CRUTCHER (H.)

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APPENDICITIS:

A TIMELY OPERATION.

BY

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The following case is reported for several reasons. In the first place, it emphasizes once more, if more emphasis were needed, the treacherous character of appendicitis. In the next place it confirms, what is now universally admitted by rational witnesses, that there are no physical signs that possess the slightest value in determining the actual pathology of a given case. Finally, it shows very conclusively what splendid results can be obtained from the practice of modern surgery.

One night, not long ago, I was aroused by Dr. Amos C. Hall, of Grand Crossing, who informed me that he had in hand a case of appendicitis which he desired me to see with him at an early hour the next morning. Supposing that the case might be in need of immediate assistance, I offered to go at once, but was assured by Dr. Hall that there was no occasion for interference before morning.

At 8 A. M. the next day we saw the patient, a railroad conductor, aged thirty-four, and a man of magnificent physical development, who was nearly six feet tall and weighed one hundred and seventy-five pounds. For the past few years he had occasionally felt pain which he located rather vaguely in his "side." This pain proved to have come from the right

iliac region. Five days before my examination, on the preceding Sunday, he had suffered so much from pain that he was compelled to leave his work and take to his bed. Monday he was better, and Tuesday he was on the street but not attending to business. The next day (Wednesday) he was attacked with violent spasms of pain which sent his pulse and temperature up beyond the hundred point. Dr. Hall was called in the afternoon, administered the usual remedies, but without substantial benefit, and came for me about midnight. The patient suffered a great deal during the night and gave his attendants no rest. As before stated, I called for the first time Thursday morning at eight o'clock.

The patient was, to all superficial appearances, much better; his pulse had fallen to 80; the temperature had dropped from 103° to 99.5°; the acute pain had gone. Moreover the bowels had moved copiously, and this would of itself have been highly conclusive to those amiable "sweet oil" and "sweet water" practitioners whose treatment of inflammatory diseases of the cæcal region ought to be suspended until they study the anatomy and pathology of the region involved. I outlined carefully the cæcal point and gave a sharp thrust over it with the tip of my index finger. The patient jumped and groaned with pain.

Being asked for my opinion, I said: "I know nothing of the actual condition. The subsidence of the pain may mean prompt recovery. It may indicate gangrene and death within two days. One thing I can say most positively. His chances are infinitely better with the appendix outside than inside."

Dr. Hall most cordially approved this opinion and urged upon the patient the greater safety of an immediate operation. The sufferer readily consented. He was glad to be on the safe side.

It was two o'clock before all of my assistants arrived, but the time spent in waiting was utilized in the preparation of the patient, the boiling of linen and the sterilizing of the room. The patient was given a large saline enema, a general bath, and otherwise prepared for the operation.

Everything being in readiness, I began the operation by what I call the high incision, namely, following the trend of

the external oblique, nearly midway between the iliac point and the umbilicus, but above the imaginary line connecting those two landmarks. I fancy this incision gives far less hæmorrhage than the lower incision, as I now recall that in three operations within three weeks, I have not applied a ligature or used torsion upon a single vessel, in the line of incision. A heavy layer of adipose tissue rendered a three-inch incision necessary. The skin and each layer of the abdominal wound was secured by silk ligatures as soon as divided by the knife. This procedure is necessary in order that the various layers may not retract beyond reach during the operation. The peritoneum was very thick and deceptive. The adhesions were firm and abundant. I found the appendix firmly adherent along its mesenteric border and separated it from its bed with considerable effort. The external appearances of the appendix were not especially pathological. It was quite red, about as large in diameter as an ordinary one-drachm round vial and perhaps five inches or more in length. The base was secured with fine chromic catgut and the tube cut away at a safe distance from the ligature. The stump was very large and the cæcum was so pointed that it was practically impossible to tell where the cæcum left off and the appendix begun. For this reason, I did not, for once, burry the stump, as I feared to impinge too much upon the lumen of the cæcum. Beginning at the lower angle of the peritoneal cut with a long catgut suture I united the five layers by continuous sutures.

The repeated use of the catheter aroused some traumatism on the sixth day, which sent up the pulse and temperature, but beyond this the recovery was uneventful. The wound united perfectly by the fifth day, leaving a fine scar that time will do much to obliterate.

