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Cases of Intestinal Obstruction :

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LAPAROTOMY :
REMARKS.



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CASES OF INTESTINAL OBSTRUCTION; LAPAROTOMY; REMARKS.²

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CASE 1.

On the night of August 23d, Dr. M. T. Scott and myself saw Mrs. P. in consultation with Drs. W. L. and H. S. Atkins. Intestinal obstruction had been diagnosed, and the following history was furnished:

On the 20th of August she was taken sick with symptoms of indigestion. At that time there was pain in the abdomen and vomiting. The bowels had moved on the 19th. A mild purgative was given, and nothing serious was thought to be the matter. On the 21st the symptoms were about the same as on the previous day, but the vomiting was more frequent. Purgatives were continued and enemata ordered.

On the 22d vomiting was very distressing; there had been no movement from the bowels, and tenderness and pain existed throughout the abdomen. Temperature and pulse were normal. On the evening of the 23d the vomiting had become stercoraceous; no movement from the bowels had occurred and the abdomen was slightly distended and tympanitic. Pain was quite severe, the temperature and pulse were normal, and the expression was good. No food had been retained for three days. It was midnight when I saw her. She was 68 years old, quite fleshy, and well preserved for one so old. Had always enjoyed good health, and with the exception of a little indigestion and occasionally "a slight bilious attack" she had never been sick. For two months before the present attack, she sometimes had felt a desire to evacuate the bowels, but on going to stool was unable to do so. Pain in the abdomen was rather severe, and she complained of it more on the right side than elsewhere. There were tympanites and distension, and some tenderness on pressure; the vomiting was frequent and stercoraceous and constipation was complete. Temperature was normal and pulse 85; and her expression good. Nothing unusual could be detected by manipulating the abdomen, nor by rectal examination. A long rectal tube was passed and a gallon of warm water with

² Read before the Kentucky State Medical Society, at Lexington, May 22, 1891.



some glycerine in it was injected into the colon. She retained this for some time, but when passed it came away clear. The enemata were ordered given every three hours, and every two hours 15 grains of calomel were administered.

On the 24th the patient seemed better, vomiting was not so frequent and was no longer stercoraceous; with the enemata came away quite a number of blackberry seeds and two grains of corn; the abdomen was not so distended, nor was there so much tenderness. Four inches to the left of the umbilicus there was slight dullness, and we thought some induration. The same treatment was continued.

On the 25th the patient was not so well. Stercoraceous vomiting had returned and the enemata had failed to bring anything further away. The expression was not so good, the appearance of the abdomen about the same. Temperature was normal and pulse 90, strength was fairly good notwithstanding nourishment had been rejected for five days. Operation advised and accepted.

At 1 P. M., assisted by the physicians present, I opened the abdomen through the linea alba with $2\frac{1}{2}$ inches incision, two fingers were passed into the peritoneal cavity and after slight manipulation the cause of the obstruction was found in the ileum, and when removed proved to be a gall-stone measuring $3\frac{3}{8}$ inches in circumference. The loop containing the stone was delivered through the incision and was in fair condition; the peritoneal cavity was carefully protected by packing the incision with sponges before incising the gut. The incision in the gut was closed with the Lembert suture, using fine intestinal silk for the purpose, and after cleansing the loop thoroughly it was returned to the cavity; the abdominal incision was closed with interrupted sutures, and the dressings were applied.

Irrigation and drainage were thought unnecessary. It was forty minutes from the time the knife was used until the patient was put to bed. Ether was the anæsthetic. Just after the operation her pulse was 90 and regular, face and extremities slightly cyanosed; temperature in the axilla $97\frac{1}{2}^{\circ}$. Hot bottles were placed about the patient and in a little while she seemed to be reacting, although the temperature remained $97\frac{1}{2}^{\circ}$. On becoming conscious she complained of the bandage being too

tight and it was loosened. For five hours the pulse remained less than 100, and all symptoms seemed favorable except the subnormal temperature and the cyanosis. Suddenly the pulse became weak and rapid, and in six hours after the operation she died.

At my first visit it was evident that there was intestinal obstruction but we were inclined to believe that the obstruction was due to faecal impaction, and might be overcome by non-operative measures. This opinion was further strengthened at the second visit, by the patient passing a great number of black-berry seeds, and two grains of corn, by an improvement in her condition after the movement, and by a cessation of the stercoraceous vomiting; also, by the belief that we detected an indurated area, and some dullness to the left of the umbilicus. At my third visit the symptoms were not favorable. The stercoraceous vomiting had returned, and there had been no further movement from the bowels. The patient's condition still seemed good and it was thought the time had come to do laparotomy: and the condition found demonstrated that in the operation was her only chance of being saved. She was 68 years old and weighed probably 200 pounds. The abdominal wall was at least two inches thick. The heart sounds seemed normal, but the mode of death, with the tendency to the accumulation of fat throughout the body, caused me to believe that she had a fatty heart. Had the operation been done when I first saw the patient, the termination might have been different, and as there was stercoraceous vomiting at that time, I feel that the procrastination was unjustifiable, and proved a fatal mistake.

