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## A CASE OF SEPTIC PERITONITIS

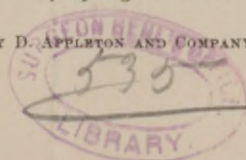
FOLLOWING ACUTE GANGRENOUS APPENDICITIS.

OPERATION. RECOVERY.

By M. S. KAKELS, M. D.

IN the *New York Medical Journal* of May 18th I was very much interested in the case of acute gangrenous appendicitis, with perforation, general suppurative peritonitis, etc., with recovery after operation, reported by Dr. Parker Syms before the Society of Alumni of Bellevue Hospital. The following contribution of an almost similar case is offered as an example where, in spite of impending death from collapse, operative interference with thorough drainage led to the recovery of a patient. In January of this year the opportunity was offered me of operating on a patient who was suffering from an attack of the diffuse form of septic peritonitis, occurring as the result of appendicitis. This case belonged to that class where a protecting wall of inflammatory adhesion was so incomplete as to allow the peritonitis and its products to rapidly extend upward toward the liver, among the small intestines toward the median line, and down into the pelvic cavity. I operated in the usual manner, but wiping out the abdominal cavity with dry sponges instead of flushing

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with sterilized water. This case is interesting on account of the fact that, notwithstanding the virulence of the septic process and of the unfavorable prognosis of a diffuse septic peritonitis, the patient ultimately recovered. The whole right abdominal cavity from the liver down into the pelvis was filled with purulent fluid mixed with fæces. The gut was found perforated at its junction with the appendix, through which fæces and gas escaped.

I saw the patient, Pauline K., aged seventeen years, on Friday, January 18th, early in the morning. She presented the following history: Her previous general health had been good, with the exception of occasional attacks of abdominal pain which she attributed to indigestion. No other previous history of illness. On the Saturday before I saw her she had one of these so-called attacks, for which no physician was consulted, thinking it would pass off as the others had. On Thursday evening, the 17th, while visiting some friends, she was suddenly seized with intense abdominal pain and vomiting. I saw her the next morning, Friday, at 8 A.M. Her temperature was 102° F., pulse 100. She had had chilly feelings with slight pain over the right iliac region which was gradually extending over the abdomen. Occasional vomiting. The diagnosis of appendicitis with probable rupture was made. Ice applications were ordered and operation was proposed but refused. Friday evening patient was about the same. Saturday morning I found dullness in right iliac region, extending over the right flank well into the back. Rigidity of right abdominal muscles, commencing tympanites. Pulse, 110 and small; temperature, 101°. Pain rapidly extending over the whole abdomen with increasing tenderness on palpation. The general expression bad, face flushed, rapid breathing, vomiting dark fluid; no gas, no stool. From the rapidity of the symptoms I more urgently requested and insisted upon an operation. The friends at whose house the patient was taken ill deferred until a consultation was had. Dr. Willy Meyer saw the case with me at 5.30 P.M. and agreed in the diagnosis and to operative interference. At 9.30 that (Saturday) night, forty-eight hours after the sudden onset of

symptoms, the patient was brought to the table in a collapsed condition. Cold, clammy perspiration, rapid and feeble pulse. Incision was made along the border of the right rectus muscle. After the peritonæum was opened there was a gush of extremely offensive, dark-colored, purulent fluid, mixed with fæces, which flowed from a large area. The incision was lengthened above and below, which allowed the purulent fluid to escape from the region of the liver, from among the coils of small intestines in the median line, and from the pelvic cavity below. Careful exploration revealed no wall of adhesion in either of these directions. By gently lifting the coils of intestine, more pus escaped from hidden pockets; they were extremely congested and the appendix was found so gangrenous at its attachment to the cæcum that it would have been hazardous to remove it. At its junction with the cæcum a perforation was found through which fæces and gas escaped. Around this perforation there seemed to be a zone of gangrene, and a dark, congestive area around this. The peritonæum was rough and congested. The cavity was carefully and as thoroughly as possible wiped out with dry sterilized gauze sponges above, below, and along the coils of intestine. Three drainage-tubes were inserted—one above under the liver, one into the pelvic cavity behind the uterus, and one toward the median line among the small intestines. Around these tubes and in among the coils of intestines in every direction strips of iodoform gauze were inserted for additional drainage. The large abdominal wound was left entirely open. Silkworm gut was inserted for secondary sutures. Ordinary abdominal dressing was applied and the patient put to bed with a more than bad prognosis. The patient after the operation was very feeble. Hypodermic injections of stimulants and all necessary means were used to overcome shock. Next day there seemed to be a cessation of symptoms of septic peritonitis. Convalescence, though slow and tedious, ultimately resulted in recovery of the patient with a fæcal fistula which is gradually closing. I will not go into details of the after-treatment. The outer dressings were changed twice daily on account of discharge of fæces and purulent fluid. Gas continually escaped from the wound until free movements of the bowels took place.

After a few days fresh strips of gauze were inserted, although two of the tubes had been removed. The tube running down into the *cul-de-sac* was gradually shortened as the discharge diminished, and finally withdrawn and replaced by a thin strip of gauze. To have removed the appendix in its gangrenous condition would have been a dangerous procedure, as I would have had an opening in the gut whose walls were surrounded by an area of commencing gangrene which afforded a bad ground for sutures. I thought it would be better to leave well enough alone, as it would have been impossible to close the perforation with its surrounding area of unhealthy tissue.

*Noli tangere* with this dangerous spot was better and wiser surgery than operative interference. The result in this case shows that it requires sometimes just as much judgment to know when one has done enough as to be too radical in our operative procedures.

This operation was done in a small room in a tenement house, with all the unhygienic surroundings one meets in such dwellings. Under the light of two gas jets and a petroleum lamp my assistants and myself were at the close of the operation markedly affected from the decomposition of the chloroform which was used for narcosis. Had the operation not been hurriedly effected, we probably all would have been overcome. It is well to be on one's guard in operating in small rooms under gaslight for the effects of the decomposition of the vapors of chloroform.



