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SECTION, WITH ONE DEATH.

BY

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OF PHILADELPHIA



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**TWENTY CONSECUTIVE CASES OF ABDOMINAL
SECTION, WITH ONE DEATH.¹**

BY J. M. BALDY, M.D.,
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THIS paper embraces the report of twenty abdominal sections taken from the surgical experience of the writer, and are reported simply as a basis for some general remarks on this class of surgery. The cases are taken consecutively, and include the only death I have as yet met with. No case has been refused for operation where there seemed a possible chance for life, and several of them were in such a condition that this chance seemed very small indeed. The general mortality is fully as low as that obtained by Lawson Tait, as reported in his last one thousand cases. Of the operations themselves I have little to say. They have been neither harder nor easier than those of a similar character done by other operators. The fact becomes daily more and more apparent to me, that all abdominal operations, with complications, are difficult; in fact, each new one seems more difficult and delicate than the last. It is im-

¹ Read before the Philadelphia County Medical Society, May 22, 1889.



possible to lay down any definite rule of procedure in any class of cases, for the reason that no two are alike; it is simply surprising to find how differently even two apparently similar cases will result. At times one has need of all his courage and skill, to meet the requirements and complications of the case.

Seventeen of the list were complicated by adhesions, more or less dense, and the difficulty, nay, almost impossibility at times of breaking these adhesions, have convinced me of the folly of even attempting to cure such cases by either electricity or massage. In some cases, the electricity would have destroyed the surrounding tissues much sooner than it would have even made an impression on the adhesions themselves, so extensive, dense, and organized were they. It is simple unadulterated nonsense to tell me that I could have done with safety, through the thickness of the tissues of the abdominal wall and vagina, that which I was barely able to do with my fingers directly on the disease, and the patient fully anæsthetized; and massage, if carried to the extent advocated by some of its votaries, loses even the merit of being harmless, but becomes extremely dangerous. If the patients of the gentlemen who use this remedy (or say they do) will submit to the pain necessarily incident to this treatment, they must be dealing with a much less serious type of cases than it has been my fortune to handle.

In eleven of these cases I have used the drainage tube; nor in any case have I ever regretted its use. On several other occasions I should have used it, but that the after-treatment was conducted by another

than myself, the patient residing in the country. In one case the tube was accidentally displaced by the patient, before she was completely from under the influence of the anæsthetic. In this case the adhesions and hemorrhage had been particularly severe, and I was considerably worried over its loss for several days; the convalescence progressed, however, without any incident worthy of note. I have since then several times done without a tube and depended on purgatives for drainage, with a greater ease of mind, especially in the out-of-town cases. Irrigation with boiled distilled water, and when that has become exhausted, simple boiled water, has been a constant resource and of the utmost benefit. There is absolutely nothing which will take its place for cleaning the abdominal cavity of clots and débris, as well as for its stimulating effect upon the patient. Of late, however, two surgeons have expressed the opinion that the flushing is decidedly dangerous, and base that opinion, each upon one case. Both the patients died after the operation in which warm-water irrigation had been used. The rest of the profession seem to be unanimous in the opinion that irrigation is safe and beneficial.

In the fatal case of M. Polaillon, a French surgeon :

“The patient *took chloroform badly*, the excited stage was long and she readily came to, though plenty of chloroform, out of a new bottle, was administered on a piece of lint. He employed distilled water, previously boiled, and containing one part of *carbolic acid* to a hundred.

“During the flushing, respiration became rapid, then

grew feeble and ceased; the face became blue. The heart continued to beat regularly. The alarming symptoms began at a quarter past ten o'clock. Artificial respiration was continued till eleven. Then a few feeble respirations began, and continued for a quarter of an hour; the pupils were then half contracted. The heart beat regularly and quickly. The patient continued unconscious. In spite of stimulants, spontaneous respiration could not be permanently maintained. Phlebotomy resulted in the escape of a few drops of very dark blood from the left arm. Gradually the heart's action became more and more feeble, the face grew pale, flatus escaped from the anus, and the pupils dilated. She was thirty-five minutes under chloroform, and about an ounce and a half of the anæsthetic had been used."

Of course, the case died of the chloroform; the history is too complete to admit of any other interpretation, nor do I think for a moment that any one but the operator could think otherwise.

The second case was a patient of Dr. Weir, of New York. Of this case, Dr. Jacobus says:

"How the death of this patient can be, even indirectly, attributed to hot douching, I cannot understand, for it was a case of recurring appendicitis, with several perforations, general peritonitis and partial collapse, operated upon on the fifth day, after having been treated by other physicians, then removed to a hospital and examined under ether, the day previous to the operation."

