PRICE (Jos.)

How to do abdominal section ×××××

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HOW TO DO ABDOMINAL SECTION WITHOUT FUSS, FEATHERS, AND FOOLISHNESS, WITH IMMUNITY FROM SEPSIS.*

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The profession was very slow to acknowledge the correctness of the pathology of pelvic diseases in women, as demonstrated by Bernutz and Goupil. Their almost mathematical presentation of the subject was received with ill-expressed disregard, and characteristic criticism, both harsh and unprofessional. Mr. Tait did much to open the way for the ultimate reception of their views, and his work must always stand a monument to the period of the most remarkable progress in modern surgery. Cavilers may carp, and envy strive to belittle, but to the minds of the generous and just, there is no question as to his merit. From 1872 to 1888 there was a remarkable regularity in the advancement of both the theory and practice of pelvic surgery, but since this latter period there is much to discourage the practical and progressive mind, which is never satisfied to abandon progress, or to go forward, looking backward, or to be satisfied with obsolete or obsolescent methods. If we take the trouble to look up the papers of this latter period, we shall find them already quivering with doubt, and quavering from disaster. Many men who without training or drill, or previous education in any branch of medicine, rushed into the abdominal field as the road to ready fame, have begun to redress their steps, doubt the correctness of their absolutely ignorant, but no less positive statements and to hedge behind their so-called conservative opinions, for which their crude work had built the foundation. This had been well, had it only reacted upon themselves, but the effect was of wider extent, and the reading profession were misled into considering their cry for quarter, as an honest surrender. This

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defection indeed has got beyond the line of current literature, and invaded the presumably standard books of the day. Men who are supposed to be an authority on what they write, because they are backed by medical colleges and standard publishers, are deluding the profession, by a counterfeit presentation of experience, and present that as general which is only the shady result of their own limited knowledge, which presumes to teach, while it has yet all to learn. The pathology of these pseudo-instructors, is at fault and their conclusions surgically considered, are not to be considered or trusted. Of pathology, there must be a working knowledge, not, necessarily a microscopic one, but such information as will enable the operator to understand what he is likely to meet, why it is thus and so, and the results of certain complications, and the necessity of dealing with each one specifically as it arises. To start out in any line of work, with a fair show of success, there must be a preparation both subjective and objective. The objective preparation in pelvic work is applied to the patient. She is to be duly purged, and her intestinal tract thereby freed from *débris* which may interfere with post-operative comfort. An empty bowel has better tone than a distended one. For the purpose of catharsis, calomel and salines should be used, according to the peculiarities of the patient. Light, simple, liquid nourishment is to be preferred, while in feeble cases the antecedent administration of strychnine is of value. The patient is to be thoroughly cleansed, and kept clean while all the rules of personal cleanliness are to be applied both to the nurse and the surroundings of the patient. It often is questioned whether successful operation can be done in and under conditions which do not permit of rigid cleanliness, so far as the room itself is concerned. My answer from an extensive personal experience, is that the best results have been obtained, under the most adverse conditions, but these have only been reached, by extra care and painstaking avoidance, of accidental introduction into the immediate field of operation, the filth of the surroundings. This last assertion is to be taken literally. Cleanliness by soap and water is all that is required. I do not use nor advocate the use of any chemicals whatever, and consider that the operator who has need of corrosive poisons to render him fit for the operating table, had better take a month's vacation to prepare himself for the safety of the patient. Chemical solutions bring into the field of operation an additional danger of irritation. This is great enough owing to the nature and character of the interference.

Here as in all other operations the less the paraphernalia and

complexity, the less the danger of annoying delays and impediments to speedy and careful, uninterrupted work.

The incision should be as short as is consistent with the removal of the diseased part. This is of importance also at the close of the operation. The smaller the incision the less we have to deal with in closing. If the tumor is irreducible, the incision must be longer than otherwise. Adhesions are to be dealt with as they are found, and not passed by. Ligation of bleeding points must be carefully attended to. All points of bleeding do not necessarily require a ligature. The hæmostatic forceps very readily controls many of these, especially in the incision. Too numerous ligatures introduce an irritating element into the surgery of the pelvis and abdomen whose evil is far reaching, and should be avoided. All pathological conditions should be removed as they are discovered. Adhesions, freed, *débris* consequent upon these removed, and the really diseased organs carefully separated and tied off. Leaking vessels must be controlled, and must be primarily handled so as to excite as little hæmorrhage as possible.

This is accomplished by breaking the adhesions down with the cushioned end of the finger, using the nail practically not at all, and the scissors or knife never, unless where it is absolutely necessary to tie. After adhesions are loosened and ligatures placed, the toilet is to be looked to. Drainage is the most essential feature, and this is begun by flooding the abdomen. The abdominal douche is as necessary for successful surgery in the peritoneal cavity as is soap for common cleanliness. The sneerers at drainage all with common consent acknowledge the efficiency of flooding out the abdomen to clear it of *débris*, pus clots and the like. Not only does it do this but it is a powerful stimulant in shock, and enables many a successful recovery to be made, where otherwise we would lose our patient. Now drainage, I mean glass drainage, not a gauze masquerade, simply continues the good work initiated by abdominal flooding. It permits the escape of lymph, the smaller clots, the serum from the irritated surfaces, and conduces to bringing the peritonæum into a more natural condition. Gauze simply abstracts fluid as such, and does not permit of the elimination of anything else whatever. It is interesting to note in this connection that those operators who so bitterly opposed drainage some little time ago, now commonly pack the pelvis full of their so-called gauze drain from vagina to and through abdominal incision, and with the same consistency yet violently oppose supravaginal extraperitoneal hysterectomy which when perfectly done does away with all intraperitoneal tinkering, and closes without even leaving a sinus. All

