

SUMMERS (J. E.) Jr.

NOTES ON SURGICAL CASES

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I.

TUBERCULOSIS OF THE ANKLE-JOINT—AM-
PUTATION.—The patient, a young lady, twenty
years of age, was first seen by me September
6th, 1888. She gave briefly this history:
Following a fall one and one-half years pre-
viously, she commenced to suffer pain and
difficulty on locomotion, in the ankle-joint.
This was treated by extension, cold, heat,
poultices, etc., until eight months prior to
my seeing her, when she went to Chicago and
entered a hospital under the care of a well-
known surgeon, who incised the joint and
evacuated some pus. Counter openings were
made from time to time, and an attempt by
drainage and irrigation with dilute muriatic
acid made, to dissolve the carious bone. After
six months of such treatment, the joint was
resected. This was a complete failure. On
October 7th, 1888, the patient being in a bad
condition constitutionally and locally, I am-
putated the leg through the middle third.
She made a good recovery.

Remarks.—Had proper fixation with a
Thomas or Sayre ankle brace been adopted,
no operation would have likely been required;
or if, after the formation of pus, instead of
simple incision and drainage, a thorough
search for and removal of its cause had been

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made, the limb would probably have been saved. Specimens are to be seen.

II.

TUBERCULOSIS OF THE KNEE-JOINT--AMPUTATION.—The patient, a man fifty-nine years old, had suffered, off and on, for years with inflammatory symptoms in the knee-joint and upper third of the tibia. Four years ago pus had discharged from a point about the middle of the upper third of tibia. Last fall, after an attack of acute inflammation in the knee, the leg was markedly flexed on the thigh, and remained so until six weeks prior to my seeing him, when it was forcibly straightened, after division of the ham-string tendons, and put in a plaster cast.

When the man came under my care, the joint was swollen and painful, and the patient's general condition approaching a critical form, two days later I amputated the thigh through the lower third. Primary union followed, and the man left the hospital in three weeks, and has continued to improve in general health.

Remarks.—My diagnosis, prior to amputation, was chronic tuberculosis, but on examination of the joint after operation I could not tell what the lesion was except an osteo-arthritis. Dr. Gifford solved the problem by the inoculation of the anterior chamber of a rabbit's eye with fluid from the joint, a typical tuberculosis of the iris resulting. Resection in this case was out of the question; the age of the patient contra-indicated it. The general condition *demand*ed the removal of the limb.

III.

SARCOMA OF LOWER END OF FEMUR COMMENCING IN THE PERIOSTEUM—AMPUTATION.—I wish simply to call your attention to these gross and microscopical specimens of

this lesion occurring in a boy nineteen years old, whom I saw with Dr. Coffman, of this city, and whose thigh I assisted Dr. Coffman in amputating, August 11 of this year. The boy is well and going about, but a recurrence, with death, is certain. There is only one case on record (Butlin) of cure in this lesion, whether the operation was made through the thigh or hip-joint. The gross examination of the specimen shows the disease to have begun in the periosteum, and the microscopical sections classify the lesion as a small round-celled sarcoma. As you remember, the typically small round-celled sarcomas are most malignant, approaching nearest in form to embryonic tissue — the spindle-celled are next in degree of malignancy, while the giant-celled are the least malignant. Clinical experience has shown that when a sarcoma commences in the bone itself, the degree of malignancy is much less than when it commences in the periosteum, and many cures after operation have been recorded. The rule to follow in these cases is amputation through or above the joint on the proximal side of the bone involved. Most, if not all, primary malignant growths of bone are sarcomas. Carcinoma of bone is secondary. Schwartz found out of 200 cases that the lower extremity was attacked 155 times. (Jones).

IV.

While on the subject of bone and joint lesions, I wish you would notice these two pieces of bone. They are the upper and lower ends of the fragments of a case of non-union of a simple fracture of the lower third of the femur. Eight months after the injury the case came under my care and I resected the femur with great difficulty, wired the ends and got

union. This is the man, who is now walking on the limb, the operation having been done in February of this year.

V.

From my hip-joint resections I select one done last May. A boy, twelve years of age, was well advanced in what is known as the third stage of hip-joint disease. The upper end of the femur was removed on a line with the lesser trochanter, and because of perforation and disease, all of the acetabulum. Six weeks after the operation the boy was out, and has been going around on his crutches, wearing a long Sayre's splint. Recently the symptoms of tuberculosis of the kidney have set in. This case had passed the period of disease when operation could be of more than temporary benefit, and is an example of the result of too long delay in explorative measures in this disease.

VI.

TUBERCULOUS TUMOR OF THE BLADDER.— July 18, 1889, a young man, aged twenty-three years, gave the following history: When two years of age he received an injury of the left hip, which was followed, judging from the cicatrices and the marked flexion of the atrophied limb onto the trunk, by a neglected hip-joint disease, which nature had cured in the deformed position. Two years ago the patient began to suffer with frequency of urination, and this increased so much that he was obliged to give up going to school. From time to time the urine was bloody and for two or three months has been more or less continuously so.

