TRANSACTIONS

OF THE

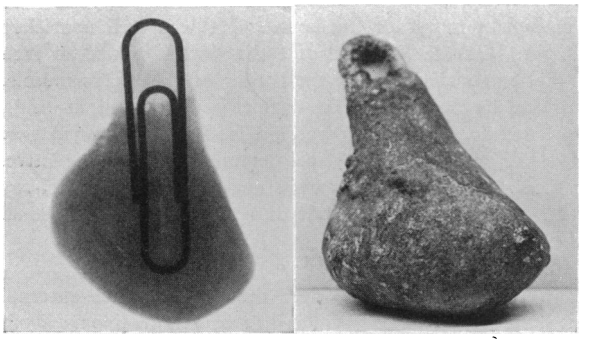
PHILADELPHIA ACADEMY OF SURGERY

Stated Meeting Held November 1, 1926

The Vice President, DR. ASTLEY P. C. ASHHURST, in the Chair

FOREIGN BODY IN THE BLADDER

DR. JAMES H. BALDWIN reported the history of a man, aged twenty-two, who was admitted to the Methodist Hospital, March 22, 1925, with the history that for a year he had suffered with a severe bladder irritation, with increasing frequency of urination and marked dysuria. No history as to etiology could be obtained from the patient, although he was of course definitely aware of the cause. An X-ray taken showed a vesical calculus containing a foreign body. (Fig. 1a.)



a b

FIG. 1a.—Skiagraph of paper clip encrusted with urinary salts. b. Encrusted paper clip removed from bladder.

This was removed through a suprapubic incision. The patient made a prompt and uninterrupted recovery. The foreign body was found to be a paper clip encrusted with urinary salts. (Fig. 1b.)

OBLITERATIVE ENDOANEURISMORRHAPHY FOR POPLITEAL ANEURISM

DR. J. STEWART RODMAN presented a man, aged fifty-six, who was admitted to the Presbyterian Hospital, May 6, 1923, complaining of swelling in left popliteal space.

About two years ago, patient first noticed swelling in left popliteal space about the size of a walnut, which has gradually increased in size. It was never painful until about a month ago, when walking home from work, he was seized with cramp-like pains in leg. He went to bed for three days; but had had no pain for two weeks prior to admission.

Examination revealed a pulsating mass in the course of the popliteal artery. The blood Wassermann was negative.

May 10, 1926.—An incision about four inches long was made in the left popliteal space and the popliteal artery exposed. A small aneurism was found. The vessel was clamped above and below and the aneurism opened. A well-formed clot was removed and both ends of the aneurism obliterated. The wound was closed in the usual manner. Convalescence was complicated by a slight wound infection and a bronchopneumonia.

Six weeks after the operation, the wound was clean, but the leg slightly swollen. This disappeared by the time of his discharge from the hospital, July 25, 1926, ten weeks after operation.

When seen three weeks ago, there was no further trouble with the leg and no intermittent claudication. The foot on the operated side was as warm as its fellow. The posterior-tibial pulse cannot be felt on the operated side.

PERSISTENT SKIN ULCERATION IN AXILLA

DOCTOR RODMAN presented a second patient, a man, aged thirty-three, who was admitted to the Womens College Hospital, July 23, 1924, complaining of a painful mass in left axilla.

Five months prior to admission he had an infected index finger of the left hand, which healed slowly. Five weeks prior to admission, he first noticed a small mass in left axilla, which gradually increased in size. Two weeks prior to admission the mass had been lanced in the dispensary. He stated that he had had blood poisoning in 1911, scarlet fever in 1915, electric burns of arms, hands and face in 1922, and occasional attacks of renal colic on the right side.

Examination revealed palpable lymph-nodes in the neck and inguinal region. There was an erythematous, irregular flush over the neck and upper part of sternum, but none on the chest or abdomen. Scars of old burns were present over both hands and arms, and the left arm was painful on motion. In the left axilla there was a non-fluctuating swelling, which was incised and a small amount of pus was evacuated and the wound packed with Dichloramine-T. Examination of blood revealed a polymorphonuclear leucocytosis with slight secondary anæmia. The blood Wassermann was negative.

Discharged to out-patient department on August 4, 1924, and made daily visits, until December 27, 1924. The lesion refused to heal completely. As it healed in one direction it spread in another, having resisted all treatment. He was readmitted on February 17, 1925. X-ray examination of the chest failed to show evidence of bone involvement around lesion in left axilla.

