RICKETTS (EDWIN)

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OPERATION FOR APPENDICITIS: REPORT OF A CASE.[1]

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Wm. R. Dabney, aged 20 years, weight 140 pounds, height five feet, seven inches, the son of my friend, Dr. D. W. Dabney, of Guyandotte, W. Va., had his first attack of pain over the region of the appendix beginning December 5th, 1890, lasting until December 21st following; the pain came on just after a free movement of the bowels; highest pulse rate 100; highest temperature 100.5°. No marked distention over the appendal region. In this case the McBurney point, as described by Dr. L. A. Stimson, held good in this and the following attacks; no vomiting in any of the seizures.

Second seizure began in the latter part of April, 1891, lasting nine days, at the end of which time he was sure that he had an escape of pus and blood through the urethra.

Third seizure came on in November, 1891, lasting eight days, complicated with an attack of grippe; temperature touching 104.5°; pulse 101 to 110; no vomiting, no obstruction. Doctors P. S. Connor, F. Forcheimer and B. F. Bebee saw him in consultation.

Fourth seizure in January, 1892, lasting six days; temperature 100° to 101°; *pulse going down to sixty-three*, remaining there during the seizure; Dr. Connor again saw him; Dr. Forcheimer prescribed ten drops of creosote in water, after meals.

Fifth seizure came on February 18th, 1892, at 6 p. m., when I decided promptly to open the abdomen, as soon as I could telegraph and get a reply from his father, who resides 160 miles up the Ohio Valley.

The medicinal treatment was the same in each attack, hypodermics of one-fourth grain doses of morphia every thirty minutes until the pain was relieved, followed by free purgation as the result of salines; while during any one of the five attacks *there was no distention, no vomiting, no obstruction*, yet *the pain* that was so marked at the McBurney point, that could be covered on the skin surface by the point of the middle finger, was simply excruciating, necessitating one-fourth grain doses of morphia, hypodermatically every twenty minutes, until four doses had been given, before the pain was relieved. He was purged Saturday and Saturday night with Rochelle salts, having had a bath at 9 p. m.

Sunday morning the abdomen was opened by an incision two and one-half inches in length, parallel with the median line, the middle of which was the McBurney point. The appendix, diseased, distended to thrice its normal size, with a tumor the size of a cherry attached to its

1. Read before the Academy of Medicine, February 29, 1892.

outer end, while firmly attached to the gut, was with but little difficulty found, and removed by applying a silk ligature within one-fourth inch of the bowel, with another half an inch toward the outer end, cutting between the ligature, carefully dissecting away the appendix, with its tumor, from the intestine. By the application of the ligatures in cutting away the appendix, no fluid can escape into the field of operation. This field was sponged with warm filtered water, following which the abdominal wound was closed with Chinese silk twist. After making the *wound thoroughly dry*, two layers of the ordinary absorbent cotton in squares of six inches were placed over the wound and held in place by three strips, two inches in width and twelve in length, of rubber adhesive plaster. As soon as any moisture of the cotton could be detected it was replaced with fresh absorbent cotton. No drainage-tube was placed. Anæsthetic, chloroform. Doctors Connor, Bebee, Bramble, Hall, Ellis, Mills, Brunning, my brothers and our assistants were present.

The patient was put to bed, surrounded by copper cans filled with warm water. His convalescence has been uninterrupted. But little morphia has been given for restlessness or pain. The bowels have been kept moving every second day. He has retained nourishment. The highest point that temperature has reached was 100.4°, while the pulse went up to 100 once.

We have so many different names given this pathological lesion that I choose one—that of appendicitis—which can, for convenience and simplicity, be divided into *acute* and *chronic*.

Previous to five years ago statistics would condemn any surgical procedure for the relief of appendicitis, save when pus was present, evidenced by rigors, sweats, emaciation, rapid pulse and high temperature. Even at this time, notwithstanding that the treatment by surgery of appendicitis has been revolutionized, we have *advocates of medicinal treatment in both the acute* and the *chronic* stage; while some say *operate late, others at the first attack*, while some urge *an operation from the first to not later than the third attack*. It took forty years to get the medical profession to understand that ovariotomy was justifiable ; now we have gone farther, showing that *it is not only justifiable*, but that it should be done *before the cyst attains great size*. It is seldom that we have a primary appendicitis going on to suppuration, but, when once the *second* attack comes on, those that fail to have the third, fourth or more attacks are the exceptions to the rule.