Two months ago the patient was examined by a surgeon, who divided a stricture two inches from the meatus. For the past two weeks the patient has been troubled with a

bad cough and raises a muco-purulent secretion. The urine is passed every hour in a small stream which frequently stops suddenly and then begins again. Family history elicits that a brother of the young man's father died of tuberculosis of the lungs. Physical signs show a little dullness over the lower portions of both lungs behind, with fine bubbling rales. Temperature $100\frac{1}{2}^{\circ}$ F. Under chloroform, after injecting three ounces of warm carbolized water, a sound was introduced into the bladder—the beak of the instrument could be easily moved to the left and towards the base of the bladder in this direction, but encountered resistance on being turned in the opposite direction, the sensation being that of a very much thickened, irregular bladder wall, or of a new growth occupying the base and front of the bladder to the right of the median line. The finger introduced into the rectum, the sound still in the bladder, confirmed the location of this abnormal state of affairs. After the examination considerable blood and detritus was washed out of the bladder.

Microscopical examination of sputum—Tubercle bacillus. Microscopical examination of urine—Tubercle bacillus.

Remarks.—Without the aid of the microscope in this case the diagnosis could not have been made, as the general condition of the patient was excellent, and the examination of the bladder proved only the presence of a new growth. My suspicions were aroused by the deformity of the hip, and the family history. The patient was sent back to his home.

VII.

STONE IN THE FEMALE BLADDER—LITHOLOPAXY—The patient, about thirty-five years of age, had suffered with symptoms of stone

n the bladder for about two years. Some months previous to my seeing her, she had been relieved by her physician of a stone which had, unaided, nearly completed its course through the urethra. The bladder was in fair condition; urine had to be passed every one to two hours. The stone was in my opinion too large to be delivered through the urethra with safety to the subsequent integrity of control over the urine. [A stone more than 8 to 10 lines in diameter should not, as a rule, be removed through the female urethra, experience having demonstrated the great risk of incontinence following such practice.] A lithotrite was introduced in this case, the stone crushed and the fragments washed out, the patient returning to her home ten days after the operation; passing her urine not oftener than every five or six hours. The operation was done in July, 1889.

VIII.

STONE IN THE BLADDER—LATERAL LITHOTOMY—A gentleman, sixty-seven years of age, with a history of stone in the bladder dating back more than two years, was first seen by me five weeks ago. Urine was bloody and mixed with muco-pus, and the bladder contracted, its walls thickened. The urine was passed every hour. The searcher disclosed a stone. Three weeks ago to-day I did a lateral lithotomy, removing a calculus about one inch in diameter. There was considerable phosphatic incrustation of the mucous membrane, and two large pediculated masses of the same material, which were removed with the scoop. The wound is closed and the urine passes through the natural channel, being voided every three hours.

Remarks—I believe there are few cases in

which a stone in the female bladder cannot be crushed and removed through the urethra, and only in the rarest cases will a cutting operation be called for. I cannot agree with the recent writings of a well known teacher and author who says (*Med. Rec.*, Aug. 17, 1889): "For stone in the female it (the high operation) should be invariably selected, when the calculus is too large or too firm to be crushed and removed per urethram." The vaginal operation, by using Simon's incision (a Y) will give ample room for the removal of most any sized stone, and only in the most exceptional cases, chiefly in young children, should the high operation be done in the female sex. The immediate or later closure of the incision is under the control of the surgeon in the vaginal operation. My reasons for doing a perineal operation in the case of the old gentleman are obvious—a median incision would have, perhaps, done as well as the lateral, because of the size of the stone, yet on the whole, I prefer the lateral in most all cases.

IX.

GUN-SHOT WOUND OF THE INTESTINE.—LAPAROTOMY.—DEATH.—I heard Dr. McGraw, of Detroit, read a paper before the A. M. Assn. some two or three years ago, advocating strongly that the incision in laparotomy for gun-shot wounds, where the point of entrance of the bullet was at some distance from the median line, should as a rule, be made through this point and in a direction giving the nearest approach to that part of the intestine probably the seat of injury—this I have reason to believe sound practice. In a case operated upon by myself a few weeks ago, where the point of entrance of a 38-calibre bullet was about two inches to the left of the left rectus

muscle, and above the umbilicus, the missile having been fired by an individual on horseback, the victim being afoot, I made my incision, a long one, in the median line, and it was with the utmost difficulty that, after the removal of all of the small intestine, I was able to close four perforations of the sigmoid flexure, the lowest being just above the commencement of the rectum. The meso-colon was so short that it was impossible to bring the wounded gut into the incision, and all of my sutures had to be made with hands and instruments deep within the abdominal cavity. The necessary manipulation of the small intestine and the length of time required to complete the operation, so added to the shock of the injury, that my patient died some six hours later, never rallying. The operation was done ten hours after the receipt of the injury. There was extravasation of faecal matter with a commencing peritonitis.

Remarks.—Had a lateral incision been done the shock would have been much less, as the points of injury could have been more readily and rapidly repaired, and the patient given some chance for a recovery. When I state, that out of fifteen laparotomies done by me within a little over two years, for varied lesions, not one, and there have been some difficult ones, has given me more physical and mental strain, you will appreciate how I feel in regard to this suggestion of Dr. McGraw's.

These cases are chosen from among a goodly number occurring in my practice during the past year, and illustrate, I believe, practical points in surgery.