At this time the edges of ulcer were curetted and packed with iodoform gauze. The pathologist reported that the sections showed probable tuberculous granulation tissue. No evidence of pulmonary tuberculosis could be found. The affected area grew gradually larger, extending to the arm.

September 30, 1925, he was readmitted, the area cleansed, and wet dressings applied, and on October 2, 1925, the edges were again curetted and the entire area skin-grafted. A second pathological examination of curettings resulted in a diagnosis of tuberculosis of the skin.

When he was discharged November 19, 1925, most of the grafts were lost, but a few remained healthy. He was then referred to the dermatological clinic. Mercury and iodides were administered empirically but without effect. At the present time, the condition of the patient is substantially unchanged.

DR. J. VICTOR KLAUDER remarked as to the pathology of this case that the pathologists did not agree to the diagnosis of tuberculosis. The consensus of opinion was that it was not a true picture of tuberculosis of the skin. Epithelioma can be ruled out clinically as well as histologically. Chancroid may also be ruled out. It fits best into that type of ulceration described by Sutton, of Kansas City, as tropical ulcer. Etiologically, it is variety of spirochætal infection; other investigators have found the spirochæte in this form of ulceration.

The study of these cases should always include a dark field examination and a histologic examination for spirochætes. There is also described a rapid ulcerative process.

The treatment of these cases is difficult. Neoarsphenamine should be used; it does serve a useful purpose, probably because some of them are infectious cases. In addition it is well to use general antiseptic and dietetic treatment. Another feature which was eliminated in diagnosis was granuloma inguinale. The question of a dermatitis self-produced was brought up, but there seemed to be no motive for such, and the man seemed to be emotionally normal.

DOCTOR RODMAN stated that in connection with Doctor Klauder's remarks concerning the fact that this case best fitted into that type described as tropical ulcer, it might be mentioned that the patient had just informed him that he spent fifteen years in the tropics—Panama and Colombia.

RECURRENT HÆMATEMESIS DUE TO SPLENIC ANÆMIA, APPENDICITIS AND CHOLELITHIASIS

DR. DAMON B. PFEIFFER reported the case of a woman, aged thirty, white, American, who was admitted to the Presbyterian Hospital, July 1, 1926, with a typical attack of appendicitis which had begun the previous day. Fourteen months previously she had been referred to the reporter for an opinion on account of recurring severe gastric hemorrhages. She was then twenty-nine years old. The family history was negative. Except for mild scarlet fever and mumps her only indispositions had been occasional attacks of nausea and vomiting called bilious attacks. At times she thought she became yellow, but no definite history of jaundice was obtainable. Her digestion was good and she was considered the healthiest one of a large family. There was no history of malaria or suspicion of syphilis, later verified by a negative Wassermann. At the age of nineteen, without premonitory symptoms or known cause, she suddenly became nauseated and vomited a huge quantity of bright red blood and clots. This was repeated five times during several days and she became weak and anæmic. Recovery, however, was then rapid and she felt well, having no symptoms, digestive or otherwise. Since then at irregular intervals of several years she has had similar attacks of profuse hæmatemesis coming on without warning and persisting until she was almost exsanguinated, followed by rapid and symptomatically complete recovery. She never had had purpura but just before her first hemorrhage she says that she had a tooth pulled and bled profusely.

She was a well-nourished, healthy looking woman of clear complexion, not anæmic at this time and the abdominal examination was entirely negative. She was not again visited until she came into the hospital in this attack, fourteen months later, having been entirely well in the meantime.

At operation, which was performed immediately, he explored the upper abdomen before disturbing the region of the appendix. The gall-bladder was thickened and smaller than normal. The stomach and duodenum presented no abnormality to palpation. The spleen was markedly enlarged and extended down to, but not below, the costal margin. It was not deemed advisable to carry out any upper abdominal procedure at this time on account of the condition of the appendix which was gangrenous throughout and buried beneath the cæcum and ascending colon. It was evident that chronic disease had long antedated the acute attack. The appendix was removed, a drain

placed in the bed of the appendix, emerging through a stab-wound in the loin, and the anterior wound closed. The next day she vomited eight ounces of blood and thereafter continued to pass tarry stools for several days, becoming very anæmic and weak. Aside from hemorrhage, the abdominal condition was entirely satisfactory. The abdominal wound was healing by first intention and the drainage in the loin was moderate and of the usual fetid character seen in bacillus coli infections.