In the case just reported there had been *five* attacks, and the only symptom was *pain*, and yet, you see, since Dr. Freeman has opened the specimen, what serious pathological changes are present. There is no pus present. The tumor is gelatinous, containing a few small concretions. The appendix is markedly thickened. While the patient gives a history of an escape of pus and blood per urethra, yet, I am inclined to question its coming from this appendix.

This early operation, done at such a time, was simple as compared with a late operation, done, perhaps, for turning out a pint of pus, in which was found partially baked beans, compound cathartic pills, grape seeds, etc., etc.

The diagnosis of acute appendicitis is not difficult, but with an extension of the disease, accompanied with marked distension it *is very* difficult. The thermal range cannot be depended on any more than in hydro- or pyo-salpinx. McBurney says that it is absurd to depend on the thermal range, and yet, this is what guides many a general practitioner, leading him too often into delaying surgical interference unduly.

At 7 o'clock of the morning of the operation, my patient's pulse was 63; when on the table at 10 o'clock, following, ready for the anæsthetic, it was 100. Under the anæsthetic it dropped to 65, and there remained during the operation. The temperature was 99.5°.

Weir says, operate as soon as it takes large doses of morphia to relieve pain. McBurney claims that it is not difficult to determine the existence of the disease, but that it *is* difficult to determine its future progress. He is guided by the character and extent of the inflammation, and advises operating not later than the third day from the beginning of the first attack. At present, with thus advocating an operation, the concensus of opinion favors doing the same not later than the third day.

A few points bearing on my case, and I am done: This patient, having had enough morphia hypodermatically on Friday night to relieve pain, was purged Saturday (the day before the operation) with Rochelle salts—freely, as we thought—yet, on Tuesday, two days after the operation, purging brought away undigested food that had been taken into his stomach on Friday, four days previous, just before the attack of pain came on. To my mind, this goes to show that "nervous depression," as the result of the patient knowing that an operation is to be done soon, with the added surgical shock, does *interfere with digestion.* I have found that I have made no mistake when I have had my patients undoubtedly purged previous to the operation, and then beginning it again on the second—not later than the third day. On the following Saturday—seven days after the operation—I had to admonish him not to do anything more with ice water than to wash out the mouth. After having partaken of some sour cream by mistake, he, during the absence of the nurse, drank rather freely of ice water, which brought on a violent attack of indigestion. From the effects of accumulated gas within the stomach and bowels, the abdomen became tense, causing great suffering. During this attack the pulse was 80, and the temperature was 98.5°. The Langdon rectal tube was introduced to the length of three feet, through which was pumped, by means of the Davidson syringe, warm water with soap suds, bringing away scybala and much flatus. Relief was soon followed by refreshing sleep.

This patient having had more or less morphia since his first attack in November, 1890, caused me to have the assistant, Dr. Gillett, administer a greater number of hypodermics than I would have done under other circumstances. I dislike its use, following abdominal sections, for the reason that it interferes with digestion, constipates the bowels—the very things that should be avoided—and, unless the patient is kept under its influence continuously, he or she becomes irritable and hard to care for. The less morphia, the more satisfactory the convalescence.

Had I waited for a rapid pulse, high temperature, obstruction, *positive evidences* of pus from the outside, more tumefaction, with protrusion over the appendal region, I am sure that this tumor on the outer end of the appendix would have burst, the patient possibly dying of septic peritonitis. These violent attacks of pain must have been caused from pressure superinduced by the recurring attacks within the appendix, and, as a result, the tumor would, in time, certainly have been followed by rupture, and I venture the opinion that just such possible ruptures are many times the cause of a great number of the so-called attacks of "idiopathic peritonitis."

Shall we open these abdomens early for pain alone, when the doing in proper hands, in cases that must end in exploration, has a death-rate of less than one per cent? Or shall we wait until the pathological lesions are so extensive that a good part of the intestines literally float in pus?

Choose which one you will serve. We can and do have an accumulation of pus in and around the diseased appendix *without a high temperature and rapid pulse.* Don't let the pain that you are so successful, perhaps, in relieving from time to time finally lead you up to a pool of pus before urging an operation, for such an operation is *very* untimely.

Recurrent localized pain of a severe nature, up to the third attack in the appendal region, is enough to *show that there must* be, within the abdomen, a cause for the same, and is in itself enough to demand that exploration, as an aid to diagnosis, should not be unduly postponed. It is not the thing to take the chances of making morphia fiends out of these patients. To explore early, with the possibility of doing a *timely* operation, offers better results than a late operation, done as a last resort. If, after three days' trial in my patient's first attack, we had failed to clear the alimentary tract by salines, aided by the use of the Langdon rectal tube, with the hypodermatic use of morphia to relieve pain, I would have opened the abdomen promptly.