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CELIOTOMY FOR ABSCESS OF THE PANCREAS; WITH THE REPORT OF A CASE.

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MRS. G., aged forty-seven, of good personal history, had also no hereditary taint. For four months before admission to the hospital she was practically bedridden. For six months she suffered from sharp burning pains in the epigastric region and complained of tenderness on pressure. Prior to this, with the exception of an occasional mild attack of pelvic peritonitis, her general health was good.

On admission to the hospital she presented a deplorable condition. Her abdomen was distended and very sensitive to touch. There was an area of dulness, extending from the ensiform cartilage half-way to the umbilicus and reaching to the left costal arch. Examination revealed an enlarged uterus, a slight bilateral cervical laceration, and a chronic endometritis. The woman was extremely emaciated; and during the few days she was in the hospital before operation, she suffered from diarrhea, going to stool at least every half-hour. Her stomach would retain little or no nourishment, and her great pain demanded frequent doses of opium. Her pulse was small, rapid, and wiry. The temperature at no time exceeded 98°; it was always subnormal in the morning. There was no history of rigors or chills; but the woman stated that previous to the onset of the diarrhea, which began about a month before coming under observation, she had fever every evening.

Nothing of clinical importance was elicited from an examination of the urine. The stools were watery, of a yellowish-gray color, and had a very strong odor. The vomited material had a greenish tinge and smelled sour. The tongue was dry and had a thick, brown coating. The examination of the lungs and heart was negative. There was no edema of the lower limbs. The pain in the epigastrium was aggravated during the acts of vomiting or coughing; but the woman experienced relief when her stomach was empty.

An effort was made to improve her general health, by carefully prepared liquid food and the administration of alcoholic stimulants, but without result.

At the earnest request of the patient, it was decided to make an exploratory incision both for the purpose of elucidating the diagnosis and with the hope that something might be done to relieve her sufferings and improve her condition. On July 16th, with the assistance of Drs. Cuneo, Hally, and Edward Walsh, an incision was made in the abdomen, beginning at the tip of the ensiform cartilage, running obliquely downward and ending about one inch above and two inches to the left of the umbilicus.

The abdominal wall was unusually vascular. On passing the hand into the abdominal cavity, a fluctuating mass could be felt beneath the greater curvature of the stomach. The great omentum was now incised, and the stomach pushed upward and the abscess-wall freely exposed. The margins of the wound were then pressed inward by an assistant and the abscess-wall stitched to them. On account of the deep seat of the swelling, I was unable to approximate the peritoneal surface with the margins of the wound. The sutures, however, answered a very good purpose, in preventing a recession of the abscess-wall after tapping, and in supporting the gauze packing, which I resorted to for the protection of the peritoneal cavity. The abscess-cavity contained

over a pint of pus, in which could be seen portions of the pancreatic gland and a curdy-like substance. At the bottom of the abscess-cavity a small portion of the body and tail of the pancreas was found attached. These attached portions were soft and easily removed by cureting with the finger. The cureting was followed by a brisk hemorrhage, which necessitated a firm packing of the cavity with iodoform-gauze. The wound was now dressed in the usual manner, the bandage being pinned as tightly as possible to keep the margins of the wound pressed inward, and to prevent any undue tension on the stitches.

At the completion of the operation, which lasted about forty minutes, the patient was very weak and had to be freely stimulated. No rise of temperature followed until the third morning, when the thermometer registered 100°. After a thorough purge it dropped to normal. On the fifth day the gauze packing was removed; by this time adhesions had formed between the abscess-wall and the margins of the wound, completely shutting off the peritoneal cavity. After a copious irrigation with a hot boric-acid solution, the cavity was dusted with iodoform, and a drainage-tube inserted surrounded by iodoform-gauze.

The most prominent symptoms before operation, such as pain, diarrhea, and vomiting, disappeared within forty-eight hours after the operation, and there was a rapid and marked change for the better. During the first four days rectal feeding was resorted to, after which the patient was able to partake of large quantities of liquid nourishment without experiencing any feeling of nausea or distress. On the eighth day the stitches were removed. The fistulous tract was now well established and the abscess-cavity had contracted to about one-fourth its former size. On the eleventh day, much against my wishes, the woman got up, dressed and left the hospital, walking to her carriage without assistance.

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In reviewing the literature at my command on abscess of the pancreas, I find no case reported in which surgical interference has been successfully resorted to for the relief of this condition. Cases have been reported from time to time in which the pancreas was found to be the seat of suppuration, but in the majority of these the actual conditions were discovered on post-mortem examination. "The two principal reasons for this may be found in the facts that abscess of the pancreas is of rare occurrence, and that the recognition of the lesion when it does exist is surrounded by many difficulties." (Senn.)

The recorded symptoms of this disease are very indefinite, and would scarcely lead one to a diagnosis. The emaciation, vomiting, constipation or diarrhea, localized tenderness, etc., are symptoms frequently associated with diseases of adjacent organs.

In the case here reported even the usual symptoms of pus-formation were wanting, so far as I could learn. According to Fitz, the symptoms are essentially those of peritonitis, beginning in the epigastrium; and he mentions pain, tenderness, localized tympany, and the gradual development of a deep-seated inflammation in the region of the pancreas, as diagnostic points.

Age, says Senn, is an important element to be considered in the diagnosis, as most of the cases of abscess of the pancreas were found in patients over forty years of age. He also states that nausea, vomiting of a clear, greenish or viscid fluid, thirst, loss of appetite, constipation, progressive emaciation, and distention of the epigastrium have been observed as prominent and somewhat constant symptoms. Taken singly or as a whole, none of these symptoms can be said to be pathognomonic; in fact, they are symptoms common to many other diseases that have their origin in the epigastric region.

We are forced, then, to the conclusion that with our present knowledge of the clinical history of abscess of the

pancreas we cannot make an accurate diagnosis without resorting to exploratory incision; and in all cases of doubtful diagnosis, when several of these symptoms are associated and when the health or life of the patient seems seriously threatened, I believe we are justified in giving the patient the benefit of operative procedures.

The operation will vary according to the size of the swelling. The cases must be rare wherein the swelling is so prominent as to permit the stitching of its peritoneal surface to the peritoneal surface of the anterior abdominal wall, but when this can be done it simplifies the operation.

It is to those cases in which the distance between the anterior abscess-wall and the margins of the wound is so great as to preclude the possibility of bringing them in contact that I wish more particularly to call attention. The management of this part of the operation will tax the ingenuity of the surgeon. In my own case I found this to be the most difficult step in the operation; and while the method employed as described gave good results and is an ideal way of dealing with such cases, providing the gauze packing would in all cases afford ample protection against infection of the peritoneal cavity, nevertheless if it is ever my fortune to have to deal with a similar case I am inclined to think that I would perform the operation in the following manner: After passing several sutures through the abdominal wall and the abscess-wall for the purpose of lessening the distance between their peritoneal surfaces, the wound should be packed from the bottom with iodoform gauze, which should be allowed to remain for several days, until firm adhesions had formed between the anterior abscess-wall and the margins of the incision. The abscess could then be freely incised and drained without the slightist danger of infecting the peritoneal cavity.