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A FEW POINTS OF INTEREST TO
THE FAMILY PHYSICIAN.

Read in the Section of Obstetrics and Diseases of Women, at the Forty
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A FEW POINTS OF INTEREST TO THE FAMILY PHYSICIAN.

It is more or less presumptuous for a specialist to attempt to teach the general practitioner for two reasons: First, a large per cent. of general practitioners are capable of furnishing more pointers to the specialist that he could use in his business than the specialist could furnish to the general practitioner. Secondly, so many epistles have come from gynecological apostles in the past few years intended for the edification and education of the general practitioner that the man who makes his living by doing family practice is beginning to seriously reflect upon what relation he bears to the specialist.

Had I not for fifteen years been actively engaged in general surgery and medicine, nothing could have induced me to place my foot in this field which is actually suffering from intense cultivation, but now that specialists in gynecic surgery are starting up in almost every county seat I think it might be well to "tap the wheels" and elicit, if possible, the ring of solid metal or perchance the dull sound which indicates a crack in the wheel of our rapidly moving train.

Those of us who have opened the abdominal cavity many hundred times and tested our asepsis in the great lymph sac have picked up many little points pertaining to aseptic and antiseptic precautions of much value to the general practitioner. He has, however, often been led to believe that there are two separate and distinct factions; the one contending for and the other against antiseptics. There are no differences. "All are but parts of one stupen-

dous whole." Therefore he has the right to throw the blame on the cœliotomist for his having committed a sin of omission, not using enough soap and water; or a sin of commission, having depended too exclusively on his bichloride solution and failed to scrub (sterilize) his hands, and even poisoned his patient with the deadly drug. The greater our experience and the more marked our success; the keener we should feel the weight of responsibility resting on us for what we teach. Reckless expressions as to methods of operating, treatment of cases, or results obtained are most reprehensible, even criminal, for in this way lives are sacrificed.

The student of human nature and the earnest seeker after truth can see the motives of those who insist that any kind of water is as good in surgical cleanliness as that which has been sterilized, or teach in their published statements and attempt to prove by their success that private hospitals are useless; that the same success can be obtained in the filth hovels of the city; that nurses who have had a large experience in supplementing the efforts of the abdominal surgeon with their wisdom obtained by observation are no better than such nurses as one can pick up. What is the difference, if in the use of chemical agents which destroy microorganisms, we advance a step farther and say prevention is better than cure; or that the prevention of fermentation—"sterilization," "asepsis," "clean surgery" are better than allowing fermentation and putrefaction to swarm with microbes, and then seek to kill them with chemic agents?

There is no difference in the ultimate aim of those contending for antiseptic surgery, and those who claim to be content with clean surgery, for the reason that cleanliness can not be secured and maintained without the aid of chemic agents of some kind. No wonder some of our surgical friends get blinded in the technique of antiseptic surgery. While wandering in their blindness they forget the principles

enunciated by the great masters like Lister and Keith. These men proved by scientific research that all fermentation is molecular life. What use would there be in the sterilization of every instrument used in the pelvic abscess if we forget that pus cavities, after being exposed to the air, become a hot-bed for the production of germ life through fermentation and putrefaction? Of what use would all the antiseptic dressing over an abscess be, as compared with perfect drainage—that precious safeguard against absorption? Our apostles of clean surgery are exceeding careful as to who clean their sponges; do not allow any decaying organic substance in their private hospitals, knowing that no sooner does one decaying substance die than it begins to live again in molecular germ life, the prolific offspring of fermentation and putrefaction. Clean surgery is what we want. How shall we obtain it? By water? No; it can not be thus secured. Suppose one of these gentlemen drops blood, pus or serum on his clothing, or gravy on the lapel of his coat. Will water remove it? No; try soap, ammonia, ether, benzine. Ah, it takes chemicals to secure cleanliness. The difference between those favoring and those opposed to antiseptics is largely imaginary, a play on words. We can get it but not without the aid of chemicals. By this, I do not mean such agents as are usually considered germicides. I doubt the propriety of killing germs lest we irritate the tissues. These pretended differences between sepsis and antiseptics can but confuse the average general practitioner or the beginner in surgery. For example: My friend who had located in the far west and had been doing some surgery, returned to make his friends a visit; found his way up to my operating room and was noticing our preparations for work. As I had once been his teacher I began answering his questions by explaining to him that the hands were the most frequent source of conveying septic material into the peritoneal cavity, and that for the past ten years I

had been studying how to clean my hands; that now I had a soap made by a chemist, with olive oil and caustic potash, practically the green soap of the pharmacopœia. I showed him my scrub brush for the hands which is boiled every time after being used and then kept in alcohol and ready for use again.

