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Report of a Case of Gunshot Wound of Liver and Stomach. Laparotomy. Recovery.


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REPORT OF A CASE OF GUNSHOT WOUND
OF LIVER AND STOMACH. LAPAROT-
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Some time in April I received a note from Dr. Eugene Hay, saying he had a case he thought required a laparotomy, and asking me to come to him.

I responded, and found the doctor at what is known as "Dirty Six," a tough suburban resort. In a small cottage, lying on a bed, was a young man apparently 22 years old. He was resting very quietly, his face covered with sweat. Turning him partly on his right side, Dr. Hay showed me the wound of entrance—a bullet hole 3 inches to the left of spinal column and just at lower border of last rib. There was no wound of exit. He had vomited quite a quantity of blood. There was no tenderness; pulse 70 but quite soft, and as stated above, his skin was covered with sweat. I agreed with Dr. Hay that indications pointed to a laparotomy, and so advised the friends of the young man and the man himself. At first he refused an operation. Then stating the case to him as clearly as I could, telling him what the hæmorrhage meant, and what his prospects were both without and with the operation, he consented to have it done. This was about 3 A.M. We then proceeded to get ready as best we could. There was nothing in the house; we



had to borrow the table, lamps, and even the hot water, from a restaurant across the street. So after boiling my instruments, I got everything in the best shape I could, and again asked him if he wanted the operation; he again consented, and was brought to the table. Dr. Hay gave the chloroform until the patient was anæsthetized, when it was turned over to Dr. How, and Dr. Hay assisted me.

The abdomen was then rendered as aseptic as we could make it with green soap, bichloride and ether, and by the light of the lamps I made an incision from the ensiform cartilage to the umbilicus, afterwards prolonging it about 2 inches below the latter point. All hæmorrhage was checked before the peritoneum was opened. When we entered the cavity of the abdomen some blood was visible, but not a great deal. At this time patient began to vomit blood, and during the straining the stomach was pushed out of the abdomen and lay in my hands; as it did so the bullet also appeared to the left of the median line, and lying loose. This was removed and handed to a bystander. I then carefully examined the anterior and posterior surfaces and the greater curvature, but could find no wound in the stomach. I then passed my fingers along the lesser curvature, but still could find no wound. Continuing my search, I found a bullet hole in the posterior edge of the liver, to the right of the aorta. By this time the flat sponges which I had used to keep the intestines in the cavity were with the latter extruded, and lay on the patient's abdomen. The intestines were carefully wrapped in warm towels and kept warm with boiled water, while I continued to search for other wounds. Finding none in the intestines, and being unable to stitch the hole in the liver, I wrapped a glass drainage tube in iodoform gauze and passed it down underneath the stomach, and placed it in the wound in the liver. This bag of iodoform gauze I packed with more gauze, thus ballooning it, and a strip of same mate-



rial was passed down the tube into the hole in the liver. After this was done, I flushed the cavity of the abdomen with warm sterilized water by passing the nozzle of the irrigator down into the bottom of the pelvis and allowing the water to fill and overflow the abdomen. In doing so some clots and blood were washed out. I then proceeded to sponge out the cavity, getting it as dry as I could. During all this time Dr. Hay was assisting me, while Dr. How was giving the anæsthetic. When this was completed, we had great difficulty in getting the intestines back into the abdomen. Patient's pulse began to grow quite weak, and hypodermics of whisky and digitalis were given. Finally the abdomen was closed with sutures of braided silk, and coaptation sutures of plain silk, the drainage tube coming out at the upper end of the incision; the iodoform bag with its packing shutting off the abdominal cavity from the wound in the liver, and also from the posterior surface of the stomach.

I saw the patient a few times afterwards with Dr. Hay, and for the subsequent data I am indebted to him.

The glass drainage tube was removed on the third day, and on the fifth the iodoform gauze was taken out perfectly sweet; drainage of bloody serum had been perfect. Into the place of the large bag of gauze I now pushed, with the sterilized handle of a tenaculum, a strip of same material, and allowed it to remain several days. This latter was removed by Dr. Hay and the hole closed with a suture.

Day after the operation temperature was 99° in the morning and 100° at night. During the next day he had considerable pain in the abdomen, with tympanitis. We now gave him saline purges until his bowels moved some eight or ten times, with entire relief of the tympany.

During the next five days he was nourished by the rectum. He was allowed nothing by the stomach but crushed ice for three days, save the saline men-

tioned, when a little water was permitted. His temperature ran from 99° to 100° during the forenoon, and to 100° or 101° during the afternoon. On tenth day we removed the sutures and found perfect union, with one stitch hole abscess. Dr. Hay redressed the wound. The day after he telephoned me that the man had been coughing and had torn open the line of union. He visited him and found the line open for about 4 inches, with a knuckle of intestine protruding. This he replaced. There were adhesions between the parietal and intestinal peritoneum throughout the remainder of the open wound. These he separated with his fingers and put in several sutures through all the tissues, and brought the wound together. The patient stood this without an anæsthetic. These stitches were allowed to remain in place for two weeks, when they were removed, the line of union being found strong. The wound was now covered with aristol and carbolyzed gauze, and several adhesive plasters strapped the latter in place, thus supporting the parts to prevent a new rupture.

During the healing process patient complained of a constant pain in one spot in the line of incision, which I think may be explained by the adhesions which had been formed. At the end of three weeks the young man was well, and in four weeks was up. He now has no trouble save some "bloating" of the abdomen from gas.

