Kryssarvägen 10, Näsby Park, Sweden
Oct. 18, 1960.

Dr. Gerald Shaftan
Dept of Surgery

Dear Gerry,

Am embarrassed to realize how poor a correspondent I really am. I received the program of the American Association for the Surgery of Trauma a little over a month ago, read it over with great interest and considerable pride, and am only writing to you after the meeting has taken place. My apologies.

I should be most interested to read in full your paper on liver injuries when a copy becomes available. Did you have occasion to use the direct current coagulator method on any of these? It would seem to me that this might be a prime place to use it. In regard to simulated injuries of the abdomen, I have had an interesting experience here. An 18-year-old boy was run down while riding a motor-bike, and was brought to the Thoracic Clinic because of obvious chest injuries, including some broken ribs, hemothorax of a liter and a half, and cyanosis. He also had had enough concussion to be unconscious for several hours. The interesting thing is that his abdomen was soft when he came in and sounds could be heard, although somewhat suppressed; but in a few hours the abdomen became board-like and totally silent. I expressed the opinion that he would be explored in Kings County Hospital. Senning said he had seen several cases of fairly massive hemothorax from trauma and with rigid silent abdomens in whom there appeared to be sound contraindications to laparotomy, and that none of these had proved to have abdominal complications after all. The boy in question was watched, ignoring the signs of rigidity and silence but taking frequent decubitus films, etc. The sounds gradually returned over the next three days, he finally healed his assorted associated fractures and went home well.

I can't help wondering if it might be fruitful to review your cases of abdominal trauma to determine if some of those explored for such indications as rigidity and silence and found on exploration to have nothing major wrong in the abdomen, also had massive hemothorax and assorted chest injuries. I suppose the boy here had serious enough injury to the diaphragm to give him some blood in the belly, and that the signs observed might have been due to this.

Did your paper on tibial fractures include the figures from the Div. A Service too? You are certainly in an admirable position to resolve the arguments about optimal therapy in this group. What were the comments at the meeting on both papers?

Do you know if Ed Brackney was made a member at this meeting? He is a very capable person, and a personable one. One of his associates is working along with me here in Stockholm this year.

Have heard very little about the progress of desegregation at KCH. I trust things have gone smoothly. I appreciate that you have one of the major problems, in trauma. Rumor has it that some <u>real</u> changes for the better are in prospect for the Emergency Romm. I hope it is true.

I continue to understand only a fraction of what I hear in Swedish, and progress is slow. It does, however, exist.

Eleanor joins me in sending regards to you and your good wife. Please say hello around the Dept for me.

Sinc.,

Clarence Dennis

Best regards -