Kelly (H. A.)

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SOME GENERAL WORK IN ABDOMINAL SURGERY, PERFORMED DURING SEVEN AND ONE-HALF MONTHS OF 1886.

BY

HOWARD A. KELLY, M.D.,

OF PHILADELPHIA.

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RESULTS OF SOME GENERAL WORK IN ABDOMINAL SURGERY, PERFORMED DURING SEVEN AND ONE-HALF MONTHS OF 1886.

By HOWARD A. KELLY, M.D.

[Read February 9, 1887.]

The notes of cases here offered for your consideration were collated at very short notice to fill a vacancy in the evening's programme. This explanation, however, I do not intend as an apology, for the subject is one of extreme importance, in which, as a specialist, all my own interest is concentrated; and I believe that I shall be able, in a few minutes this evening, to draw your attention to a list of cases remarkable for its variety, including one or two topics quite new.

Many here to-night remember the time when the large cystic ovarian tumor was considered the only indication for abdominal section, and, if other conditions were accidentally discovered, the incision was simply quietly closed. The dangers of the operation itself were so great that surgeons were loath to interfere until the patient's wretched condition seemed to warrant the risk.

As, however, our race cultivated a familiarity with the peritoneal sac, and learned its limits of toleration and intolerance, a bolder and more successful work was entered upon. With dropped pedicles, innumerable ligatures for hemorrhage, peritoneal toilet, drainage tube, and, above all, an unremitting care to secure *microscopic* cleanliness throughout, we have become masters of the situation, and our failures, when they occur, are no longer *mysteries*. And with these improvements has come a recognition of a greater variety of indications for abdominal section, until, as to-night, I am able to present, out of twenty-eight successive cases, at least nineteen separate morbid conditions. Before calling your attention to the list of my cases (which shall be only cited briefly by name), I would ask you to consider with me a few important points bearing directly upon the work.

In the first place, as to *percentages*. While I have a personal pride in my work which induces me to say that it will bear the strictest criticism, yet I cannot but deprecate the bitter spirit which animates so much of the percentage discussion. The time *was* when, by this means alone, by means of the striking differences which existed, we

were enabled to determine, in the absence of personal experience, the relative value of *methods;* but that time has *passed*, and with the closure of the chapter on ovariotomy, this spirit of emulation survives no longer in the interest of *science*, but is *personal* and unworthy of our cause. Further, it is manifestly absurd to compile statistics from a class of heterogeneous cases.

In the removal of small tumors in the pelvis, in the removal of ovaries and tubes not to the naked eye diseased, we are most often compelled to operate for *pain.* The patients themselves, *seeing* nothing amiss, are very loath to submit to "being opened" until their misery makes life a burden—at least this has been my own experience with women, to whom I always explain, in the fullest possible manner, the exact nature of what I propose to do, and its consequences. It is gratifying to the operator, who has finally been driven to this expedient, to find gross lesions suitable for class demonstration, but the most typical relief often comes where the disease cannot be so easily demonstrated; and in cases where there are palpable tumors, the surrounding infiltration and cellulitic inflammation are often serious enough to delay convalescence, for a long time defeating the operator.

Thus, if I were asked, in my own work, which of my cases had given the most gratification—that is, where had the relief been most typical and striking from a condition of suffering—I would point out a patient who was for more than two years unable to take a step on account of the great pain in the right ovarian region; in addition, she was a most wretched sufferer throughout the whole time. There were no gross lesions in the ovaries, and it was long a question with me whether she had not some other serious organic disease, which question I debated under the most varied and patient efforts at general and local treatment, until, with the removal of ovaries here shown, she rose up as if a great weight had been lifted off her and went home to Barnesville to her parents and friends, a walking miracle.

Another case, well illustrating this point, is that of Mrs. W., here shown. She suffered, as she only can describe to you, ever since her first menstruation, from pains which left her a most degraded picture of misery when she came to my office. I found the remains of chronic ovaritis and the wiry tubes of a chronic salpingitis and perisalpingitis, which had contracted down so tight and adhered to so many surrounding structures that they were exposed and removed with the utmost difficulty. This patient has gained eighty pounds since the operation.

