

CATES (B.B.)

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CLINICAL REPORT OF SOME INTERESTING SURGICAL CASES.¹

FRACTURE OF NECK OF RADIUS.

CASE I.—Miss M., single; aged 60. On August 12, 1892, she tripped and fell down a slight incline, falling on and injuring her left arm. I did not see her till the eleventh day after the accident, when I happened to be passing, and was asked to stop and prescribe for a sprained arm.

Examination showed a forearm considerably swollen and discolored even to the hand. The patient was unable to pronate or supinate the hand or flex the forearm. Placing my finger over the head of the radius and forcibly supinating and pronating the hand, I failed to feel the head of the bone rotate. There was much pain complained of, and crepitation was very patent.

Diagnosis.—Fracture of neck of left radius.

Treatment.—Internal rectangular splint and compresses over seat of injury, held in position with spiral reversed bandage. Owing to the difficulty in keeping the dressing on the limb, I removed splint and applied a plaster dressing. Patient recovered with a fairly useful arm.

According to Agnew and Ashhurst this is a very rare injury, only one or two cases being on record, and one of these is in the Mütter collection in College of Physicians, Philadelphia. On the other hand, Mr. South says fracture of the neck of the radius is quite common. Of three cases of injury in this region Hamilton was not convinced that fracture of the neck of the radius existed. Sir Astley Cooper says it cannot occur, and Malgaigne says it is quite uncommon.

FISTULA IN ANO.

CASE II.—Man; white; aged 43; teacher. For six years before operation had been troubled with fistula in ano.

Examination showed a complete fistula in ano on left side one and one-half inches in length, extending towards centre of perineum.

Operation.—October 18, 1892, I laid open tract and dissected it

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Presented by the author



out, when I found it had burrowed up the left side of the bowel for two inches, also encircling the anus for two-thirds of its circumference. Laying open the ring around the anus with a bistoury, I then tore through the bowel with my fingers as far as the upper limit of the tract at its side (which prevented much hemorrhage), and packed the entire tract twice daily with bichloride gauze, allowing it to fill up from the bottom. Patient improved from the start, and was dismissed as cured November 18.

The wonderful achievements of modern surgery are nowhere better illustrated than in the treatment of phlegmonous inflammation with suppuration and its allied diseases, such as progressive purulent infiltration.

This is due entirely to a better understanding of the etiology and pathology of the affection, together with a knowledge of the means that will render a further progress of the disease impossible, by entirely destroying the noxæ, or at least holding them in abeyance till the depraved tissues have sufficiently recovered themselves to successfully combat the microbes and their ptomaines.

The etiology is the same whether it results in phlegmonous inflammation with suppuration, progressive purulent infiltration, or progressive gangrene. And whether one or the other affection obtains depends in a large measure upon the injuring force, the physiological condition of the tissues,—whether or not they are below par,—the activity of proliferation, the virulence of the microbe, and last, but by no means least, the proper treatment of the primary lesion.

Given a minute infection atrium, such as a small abrasion of the skin, carelessly treated, as by the application of the now obsolete poultice, which invites the entrance of the pus-microbe with all the dire consequences of its too rapid proliferation, the end is too often death from pyemia or exhaustion.

Whether fortunately or unfortunately, it has been my lot to have under my observation within the last few months two cases that punctuate very forcibly the importance of early and thorough attention to the antiseptic treatment of wounds, however trivial. The first was forced to undergo a mutilating operation; the second barely escaped with his life.

GANGRENE OF FOOT FOLLOWING PUNCTURED WOUND; AMPUTATION.

CASE III.—Man; white; past the meridian of life. Has always had fairly good health, though a cripple from his youth up. February, 1892, he accidentally inflicted a punctured wound with an iron poker, penetrating between the first and second metatarsal bones of the left foot. This was followed in a few days by a rapidly-swelling, painful,

ascending, progressive gangrene, involving the entire foot and extending up to the junction of the lower and middle third of the leg. When I saw him, several days after the accident, he told me the pain had suddenly ceased, which at once excited my suspicion. He also had considerable fever, bounding pulse, anorexia, thirst, and diarrhea.

The objective symptoms were a very much swollen foot and leg of a pale, waxy color, bordering on a greenish hue; boggy crackling on pressure, and covered with bullæ. In places the part showed black spots and emitted an offensive odor, indicating the entrance of gasogenic bacteria. I at once advised amputation, and with the patient's consent I performed Sédillot's operation, using, of course, all antiseptic precautions. The patient rallied well, and ultimately though slowly recovered, and is well to this day.