This is the flimsy evidence on which the objection to irrigation is founded. If surgeons will overdose their patients with chloroform or wait until the eleventh hour to operate, they must expect them to die. I have repeatedly flushed the abdomen to the diaphragm and have yet to see anything but good results. My observations and inquiries amongst my

friends have disclosed the same experience without an exception.

A number of these cases were confined to bed with a peritonitis at the time of the operation. All sorts of complications have been met with. In three cases the vermiform appendix had to be freed and then removed on account of its diseased condition. In one, when torn loose, it was found perforated in two places; the appendix was simply ligated and cut away. In none of these cases did any unpleasant symptom arise from this procedure.

The patients have for the most part been operated on at their own homes and in several instances were nursed by their friends. This has, of course, necessitated an enormous amount of extra work for myself; but otherwise they would not have been operated on, having absolutely refused to go to a hospital. The result only helps to emphasize the fact that hospitals are more luxuries than necessities for these operations, notwithstanding the opinion of some operators to the contrary.

In two of these cases there have resulted ventral hernias. In three fistula tracks have followed. A ligature has recently come away from one of these fistulas and it will now probably close. The other two fistula tracks both followed supra-vaginal hysterectomies.

The after-treatment has been practically, in many cases, nothing. Unless special indications arise they recover without having had a single dose of medicine, excepting sulphate of magnesium, which is generally given on the third day. Until the third

day they get nothing to eat. Solid food is given by the fourth or fifth day, if they wish it. If thirst is great, it is relieved by rectal injections, at intervals, of about half a pint of warm water; otherwise tablespoonfuls of soda water are depended on. Opium I have never used and never expect to.

The simpler the details of the operation the better. In ordinary cases my whole armamentarium consists of two ligature needles, two or three suture needles, a knife, a pair of scissors, a sponge-holder, half a dozen hæmostatic forceps, a drainage and an irrigating tube. Pure silk is used both for ligatures and sutures. The dressing consists of a few strips of gauze, a pad of absorbent cotton and a six-tailed bandage. My bag stands near by and contains all other necessary instruments, but it is exceedingly rare that I have to resort to them. The less work done with instruments and the more with the fingers the safer it is for the patient. One often sees operators with six, eight, or even ten pairs of forceps hanging to the sides of the incision. These instruments are not at all desirable and where it is necessary to use them to control hemorrhage, they can safely be removed by the time the peritoneum is opened. It is exceptional that I have a single pair hanging to the vessels when my fingers enter the peritoneal cavity. They crush and bruise the tissues and only tend to prevent good union. In all the details of the preparation for the operation and of the operation itself, the most perfect and rigid attempts at cleanliness have been observed. All in-

struments, sponges, dressings, etc., used about an operation are prepared by myself, when possible.

It is daily becoming more apparent that inexperienced and untrained men should not be tempted lightly to enter into the abdominal operation. An alarmingly large number of operations have lately come to my notice, by men who have presumably never attempted the procedure before, and who have been assisted by men equally inexperienced and incapable of dealing with possible complications. A considerable number of these cases have, of course, ended fatally—cases which should have all recovered had a skilled operator undertaken them. I do not mean to say that a physician with only a limited experience should never attempt an abdominal operation, because I am very decidedly of the opinion that every surgeon in the land should be prepared in an emergency to open the abdominal cavity and attempt to deal with what he finds. Our country is so large, and the different settlements and towns so wide apart, that it is an impossibility always to obtain skilled assistance; even where it could be obtained there are times when physicians have no moral right to wait long enough for its arrival. If a tubal pregnancy has ruptured and the patient is bleeding to death, that belly should be opened at once, and by the first man with any respectable amount of surgical experience who may first see the patient. Any physician attending a case of labor, perhaps in the country, may meet with a ruptured uterus, and will give his patient a much better chance for life if he open the abdomen immediately. And so it is with many cases of intestinal obstruction,

gunshot and stab wounds. A delay of even a few hours in these cases is responsible for their terrible mortality, and it would be better for any one with good general surgical judgment and skill to open the abdomen, than to leave it unopened or even to delay. It is full time that members of the profession had learned the importance of this and realized their own individual responsibility in allowing such patients to die, without an effort to save them.

But excepting as an emergency and life-saving procedure, I am just as decidedly of the opinion that men without special experience should never open the abdominal cavity, both for their patient's sake and for that of their own reputation. If a simple ovarian cyst is found the operation is easy enough and any tyro could finish it successfully; but just as surely as serious complications are met with both the patient and doctor are in trouble.

I may mention some of the more recent cases of which I am cognizant, which will serve to illustrate some of the points.

