

TRANSACTIONS OF THE PHILADELPHIA ACADEMY OF SURGERY.

Stated Meeting, October 5, 1896.

CASES OF ABDOMINAL CYSTIC TUMOR IN THE MALE.

DR. W. J. HEARN read a paper with the above title, for which see page 703.

DR. H. R. WHARTON said that he had not injected hydroceles for several years. He simply exposed the sac, cut out a small portion, and sutured the edge of the tunica vaginalis to the skin with catgut sutures and put in a little piece of gauze or protective. The cure seems to be radical, the patients have all gotten well, and there has been no constitutional disturbance. This is simply the revival of an old operation with aseptic precautions. He had never been troubled with severe sloughing, but it was very important that great care should be exercised as regards asepsis, for if the sac becomes inflamed serious complications may follow. With regard to bilocular hydrocele in which the liquids in the two sacs were different, he had seen several such cases. The turbid fluid probably contained spermatic elements. He thought these multiple hydroceles were apt to be spermatocetes, at any rate one of the sacs is apt to contain spermatic elements. He operated recently on a case of that kind by incision, and stitching the sac to the skin which did well. In this case an examination of the fluid showed it to be teeming with spermatic elements. He was inclined to think that it would be safer in almost every case of hydrocele to make an examination of the fluid before operation. He did not know that spermatocetes were operated on with any especial danger, although they used to be considered unfavorable for injection, for testicular complication used to follow injections in these cases, while such complications were extremely rare in cases of ordinary hydrocele treated by injections.

OPEN MEASURES IN THE TREATMENT OF SO-CALLED
SIMPLE AND COMPOUND FRACTURE.

DR. O. H. ALLIS read a paper with the above title, for which see page 698.

DR. W. J. HEARN said that a simple fracture may not be so simple after all, as in the case of a boy recently under his care who had fallen and sustained a fracture of the femur, the bone almost penetrating the skin. Dr. Allis was with him; they opened it up and made a compound fracture of it. It was a good thing that this was done, for otherwise they could never have gotten union. A few months since he had a case of fracture of the clavicle which he could not keep in position. He converted it into a compound fracture, and then found that the cause of the trouble was that a piece of the clavicle had broken off and had become interposed between the ends of the main fragments. He wired the fragments together and union with very little deformity resulted. He had frequently treated such cases in this way and had had very little deformity. He made an incision below the clavicle and lifted up the flap. It was a very easy operation and any novice could do it. He had employed silver wire and had had no bad results. In an article recently on fracture of the clavicle a case was mentioned where a hæmatoma had formed over the clavicle. The surgeon opened the hæmatoma and the patient expired. It was apparently a simple fracture, but the fragment had evidently penetrated a vein, through the opening in which air had entered causing death.

DR. THOMAS R. NEILSON agreed with Dr. Allis in the suggestion that unfortunate results may occur from confusing the terms "simple" and "compound." All who have had much hospital experience have seen cases of so-called simple fracture, where interference for the better apposition of the fragments was necessary, and sometimes imperative in order to obtain reduction at all. He had had several such cases, and had opened them fearlessly. In such cases the procedure is not only indicated but demanded. A surgeon would hardly be justified in leaving a case of fracture in bad apposition, when he could get perfect apposition if he were to open the parts. He always pursued the course which Dr. Allis had suggested in handling compound fractures,—viz., open freely and effect perfect apposition, if necessary, by mechanical means, after which he applied a fixed dressing without too close apposition of the wound.

DR. H. R. WHARTON emphasized the statement of Dr. Allis that simple fractures are often complicated. He had often, after amputations, examined simple fractures in the amputated parts and had been surprised to see the extensive comminution of the bone or the extensive laceration of the soft parts. Since he had been wiring and making primary fixation in compound fractures he had been impressed by the amount of damage to the bone and soft parts that results from fracture. On the surface there may be only a small wound, but when the parts are laid open extensive laceration is found. From his experience with ununited fractures he believed that almost all cases of non-union result from muscle or fascia being interposed between the fragments of the bone, and that improper dressings had very little to do with non-union in fractures. With regard to primary fixation in simple fractures he believed the time would come when surgeons would interfere with simple fractures more freely. In cases of simple fracture with extensive laceration of the soft parts, he considered the safest procedure to be to make a clean incision. As to the nomenclature of fractures, it is hard to change the present names. The terms "open" and "closed" fractures express the conditions very well and are good terms. With regard to wiring simple fractures this may be required where it is impossible to keep the fragment in apposition. He had recently wired a simple fracture of the clavicle where this condition existed, with good result.

DR. JOHN B. ROBERTS said that some time ago he suggested that the terms "open" and "closed" be used in the description of fractures. There are certain so-called simple fractures that should be opened. He had dwelt upon this subject four or five years ago in connection with fractures of the lower end of the humerus and before that time in relation to fractures of the scalp. He would not cut down upon many simple fractures, but there are some in which he would do so. There is a certain definite class of cases of closed fracture and of open fracture where it would be necessary to cut down for purposes of exploration, and it depends upon the time that the surgeon sees the fracture and the changes that have taken place in the fracture itself as to the propriety of the procedure.

There are a few cases of dislocation which should be treated in this same way. He had had several cases of unreduced dislocation that would have done far better had he cut down upon them, instead of making vigorous efforts to reduce. Mr. Lane, of London, has lately written upon the subject of the open treatment of fractures of the lower end of the tibia.

DR. J. M. BARTON said that where deformity exists that cannot be otherwise corrected he saw no objections to opening a simple fracture, provided the operation be done where reliable antiseptic precautions could be secured.

He had been in the habit of opening simple fractures of the patella for the last nine years, as he did not consider those produced by muscular contraction could be put in good position without. Much less would he hesitate to cut down on the shaft of a bone, where no great joint is exposed to infection.

One objection to making all fractures compound, as Dr. Allis suggests, is that the ambulant method of treatment could not so often be used. He had recently made a slight modification of the ambulant dressing to which he desired to call the attention of the Academy.

It has been found that the plaster of Paris of which the ambulant dressing is composed soon breaks even when strengthened by tin strips. The breaking is often due to the patient bearing his weight on the toe portion of the splint in the last half of his step, the foot portion of the splint acting as a lever tending to break the leg portion.

To remedy this difficulty it has been suggested to strongly flex the foot before putting on the plaster and to fix it in that position by the plaster, so the patient would walk on the heel alone, but, on trial, he had found this fixed, forced flexion soon to become unbearable. He had met the difficulty by putting a large wad of cotton, fully an inch and a half thick, under the heel alone after the usual inch of cotton had been placed under the entire foot. After the plaster has become firm over this, the patient is able to stump around, bearing all his weight, in all positions, on the heel alone, the toe end of the splint never coming in contact with the floor.

DR. L. W. STEINBACH thought that the use of the fluoroscope would be a valuable aid in determining the necessity of resorting to incision in the treatment of a fracture.

DR. JOHN B. DEEVER agreed with Dr. Allis as to the nomenclature. It struck him as being very important from a medico-legal stand-point, especially the words "infected" and "non-infected." The question of cutting down upon a simple fracture must be governed by the judgment of the individual surgeon. He did not think it is always advisable to make simple fractures of the patella compound and wire. A minimum amount of infection in the knee-joint is capable of setting up a maximum amount of trouble.