TRANSACTIONS
OF THE
PHILADELPHIA ACADEMY OF SURGERY

Stated Meeting held May 5, 1919

DR. GEORGE G. ROSS, Acting President, in the Chair

RECOVERY AFTER OPERATION FOR TRAUMATIC LACERATION OF THE LIVER.

DR. JOHN B. ROBERTS presented a little girl about seven or eight years old who had rupture of the liver the result of an automobile accident which occurred about the middle of February. The child was sitting on the curb when the automobile struck her on the legs throwing her on her abdomen upon the pavement. She was brought into the Polyclinic Hospital suffering great pain in the upper abdomen. Percussion showed that there was fluid in the abdominal cavity. Upon opening the belly he found a tongue-shaped flap about 2½ inches long and 1½ inches wide had been torn off from the lower surface of the liver near the gall-bladder. The pedicle was posterior. There was blood in the abdominal cavity, the retroperitoneal space and in the layers of the gastrohepatic omentum. By turning the flap up and pressing a thumb upon it, it was held in place and the bleeding was checked. He put against the replaced liver tissue a packing of two yards of bandage 1½ inches wide. This he held in place by an old-fashioned glass drainage tube with its bell-shaped outer end against the packing and brought the end of the tube obliquely through the abdominal wall. The child was in the hospital for about two months and has now been out for two weeks. There will probably be a hernia where the packing was allowed to extend outwards. It was gradually removed in about three weeks. He presented the case because traumatic rupture of the liver with operative recovery is rather unusual. The fortunate result was due to getting the abdomen opened promptly and the torn piece of liver replaced before a large amount of bleeding had occurred. He reported some years ago to the College of Physicians of this city a case in which he lost a patient after traumatic rupture of one of the hepatic veins upon which he had operated.

DR. GEORGE G. ROSS said that he had had two cases of rupture of the liver from traumatism. Both were ruptures of the right lobe and both were treated by packing, without attempting to suture. The first case recovered after a stormy convalescence. In the second case after the rent had been successfully packed it was reported that one piece of gauze was missing. In order to account for this it was necessary to search the abdominal cavity and in so doing the gauze which had been packed into

the rent of the liver was displaced and before it could be put back the man bled to death on the table. In rupture of the liver with excessive hemorrhage and shock, a minimum amount of surgery is all that should be attempted. In three cases in which there was rupture of the spleen, instead of taking the spleen out, he used packing, with recovery in all three cases. In a case seen recently the patient was wrestling with another boy weighing 200 pounds who fell across his abdomen, causing a rupture of the spleen. The abdomen was opened by a left rectus incision and the rent in the spleen felt. Packing was inserted and the boy put to bed. He reported four or five months afterward apparently in perfect health.

A CHILD WITH DOUBLE CLEFT OF LIP AND PALATE, PROTRUSION OF THE INTERMAXILLARY PORTION OF THE UPPER JAW AND IMPERFECT DEVELOPMENT OF THE BONES OF THE FOUR EXTREMITIES.

DR. JOHN B. ROBERTS showed an infant of Italian parentage, belonging to a family in which there was a good deal of intermarrying. The parents of this child are first cousins. There are two living children, one eleven years; one, three, both girls. The first child, born in Italy, was a monstrosity and is dead. The two next children are normal in development. Three years ago a girl was born almost identical in deformities with this male child shown the Academy. The girl just mentioned died shortly after birth and this boy will probably not survive many days. He is now about a week old. (NOTE.—The child did die when fifteen days old.)

The X-ray pictures taken show that the femurs were quite well developed, but the bones of the leg proper on both sides are almost absent. The bones of the arm are apparently absent, though both upper extremities have the radius and ulna. The photographs accompanying this report show the peculiarity of the child better than any description that can be given in a short communication. Doctor Roberts expects to deposit the infant in the Mütter Museum. There is now in the Anatomical Laboratory of the Polyclinic Hospital the preserved body of the sister, born three years ago, belonging to Dr. Addinell Hewson's collection. The two children are almost identical in appearance, and the sister died when only a few days old as has previously been reported.

THE METHOD OF RECORDING SURGICAL OPERATIONS AT THE FRONT

DR. ASTLEY P. C. ASHHURST read a paper with the above title, for which see page 241.

DR. THOMAS F. MULLEN, Major U. S. A., of Pocatello, Idaho, said that he had had some experience with French and American records and he was absolutely in accord with what Colonel Ashhurst had said about the

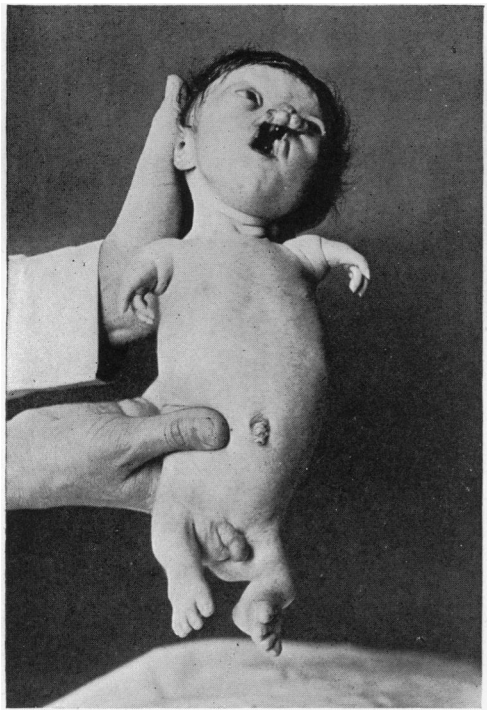

FIG. 1.—Louis M. Case of cleft palate and other congenital deformities of bones.

