SHORT NOTES

ON THE

SURGICAL DISEASES OF CHILDREN.

BY

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Mr. President and Gentlemen:—What little I have to communicate upon the surgical diseases of children is based upon personal practical observation. It may not contain any very new information, but, as we are all interested, it will add at least something to our collective treasure of knowledge and experience. As such I offer the following remarks, leaving out all theory, criticism, and quotations:

I.—CONGENITAL.

Harelip.—For a single, simple harelip, after having tried the various methods known, I operate now with the object of not losing or destroying any tissue if possible. I insert a very fine needle knife and pierce through the skin of the lower margin of one corner of the lip, sweeping the knife around to the opposite corner, thus leaving a complete and continuous bridge between the two parts of the lips. (See Fig. 1: dotted line indicates the incision.) I then pull it down (see Fig. 2), and unite the wound with three or four fine cambric needles deeply inserted. Upon the needles a small piéce of cork is put upon each side (see Fig. 3); a single figure-of-eight ligature to hold it in its place, and the whole is pencilled over with flexible collodion. In youths or adults I use small glass beads instead of cork, two or three on each needle. If swelling should occur I can break one or more beads and thus relieve the tension. I prefer to operate as soon as possible; the earlier the better for the unfortunate creature and the better success for the surgeon. The advantages of this plan are that the cork as well as the glass does not irritate the skin, and if any swelling should

occur the ligature can be loosened without risk of separating the wound. The cork retracts slowly and enough to correct this swelling. Not dividing the lower margin nor sacrificing any tissue, leaves me a complete natural bridge,—a great advantage in cases where union by first intention is not obtained. It also fills up the gap better. The objections that one may

FIG. 1.

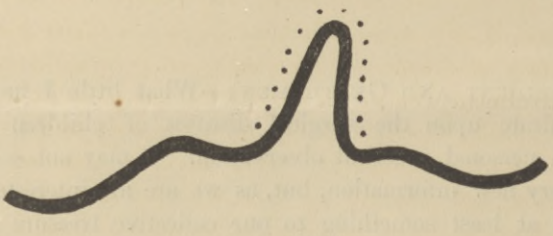


FIG. 2.

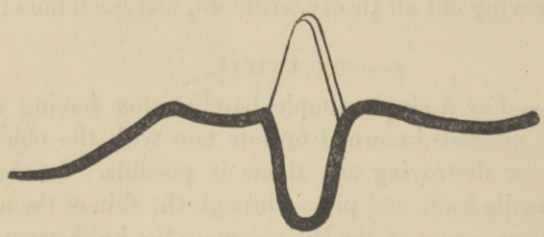
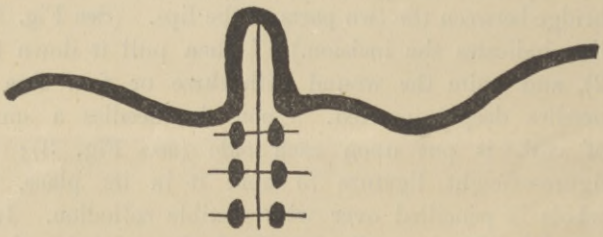


FIG. 3.



raise who never has tried this plan may be that it leaves a pendulum or a flap hanging down; but if you have patience and wait, that which at first may seem a little unsightly to the eye will in a few months disappear; so to say, it will be appropriated or absorbed by the surrounding tissue. If, however, there remains a small protrusion, it can easily be removed

with the knife to suit the case, and a much better result is obtained.

In double, simple harelip I operate on one side at a time. After a perfect or complete healing of the same I operate on the second.

In simple, complete harelip running into the nostrils I operate in a similar way, paring the edges according to circumstances, let the flap hang down, and remove the superfluous portion, if any, some time after union has taken place.

Hypertrophy of tonsils.—I have seen no permanent cure from any treatment whatsoever except the complete extirpation of the tonsils, which is to my mind the only safe treatment. Sometimes a temporary relief may be obtained by other remedies, but generally we find ourselves disappointed. I prefer to take out all of the gland, or as much as possible,—either one or both, as circumstances demand. The slicing off of a small piece only, and depending upon the remaining portion becoming smaller by atrophy, has been to me a disappointment. I have not observed impotence in adults who have had their tonsils removed in childhood. I know a few whose tonsils I removed when they were children; they grew up and married, and their wives and children, and the offspring, had all or most of the "ear-marks" of the tonsilless father; and I know more than one girl whose tonsils I removed that grew up, married, and became the mother of children.

Phimosis—Circumcision.—The frequency with which one meets with this affection and its many different degrees is remarkable; indeed, so remarkable that the question may be asked, What is really considered a perfect, natural prepuce? I would answer, Whenever the prepuce is so formed that the opening is sufficient to uncover the gland, or at least the greater part of it. And now I would ask, With how many such formed cases have you met? I have met very few that presented this condition. I observed closely every case when I was engaged in a pretty large obstetrical practice as a general practitioner years ago; admitting, however, that I operated comparatively seldom during that period, and then only in the most urgent cases, letting the greater part remain undisturbed,

like many other practitioners have done, and do now. What the beneficial or detrimental result of thus leaving to nature had in after-life in each and every case I cannot tell, but I do know that in some of the cases which I did not operate on I had an opportunity to correct, for some cause or another, this deformity during their childhood or later during their manhood.