CASE 2.

H. S.: Aged 82 years, on the evening of January 19th was taken suddenly with a pain in the right inguinal region. For eight years he had worn a truss for a small direct inguinal hernia on the right side, but had never experienced any trouble in preventing its descent. At the time he was returning from a short drive, and had gotten out of the buggy to open a gate, when he experienced a severe lancinating pain in the region of the hernia, and soon became nauseated and very weak, and just at the external abdominal ring he noticed a slight swelling.

He was a tall, thin man, and for several months had suffered with great debility. A physician was soon summoned, and making a diagnosis of strangulated hernia, attempted its reduction, but failed after persistent taxis to relieve him. His pain was partly controlled during the night by the administration of opium, but he continued to suffer a good deal, and on the morning of the 20th, I saw him with Drs. Whitney and Holloway. At that time there was a good deal of pain and restlessness.

The pain on manipulation was considerable, so chloroform was administered and taxis again employed, but we failed to reduce permanently the swelling.

There being evidently intestinal obstruction, we advised surgical interference, although his advanced age and weak condition made the case a very unfavorable one. After a thorough discussion the patient and his family consented to an operation.

Everything was gotten ready, and at 12 M. I operated, assisted by Drs. Whitney and Holloway.

I thought the case was simply one of strangulated hernia, and expected to find the constriction at the external ring; but in this I was mistaken as the operation demonstrated.

OPERATION.

Chloroform being administered, an incision was made over the swelling parallel to Poupart's ligament. The skin and superficial tissues were divided until the sac was reached; and at that point some difficulty was experienced in determining whether I was upon the sac or gut. The sac was injected and on incising it, a nuckle of the small gut presented, very dark, but firm and apparently viable. On passing my finger down to the ring, within the sac, the constriction could not be felt, and the gut was quite movable within the ring. After a little manipulation I was convinced that the constriction was inside of the abdominal cavity, and to reach it I would have to extend the incision and convert my herniotomy into practically a laparotomy. This I did by deepening the incision already made, and by extending it outward and upward, entering the cavity with an incision two inches long. There was considerable fluid in the peritoneal cavity, but its presence was due, I think, to

some degenerative change, and was not dependent upon the strangulation present.

Passing my finger into the cavity I felt a constricting band about one-half inch back of the external abdominal ring, and this I divided without trouble. The gut, after being released, was delivered through the incision and carefully inspected; the lumen was entirely occluded, but the mesentery, was not involved. Warm cloths were applied for a few minutes to the gut before returning it to the cavity; the incision was closed with silk sutures, and the dressing applied. Duration of operation about half an hour.

Towards the end of the operation, the pulse being rapid and irregular, hypodermics of digitalis and whisky were given. He was put to bed, hot bottles placed about him, and he soon reacted fairly well, although for some days his pulse continued rapid and irregular.

The patient was extremely restless during his entire convalescence, and on account of this and his general debility, morphine and stimulants were given for about ten days. His bowels moved regularly after the second day.

Several times he saturated the dressing with urine and the stitch-holes discharged pus for about a month, due, I think, to infection from this source. At the end of five weeks the wound had entirely healed, and he could dress himself and walk about his bed-room.

The symptoms in this case were sudden and pronounced, fœtid vomiting appeared in 18 hours after he first noticed the pain. The diagnosis of intestinal obstruction was clear, and previous to the operation the constriction was thought to be at the external ring, and the incision usual for herniotomy was made.

In this case the incision served my purpose better than the median incision could have done. Had it not been for the swelling present, and the history of an old hernia, I would have opened the abdomen in the median line. There had probably been some peritoneal inflammation in the region of the external ring, caused probably by the existing hernia, and a band had at some time previous been thrown out, and behind this band the gut became constricted. The constriction being near the external ring, the strangulated gut projected into the dilated canal and produced the swelling that was present.

This accounts for our ability to reduce the swelling, and also for the fact of its returning when the pressure was removed.

The favorable termination of this case was due largely to the early co-operation of the attending physicians and in the prompt operation, it being done within twenty-four hours after the first symptoms of obstruction appeared.