gauze packing opposes prompt healing, except that by adhesions, and therefore the less of it we use the better we are off, except in those cases in which it is desired to wall off a cavity, such as the seat of a suppurating appendix which it is impossible or rash to remove at a primary operation. The closure of all abdominal wounds should be made with silkworm gut. This makes a perfect splint for the abdominal walls, is nonirritating, and safe. For other needs of abdominal work, I find fine silk the desideratum, it has many advantages over catgut, but above all is safer and cleaner. Again it is much stronger in the finer threads, and therefore permits the use of a less bulky thread. After the essentials of the operation comes the after-treatment. Here I find no reason to diverge from the lines I have so often laid down, to wit : that rest, position, and simple diet without anodynes are the essentials. I do not allow my patients to be shifted for the first twenty-four to thirty-six hours, for the reason that in abdominal wounds and tying, absolute quiet, I hold, is just as essential as in other surgery, such as that of bones, or plastic work, and after all much of abdominal and pelvic surgery is only plastic work on a large scale. Milk should be avoided as a diet in most cases. Anodynes are not indicated save in those cases in which the opium habit has been previously contracted, and the operation urgent.

The vast majority of patients are better without it, in every way, physically, morally and mentally.

So much for the real necessary common sense of abdominal section.

As to the opposite of this, in all that pertains to abdominal work of every sort, there has been so much written, and so much said, suggested, and attempted, that just at the present time, we are in a tremendous muddle. Men who do not know how to drain, cry out "There is no need of drainage in abdominal work. The man who is in favor of it is a dirty operator." These same men would not argue drainage away from other branches of surgery, and yet in the abdomen, where in many cases the dirt and *débris* are boundless, they waive this important step in the technique of abdominal section aside, forgetting that assertion is not argument.

These same men are ever ready to adopt anything new, or original, be it suggested by a nightmare or hypnotic ecstasy, only so it attract by its air of novelty, be it by a patent abdominal sewing machine, or a new German Salvation, vacuum, wherein both patient and operator are made to breathe sterilized ethereal ozone, and perspire some never-failing never-ending antiseptic.

Boiling water to these oglers of foreign fads, has become so cool, that it will no longer scald or cleanse (at least, so it is believed in Germany, where they ought to know), and in its stead is imported, a real German bake oven, which can be heated hotter than the scriptural fiery furnace, and the little sinning microbes, unlike Shadrach and the other two, can not stand the strain. All this is a combination of fuss and feathers. Let us see. Instruments baked, assistants oxalated, permanganated, bichlorided, floor tiled, with the chance of three out of five of the nurses menstruating, or ending it up with a discharging irritating leucorrhœa, with the water supply and drain communicating directly with a sewer, and the operation attended, perhaps, by fifteen or a dozen men, all of whom have come from filthy street-cars or dirty carriages, or perchance even from stables, if perhaps they have an oversight of their own conveyances. This is fuss, feathers, and foolishness. The trouble is that too many err in imagining that cleanliness comes from antiseptics. This is not so. The man who can not be clean without bichloride, can not be clean with it.

Being clean by spasm is like trying to become a society man by buying a dress suit. It is all right for theory, but it won't work. If looks were all, and nothing back of them required, the goal would be reached ; but not so. Put it down, that the men who dwell the most on the ultra-refinements of Listerian surgery, do so only in the hope of succeeding in some way to overcome failures, in themselves, which they are loath to acknowledge.

This is not fuss or feathers or foolishness alone. It is false pretense. He parades to the learner and to the outside world, that all surgery is reduced to the hoo-doo of chemicals, or the Trendelenburg position, and that these make surgeons and surgery easy. We are waiting for the book, *Every Man his own Surgeon: A Crying Need to protect us from Quackery.*

Fuss in surgery is of two kinds, as are most other sensations, subjective and objective. Objective sensational fuss is of the sort I have briefly and generously and gently referred to, withal, seriously. Subjective fuss is due to the natural tendency, drilling and disposition of the operator. I have known an operator to leave his patient before closing the incision to discuss a specimen removed. Only a pathological devotion completely overshadowing the surgical instinct, can explain a freak like this. In my work I hate stupidity, whether in assistants, nurses, or onlookers. I hate it worse in myself. When I quarrel with myself in my work, I know I am a ringleader in a conspiracy against the life of my patient. If I learn that an operator

curses his sponges, nurses, damns the eyes of his needles, and sends his knife to a place hotter than his Dutch bake oven, I look for many of his patients in another direction.

One thing an operator has to learn. He is the head, judicial legislative, and operative in all that concerns his patient. He is bound to see that all is in working order, before he begins work. He is to know that all around him are trustworthy and efficient. If he is in doubt about this he has no right to begin work.

If he begins work without skilled assistance, he must know himself capable of going through it without assistance. In the event of failure, he has no right to bulldoze those around him or lament their inefficiency. Subjective fuss combined with objective feathers, reduces surgery to a farce, and the operation often to a tragedy.