CASE I.—A young married woman with a good-sized cystic tumor of the abdomen; in good general health; within one hour's ride of Philadelphia. Operation undertaken by several young men, but without even a good knowledge of general surgery. A long time was wasted in obtaining entrance into the peritoneal cavity. The cyst was found adherent and adhesions bled on being freed. Operation lasted over two hours, and finally ended by leaving it only half finished, with part of the cyst *in situ*. Death on the following day.

CASE II.—Young healthy married woman with cystic disease of abdomen. Operator's first case. Cyst adherent. Bleeding profuse, and large hæmostatics plunged blindly into pelvis in hopes of controlling it. Operation over three hours. Death in a few days.

CASE III.—Young healthy married woman. Unruptured tubal pregnancy diagnosed. Patient lived in a town which could have been reached in a short time by an expert. The ambitious attendant put the woman to bed, took several days to prepare for the operation, and together with four friends opened the abdomen. Operation lasted for five hours; not finished; patient bled to death on the table.

This is the only case of tubal pregnancy I have ever known to be killed by an operation. I could relate many more equally as distressing, but these cases tell all that is necessary and will justify the remarks I have already made.

There are two complications in abdominal surgery constantly met with, and in dealing with which men show their skill and judgment or display their total unfitness for such work: these are adhesions and hemorrhage. They are, moreover, constant companions; where there are adhesions to be dealt with, there is also nearly always, of necessity, bleeding. Adhesions are not things to be blindly torn loose. In dealing with them, the utmost care and judgment must be constantly exercised, and the almost instinctive knowledge of when to break and when to ligate them, must be ever present. Nor are adhesions things to be afraid of. It matters not how dense they are, it is exceptional that they cannot be successfully disposed of. The man who loses his head and becomes frightened because of tight adhesions, had better never attempt this class of surgery, as they are almost sure to be met with in greater or less degree.

A careful survey of the whole field should first be taken by the surgeon, for the most part with his

fingers, and a decision carefully arrived at as to whether or not it will be possible and safe to remove the disease. The decision once made in the affirmative and the enucleation once begun, it should never, but under very exceptional circumstances, be stopped. The worse results obtained in abdominal surgery are in these unfinished operations. The great danger of this half work was sounded some years ago by Lawson Tait, and is to-day accepted as sound teaching by all who have a right to an opinion on the subject. There is constant danger attending the breaking up of adhesions. One may at any time open an intestine and have the question of a resection to decide; a ureter may be torn out at any moment and a nephrectomy must of necessity follow. I have known of the whole circumference of the sigmoid flexure of the bowel being torn away and a closure of the two ends of the gut necessitated; often the coats of the intestine are torn away down to the mucous lining, and a perforation may occur some days subsequently. The bladder has been opened a great number of times. With these dangers ahead, it can readily be seen why untrained men should keep their hands off, unless absolutely necessary.

In addition to all this, bleeding is constant, as I have said, and may be of two kinds, either venous or arterial. Fortunately, the vast majority of it is simply venous or a general oozing. Where an artery of any size is torn, it must be at once secured and ligated, but otherwise the bleeding had better be left alone or controlled by skilful handling of sponges; it will not be often that this cannot be done. But

whether controlled in this manner or not, there is no time to be wasted over it. The very best chance of stopping it is to finish the enucleation quickly and apply the ligature to the pedicle, then there is time and room enough to deal with what may be left, which does not often amount to much. It has lately been proposed and found necessary to throw a ligature around the uterine artery on each side, by passing a threaded needle deep through the sides of the uterus and thus include the artery. I have never seen a case where I even had to think of this procedure, and I have seen some very free bleeding; surely it would take very rough and careless handling often to necessitate a resort to it. However, an uncontrollable case may at times occur, and it is a point well worth bearing in mind. Often the mere bringing together of torn peritoneal edges over a denuded and bleeding surface is sufficient to control an otherwise troublesome point. Much of it may safely be left to the drainage tube. I never like to use s'yptics when it can be avoided. It is the premature attempt to control bleeding which is often so disastrous. Men find a pretty free flow of blood, and, not being accustomed to it, become frightened and stop everything in the endeavor to control it. This they find oftentimes impossible; the indication then is to finish quickly and stop the bleeding at its root. The pedicle ligature will stop it all, or what is still left is not alarming. Had such been the course pursued in the tubal pregnancy case mentioned, the operation would most probably have been finished and the patient survived. The one redeeming feature of that case is, that the same men and their

friends will never be tempted into another such operation; but, unfortunately, the woman's friends and acquaintances will also never be tempted into one. And so indirectly that one case will probably be responsible for the death of half a dozen or more others, who might be saved did they not refuse assistance.