These results, and some others I might detail had I time, are undeniably brilliant; but cures are not always so typical, and I am

often satisfied if I can but remove one element (perhaps the most distressing) of my patient's sufferings. If my patient can only come back to me and say, "you have taken away that dreadful pain in my back and stomach; life is now bearable, before it was unbearable," I am well content.

Mrs. B. (here shown) exhibits this well. She had a rapidly growing tumor in the right ovarian region, which seemed, in a most unaccountable manner, to prostrate her general health. I decided this to be a case of extrauterine pregnancy, and I believe my section proved it. She is now like another woman, although still under treatment for an induration of the left apex, undiscoverable before operation.

I do not, Mr. President, therefore, claim wonders for this field of work. I claim for it what is asked for other fields of our art—that the *results* justify the means. It is of *results* I wish now to speak, with a brief preliminary as to *difficulties*.

The difficulties encountered in handling small pelvic tumors are often very great, far exceeding those of removing an ordinary cystoma.

First, the abdominal walls, which have never been distended, press tightly down upon the contents, and the recti pinch the fingers like a vice, utterly defeating any effort to catch or raise pelvic viscera, and this in spite of ether and chloroform. I have been obliged twice to overstretch the recti before I could proceed.

Secondly, in case of chronic peritoneal inflammation, the bleeding from the more superficial vessels of the abdominal wall may be extreme.

Thirdly, the intestines, in this close sac, often cling to the fingers until they feel as if they were clothed with several pairs of gloves, and are just as useless.

Fourthly, when the patient is very obese, the embarrassment of the operator is greatly increased, requiring a much larger incision, prolonged manipulation, with difficulties of closure and subsequent dangers.

Fifthly, cellulitis, so common a concomitant, so draws down and anchors everything in the pelvis that the structures are elevated with extreme difficulty, and only a pedicle, in the *technical* sense, can be secured. The dangers of secondary hemorrhage from this kind of a tie is, I know, very vividly before the minds of all operators of experience. It is, at times, about like tying the apex of a broad-based pyramid. I tied off some broad ligament structures on a fibro-cystic tumor the other day which impressed me for all the world like putting a ligature on a papered wall.

Lastly, these smaller diseased structures often become parasitic on neighboring tissues and organs for their blood supply, and when they

are torn loose, the bleeding is alarming; and it may be deep down in the pelvis, possibly requiring an enlargement of the original incision, and then only seen with the utmost difficulty of exposure and illumination.

With this introductory, I will read a table of cases operated upon by me in 1886. All the operations were performed within the seven months and a half during which I was at home, and almost all in my private hospital in Kensington. The condition of the patients is either settled or weekly improving, so that I feel at liberty to speak of *results*.

On but two cases of the list will I dwell any more in detail.

In one, James Dougherty, I did what has, I believe, never been done before: opened the abdomen upon a diagnosis of hypertrophic cirrhosis of the liver, with the intention of puncturing—hepato-phlebotomy.

The patient, about forty years of age, had a very large ascites, which had been treated for some weeks, but never tapped; and with full confidence in the safety of a simple incision, I made a free opening, large enough to admit two fingers, just below the umbilicus, thoroughly emptied the peritoneal cavity of two bucketfuls of fluid, and on reaching the liver found the organ contracted and hob-nailed; I consequently closed the incision, which healed perfectly. The fluid reaccumulated very slowly until the man died, some weeks after, in the natural course of the disease. My friends, Dr. R. P. Harris, and Drs. Freeman and Bradford, residents of the Episcopal Hospital, were present. I had long intended to use this direct method of abstracting blood from the liver, in view of my experiences in hospital and private practice since, before Dr. George Harley recommended plunging a trocar into the liver through skin, subcutaneous tissues, and two coats of peritoneum, in the right hypochondrium, with the same end in view—hepato-phlebotomy. If, however, I am going to draw blood from this organ in a state of inflammation, I prefer an incision free enough to allow me to handle the organ, and, under full control of the eye and touch, to direct the trocar to the proper place, free from the danger of wounding other structures or large vessels. The incision should be made just above the umbilicus.