July 8 the blood count was as follows: Hb. 30 per cent., red blood-cells 1,590,000, white blood-cells 15,850. July 12 she received a pint of blood by the citrate method and suffered a slight reaction a few hours later. Her convalescence after this was uneventful. She recovered rapidly. August 6 the blood showed Hb. 45 per cent., red blood-cells 2,580,000, white blood-cells 4000. She was discharged August 8.

It was intended to have her return to the hospital later for cholecystectomy and splenectomy, with a view to obviating, if possible, further hæmatemesis. She was troubled slightly with indigestion, but continued to improve until September 3, 1926, when she was awakened at 3 A.M. by a desire to go to stool. She went to the bathroom, passed a tarry stool, and vomited a large amount of blood. In the next two days she had six severe hemorrhages. The following day she was brought to the hospital and was given 5 c.c. of thromboplastin, intramuscularly. September 5, she was given 500 c.c. of blood by the citrate method. No reaction followed but the day following she vomited about the same amount of blood that she had received. Two days later another small hemorrhage occurred following which there was no further hæmatemesis. At this time the blood count showed Hb. 20 per cent., red blood-cells 1,270,000, white blood-cells 4400. She was again transfused without reaction. Following the cessation of hemorrhages, her recovery was rapid. October 15 the blood showed Hb. 55 per cent., red blood-cells 2,850,000, white blood-cells 5300; coagulation time five minutes; bleeding time two and a half minutes. The following day, almost eleven years from the date of her first hemorrhage, the reporter removed the spleen and the gall-bladder. Another transfusion was given before she left the table. The spleen had increased in size, its lower border being three finger-breadths below the costal margin. There were no adhesions. The vasa brevia were large and thin-walled. The attempt to deliver the spleen in order to attack the pedicle from behind, ruptured some large vessels in the lieno-phrenic ligament and the attempt was abandoned, the bleeding being controlled by a gauze pack. The pedicle was then divided anteriorly in sections and tied and the organ removed without much loss of blood. It was noteworthy that all vessels, including those in the abdominal wall, showed an increased tendency to bleed. The torn vessels posteriorly were secured with a snaking suture. The gall-bladder was thickened and adherent to the duodenum and very atrophic. It was removed and the cystic duct tied. Both duct and gall-bladder contained pultaceous precipitated bile salts. The cystic duct was tied and an attempt made by suture to control oozing from the cystic fossa. The liver was so soft, however, that this had to be abandoned. Oozing was controlled by pressure with a gauze pack for a few minutes. The operation was performed through a left rectus incision and a stab drain placed through the right rectus muscle into the cystic fossa. The liver was dark, congested, and as previously stated, unusually soft rather than cirrhotic. The stomach and duodenum showed no visible or palpable abnormality other than the varicosity of the vasa brevia above mentioned. The incision was closed without other drainage. Convalescence was uneventful.

The blood count, October 30, showed Hb. 65 per cent., red blood-cells 3,310,000, white blood-cells 6600. Differential, polymorphonuclears 55 per cent., small lymphocytes 11 per cent., large lymphocytes 2 per cent., large mononuclears 11 per cent., eosinophiles 14 per cent., basophiles 4 per cent., megalocytes 4 per cent. Poikilocytosis and anisocytosis; no normoblasts. Reticulated cells 4 per cent., blood platelets 450,000 per c.c.

