reality intraperitoneal, and not extraperitoneal or cellulitic. Extraperitoneal abscess may occur, but such cases must be exceptional. Abscess in the broad ligament may be due to rupture of a

pus tube into the layers of the broad ligament. I have had one such case.

Inflammation in the cellular tissue may occasionally arise from laceration of the cervix, but abdominal surgeons frequently find pus tubes in cases sent for the repair of a lace-

Fig. 9.—Tubercular pyo-salpinx.

rated cervix or in cases in which the laceration has been already repaired without curing the patient.

Many of these cases are deluged with hot water, are treated for endometritis, have the operations of trachelorrhaphy and

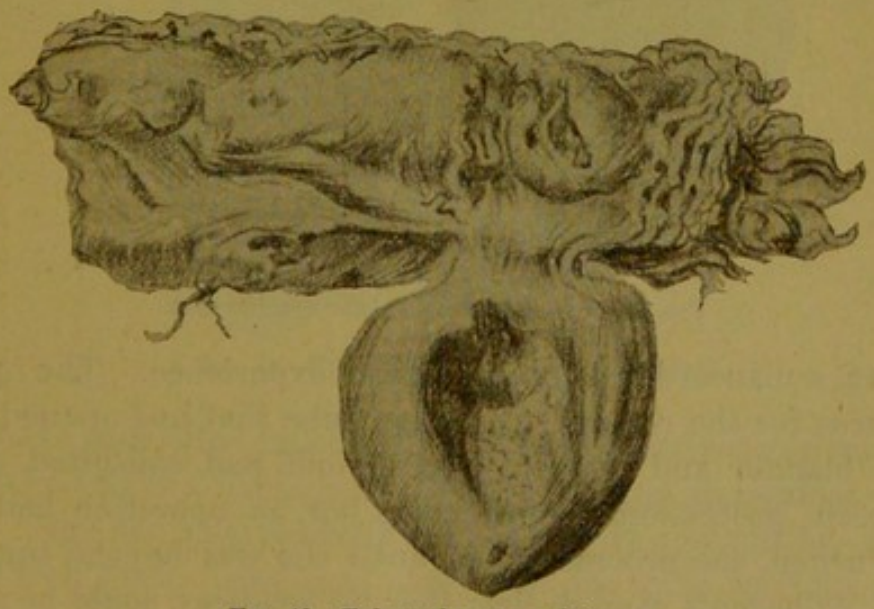


Fig. 10.—Tubercular pyo-salpinx.

perineorrhaphy performed, and the true condition of the pelvis is overlooked owing to the prevalent notions of pelvic cellulitis. Nothing is more difficult to make than an accurate diagnosis of intrapelvic disease. The history of the case will often give the abdominal surgeon of experience more infor-

mation than a vaginal examination. On two occasions I have not found disease in the pelvis after exploration, and have closed the wound without making an operation by removing healthy ovaries and tubes. But to offset this I have over and over again been amazed at the intrapelvic condition disclosed by abdominal operation after most careful examination per vaginam under an anesthetic. After years of invalidism these patients are cured, and they wonder why every operation but the right one has been performed and why the right one has been deferred so long.

I had present at an operation recently an eminent medical

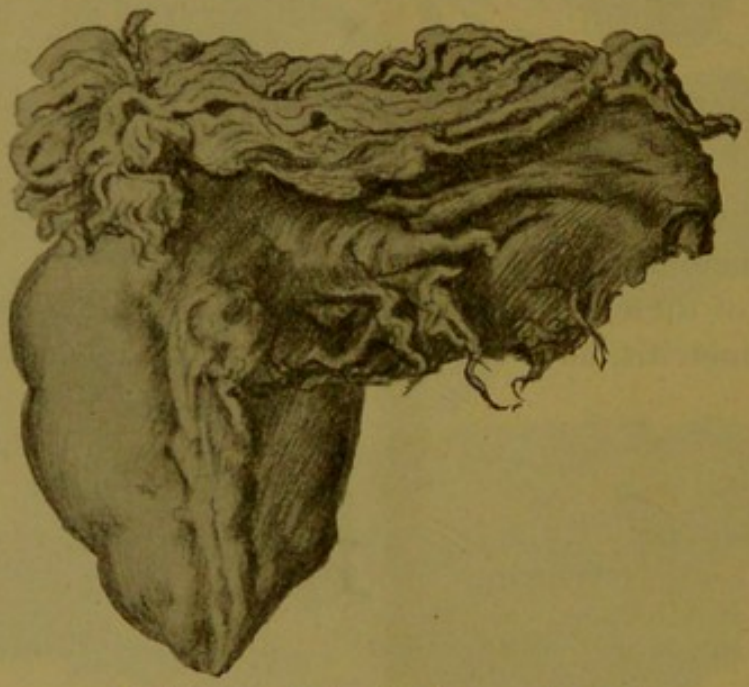


FIG. 11.—Pyo-salpinx with tubo-ovarian cyst.

author, a man of large gynecological experience. The operation was for the removal of a pus tube that had opened into both bladder and bowel. The patient had consulted some fourteen professional gentlemen, but, as operation had not been urged, she procrastinated until she was beyond surgical aid. Adhesions were so firm that no headway could be made without excessive risk, and her husband was not willing that she should undergo this excessive risk. The gentleman suggested that the case was one of "parametritis." It was indeed a case of the "parametritis" of the past—a pus tube of the present and future.

