TRANSACTIONS

OF THE

PHILADELPHIA ACADEMY OF SURGERY

Stated Meeting Held May 2, 1927

The President, Dr. Charles F. Mitchell, in the Chair

EXPERIMENTAL SURGERY OF THE ŒSOPHAGUS

Dr. George L. Carrington, of Durham, N. C., by invitation, read a paper with the above title, for which see vol. lxxxvi, page 505.

The author said that the object of his work was first to get satisfactory anastomosis and then substitution. Mobilization of the stomach, pulling it up into the chest and resuturing it to the diaphragm is what the speaker has had in mind. Considerable care is required in the suture to the diaphragm or else hernia may occur and the dog die, if not promptly of dilatation of the stomach; then certainly a few weeks or months later. The mechanical part of such an operation can be handled, but the thing that worries one is the question of infection. Other surgeons interested in the chest have encountered the same difficulties. Some have had the experience of losing all the dogs operated upon and others feel that they can open the chest with impunity. Two workers, whom he has consulted, have had adverse experiences. One thought that dogs that came through without infection had had distemper and recovered, and those that died had not had distemper. Another had come to the conclusion that the pleura was very susceptible to infection. If the question of biological or chemical immunization can be worked out satisfactorily, the surgeon can then feel safe in performing many chest operations now seldom attempted.

PERFORATION OF THE GALL-BLADDER

Dr. Emory G. Alexander read a paper with the above title, for which see page 765.

Dr. John H. Jopson recalled that this subject was discussed before the Academy in 1913. At that time, several cases were reported. He himself had had two cases of acute perforation into the peritoneal cavity. In looking up the literature, the latest statistics at that time showed 50 per cent. mortality, which is about the same as at present. This winter he had a third case with certain interesting features—among others, the vomiting of blood. Doctor Jopson had been impressed with the fact that the cases seen of rupture into the free peritoneal cavity are cases in which the danger symptoms have been disregarded too long, not only by the physician but often by the patient, and it is a wonder that, treating gall-bladder cases as we do, the accident does not take place more often. Of course most surgeons hope

to be able to tide the patient over the attack of acute cholecystitis until the acute symptoms subside. This is the speaker's practice. In a case outside the hospital or even in the hospital, he tells the consultant or resident that the continuance of intense pain will mean operation, even if the time does not seem suitable, because in his experience these are the cases which perforate. For example, the case this winter was that of an elderly man, who had had repeated attacks of gall-bladder disease. He was seen after he had been ill for a week and a diagnosis of probable empyema of the gall-bladder was made, pointing out to his physician that a recurrence of severe pain might indicate perforation. The following morning the patient vomited blood and was more or less collapsed. Operation was performed on the same day while in a desperate condition. The gall-bladder had perforated into the peritoneal cavity and a large number of small stones were found in the subhepatic space. These were scooped out as thoroughly as possible. A cholecystostomy was performed and subhepatic drains inserted. For a long while stones were washed out of the drainage tube. He finally recovered. The condition is akin to perforated duodenal ulcer as an emergency and in his opinion much more serious. The speaker expressed surprise that there were not more cases of the encapsulated type of perforation in the Episcopal Hospital series, as he had thought that they were more common than Doctor Alexander reported. There, cholecystectomy is usually the operation of choice.

DR. A. P. C. ASHHURST said that since the meeting to which Doctor Jopson refers, Dr. J. J. Buchanan, of Pittsburgh, before a meeting of the American Surgical Association, stated that he thought cases of biliary peritonitis without visible perforations were due to retroperitoneal perforations, and the bile trickled out through some aperture not seen at the operation. The fact remains that in a number of these cases, the surgeon declares he has seen bile "sweat" out of the gall-bladder. This bile can be wiped off. One condition which may be mistaken for a pericholecystic abscess is passive congestion of the liver from heart disease, and this should be borne in mind. The speaker was fooled once. The patient was a very fat woman, desperately ill, and with a tender mass in the gall-bladder region. The presence of cardiac decompensation was recognized but it was thought she was forming a pericholecystic abscess. Operation revealed a large blue liver. It was then realized that she had congestion of the liver from her heart lesion, and she died from the latter condition three days later. Another time, a patient was sent to Doctor Ashhurst by her physician with a diagnosis of gall-bladder disease. He thought she had only passive congestion of the liver and did not operate, this patient got well.

CHRONIC INTRACRANIAL HEMORRHAGE

DR. FRANCIS C. GRANT read a paper with the above title, for which see vol. lxxxvi, page 485.

DR. J. S. RODMAN said that generalized subdural hemorrhage is more

common than localized but localized hemorrhage is notorious for its difficulty of diagnosis. Persistent irritating phenomena following trivial injury is at least suggestive of localized hemorrhage. The mortality is high and the speaker regards Doctor Grant's estimate of 25 per cent. as too conservative, believing that 45 per cent. is more nearly the average.

VITAL FACTORS IN THE MANAGEMENT OF PROSTATIC OBSTRUCTION

DR. B. A. THOMAS read a paper with the above title, for which see vol. lxxxvi, page 563.

TREATMENT OF BURNS

DR. WALTER ESTELL LEE and DR. WILLAIM MCCLENNAHAN (by invitation) showed a film of motion pictures illustrating the progress of a severe burn case. The film followed the case from the admission to the hospital, through the various stages of the treatment and finally to the autopsy at which a " Curling's Ulcer " of the duodenum was demonstrated.