Regarding the last case, that of my office nurse here, number twenty-one in the table, I will content myself by briefly remarking that she suffered constantly for four years with a dragging pain in the left side, and two years ago last December she was tapped for what was believed to be a large ovarian tumor. The fluid was straw-colored and coagulated spontaneously in the bucket. She came to me from

No.	Name.	Diagnosis.	Operation.	Date.	Result.	Remarks.
1	Mrs B.	Cystic papilloma of broad ligament	Incomplete removal.	Jan. 2, 1886.	Died.	Private hospital. Death in six days of peritonitis.
2	Mrs. D.	Menorrhagia.	Both ovaries and tubes removed.	Jan. 31, 1886.	Recovered.	Private hospital. Worn to a skeleton by hemorrhages which had lasted for years two weeks at every menstrual period Perityphlitis after operation. now in blooming health. Cured.
3	Mrs. C.	Ovarian tumor.	Removal.	Jan. 14, 1886.	Recovered.	Private hospital. Operation by Dr C. B. Nancrede assisted by me Fecal fistule six months after. Improved.
4	Mrs. H.	Cystic ovary.	Removal.	Jan. 23, 1886.	Recovered.	Private hospital. Ovary large and full of extensive hemorrhages. Cured.
5	Mrs. W.	Hæmatosalpinx.	Removal.	Feb 17, 1886.	Died.	Private hospital. Peritonitis.
6	Mrs. B.	Hydrosalpinx.	Removal.	Feb. 27, 1886.	Recovered.	Private hospital. Tubes large as sausages. Cured.
7	Miss S.	Menstrual epilepsy.	Removal of tubes and ovaries.	Feb. 24, 1886.	Recovered.	Private hospital. Remarkably improved after a temporary relapse. Condition yet doubtful.
8	Mrs. P.	Abscess of right ovary.	Removal by enucleation.	Mar. 27, 1886.	Died.	Private hospital. Found, post-mortem, large pus sac in pelvis.
9	Mrs. B.	3 months tubal pregnancy.	Removal	Mar. 20, 1886.	Recovered.	Private hospital. Pregnant. Later delivered of a large female child.
10	Mrs. U.	Cellulitic adhesions of ovaries.	Adhesions freed.	Mar. 13, 1886.	Recovered.	Private hospital. Now well.
11	Mrs. W	Ovaritis, salpingitis, and perisalpingitis.	Removal tubes and ovaries.	Mar. 17, 1886.	Recovered.	Private hospital. Well; has gained eighty pounds.
12	Miss W.	Hydrosalpinx and stump of ovary	Removal.	Apr. 20, 1886.	Recovered.	Private hospital. No pelvic pains whatever, but frequent headache. Improved.
13	Mrs. W.	Dermoid cyst.	Removal.	Apr. 25, 1886.	Recovered.	Private hospital Patient operated on by Dr. T. R. Neilson, assisted by me.
14	Mrs. G.	Ovaritis chronica.	Removal tubes and ovaries.	Apr 17, 1886.	Recovered.	Private hospital. Vastly improved.
15	Mrs. T.	Chronic cellulitis.	No attempt at removal.	Apr. , 1886.	Recovered.	Private hospital. Improved.
16	Miss S.	Pelvic abscess.	Stitched to abdominal wall.	Mar. 21, 1886.	Recovered.	My home. Died in Pennsylvania hospital in summer.
17	Mrs. W	Pelvic cellulitic adhesions.	Separated; no removal.	Apr. 21, 1886.	Recovered.	Private hospital. Since bore child, and feels well.
18	Mrs. H.	Pyosalpinx and abscess of ovary.	Enucleation of large fetid abscess.	May 5, 1886.	Recovered.	Her own home. Cured.
19	Jas. D.	Cirrhotic liver.	Exploratory incision.	Oct. 29, 1886.	Recovered.	His home. Improved from free tap. Died natural course of disease.
20	Mrs. G.	Pelvic abscess.	Abscesses opened into rectum.	Oct. 4, 1886.	Recovered.	Private hospital. Improved.
21	Mrs. M.	Tubercular peritonitis.	Opened; cleansed.	May 12, 1886.	Recovered.	Private hospital. Recovery apparently perfect, with relapse in eight months, and again recovery.
22	Mrs. B.	Ovarian pregnancy.	Removal.	Nov. 4, 1886.	Recovered.	Private hospital Cured.
23	Mrs. B.	Hydrosalpinx; metrorrhagia.	Removal.	Dec. 17, 1886.	Recovered.	Private hospital. Cured.
24	Mrs. B.	Racemose ovarian cyst.	Removal.	Nov. 13, 1886.	Recovered.	Private hospital. Cured.
25	Mrs. T.	Chronic metritis and endometritis.	Removal of appendages.	Nov. 18, 1886.	Recovered	Private hospital. Cured.
26	Mrs. P.	Papillomatous monocyst of ovary.	Removal	Nov. 18, 1886.	Recovered.	Private hospital Cured.
27	Mrs. J.	Retroperitoneal sarcoma.	Exploratory.	Oct 4, 1886.	Recovered.	Her home. Now being tapped.
28	Mrs. S.	Papilloma of peritoneum.	Exploratory.	Dec 24, 1886	Recovered.	Private hospital. Temporary improvement.

