

Cumston.

NOTES FROM THE CLINICAL  
LECTURES.

BY

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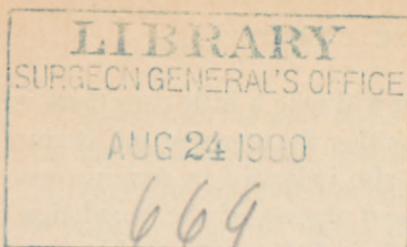
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## NOTES FROM THE CLINICAL LECTURES.

CHARLES GREENE CUMSTON, M.D.

*Treatment of Parametric Abscess.—Dermoid Cyst of the Ovary.—Tuberculosis of the Coecum.—Inguinal Hernia in Children.—Bubo Following Ulcus Molle.*

CASE I.—B. H., æt. 27, unmarried, was seen for the first time in October, 1896, at which time the patient presented all the usual symptoms of an acute gonorrhœal infection of the uterus and bladder. After a few weeks she complained of much pain in the lower abdomen and the temperature was  $39^{\circ}.2$  C.

Vaginal examination revealed a fluctuating tumor in the posterior cul-de-sac and the diagnosis of localized pelvic peritonitis and peri-uterine abscess was made. The patient entered the hospital, and on the following day (November 13, 1896), and a posterior vaginal cœliotomy was performed, which gave issue to 125 cc. of thick yellow and odorless pus.

The cavity was drained for some ten or twelve days, after which the wound was allowed to close, as all discharge had disappeared and the temperature had remained normal for several days.

I now show you this case in order to point out how well such patients do when they have been subjected to so slight an operation and I have, as you are aware, on many occasions told you how adverse I am to the more radical operations under such circumstances.

Posterior vaginal cœliotomy is in the first place a conservative and simple operation, and is indicated in both acute and chronic purulent collections in the pelvis. The incision should always be preferred and puncture with an aspiratory needle or trocar should *never* be resorted to.

The vagina is to be prepared in the same manner as for vaginal hysterectomy, and after the pus has been evacuated the cavity

should always be drained. If you will take a little care there is absolutely no danger of wounding either the uterus or the uterine arteries. The vaginal incision is also indicated in certain cases of pelvic peritonitis, salpingitis, and abscess of the broad ligament, but when there are several foci of suppuration, this treatment is insufficient. Vaginal cœliotomy should not be resorted to if by palpation the walls of the abscess are found thick and rigid, because after the evacuation of the pus they do not collapse and come in contact and consequently a large cavity remains which keeps up an eternal suppurative process, and which is most difficult to close.

I wish to particularly insist that in every case in which the patient is a young woman, a vaginal incision should be resorted to in order to leave the adnexa intact, and I have operated on a number of women who afterwards became pregnant and have become mothers.

And you must remember that a vaginal incision will in no manner prevent a future vaginal or abdominal hysterectomy if the condition of the patient should justify such an interference.

It is of course quite evident that suppurative processes in the pelvis demand different treatments according to their situation, size and number, and it is for this very reason that you should endeavor to make as accurate a diagnosis as possible, because no one method can be applied to each and every case. Consequently I would say that each time that you find a suppurating process which may be easily reached by the posterior vaginal cul-de-sac and which resists proper medical treatment, a free incision and free drainage is the proper method of treatment.

CASE II.—Mrs. W. B., æt. 34, mother of four healthy children, first menstruated at the age of twelve, but the menses have always been scanty, lasting not over two or three days. About two years ago, after the birth of her last child, the patient complained of severe pain in the abdomen which lasted for a few days, but since this time there has always been some pain in the left iliac region which becomes more acute during the menses.

Examination shows a bilateral laceration of the cervix; the cervix is situated far back in the vagina, the uterus being in physiological anteversion and the fundus somewhat pushed to the right. Nothing is to be felt in the right iliac fossa, but in the left a round, movable tumor, about the size of an orange, can be made out with ease.

I believe that we may make a diagnosis of ovarian cyst in this case and the neoplasm is probably a dermoid. Dermoid cysts of the ovary are congenital neoplasms and their pathogenesis is as yet unknown, but the theory of inclusion is probably the correct one.

The prognosis of these cysts is not without some gravity, as serious complications, such as torsion of the pedicle, septic injection or secondary neoformation taking on the character of a pavement cell, epithelioma may occur. All these possible complications are quite sufficient to justify an early operation, because a tardy interference may compromise the result of the operation, either on account of the difficulty in enucleating the neoplasm or by reducing the patient's health so as to render surgical treatment dangerous.