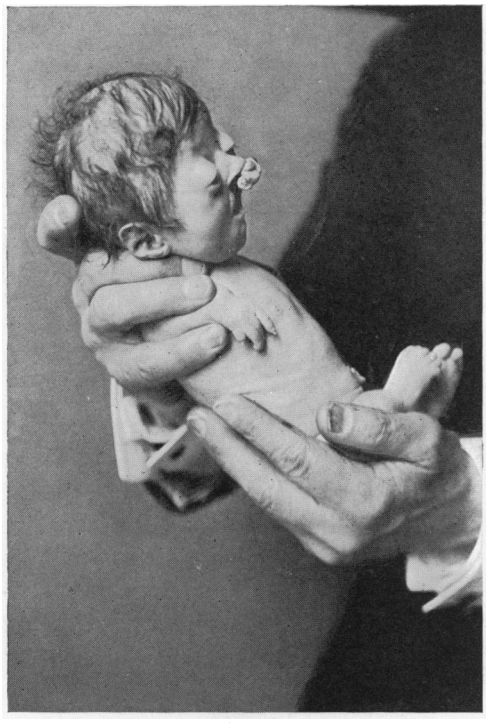

FIG. 2.—Same patient as Fig. 1, one week old.

completeness and the good appearance of the French cards. The American cards are usually written in pencil which is apt to be rubbed off and the cardboard breaks easily. It is interesting to hear what happens to the cards after reaching Washington, because in the midst of their work they received a general order that the surgeon in charge of the service must personally see that all field cards were kept, giving diagnosis, clinical, operative and final notes. Before leaving Paris an attempt to do that was made. Colonel Hutchins made very complete records, at his own expense in employing stenographers. In some instances he detailed their own clerks, but the records made in the operating room by the anæsthetist or assistant operator necessarily often proved unsatisfactory. The French record card was very good because it needed only a check or underscoring of one of the printed forms accompanying it. Usually they were enclosed in their envelopes and not apt to get lost. Often the American cards did not belong to the soldier of whose case they were supposed to be a record.

Dr. Charles F. Mitchell said that the British field card is a much smaller card than the French with four sides and is pretty much the same as Doctor Ashhurst described. It gives the name of the patient, when he was injured and other data, and is very satisfactory in every way. If an X-ray had been taken at the field ambulance or casualty clearing station all the data were on the card. If a case remained for some time at the field hospital some extra temperature charts accompanied the card. It seemed to him a great advantage to have everything on one card rather than to have a lot of papers with the card. It was a simple matter to make these memoranda and while working at the casualty clearing station Doctor Packard was with him, and while sewing up a wound he would take the notes dictated to him. He never felt that they needed a clerk. As a matter of fact, their quarters were so small that they would not have had room for more people. The English card is really the ideal one.

Dr. Edward B. Hodge said that he felt a good deal as did Doctor Mitchell. The French card looks like a good one, but he would prefer the British. An advantage of the British card was that it did not have loose slips of paper which could be easily lost. He never worked with the French but he could appreciate their thoroughness. Most of the trouble, in his opinion, was due to inexperience of operating teams. The British card is complete and thorough and, when well worked, went through in good style. All that was needed was there and, like everything else, when properly worked, gave good results.

Dr. George G. Ross asked Doctor Ashhurst whether he had seen the German field record card, which is made of material something like linen paper and is difficult to tear and has a series of perforations by which certain portions of the edges can be detached. There were five or six different headings, giving time of injury, character of wound, when first

aid treatment was given and whether operation had been performed. For simplicity and general outline of what had been done the card seemed to him nearer the ideal than any other seen. He happened to get one from a wounded German who was brought into the field hospital where he was working. Probably Doctor Ashhurst's approval of the French card may be due to the fact that he was able to read, talk and live French, which many others could not do. He asked whether about the time of the 18th and 19th of July at Soissons, when the men were coming back by the hundreds and the surgeons were working from twelve to thirty-six hours, they could be held morally responsible for not keeping accurate records.

At Field Hospital No. 12 there were three teams to start with, later increased to seven. There were three tables and one scribe to take all the notes dictated by the surgeons and the assistants. During six days 3500 patients passed through this unit. The notes were taken with pencil in bad handwriting and no doubt worse English. Copies were made of the data so that after all most of the material was preserved. In certain times of stress it was not possible to do this.