I explained how it takes repeated rinsings to get rid of the soap suds from the pores of the skin before we place the hands within the abdomen. He answered me, "I have no use for all your details. I simply put my hands in the solution of bichloride of mercury and then I know that I am safe." I attempted to reason with him, stating that if I used a germicide for the hands it would be aqua ammonia, which would not only bring tears to the eyes commensurate to the solemnity of the occasion, but would penetrate deeply into the pores of the skin chasing the microbe home, and by its extreme alkalinity, if not killing him outright, weakening him until he would be comparatively harmless. Whereas, his bichloride of mercury by its astringency, would close the pores of the skin, thereby shutting the door after the microbe which it had frightened into its den. This doctor believed that there were two factions and had chosen the chemical side of the question.

I read in a medical journal an article by one evidently willing to teach the average doctor. In this article he describes the bleaching method much used in the Johns Hopkins hospital and other places. He says: "Making the hands brown in a solution of permanganate of potash, then immersing them in a solution of oxalic acid until the color of the potash is removed; the hands will be of a pink color." Here it is that "a little knowledge is a dangerous thing." The pink color is evidence that the acid is retained deeply in the pores of the skin of the hands, even after repeated rinsings under a stream of running water. Such hands put into the peritoneal cavity would be dangerous. Aqua ammonia applied freely

will prove the presence of acid by making as much lather as could be made with a good article of soap. This repeated a few times the pink color is gone and the hands are anemic. This alternate flushing and shrinkage of the capillaries, making the pink color, no doubt helps to sterilize the hands. It could be as well done by alternately immersing the hands in cold and hot water.

Another friend asks me to meet him in consultation, his patient having been confined a few weeks before. He fears peritonitis and yet thinks it not possible, as the temperature has not been above 101, though the pulse is 140, wiry and feeble. The abdomen is badly distended. The pulse, the tongue and the countenance all point to septic peritonitis and death. Following the doctor I made a careful examination of the case. I asked for some soap and water to wash my hands. They furnished soap which had probably been selected, not because of its known chemical composition, but because of its recommendation in the newspapers, including a certificate from a Brooklyn minister. The water given me was hard, containing much lime, magnesia, etc. I whispered to my friend that I could not remove septic germs from my hands with such material. He immediately brought his satchel, and after handling nearly everything in it gave me some tablets of bichloride of mercury to put in the water, and thereby to increase the chemical composition of the water and render it more worthless in cleansing hands.

After handling everything in his satchel he washed his hands in a solution of bichloride. Now, had he carried a hand brush boiled every time it had been in doubtful use, a vial of aqua ammonia to soften the water and a piece of soap made of olive oil and caustic potash, imitating the time honored soft soap of his grandmother, his armamentarium for sterilizing hands would have been nearer to my notion. There is something in soap. I ask the man in the alley back of my stable what he is going to do with

the putrefactive, maggoty carcass of a dead dog he has laid in his cart. His answer was that he hauled them to the soap factory. I repeat there is something in soap. I insist there was a good deal in that soap. The nearer we stick to the religion and soap of our grandmothers the nearer we will approach moral and physical cleanliness of body and mind.

This good doctor was deceived as to the disease by too implicit reliance on his thermometer. I have many times seen a patient with septic peritonitis lie down and die, while I have never known a pulse to deceive me. We had in the profession more good pulse feelers before we had so many thermometers.

I get into my friend's buggy to ride home. He buttons up two coats, strokes down his long full beard, with hands and sleeves teeming, as I believe, with germs of septic peritonitis, then puts on a heavy pair of warm driving gloves which had done him service two winters,—surely nothing but fire could ever sterilize them. Five days later my good friend rushed into my operating room as we were getting ready for an abdominal section waving these same driving gloves in his hands. I asked him to retire. He did so, but remarked that he had changed his clothes.

This doctor's antiseptic precautions were faulty because of too implicit reliance on germicides which led him to overlook the fact that any microbe, having a particle of self-respect, would not attempt to stay where soft water, clean scrub brushes, plenty of elbow grease and repeated changes of clothing were customary.