I now return to the appendix. The probe passes into a healthy lumen at the base and proceeds for an inch, where it encounters an impenetratable stricture. Slitting the appendix along the free border we notice its sudden partial collapse. For fully three inches the mucous membrane is gangrenous and gives forth a foul and sickening stench. Within an inch of the tip was another stricture, beyond which the lumen was healthy. This, then, was the condition: The base and the tip, each for

about an inch, perfectly normal; the central segment gangrenous and ballooned with the gaseous products of decay. It was like the hood of the cobra and was charged with poison as deadly as the vemon of that well-known and terrible reptile. There was no concretion or obstruction of any kind found within the lumen of the appendix. As to the formation of the strictures and the cause of the gangrene, I have no idea whatever. That an explosion of those confined gasses was inevitable, and that a fatal infection of the peritoneum would have followed, is perfectly apparent. My judgement is that the patient would not have lived seventy-two hours without surgical relief.

Now, will any sane man of experience claim that therapeutic measures would have lengthened this patient's life a single hour? Would sweet oil or olive oil or rain water or sweet cider or any other liquid have removed that stricture? And if so, where is the case recorded in which those fluids have cured gangrene? The truth is, the olive oil practitioner would have pronounced his patient better on the day the operation was performed and would have buried his patient along with his blunder a few days later. This patient owes his life to the diagnostic skill and sound judgment of Dr. Hall, whose hesitation or ignorance would have cost his patient his life.

My experience, while not so extensive as that of some, certainly entitles me to speak with some confidence as to the management of these cases. Within a few months I have seen probably twenty-five cases, some medical, some surgical, and this fact has been demonstrated, beyond the shadow of a doubt: that the foolish and irrational expedients that are so commonly recommended in this trouble, poultices, enemas, etc., are not only useless but positively injurious. They mask the condition and mislead the surgeon. Appropriate medicines will relieve promptly all *curable* cases; and when therapeutic measures fail to give relief it is an undoubted indication for immediate surgical interference.

There are, of course, those who believe that medicine will cure everything, and their testimony is almost as reliable as that of those who assert that medicine will cure nothing. Most of us are human; we are not blessed with an unlimited knowledge of an infallible materia medica, as some are, and

we must do the best we know how. When our best efforts at therapeutics have failed, we had better forget ourselves for a time, save our patient and argue the case later.

Appendicitis differs from most diseases in that *its true condition is masked*; many lesions of the brain are as clear as sunlight when compared with the changes in the cæcal region. The sportsman who drops his hook into thirty feet of muddy water and guesses from the impulse communicated to his rod what sort of fish he has caught on his line is likely to be correct once in a while, but it will be generally admitted that his task is easy compared with that of the physician who attempts accurate diagnosis in appendicitis. It is, in short, impossible.

The mortality from primary appendicitis is given at 12 per cent, that is, one in eight. Here are eighty-eight recoveries, all of whom oppose operation; the other twelve are in their graves, and are therefore not present to advocate either medicine or surgery; the vote is necessarily cast unanimously against operation. "Are we not an overwhelming majority? Have we not had appendicitis? Did not medicine cure us?" This is the town-meeting plan of deciding scientific questions. But the twelve dead are surely entitled to some consideration. There are, it is true, eighty-eight living, but they are booked for succeeding attacks, more dangerous than the first, and each attack is sure to decimate their ranks more disastrously than the one preceding. If all had been operated upon at the first symptoms of acute inflammation about ninety-nine would be alive instead of eighty-eight, a clear gain of eleven and a positive assurance against all future attacks.

In conclusion I may present some rules for general guidance that I think will prove reliable:

1.—The pulse and temperature are not safe guides as to the local condition.

2.—Cessation of pain may indicate either approaching recovery or impending death.

3.—Where acute pain is aroused by digital pressure over the cæcal point, operate at once.

4.— "Early operation" means before pus has formed.

5.—When pus has formed do not invade the peritoneal cavity unless such a course is imperatively demanded.

6.—Medical cases are relieved promptly by appropriate remedies; surgical cases ought to be relieved as promptly by surgery.

7.—To allow a gangrenous appendix to butcher a patient is worse than any abuse charged against surgery.

8.—One attack of appendicitis invariably predisposes to a second attack.

9.—Succeeding attacks are increasingly dangerous.

10.—A mistake on the side of non-interference gives the patient seven chances out of eight; a mistake on the side of interference, if mistake is ever made on that side, gives the sufferer forty-nine chances out of fifty.

11.—When in doubt, OPERATE.

Whilst I do not believe that one man's exprience should count for more than it is worth, I state it as a fact that all of my late operations (those with pus, preforations, gangrene and general sepsis) have died, every one of my early operations have recovered.

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