REMARKS.

In reporting these cases it is not my desire to speak of the forms of Intestinal Obstruction nor of the symptoms or operative procedures, but more to urge upon the surgeon the necessity of prompt action, and upon the general practitioner, the importance of having the surgeon called early in consultation.

The general practitioner should not wait to make a diagnosis before summoning the surgeon, but should have him called as soon as intestinal obstruction is suspected and the two should then watch the case jointly, ready at any time to interfere should it become necessary. We must remember that the symptoms in some of these cases are not indicative of so serious a condition as really exists, and sometimes when there is complete closure of the gut, the patient's general condition may seem fairly good, even to the time of gangrene appearing. Should we wait to make a positive diagnosis in some of these cases before operating, the operation will certainly be too late to offer much prospect of relief. The danger of an exploratory incision *per se* is not great, and should unhesitatingly be resorted to when necessary. It is only when there is already marked depression that the shock attending laparotomy is so quickly fatal. The large mortality in laparotomy for intestinal obstruction in the past should not deter the surgeon.

The operation has usually been done as a *dernier resort* and upon dying patients, and death was, of course, the inevitable termination. There can be no reason why many cases of intestinal obstruction should not recover after laparotomy, provided the operation be done in time. The operations are often simple, and the necessary manipulation to remove the obstruction may be slight. In doubtful cases where exploration has been resorted to, I have never seen the abdomen opened without finding a condition justifying the operation, but have occasion-

ally seen the procrastination continued until the patient was beyond any possible relief. Have also known patients to die without any surgical effort to relieve them.

The medico-legal aspect of these cases must influence the surgeon's action, and with the present unsettled state of the professional mind, relative to exploratory incisions, a conscientious and competent surgeon might be greatly harrassed and injured in reputation and financially, should he open the abdomen and find nothing there requiring such a procedure. After using the recognized non-surgical methods to perfect his diagnosis, and failing, the symptoms continuing to indicate intestinal obstruction, the surgeon should make an exploratory incision, and the profession should support him in the procedure, even if he fail to find a local condition requiring the operation. In chronic cases, the operation, even when the diagnosis is clear, is often put off from day to day on account of some deceptive improvement, and when it is finally resorted to, the patient is much exhausted, and is in a most unfavorable condition for an operation. If there be one thing that must impress the physician, in studying the past history of intestinal obstruction, it is the very evident fact that all surgical interference, when it has been resorted to, has usually been done when the case was hopeless, and that in the future, if we can ever succeed in decidedly reducing the present mortality rate, it will be due largely to the early co-operation of the general practitioner and the surgeon, and in the prompt performance of laparotomy when it becomes necessary.

H. C. aet. 49, first consulted me in June, 1890. He had been sick a year. Chronic diarrhœa was the marked symptom of which he complained, and at times there was a severe pain over the descending colon. His general health seemed good. Nothing could be detected by manipulating the abdomen nor by rectal examination.

I diagnosed the case chronic colitis, but after several month's treatment there was no improvement. The diarrhœa continuing, the blood and mucous increasing, the pain not diminishing, and the evacuations being constantly fluid in consistence, I concluded there was intestinal obstruction, and so informed the patient, advising him to submit to an operation.

He continued in this condition till May 2nd, 1891, when I was called to see him. There was then total obstruction. For two days he had been unable to evacuate the bowels or pass gas; the abdomen was distended; vomiting frequent and severe, and the pain intense. Enemata of Epsom salts and glycerine finally relieved him. On June 2nd there was again total obstruction, and the enemata once more were effective. After this attack he was much prostrated, and decided to have the operation done.

The point of obstruction could not be located with certainty, but was thought to be in the sigmoid.

OPERATION.

On June 23rd I operated, assisted by Dr. McMurtry, of Louisville, and Dr. Kinnard. An incision three inches in length was made in the linea alba. The obstruction was at the junction of the sigmoid and rectum, and was due to an indurated mass about the size of an egg which we considered cancerous. On manipulating the mass, there was some hemorrhage. The incision for left inguinal colotomy was made and the colon was stitched into the opening. The peritoneal cavity was flushed, a glass drainage tube inserted, and the incision closed with silk-worm gut. The tube was removed in eighteen hours. Artificial anus was established on the fifth day. Convalescence has been smooth and uneventful.

July 28th. Patient goes about the city and is comfortable, eats well, has gained ten pounds and is glad the operation was done. Of course, he has not been cured, but his life has been prolonged and made much more comfortable.

1 This patient was operated upon June 22d, 1891, nearly one month after the meeting of the Kentucky State Medical Society, and is added to the report then made.