The doctor's change of clothes was not satisfactory to me, so long as the gloves were used into which he had placed his hands after examining the case of puerperal septicemia. It requires the utmost painstaking to have our chain of antiseptic precautions strong in its entirety. "No chain is stronger than

its weakest link." In studying septic precautions and applying the principles in our practice we often strain at a gnat and swallow a camel. This being true of those who are specially engaged in intra-peritoneal work so that the least deviation from the strictest asepsis will be detected in the results obtained, how much more likely is he who is engaged in general work to overlook some important detail in the change of clothing, and especially in what he is handling with his hands, including the gloves.

It was taught in former years that the obstetrician should stop practice after attending a case of epidemic child-bed fever.

These cases we now believe to have been puerperal septicemia, and despite my unbounded confidence in soft water, soft soap, scrub brush, ammonia, turpentine and alcohol, I am of opinion that no man is warranted in opening the abdominal cavity or attending an obstetric case within five days after his hands have been in contact with a case of septic peritonitis, if that peritonitis is at all in any possibility during its acute stage; and not even after the expiration of five days unless in this space of time there shall have been repeated changes of clothing, daily scrubbing of the hands and arms with soft soap, soft water, with ammonia poured into the brush and the hands immersed in turpentine afterwards. In this purification the hair and beard should receive due attention.

This statement may be challenged by those who make abdominal sections in cases of pus tubes, but I must draw the line between cases of sub-acute and acute septic peritonitis whether the same be puerperal or not. In a recent conversation with Dr. Dudley of Chicago, I find that this conscientious man has been thinking in the same line and arrived at the same conclusions as myself in this regard. Have we not erred in publishing to the general practitioner what numerous lives we could save by abdominal surgery? Would it not be better to give him the benefit of our

experience and some of the details of our aseptic precautions, and thereby enable him to avert the probability of carrying the death warrant of his patients in the hair follicles on his hands, under the finger nails and in the gloves? Is it not time that we quit contending that there are two factions in antiseptic surgery, one depending on water, the other on chemicals? Inasmuch as chemicals are useless without water and water without chemicals, even a soap of known chemical composition, the systematic combination of the two in the proper way of their use upon the hands is what the average physician needs to know. The man who is daily dealing with the peritoneal cavity has a store of knowledge of great utility to the general practitioner. And yet we must forget self and publish only that which we have proven to be right and safe, like Dr. Kelley who discarded the *American Journal of Obstetrics* when he found that his bleaching solution of potash would not kill bacteria in a skein of silk.

I meet my friend in consultation. He had told me to bring all kinds of probes to get entrance into the cervical canal as he had failed to find an entrance into the uterus, notwithstanding he had used the speculum many times. I found the uterus crowded up behind the pubes by an ovarian cyst as large as a water bucket which the doctor had not detected; secured the consent of the patient and set the day to remove the cyst. As we were about to leave, the doctor asked if I had not better use the speculum to see if we could not pass a sound. I replied that fingers were made before forks, speculums or sounds and that conjoined manipulation gave so much information that sounds were going out of use. A very large majority of practitioners I meet are capable diagnosticians. A few are sadly deficient in physical diagnosis of abdominal disease. It is often a lack of persistence in abdominal palpation and determination to master the subject. They have not the art of moving the fingers over the

viscera carrying the skin with fingers. And sometimes they do not even obtain a knowledge as to whether the tumor grew from above downwards or from below upwards. If from above downwards, can it be manipulated back, as in floating kidney, or moved from side to side, not upward, as in distended gall bladder. They do not understand that palpation of an ovarian cyst should give signs of fluctuation, and a fibroid of a solid; that in both there would be dullness on percussion. Whereas, in ascites there would be resonance. I mention these points because there is some danger of inspection, palpation, auscultation and percussion becoming a lost art. There are so many anxious to make exploratory abdominal section.