Those who cry out against these operations stand on a theo-

retical pinnacle and they will not take the trouble to come down among practical, every-day operators to learn. My views on those horrible operations—removal of healthy ovaries the seat of imaginary disease—are well known and need not be repeated here. I have to-day seen a lady with a quiescent pus tube who recently consulted an eminent gynecologist in his office. He told her that she needed no operation, and I am sure that he failed to find the pus tube. I have endeavored to map it out more than once without an anesthetic,

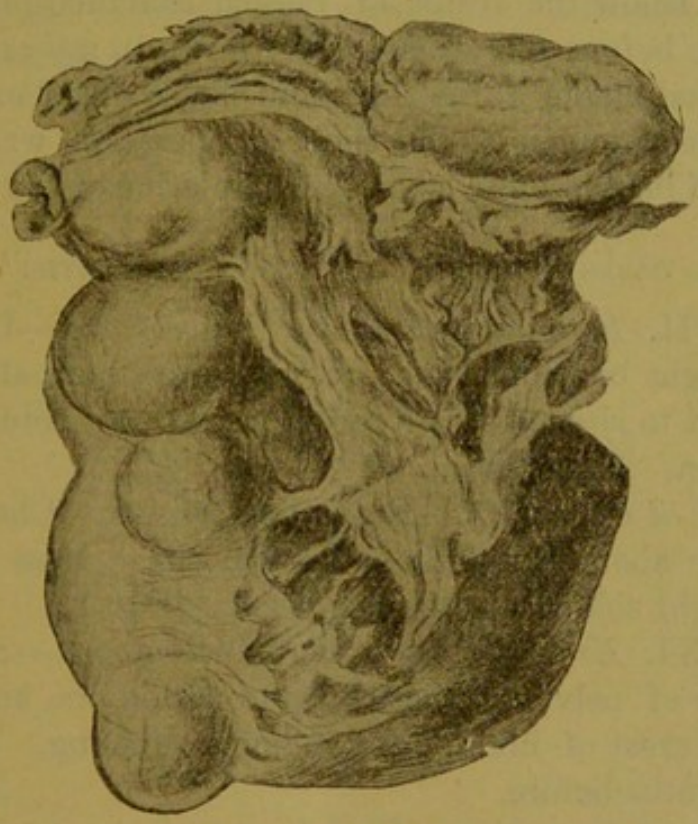


FIG. 12.—Pyo-salpinx with tubo-ovarian cyst.

and have each time failed owing to her excessive sensitiveness to pain and the consequent rigidity of the abdominal muscles. She had puerperal fever four years ago and has never been well since. She may carry the pus tube for four more years and may go about as usual, but, like my friend Dr. Price, I expect to be called at any time to find her suffering from a general peritonitis.

Many cases recorded as cases of dissipated pus tubes have been cases of mistaken diagnosis.

If a patient continues to suffer from recurrent attacks of

pelvic inflammation after an attack of gonorrhea or puerperal inflammation, and a "pelvic matting" can be made out by means of an anesthetic, nothing but an abdominal operation will cure her. Those who cure so many of these cases by other means simply lose sight of them and they fall unknown into other hands. The periods between attacks may often be of many months' duration. The old ideas about idiopathic peritonitis in the pelvis have been exploded, and when pelvic peritonitis recurs in a woman it always has an intraperitoneal cause, and to cure the patient the cause must be removed.

I give below the result of vaginal examination under an anesthetic before operation, written down in my case book by my hospital clerks at the time, and the result of examination inside the abdomen at the time of operation, written down by myself immediately after the completion of the operation.

CASES OF TYPICAL "PELVIC CELLULITIS."

CASE III. *Examination under Chloroform.*—Uterus normal. Right ovary normal size, left ovary normal size. Enlargement to right side of right ovary. No actual sense of fluctuation. Gonorrhea.

Found at Operation.—Right pyo-salpinx. Cheesy, thickened tube about three times normal size. Mass previously felt at right side was adherent bowel. (Fig. 1.)

CASE XI. *Examination under Chloroform.*—A mass to right side of pelvis extending up to within one and one-half inches of crest of ilium. An indefinite feeling. Gonorrhea a few months before.

Found at Operation.—Found mass to be an abnormally long omentum rolled up in a coil like a rolled pancake. Firm adhesions. Could not make out ovaries and tubes owing to the extensive adhesions.

