TRANSACTIONS
OF THE
PHILADELPHIA ACADEMY OF SURGERY

Stated Meeting held February 13, 1919

First Vice-President, DR. GEORGE G. ROSS, in the Chair

CHOLECYSTITIS FOLLOWING TYPHOID FEVER IN CHILDHOOD

DR. HARRY C. DEAVER read a paper with the above title, for which see page 534.

PYLORIC STENOSIS IN INFANCY

DR. FRANCIS O. ALLEN read a paper with the above title, for which see page 531.

DR. HENRY R. WHARTON said that in the cases of pyloric stenosis seen by him a peculiar feature is the very distinct tumor which seems to be about the size of an ordinary shellbark hickory nut and which when divided separates almost like cartilaginous tissue. Doctor Allen spoke of a case in which he failed to find a pyloric tumor but did find adhesions. A few days ago the speaker had a case at the Presbyterian Hospital which had many of the symptoms of pyloric obstruction but in which they failed to palpate a tumor. The gastric peristaltic wave was present. Operation revealed no distinct pyloric tumor, but the pyloric end of the stomach was firmly adherent in the region of the gall bladder, and was separated with some difficulty. The following day the patient was doing very well, had no vomiting up to the time of his death. At the end of the third day the pulse failed and the patient died but presented no abdominal symptoms. Attention has been called to the fact that in these cases a certain number die with marked thymus symptoms. There seems to be some association between cases of thymus gland enlargement and pyloric tumor.

DR. H. C. DEAVER said that during the last five years thirty-four cases of pyloric stenosis had been under care at the Children's Hospital of the Mary J. Drexel Home. Dr. John B. Deaver and the speaker had operated upon an equal number.

In the early cases they did a posterior gastro-enterostomy for this condition, with a mortality of 18 per cent. During the past two years they have been doing the Rammstedt operation.

The youngest patient, a child six days old, was born in the Lankenau Maternity by Cæsarean section. This child vomited continuosly until the sixth day, when he was operated upon and a congenital stenosis demonstrated.

The Rammstedt operation is a very simple one, entailing little shock

and requiring not more than fifteen minutes for its performance. The amount of shock depends largely upon the condition of the child.

In their early work for this condition these children were emaciated and very poorly nourished, but during the last two years pyloric stenosis is being recognized, and hence these cases are being referred for operation much earlier than heretofore, and for this reason they are better subjects for operation.

Since they have been doing the Rammstedt operation their mortality has been 10 per cent. Hemorrhage has been a factor in this mortality. In releasing the stenosed pylorus care is necessary to guard against opening the lumen, especially at the duodenal end, where the bowel is very thin. This accident had happened to him in two instances. In both instances he promptly closed the perforation with no ill result.

He makes his incision through the anterior surface of the stenosed pylorus, making the incision parallel with the small vessels which run through the peritoneal covering; and, where there is bleeding, he transfixes the vessels and ties them. He never drops the pylorus back until he is sure that all oozing has ceased.

Regarding diagnosis, the only cases they get are those sent in by the pediatrician, the family physician never recognizing the condition. As a rule, these children are always emaciated and poor subjects for any operation. Fluoroscopic examination is a great help in confirming the diagnosis, and it also converts the skeptical.

Some writers say that the absence of bile in the vomitus is pathognomonic; he does not think this is so because the fluoroscopic examination has demonstrated in several instances the pylorus not completely obstructed. There has been absolute constipation in all their cases.

They had had two cases where the incision opened up on account of the sutures giving way. He now uses through and through silkworm sutures, not removing the sutures for ten days to two weeks.

In the thirty-four cases operated upon the diagnosis in each instance was confirmed by the operative findings.

The oldest child operated upon for pyloric stenosis was six months of age; the majority of the cases have been from six to ten weeks old.

Dr. E. L. Bauer said that the diagnosis of pyloric stenosis in practically all the cases he had seen in the services of Drs. Harry C. and John B. Deaver had been rather easily made. He had seen some cases in the dispensary and some outside. If there has been any question in diagnosis the fluoroscopic examination was made and the cases studied carefully, not, however, losing any time in this study. He was not in sympathy with the attempt to feed these children as suggested by many pediatricians. Practically all such methods fail. He believed the cases to be essentially surgical and should be referred to the surgeon promptly before the chances of benefit are lessened by temporizing with medical treatment. There is always a question of doubt in diagnosis in unoper

ated cases, particularly those that are reported as having recovered. In all the cases operated on by Doctor Deaver the pylorus was shown to be hypertrophied. Medical cases reported as recoveries are usually instances of digestive disorders in children simulating stenosis. The typical case is not likely to be overlooked. In a case at Hammonton seen in consultation by an acquaintance, the mother of the child had made the diagnosis from the text-book. If the family physician is taught that these cases should come to the operating table early the mortality records will be considerably reduced. The six-months-old child operated on by Doctor Deaver came into the Mary Drexel Home through one of the doctors on the surgical staff at the Lankenau to whom it had been referred. The child was extremely emaciated and in bad condition. The operation was attempted but with not much hope of securing good results. The child survived the operation and did well for about six weeks. It was thought that it should be kept in the hospital rather longer than the average child in order to feed it, but as with many of the cases staying long in the hospital, it picked up an infection and died of broncho-pneumonia six weeks after the operation.

DR. ALLEN, in closing, spoke of a case which he had not reported, that of a girl five years of age, who, he was convinced, had pyloric stenosis, but he was not able to prove it. There was enormous distention of the abdomen. The child was under the care of a physician during its life, being seen by him from time to time, and there was always present more or less stomach trouble. The distention was enormous. The child was having great difficulty in breathing, and though Doctor Allen could not offer any great hope of benefit, he thought he might relieve the distention by making an abdominal incision under a local anæsthetic and puncturing the bowel. He found that the distention was all in the stomach; the posterior wall of the stomach presented below the umbilicus. He put in a trocar and let out an enormous quantity of fluid and gas, but the child died before he could do anything further. He did not enlarge the incision to see what the difficulty was. The history suggested a pyloric obstruction and the distended stomach corroborated the diagnosis, but he could not say positively that a tumor of the pylorus was present.