To the question, When and how is the operation to be performed? my answer would be to the first, Whenever indicated and as early as recognized. To the second, Operate in such a manner as to accomplish the purpose well for which you operate. Every case stands upon its own merit; no one certain operation—no one certain method—answers in each and every case. Good judgment must be used in each separate case; and the kind of operation or method of operation indicated for each case should be separately selected, for the promiscuous slicing off of a piece of the prepuce, and clumsily done, may produce an evil as great or greater than the one which we aim to correct. I am guided by the following, and operate accordingly: If the opening of the prepuce is very small—the prepuce not too long—I make a simple incision with the knife upon the dorsal side, sufficient to uncover the gland completely, and in the majority of such cases a small or comparatively small incision will accomplish the object satisfactorily. In cases where the prepuce is extraordinarily long, with either a small or large opening, I prefer circumcision, removing more or less as the case may require. I use a flat forceps, made out of German silver, which I hand around for your inspection. You will observe that it has a channel which is intended for the knife to pass through. The prepuce is grasped with the forceps and the knife slides through the channel. I use ligatures occasionally and occasionally operate without ligatures, as the case may demand. I take plenty of time and try with the utmost care to make the operation as neat as possible and to leave a handsome and nice penis, so that the operation may be a credit to the surgeon, the member may be a benefit and comfort to the patient, and that others may derive pleasure therefrom. I need not mention all the defects and ailments for which this operation is recommended

as relief or prevention; neither will I speak of the mischief that may be done by an imprudent operation; it would take up too much time. I only wish to call attention to this important observation, that in cases where there is but a small opening in the prepuce and the prepuce is short, the gland not uncovered or has never been uncovered until maturity, there the gland is always very small and atrophied, the penis is not well developed, oftentimes very short, and then unseemingly so in comparison with the other parts of the body.

I operated upon a young, handsome, well-developed married man, the son of a physician, who had congenital phimosis, and who presented the above picture, and who informed me, like many others, that he never could enjoy the act of coition; that erections were always accompanied with pain, almost to distress. He had no children. Circumcision relieved the gentleman; in time the penis was better developed, and his family increased also.

II.—ACQUIRED.

Under the head of fractures and dislocations I will state that I find the latter, as a rule, easily reduced and kept in place; not often followed by unpleasant sequelæ, with the exception of dislocation of the head of the radius, which is the most difficult bone to replace into its proper position, and if success accompanies the attempt, it is as difficult to keep it there. The reasons why are obvious.

I would also call your attention to my method of reducing dislocation of the vertebræ by suspending the patient by the head. (See case reported in *Medical and Surgical Reporter*, Philadelphia, Pa., January 31, 1885, vol. lii. No. 5.)

Fractures I treat in the most simple manner. My observation has been that the more play and freedom you allow the little patient the better the result; that confinement of any kind does not suit children; it produces forced resistance and mischief. For instance, I treat fractures of the femur with a simple, single pasteboard splint, extending it from the crest of the ilium to below the knee, using a bandage and starch, and employing no extension or counter-extension; I leave the child alone upon a good mattress. After union has taken place I cut off the lower part of the splint a little above the

knee, so as to make a short femur splint, and again allow the little creatures the free use of their limbs. I am not afraid that they will abuse it.

In fracture of the radius near the carpal joint, the best result has been obtained by me with the straight splint upon the flexor side, from the elbow to the metacarpo-phalangeal joint, fingers free. After union has taken place, a light pasteboard splint is applied over the radial side for a short time for safety's sake, and free use of the arm and hand is permitted.

The epiphyses.—Separation of the epiphyses—I mean here by fracture—I see much more frequently in late years than formerly, in all shapes and forms, at all stages; sometimes directly after the injury has occurred; at other times weeks, months, and years afterwards. My observation has taught me that separation of the epiphyses of the humerus and femur are the most frequent, and no matter at what time the injury is recognized, nor how carefully it is treated, the results are never very satisfactory. The separated epiphysis is partly or completely absorbed and therefore have only partial or no union at all, and the limb will have a dangling motion, though time may improve the usefulness of the limb; but the patient never recovers as well as after a fracture in other parts of the bone.

Hip-disease.—In the second stage of hip-disease—that is, the stage of effusion—we have, among other symptoms, great pain. If the case goes from bad to worse,—that is, from the second to the third stage,—suppuration takes place, and as soon as the capsule is perforated the pain ceases. I have therefore been led in several cases to open the capsule by a subcutaneous incision during the second stage, with the most gratifying results. By this means I let the fluid run into the surrounding tissue, to be absorbed by nature. The pain ceases immediately; the patient is then put in as comfortable a position as possible; the limb is easily straightened by manipulation. The best method that I have employed is to put upon the patient a pair of wire breeches. No forced extension is employed. I will say that aspiration as a curative method has failed in my hands.

