JOINT MEETING OF THE PHILADELPHIA ACADEMY OF SURGERY AND THE NEW YORK SURGICAL SOCIETY

Held at the Jefferson Hospital, Philadelphia, February 10, 1926

DOCTOR CHARLES F. MITCHELL, President of the Philadelphia Academy, in the Chair

LARYNGECTOMY FOR CARCINOMA OF THE LARYNX

DR. FIELDING O. LEWIS presented six cases in which he had performed total excision of the larynx for carcinoma. The longest time that had elapsed since operation was four and one-half years. The most recent case was operated upon February 6, 1926. Three of the six patients were able to talk sufficiently well to make themselves understood. All of the three said that they were able to talk better after a large meal. The technic of the operation was illustrated by lantern slides. The operation in each instance was done in one stage, and rectal anæsthesia was used routinely.

DR. CARL EGGERS of New York, discussed Doctor Lewis' presentation, and said that as a general rule he favored the two-stage operation, especially where there was involvement of the lymphatics of the neck. He thought that perhaps laryngological surgeons did not have quite the same conception of lymphatic extension of malignancy as the general surgeon. He added, however, that Doctor Lewis' results spoke for themselves.

TULAREMIA

DR. JOHN B. FLICK read a paper entitled "Tularemia," containing a report of two cases.

SYPHILIS OF THE STOMACH

DR. J. STEWART RODMAN presented a colored man, aged fifty-two years, who was admitted to the Woman's College Hospital, November 9, 1925, on account of pain in stomach with vomiting for the past four months. Has lost 40 pounds in weight in the four months. Is afraid to eat on account of the pain. Bowels move regularly.

Abdomen.—Skin very dry and thin. No subcutaneous fat. Liver margin palpable two fingers below costal margin. There is a suggestion of a mass in the midline and just to the right and below the liver. Very tender over this same area. No rigidity, no other masses felt. Extremities negative but very thin. Reflexes negative. Wassermann—4 plus.

X-ray showed the greater curvature of the stomach in its upper half marked irregularity in contour, with a narrowing of lumen, evidently due to a pathological process. There is extreme tenderness over this area. The pylorus appears to be normal. The duodenal cap is large, with a filling defect on its upper border and with adhesions about the duodenum. There was no obstruction to the passage of the meal, but rather a hypermotility of the entire tract, as the whole meal was evacuated in about twenty-four hours. November 16, 1925, a laparotomy was done. On exposing the stomach it was found to be entirely occupied by a new growth from cardia to pylorus. Stomach was contracted, the growth felt hard and smooth. There was no glandular involvement either along the lesser or greater curvature. No evidence of metastasis to the liver or other abdominal viscera. Because of the fact that the entire stomach was apparently involved in the tumor mass; that the

patient's condition did not warrant a total gastrectomy, and that it seemed necessary to feed him, a jejunostomy was done. The patient left the operating table in good condition.

Post-operative Record.—After the fourth post-operative day, the patient began to feel most comfortable, feeding through the jejunostomy opening having been started on the second day. At this time he was put on mixed treatment of biniodide of mercury gr. 1/32; potassium iodide gr. 10, three times daily. His improvement began almost at once and at the end of two weeks following operation he was able to take a semi-liquid diet without pain. His condition continued to improve and a second X-ray was taken six weeks after operation, at which time he was eating soft diet without any discomfort. This second X-ray showed a very marked improvement in that the tumor mass was apparently greatly reduced in size, and in fact the stomach, although contracted, filled with bismuth throughout. He was discharged from the hospital on the 30th day of December, 1925.

On the day of this report, February 10, 1926, his improvement has continued. He has gained about twenty-five pounds in weight, is eating any kind of food and digesting it without pain and his jejunostomy opening is closed.

In comment the speaker referred to the paper of Doctor Hartwell in the ANNALS OF SURGERY for April, 1925, in which Doctor Hartwell has reviewed the literature and finds since the original report of Andral in 1834 of two cases, that there have been some twenty-three others in addition to those reported by G. B. Eusterman in 1923 from the Mayo Clinic. Chiari, in 1891, in reporting two cases and in collecting seven from the literature, stated that it was his belief that only histological proof of syphilis of the stomach should be accepted. Since that time the Wassermann and X-ray have been perfected and is more to be relied on at the present time, in the writer's opinion, than histological findings in so far as syphilis is concerned.