CASE XIV. *Examination under Chloroform.*—A mass found on the left side of the uterus. Boggy feeling. Gonorrhea nine weeks before.

Found at Operation.—Found adherent intestines, omentum, ovaries, and tubes. Ovaries normal in size. Tubes normal in size, but filled with pus. (Fig. 6.)

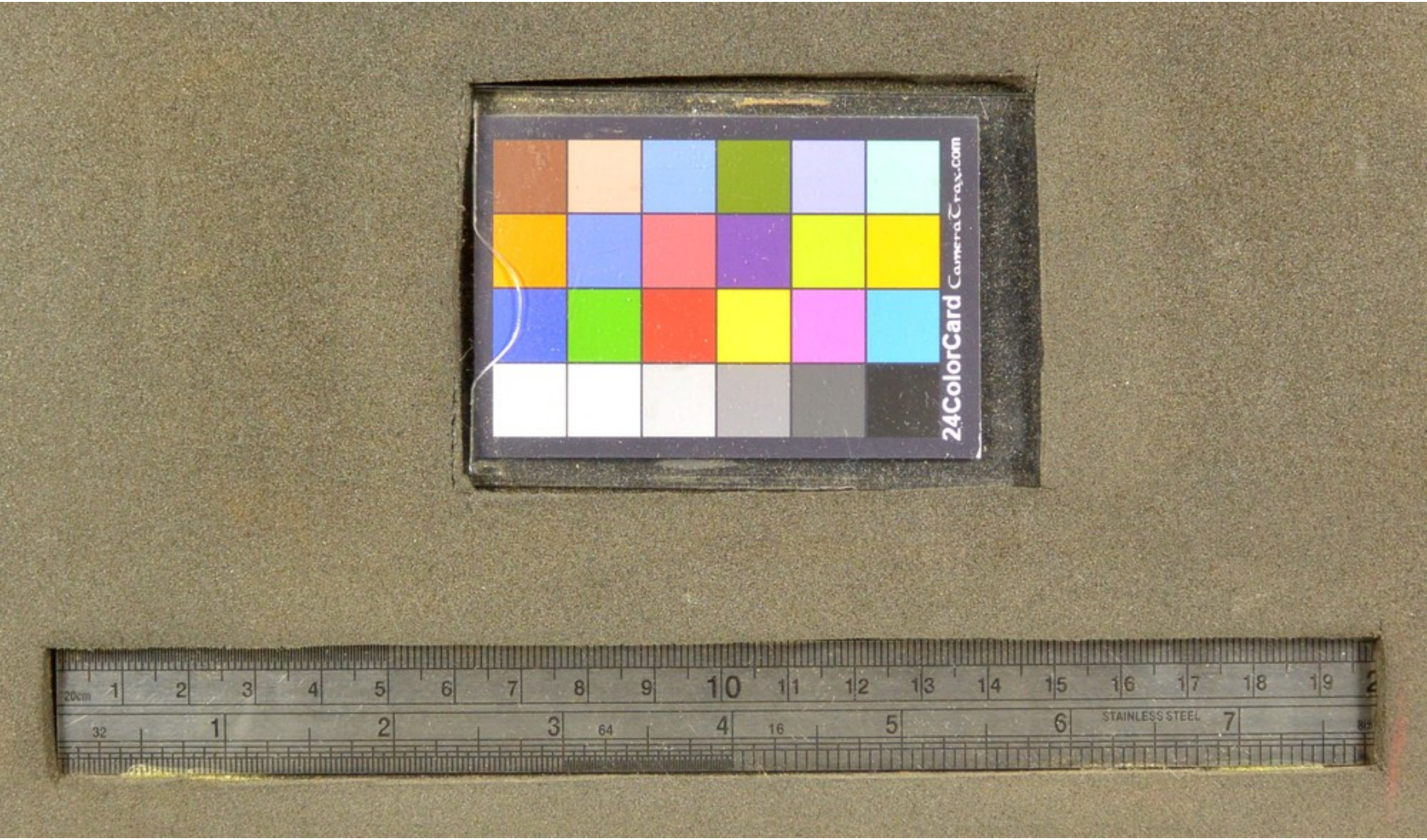
CASE XV. *Examination under Chloroform.*—Had her cervix stitched. Found boggy mass on each side of uterus.

Question whether double pus tubes or ruptured ectopic gestation, owing to boggy feeling. Gonorrhea three years before. (Fig. 7.)

Found at Operation.—Bowels matted together and adherent to double pus tubes. One ovary filled with blood cyst.

Case XIX. *Examination under Chloroform.*—Narrowing of rectum by pressure from without. Mass in pelvis on both sides, more extensive on the left. Uterus adherent. Ovaries not found. A typical case of pelvic cellulitis.

Found at Operation.—Intestines and omentum adherent to a softened and inflamed uterine myoma. Inflammation following miscarriage.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