Ogdensburg, N. Y., twenty months ago. There had been no reaccumulation of the fluid, but she suffered constantly with dragging pains in the left side. I found here masses attached to the left cornu uteri, which I mapped out in my book; but, to my astonishment, I found, in the course of a few weeks, while under treatment, that the tumor diminished and seemed to have shifted its site. Bimanual examination, while still revealing well-defined masses in the neighborhood of the uterus, yet yielded such a different find that I was disposed to distrust my records. As her suffering increased, I made an incision last spring, and found the intestines universally adherent, like one great sac, but free from the abdominal wall; the pelvic structures were so bound up that I could define nothing. Some serous fluid oozed up into the incision and coagulated *in situ*. This was carefully cleaned out of the whole peritoneum, a piece of membrane, containing isolated tubercular granulations, snipped off for microscopic examination, and the incision closed. She apparently made a perfect recovery, and returned to New York, doing a great deal of hard work all summer (had not been so well for twelve years). She returned to me upon my return from Europe, and, until seven weeks ago, remained in perfect health. The old pain then began to distress her again, and with it was a continuous elevation of temperature. After waiting until it was impossible for her to drag herself around any more, I again made an abdominal section, by a smaller incision to the right of the old incision, for the purpose of cleaning out the cavity and dusting well with iodoform. She insisted upon preparing everything for the operation herself, and lay down upon the table and submitted to the section *without a general anæsthetic*. I made multiple hypodermatic injections of a few drops of a four per cent. solution of cocaine in the line of the incision. The pain of the incision was but slight. It increased with the introduction of two fingers within the peritoneum, but was easily bearable. In fact, once she warned Dr. R. P. Harris, who was present, not to make her laugh. The only severe pain felt was in handling the matted structures in the left side of the pelvis Sixty-two grains of pure powdered iodoform were sprinkled over the peritoneal surfaces, the incision closed and the patient put to bed without the slightest shock or discomfort. She insisted on unbuttoning the jackets worn by the operator and assistant, and was as comfortable from that moment until she rose on the sixth day, to take a drive on the seventh day, as if there had been no operation. All trace of the induration has disappeared and she has since felt perfectly well, although the ultimate result remains very doubtful.

Eleven of the cases referred to in the above table were exhibited to the Society, and showed the scars of their incisions.