This case is reported, therefore, as an instance of syphilis of the stomach because of (1st) the fact that he unquestionably had a tumor of the stomach as proven by clinical history, X-ray and operative findings. (2nd) That he had a positive Wassermann, it being 4 plus. (3rd) That the X-ray findings were characteristic, and (4th) of his rapid improvement under anti-syphilitic treatment.

SIMULTANEOUS BILATERAL MAMMARY CANCER

DR. EDWARD J. KLOPP presented a woman, sixty-three years of age, who noticed a lump in the left breast in March, 1924. At examination April 16, there was found in the left breast a small hard, movable nodule, about 3 cm. in diameter, in the upper outer quadrant of the left breast; no palpable nodes in the corresponding axilla. A similar mass was found in the right breast partly beneath and to the left of the nipple. She had no knowledge of this second tumor. The right axilla also was free of palpable nodes. The breasts were smaller than the average.

There had been no pregnancies. Menopause at forty-five with no unpleasant symptoms. X-ray of her chest showed no evidence of pulmonary metastasis.

May 14, the left breast was removed by the Stewart technic; twelve days later the right was likewise removed. The pathological report stated that the microscopic appearance of the tumor from both breasts of this patient shows a very marked similarity in type. They are both adeno-carcinoma, and

the picture strongly suggests duct origin. The axillary glands of both specimens showed no microscopical evidence of metastasis.

This undoubtedly is a case of simultaneous cancer of both breasts, said to occur about once in five hundred cases.

IMPERFORATE RECTUM WITH VESICAL OUTLET

DR. EDWARD J. KLOPP presented a male child, born June 26, 1925. Birth was spontaneous. It was the sixth child. No other malformations in the family. The following day the baby was referred to the reporter at the Pennsylvania Hospital where it was admitted in Doctor Gibbon's service. The child had an imperforate anus. There was no anal dimple. The urine contained meconium. There was no discharge of meconium when the child did not void. Vomiting had not occurred.

The child was operated upon thirty-eight hours after birth. The perineum was infiltrated with ½ per cent. procain. An incision was made in the midline extending from the scrotum to the coccyx. The sphincter muscles could not be identified. Continuing upward for at least seven cm., he failed to find bowel. Crying and struggling caused some bulging from above, but not sufficient to definitely identify large bowel. Neither did he find the communication between the bowel and bladder.

Sigmoid colostomy was done and the bowel was brought to the surface of the abdomen with difficulty, as it seemed to be fixed below. The bowel was opened and a large catheter inserted. There was a copious discharge of meconium. The catheter was removed in three days. The perineal incision was allowed to close.

Feeding presented a difficult problem. Digestion was poor, but he began to gain consistently in September, and was referred to the X-ray department for the purpose of determining the location, position and contour of the blind pouch. The röntgenologist reported that the lower opening in the colostomy corresponded with the proximal loop of the bowel. At operation it was intended to bring the bowel up without twisting or changing its direction.

December 30, with a catheter in the rectal pouch an incision was made in the perineum and dissection carried upward until the catheter was felt through the bowel. After freeing it as much as possible it was brought down, opened and sutured to the skin.

The X-ray films with catheter in both proximal and distal loops shows that the afferent and efferent portions are close together for 3 cm.

January 25, 1926, a light hæmostat was applied to the spur between the two loops in order to crush the septum. Feces passed through the artificial anus five days later. The clamp was removed on the sixth day. X-ray with barium meal injected through the colostomy opening shows a slight narrowing about 6 cm. above the anus. Judging from the appearance of the shadow over the perineum there is no anal sphincter action.

The anus is about 1 cm. behind the normal location. It is doubtful whether anal sphincter action will ever develop, but is hoped that the levators will assume this function, at least in part. No attempt will be made to close the colostomy until it is found whether this procedure would be justifiable.

NERVE ANASTOMOSIS IN RECURRENT LARYNGEAL PARALYSIS

DR. CHARLES H. FRAZIER read a paper entitled "A Review of Results of Nerve and Anastomosis in Treatment of Recurrent Laryngeal Paralysis."

FECAL FISTULA

DR. JOHN B. DEAVER read a paper entitled "External Fecal Fistula Following Appendicitis."