Extension and counter-extension, employed upon the fanciful

theory that thereby the head of the femur is separated from the acetabulum, is useless. In a healthy joint it cannot be done. The two surfaces are in such close relation—move upon one another so accurately—that there is no room; the vacuum is so small, indeed, and the joint hermetically sealed; therefore it cannot be pulled asunder. Separation of these two surfaces can only take place when disease has destroyed the ligaments and the capsule is opened.

Club-foot.—I do not think that we surgeons up to the present time have accomplished all that might be accomplished for the successful treatment of club-foot, notwithstanding all the modern improvements for the treatment and cure of the various kinds of club-foot. There is not a single method, ever so much praised, that will answer for all cases belonging to one or the other class of club-foot. There is no apparatus that will answer for all cases. Each case requires a careful study, and though several cases may present the same features, each separate picture may be produced by a different cause, consequently the treatment applied to the one case may not answer for the other. Has not every surgeon seen cases of club-foot successfully treated by one or another method? and has not every surgeon seen the same case so successfully treated by him fall into a relapse again after a time? Most certainly. Then what is the cause of these relapses? Has the fault been in our diagnosis or with our treatment? That is the question to be answered. Now, it may be with one or the other, or it may be both, or there may be something else which, as yet, we do not know; but certain it is that these relapses do occur over and over again, and more often than we are willing to admit. I think that success greatly depends on the diagnosis. A careful diagnosis between the physiological club-foot and congenital pathological club-foot of the infant is of the utmost importance; the first of which, according to my observation, every infant possesses in a greater or less degree, and which is always corrected as soon as the child begins to walk, and these are the cases that the child will outgrow. Now, if the apparent deformity of the physiological club-foot is subjected to the treatment of a congenital pathological club-foot, then surely there will be some mischief produced, and a permanent

deformity will remain in the future. When the child begins to walk, then the deformity will be increased and has to be corrected over again. Again, if a congenital pathological club-foot is looked upon as the natural physiological position of the feet, and left to itself to outgrow, we will be sadly disappointed again, for the deformity, if not corrected early, will increase rapidly and fearfully as soon as the child begins to use its feet in walking. It is more difficult then to correct the same; the more advanced the case the more severe treatment it takes. If no treatment is instituted the case grows worse and worse until at last no kind of treatment will correct the error. A correct diagnosis and as early a treatment as possible is essential for success. But different forms of treatment are required for the different forms of acquired or congenital club-feet. For example, to try to cure a club-foot or genu-valgus which was caused by congenital paralysis by complicated mechanical appliances would be in vain, and it would be useless to attempt to correct such a deformity by the operation of tenotomy, osteotomy, and so forth; it would not alone be a failure, but a discredit to the surgeon.

I pursue no one method for all cases. I adapt my treatment to each individual case, and am well satisfied with the general result that I have obtained.

Tracheotomy.—This operation is an unthankful one. Out of eight cases this year I have lost seven,—one of them died upon the table. It was a child only eight years old, the only daughter,—a handsome, bright child. All these cases I saw in the last stages of diphtheria or membranous croup, being called merely to perform the operation as a *dernier ressort.* The remaining cases all lived from two to twenty-four hours. They have occupied my mind, and I have asked myself the question, What can be the cause of all these fatal terminations? consoling myself at the same time that others have had no better luck. In my seven cases chloroform was administered and the operation done at night by gas or kerosene light. All care was taken by myself, and the necessary attention bestowed at the time and in the after-treatment by the watchfulness of the attending family physicians. Now, whether the chloroform, or possibly the mixture of the gas or kerosene

with the chloroform, may have been a factor in these cases I cannot determine; but it occupies my mind at present for solution. The eighth case—a child four years old—suffered with membranous croup, and the dyspnœa was very great; the patient was almost cyanosed. I operated without chloroform and quickly, on a bright day. This child recovered after careful treatment and attention by the family physician. About twelve years ago, during a season, I performed ten tracheotomies with five recoveries. It has not and may never again repeat itself. Tracheotomy for the removal of foreign bodies hardly ever terminates fatally.

Diseases and injuries of the spine are very interesting studies, and under that head I will only say a few words about what is known as Pott's disease. The principles of the treatment of the trouble, though important, are very well understood, but of the pathology of this affection I think we can still learn a good deal by more close investigation. The question is, What is the general cause? This seems, even at the present day, not quite settled; the opinions are various, and a few cannot give up the old inherited theory of scrofulous diathesis. My observation, studies, and investigation have taught me that in by far the majority of cases the cause of caries of the spine has been produced by mechanical injury. So with the diseases of joints, such as abscess, etc. The tubercular origin of such has not been, and cannot be, satisfactorily proven; it is only a convenient theory.

Mr. President, there are other interesting topics, such as congenital tumors, hernia, spina bifida, etc.; but I have already taken up my allotted time. One could write a good-sized monograph upon every single affection. The points which I have touched upon in this paper were brought forward for the purpose of eliciting discussion upon this interesting field of surgical diseases of children and thereby obtaining the views and opinions of others, in order that we might listen to the personal observations of so many distinguished gentlemen present here.

I should like to have said a few words upon laparotomy in children, but will reserve it for another occasion. I thank you for your attention.

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