One of the ablest practitioners of my State calls me in consultation. His telegram suggests that I come prepared to make an abdominal section. The case is a boy and he has been suffering three days from inflammation with excruciating pain in the region of the vermiform appendix. The doctor has made postmortem examinations, finding a gangrenous vermiform appendices, and from his knowledge gained by the postmortem and by his reading the current literature of the day, especially the teaching of Morris of New York, that all cases of appendicitis should be operated upon, believed that success would follow and life be saved if we only operated early enough. I, having seen a few operations followed by death because the inflammation was yet in an acute stage, that is to say while the circumscribed septic peritonitis, which sometimes accompanies cæcitis and appendicitis was acute not sub-acute, believed that an operation would surely be followed by death, and that if by opiates we could arrest the progress of inflammation and seize the opportunity in the interval of the attack, operative interference might do some good. Knowing also that some of these cases make fairly good recoveries without operation I declined to operate. Neither the doctor nor

myself were satisfied with the results in this case, and this subject is of such vital interest to the general practitioner that I quote from a recent article by Dr. Schaefer as being in point: "It has been asserted by McBurney of New York, that 90 per cent. of all cases called perityphlitis are really cases of appendicitis, and this statement seems to have been almost universally accepted by the profession of our country, for the term perityphlitis has been almost entirely dropped from the textbooks and the writings of most surgeons, and appendicitis adopted as a substitute. This change of terms has been accepted with too great haste in our judgment and is in all probability one of the chief causes which lead to the great differences of opinion relative to the question of operating; for we shall find upon searching the literature of this subject that various conditions may be and in all probability are described under the term 'appendicitis.' I am led to believe through my experience that a larger percentage of cases of so-called appendicitis than we are aware of are inaccurately diagnosed. This, of course, will be difficult to prove, but when we look at the facts produced by practical experience, enough presumptive evidence can be brought forward to indicate that the assertion is not without foundation. How do we arrive at the facts concerning the statistics of appendicitis? 1, by noting operation. 2, by recording results of autopsies. But is it not reasonable to suppose that the greatest source for statistics for lesser diseases of the caput coli is lost in the fact that they recover (it is claimed by Treves that 90 per cent. of all cases get well spontaneously) so that no autopsies are made? I feel convinced that a simple catarrhal cæcitis with an accumulation of fecal matter, is mistaken for appendicitis much more frequently than is generally conjectured, having had at least five cases of this kind recently myself which recovered. In each, after the acute symptoms were subdued, repeated colonic flushing brought away large quanti-

ties of dry, lumpy, fecal matter and the tumor vanished. In considering this subject we are at once confronted by two problems: 1, diagnosis. 2, the question of operation. In perusing the literature of perityphlitis and appendicitis which during the past few years has become extraordinarily voluminous, one is struck with the fact that most writers and operators take a radical stand for or against operative procedure, and those who favor operating are again divided upon the issue of 'early or late' operations. It seems strange to the casual reader that minds experienced in the same line of work should differ to so great an extent in considering questions of so practical a nature. There is an old maxim, 'whenever pus is discovered let it out if possible.' That the indications for the evacuation of pus in this instance are of greater import than in any other conditions or locations no one will dispute. What, then, causes the hesitation? 1, the difficulty lies in finding the pus. 2, the great danger to the peritoneum and its sequelaë. The first difficulty the surgeon will always be confronted with in a proportion of the cases. The second difficulty will be more and ignored as we become more familiar with the work, and more perfect in antiseptic surgery."

Here is common ground where a wise general practitioner with large experience and much reading meets the specialist, both determined to do the very best thing for the patient, and yet they can not see alike.

A man's business is likely to control his thinking and induce him to look at every subject from the standpoint of his life's work. The farmer deals with many-sided questions in a general way. He may have a good crop or the seasons may be unfavorable. If his crop is good he can not fix the price. The price is fixed for him in Chicago or New York. He thinks in a general way, not a special way; trusts to the seasons and becomes accustomed to many disappointments. The shoemaker looks at the

passing jumbo elephant in no other light than to think that if his loose hide had been lasted it would cover two elephants. It is the same between the general practitioner and the specialist; the one looks at the thing in a general way and the other in a special way. They are both instructed by association together over a given case. The ideas of the specialist are widened. The ideas of the general practitioner are narrowed to a closer study as to the particular stage of the disease suitable for operative interference; and ultimately we shall, as I believe, unite in a mutual faith that when to operate is a vital question requiring much skill and surgical wisdom to answer, and even then we will sometimes find that our best judgment and conscientious actions have failed to save a life. I believe that the specialist should concede much to the experience and judgment of the general practitioner. What success I have had is in a measure due to association with successful, intelligent, general practitioners. I believe the specialist should be as a hand maid to the family physician, by no means supplanting her mistress nor yet usurping her rights but always assisting her to maintain them.