Abdominal section is the only proper treatment, and this should be done, even if the patient be pregnant, for the pressure of these cysts may give rise to serious complications during both pregnancy and labor.

CASE III.—I wish now to refer to a patient that some of you saw with me at the commencement of this year's term and upon whom we removed the appendix. The operation was performed on October 12, 1897, and when the abdomen was opened a large juicy appendix was found, while the cœcum presented three indurated nodules that I took at that time to be tubercular products and my supposition has since been demonstrated to be correct.

The patient in question was a young man of twenty-seven years of age, of slight build, but whose family and personal history were fairly good. He gave a history of an acute attack of appendicitis about two months previously from which he recovered, but since he had been constipated, and the right iliac region was tender and palpation revealed a doughy mass in the region of the cœcum.

The patient was apparently much benefitted by the operation, and up to the latter part of December of last year he was feeling quite well and had gained in weight. Suddenly he was taken with a cough and diarrhoea and he died last week. The autopsy demonstrated the presence of a pulmonary and intestinal tuberculosis.

This was a case then, of tuberculosis of the appendix and cœcum, which anatomically is present as a thickening and indu-

ration of the intestinal walls with ulcerations of the mucosa. Microscopically we find an embryonal cell infiltration of all the tunics of the intestine and part of the mucosa.

Clinically we divide two types, viz., the *neoplastic* and *recurring inflammatory type*. In the first variety a tumor can be felt in the right iliac fossa and having a cylindrical or round shape and varying in size in different cases. The tumor may be either movable or bound down by adhesions and is quite painful when pressed on. Periodical attacks of pain are complained of and there may be either diarrhœa or constipation.

In the second type we have an induration and a diffuse doughyness in the region of the cœcum, and if not treated, stercoral or purulent fistulæ result, while a differential diagnosis with that of carcinoma is difficult to make either microscopically or macroscopically.

The treatment is entirely surgical. Total extirpation of all the diseased parts by a resection of the intestine is a severe operation and the intestinal sutures are liable to give rise to much trouble. Palliative operations, such as partial resection of the walls of the cœcum or entero-anastomosis are apt to give rise to fecal fistula.

The best treatment, I believe, is to simply perform an abdominal incision, remove the appendix and expose the cœcum to the air for a few minutes and then close the abdomen a few cases have been recorded which were most successful.

CASE IV.—This little boy, four years old, came to the Tremont Dispensary three weeks ago, for an inguinal hernia on the right side. He had worn a truss for about two years but without any result. Ten days ago I operated on him. The operation was easily executed and did not last over fifteen minutes. Two days ago I removed the skin sutures and found the incision well cicatrized.

Today I only wish to make a few remarks regarding the contra-indications to the operation, the after care and the possible complications which may arise during convalescence.

Before operating, care should be taken to inquire carefully as to the health of your little patient. A bronchitis or a cough from no matter what cause, any pulmonary trouble for that matter, are contra-indications for operating. Leaving aside the dangers from the anæsthetic in such cases, the effort caused by coughing

will compromise the ultimate result of the operation. The deep sutures may give way from the strain put upon them, and a recurrence of the hernia is to be feared.

A syphilitic or scrofulous child should not be operated on until a proper treatment has built up his system. Weak or rachitic subjects are likewise to be let alone until they have been generally improved by a suitable treatment.

Coexisting malformations are a contra-indication for the radical cure of a hernia and the latter should only be operated on when symptoms of strangulation occur. Very large hernia, which are not infrequent in rachitic children should not be operated on, but this contra-indication is only temporary because as the child grows the disproportion in the size of the hernia and that of the abdominal cavity becomes less marked and then the condition may be radically cured.

Now when we have a case of multiple herniæ what should we do? Usually it is one of double hernia, and in such a case we are to be guided by the general condition of the child. I think it is better, if operation is decided upon, to do one and then later the second hernia than attempt to operate on both at the same séance.

As to multiple herniæ, properly speaking, such as double inguinal hernia, umbilical hernia, crural hernia, etc., I think that it is better judgment not to be in a hurry to surgically interfere. As the child grows up an umbilical hernia will disappear spontaneously and the subject will only keep his double inguinal hernia and when in good condition these may be treated.