EXTENSIVE PHELGMONOUS INFLAMMATION FOLLOWING SLIGHT WOUND OF LEG.

CASE IV.—G. B.; man; white; aged 40; laborer. I first saw patient September 1, 1893, but one week previously he had knocked the skin about the size of a silver half-dime off of right shin. The attending physician, an eclectic, had used poultices in the mean time. The leg was considerably swollen from a little below the calf upward to the middle of the posterior surface of the thigh; this area was deep red in color and boggy on pressure. The swelling did not involve the entire limb, only its posterior surface, being influenced, no doubt, by gravitation.

However, it did undermine skin on outer and front of the thigh up to the junction of middle and upper thirds. Thoroughly cleansing the limb with antiseptics, I made three or four long incisions over the calf and popliteal surface of thigh, inserted drainage-tubes, irrigated with bichloride solution, 1 to 1000, and iodine water and peroxide of hydrogen solution. It was then dusted with iodoform powder, covered with iodoform gauze and bichloride cotton.

This was in the afternoon. By morning it had extended up the thigh six inches, necessitating another long incision and more drainage, with the same dressing as in previous sitting. By the following afternoon the onward march of the disease had burrowed above the crease between the buttock and thigh, the redness extending to the crest of the ilium. I made another incision just below the above-named crease, and, in addition to the previous course of treatment, used all night a constant stream of a warm boracic solution, which seemed to stay the spread of the disease.

Subsequently large pieces of necrotic connective tissue were thrown off, leaving the muscles in places absolutely bare, especially over the calf and above the popliteal space. The patient ultimately recovered,

after an illness of several months. I am under many obligations to Dr. A. D. Scrugg for valuable assistance in the treatment of this case.

TALIPES EQUINO-VARUS; UMBILICAL HERNIA.

CASE V.—Boy, aged 10 months. Had congenital talipes equino-varus of both feet. Operated on both feet twice, dividing in the first sitting the tendo Achillis, the tendons of anterior tibials and plantar fasciæ, then placing in plaster casts. Result, *nil*.

A second sitting was necessary, when the anterior tibial tendons and the plantar fasciæ were divided, and plaster applied as before. Result: right foot negative; left foot straight. Subsequently the child developed an umbilical hernia.

December 9, 1893, assisted by Drs. C. Deaderick and C. P. McNabb, I operated for the radical cure of umbilical hernia by cutting down through the navel, dissecting up the sac for a short distance inside of the ring, and tying kangaroo tendon around the sac at the margin of the ring. This acted as a plug in the ring. After cutting away the redundant portion of the sac, the stump was fastened in the opening, using Halstead's mattress suture of kangaroo tendon by passing from one side of the margin of the ring to the other, then back again, each time including the peritoneal plug in the suture, and tying the suture at the starting-point. I used three sutures of kangaroo tendon. Then, removing an elliptical piece of skin, I closed up the skin wound with silkworm gut and applied an antiseptic dressing. The wound healed kindly, without the formation of pus and without fever. Result, good.

April 20, 1894, assisted by Drs. C. Deaderick and E. L. Deaderick, I did Phelps's operation on the right foot.

An open incision was made, "commencing in front of the ankle-joint, extending across the inner side and two-thirds the distance across the sole of the foot through the skin and cellular tissues," dividing everything tense down to the bone until the foot could be placed in a supercorrected position, when I applied a plaster cast to retain it there.

In addition to the deformity of talipes equino-varus, the cuboid bone of the foot was displaced.

Result good. Child is now walking on the foot.

CASE VI.—M. L.; white; aged 14. On January 1, 1894, let fall a pane of glass across anterior surface of right forearm, one and a half inches above wrist-joint, making an ugly gash two inches in length, running upward and inward, and severing the flexor carpi ulnaris muscle where it joins the tendon. I flexed wrist and forearm in order to relax tendon and muscle (the muscle having retracted two inches or more within its sheath), then approximated the cut ends with catgut, making the first suture penetrate the entire thickness of the muscle and

its tendon half an inch or more from the cut end. Then I applied superficial sutures of catgut before and behind, and closed the wound in the skin with silkworm gut, between the alternate threads of which I inserted fine aseptic silk so as to bring the skin *vis-a-vis*, thus making the least possible scar. The proper antiseptic dressings were applied, over which I fastened an anterior obtuse-angle splint of sole-leather, to which I bound the forearm and hand so as to keep the muscles relaxed. January 26, dismissed patient as cured and with function of cut muscle fully restored.

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