Abdominal surgery, of necessity, has enough legitimate deaths to answer for, without being loaded down by such unnecessary and frightful examples.

NOTE.—Since the above was written I have had a patient die of apoplexy, on the seventeenth day after operation. The case was one of intra-ligamentous papillomatous cyst. Second operation. Had done well from the first. Small quantity of pus from tube. Tube had been perfectly dry and clean for some days, pulse and temperature normal. Said she never felt better in her life. Had slept soundly all night, ate a good breakfast and was talking and joking with nurse when she suddenly had a convulsion; became unconscious and died within twenty minutes. Post-mortem revealed a calcareous condition of the mitral valves of the heart. At the bifurcation of two vessels in the fourth ventricle, a piece of the calcareous plate was found lodged, one of the vessels was ruptured and the ventricle half full of blood-clot. Everything else in the body was healthy. A full report of the case will be shortly published. Of course, I do not consider this a death from operation, but have thought it proper to speak of it in connection with this paper.

No.	Pathological condition or symptoms.	Drainage.	Adhesions.	Result.	Effect of operation.	Remarks
1	Pelvic inflammatory disease; ovarian cyst.	No.	Dense and universal.	Recovery.	Great relief from symptoms.	Adhesions so great that it was impossible to reach pelvis; nothing removed. Ventral hernia.
2	Constant local pain; convulsions during menstruation; impossible coition from pain; chronic salpingitis; small cirrhotic ovaries.	No.	Yes.	Recovery.	Only gradual relief; not yet complete; convulsions seldom; coition possible and easy.	From being a chronic almost bedridden invalid, is now able to attend to her household and marital duties.
3	Left puerperal pyosalpinx.	Yes.	Dense and universal	Recovery.	Cure.	First case of the kind ever operated on in which life was saved.
4	Pyosalpinx.	Yes.	Universal and dense	Recovery.	Cure.	Three weeks in bed with peritonitis; disease seven years' standing
5	Cirrhotic ovaries, prolapsed and adherent.	No.	Yes.	Recovery.	Cure.	Relief gradual but complete; convulsive attacks, which were cured.
6	Ovarian cyst; retro-peritoneal cyst; enlarged cirrhotic ovary.	No.	Yes.	Recovery.	Pelvic abscess.	Fourth day walked to kitchen and ate her dinner, sitting at table; out of bed frequently.
7	Pelvic abscess.	Yes.	Yes.	Recovery.	Cure.	Ventral hernia.
8	Fibroid uterus; enormous distention from ascites; hysterectomy, extra-peritoneal.	Yes.	No.	Recovery.	Cure.	Fistula track; ventral hernia; had been tapped eight times.
9	Ovarian cyst; ventral hernia.	No.	No.	Recovery.	Purulent peritonitis.	
10	Purulent peritonitis.	Yes.	Yes.	Death.	Same as Case 9. Lived six days. An earlier operation would have saved her. Almost died of hemorrhage on the table.
11	Double pyosalpinx.	Yes.	Dense and universal.	Recovery.	Cure.	
12	Right pyosalpinx and ovarian abscess; left hæmatocele.	Yes.	Universal.	Recovery.	Cure.	Peritonitis at time of operation.
13	Prolapsed and adherent ovaries, four times natural size.	No.	Yes.	Recovery.	Cure.	For a few months complete cure; lately some pain, probably from adhesions.
14	Fibro-cystic uterus; supra vaginal hysterectomy.	Yes.	No.	Recovery.	Cure.	Fistula track; had been diagnosed and treated for hernia.
15	Extra-uterine pregnancy	Yes.	Universal.	Recovery.	Abscess.	Of a month's rupture and commencing gangrene.
16	Multiple abscesses.	Yes.	Yes.	Recovery.	Cure.	Fistula track; ligature recently came away, and track will probably close
17	Left ovarian cyst; right pyosalpinx and ovarian abscess.	Yes.	Universal but light.	Recovery.	Cure.	Had severe attack of peritonitis during convalescence.
18	Right ovarian cyst; left cirrhotic ovary	No.	Yes.	Recovery.	Cure.	Peritonitis at time of operation.
19	Ovaries greatly enlarged, prolapsed, adherent, and painful.	No.	Yes.	Recovery.	Cure.	Inversion of uterus had been reduced, but constantly tended to re-invert; operation to correct this tendency.
20	Pyosalpinx and chronic salpingitis.	No.	Yes.	Recovery.	Cure.	Right tube adherent to uterus from over fundus to vaginal vault.



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