DOCTOR PFEIFFER remarked that the explanation of profuse gastric hemorrhage, and therefore the appropriate procedure to be used in treatment, are often difficult. The pathology of certain types is sufficiently clear, such as the erosion of a vessel in the bed of an indurated ulcer, benign or malignant, or the rupture of an œsophageal varix. Benign tumors such as myoma or polyp, while uncommon, may bleed profusely. On the other hand, the source of the bleeding and reason therefore are not always apparent. The descriptions of so-called mucous erosions are not convincing as an explanation of massive gastric hemorrhage and to most of us this conception seems scarcely more than a refuge when the actual source remains unknown as may well happen in the difficulties and dangers of complete examination under clinical conditions. The "exulceratio simplex" of Dieulafoy seems better attested and there is no reasonable doubt that on occasions an acute gastric ulcer may open a vessel of sufficient size to provide alarming hemorrhage. The rôles of toxic states, infective or otherwise, of jaundice and blood dyscrasias, of coexistent disease of the appendix or gall-bladder in gastric hemorrhage are far from clear. It is certain, however, that certain splenic enlargements are prone to be associated with gastric hemorrhage and in several fatal cases large varicose veins in the fundus of the stomach have been found post mortem, erosion into one of which veins has been the source of the hemorrhage. It is not necessary that the liver be cirrhotic in all cases of varicose veins of the stomach. In the case of splenic enlargement it seems probable that the greatly increased blood supply to the spleen results in a similar increase in that of the fundus of the stomach through the left gastro-epiploic which in time causes enlargement of the drainage veins of this area. Presumably the hemorrhages of splenic anæmia are due to the ease with which superficial erosions of the gastric mucosa may open a vessel of considerable size. Hence it is that such hemorrhages are apt to recur even after the spleen has been removed, since the change in the venous channels must be permanent to a considerable extent. That these cases are less often fatal than massive, bleeding from callous ulcer may be due not only to the fact that in ulcer the vessel lies in fibrous tissue and is unable to retract or contract, but also because the bleeding vessel in ulcer is often an artery while in splenic anæmia it is a large venous channel containing blood under low pressure. Splenectomy is the treatment of choice and in many cases has resulted in cessation of hemorrhages. In late cases, however, bleeding often recurs. During the stage of active hemorrhage operation is inadvisable and these cases rarely die of acute loss of blood unless their general health is depleted as in the later stages of the disease. Supportive measures, with transfusion

if danger becomes acute, will usually bring the patient into condition for an interval splenectomy.

DR. JOHN B. DEAVER remarked that he sees a number of these cases; only recently he operated upon a similar case where the only symptom was hæmatemesis. In his experience the hemorrhages frequently recur even after ten or more years of supposed cure. A number of such cases have resulted fatally. He sees more liver changes, personally, than are reported in the literature and a small percentage with extensive ascites; this, however, does not prevent recovery after splenectomy. The condition, in his experience, is not at all uncommon.

DR. JOHN EIMAN demonstrated lantern slides made from colored photographs, of the specimens removed at the operation upon Doctor Pfeiffer's patient. The photographs were made by the new German process, which is somewhat similar to the lunear but which gives a much finer differentiation. The process is comparatively simple, and anyone familiar with ordinary photographic work can, with a little experience, prepare these color plates. It is impossible to reprint them on paper except by a three-color process, which is very expensive. The advantages of having a permanent and accurate record of this type are very great.

GAS GANGRENE IN CIVIL SURGERY

DRS. JAMES H. BALDWIN and WILLIAM R. GILMOUR read a paper with the above title, for which see page 161.

DR. JOHN EIMAN recalled two cases of gas gangrene which had occurred at the Presbyterian Hospital and had possibly been reported by Doctor Jopson.

One was a colored boy whose biceps was cut. The serum saved his life.

The second case was a case of ruptured appendix with localized peritonitis. Hypodermoclysis of salt solution was given and 24 hours later the patient developed gas gangrene at the site of puncture. The possibility of infection having been carried under the skin by the hypodermic needle was considered, but this could be eliminated. The literature disclosed the fact that German writers had reported similar cases. They have been able to prove definitely that these individuals had in their systems and possibly in their blood streams some of the gas bacilli and the needle produced trauma sufficient to start trouble.

DR. THOMAS SHALLOW said that he had seen a case of this kind the year before last at the Blockley Hospital. The patient had a hypodermic syringe used at 9 P.M. and was dead at four the next morning from gas gangrene. The patient was under treatment for cardio-renal disease.

He recalled another case in the Philadelphia Hospital which would seem to be gas gangrene, from all the symptoms. The patient had a head injury, due to a blow from a foreign body. Gas gangrene developed. In neither of these cases was there any crushing injury, such as is usually described as preceding gas gangrene.

DR. DAMON B. PFEIFFER remarked that he saw a case of gas gangrene several years ago following a hypodermic injection. The injection was given in the morning and in the middle of the day the gas gangrene infection was present. By four o'clock the patient was dead. He is particularly interested in the remarks made by Doctor Eiman. It was felt that some one in the hospital might have had something to do with the introduction of the infection. They never thought of the patient's having had the infection and the hypodermic injection merely being responsible for its localization.

SURGICAL PATHOLOGY OF THE GALL-BLADDER

DR. V. G. BURDEN read a paper with the above title, for which see page 239.

DR. JOHN B. DEAVER said that biliary cirrhosis, the result of gall-bladder disease, should be mentioned. He recalled the case of a prominent Philadelphian who was operated upon for this condition. He is now seventy years of age, and is better than he was ten years ago, before he had any trouble. This is the result of prolonged common duct drainage.