Tuberculosis of the bones, such as Pott's disease, osteo-arthritis, spina ventosa, etc., is a decided contra-indication to operation. The same is true for children presenting an adenitis or a suppurating focus of any sort and in order to be successful we should only operate on those children who are exempt from infective processes.

Children support poorly rigorous antisepsis generally speaking, especially iodoform and carbolic acid, and for my part I prefer asepsis rather than antisepsis when dealing with little ones. I advise you to employ subgallate of bismuth gauze as it is non-toxic and a most efficient antiseptic.

To protect the wound from becoming soiled and thus infected, the following adhesive paste will be found of use:

R.	Zinci oxyd.	10.0
	Gelatin.	30.0
	Glycerini	25.0
	Aquæ	35.0

M. D. S. For external use.

At the ordinary room temperature this formula is in a solid state so when it is to be employed it is heated on a water bath to liquify it, afterwards it is applied with a brush like collodion. The fluid is freely applied around the borders of the closed incision and when the gauze is spread over the latter it adheres intimately to the skin. Another layer of the paste is then spread over the gauze and thus the incision is protected by a layer of impermeable dressing of excellent occlusive properties. Over this a few layers of absorbent cotton are applied and a spica bandage keeps them in place.

In very little children, retention of urine rarely occurs on the day of operation, but if it does a catheter must be passed. No elevation of the temperature will occur if your asepsis has been complete. Constipation is not infrequent, but one or two glycerine enemata will bring away the feses, and the temperature will come down to normal if by chance it has gone up.

A milk diet should be ordered for the first few days following the operation, and by the fifth day the child may be given its regular diet.

The dressings are to be removed on the eighth or tenth day, the sutures in the skin are taken out and another occlusive dressing applied, but this time without a spica. The child may be allowed to get out of bed by the end of the fourth week.

There is one post operative accident that will occur very often but which should give you no alarm, and that is a marked edema of the serotum with a hydrocele of the vaginal tunic, all of which will disappear in from three to four days. The hydrocele is not caused by the manipulation of the vaginal tunic because it takes place in cases in which the hernia is not scrotal. It is probably caused by a permanent compression of the spermatic cord at the external ring, the circulation in the spermatic veins is hindered and we consequently get a serous collection. The fluid will disappear in three or four weeks.

As to post-operative complications, they are mostly infective and are due to carelessness on the part of the operator. A peri-

tonitis is inexcusable. Broncho-pneumonia, which is usually fatal, is rarely met with if you will take the precautions I have already mentioned, when you examine the child before operating. When due to the anæsthetic it makes itself manifest on the second or third day, rarely before.

A septic inflammation of the stump of the mesentery will occur if your ligatures are not perfectly aseptic, its symptoms being those of an ordinary localized peritonitis.

A collection of blood will sometimes occur after a difficult and extensive dissection of the sac, and the only means we have to prevent this complication is to drain. And lastly an *aseptic* suppurative process may occur when the deep sutures are tied too tightly. This process is, as you know, due to the thermogenic products absorbed from an aseptic necrobiosis of the tissues; the soft tissues included in the sutures become necrosed partially and are eliminated in shreds, similar to those seen in anthorax.

For prudence sake I think it best to have the child wear a support for a year or so after the operation, but the herniæ met with in childhood are recent, the tissues are in a healthy condition, both conditions being particularly favorable for a rapid and complete repair.

A truss will sometimes alone be enough to bring about a cure of a hernia when the canal is nearly normal and the rings moderately dilated, but a radical cure can only be obtained by operation in cases in which the abdominal wall is relaxed and when the inguinal canal is in a state of malformation, and I would add that the best time for operating is between the second and fourth years.

CASE V.—This patient has been under treatment for several chancroids of the labia and a suppurating bubo in the right inguinal region. The other day the bubo was incised, curetted and packed with subgallate of bismuth gauze, and on changing the dressings today we find the wound in good condition.

Inguinal adenitis follows an *ulcus molle* in over fifty per cent of cases and is usually a *poly-adenitis*. The bubo may become infected by the specific bacillus of chancre after it is opened or even before suppuration occurs.

Before suppuration has taken place a bubo should be treated by rest, blisters and compression.

When suppuration is established we have several operations

which are to be selected according to the condition of the adenitis. When only one gland is the seat of the trouble, simple incision with drainage is sufficient, but when there are several infected glands incision curettement and drainage are necessary. If after incision digital exploration reveals a large poly-adenitis, the extirpation of the mass must be resorted to.

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