TRANSACTIONS

OF THE

PHILADELPHIA ACADEMY OF SURGERY

Stated Meeting held January 5, 1920

The President, Dr. George G. Ross, in the Chair

THREE-WEEKS-OLD EXTRA-UTERINE EMBRYO

Dr. Astley P. C. Ashhurst reported the case of a woman, aged twenty-six years, who was admitted to the Episcopal Hospital during the night of August 21, 1919, complaining of pain in the lower right quadrant of the abdomen. Her last menses, which began August 5, were normal. Eight days before admission (that is, August 13) she began to bleed again, and to suffer some abdominal pain. On admission she was thought by the receiving ward interne to have salpingitis, and she was sent to the ward over night. In the morning she appeared slightly anæmic, and a diagnosis of ruptured extra-uterine pregnancy (right) was made. The pain persisted, and there was a very tender mass in the region of the right tube.

On opening the abdomen the presence of free fresh blood confirmed the diagnosis; the right tube was distended and tense with blood, and bleeding from the fimbriated extremity continued. The tube and ovary (and, incidentally, the appendix) were removed, the blood evacuated, and the abdomen closed. Recovery was uneventful.

Section of the tube discloses an embryo (Fig. 1), apparently about three weeks only in age, lying lengthwise in the tube, in the midst of blood clot. The membranes were intact. Evidently tubal abortion was impending at the time of operation.

Dr. W. H. F. Addison, Professor of Histology and Embryology in the University of Pennsylvania, very kindly examined the specimen under the microscope, and reported its length as 10 mm. The cephalic extremity was somewhat crushed, but the limb buds could be detected; they showed no indication of any digitations, nor even club-shaped expansion of their ends. From these data he estimated its age at about thirty days.

SAC OF INDIRECT INGUINAL HERNIA WITH COMPLETE OBLITERATION AT ONE POINT

Doctor Ashhurst also reported the case of a man, aged twenty-six years, who wore a truss for about eighteen months, when a small boy, for right inguinal hernia. Since childhood the hernia had not been down

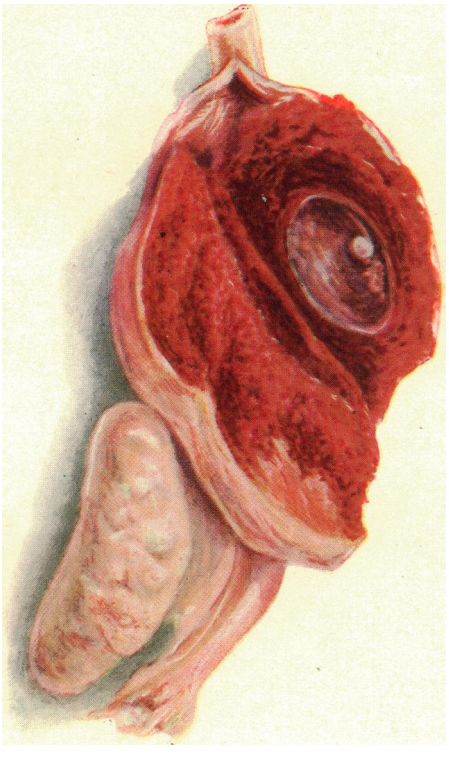

FIG. 1.—Very early extra-uterine pregnancy (three weeks). Embryo lying in a mass of blood clots in the tube—actual size.

until it appeared as an incomplete indirect right inguinal hernia, after a lifting strain a few days before operation, which was done January 2, 1920, at the Episcopal Hospital. The sac extended below the level of the external ring, and its fundus was distinct from the tunica vaginalis testis. When the sac was opened near its fundus, it was found obliterated about 4 cm. distal to the internal ring. The proximal portion of the sac, continuous with the peritoneal cavity, was then opened, and both portions of the bilocular sac excised; and the inguinal canal was repaired in the usual way (after incidental appendectomy through a McBurney incision).

Doctor Ashhurst remarked that one knows how frequent it is to meet with partial occlusions of such hernial sacs, at one or more levels; and the occurrence of hydrocele of the cord proves that complete obliteration may occur. But the question is, does wearing a truss for eighteen months, or even for eighteen years, produce such an obliteration? It seems very unlikely that it ever does; certainly nothing he had ever encountered in an operation for inguinal hernia indicates that it does; and even granting that this case is an instance of the occurrence, the fact remains that the obliteration occurred not *at the internal ring,* where it might prevent recurrence of the hernia, but in the course of the sac as it passed through the canal, and that the hernia did recur in the proximal portion of the sac.

ABNORMAL DRAINAGE FOLLOWING CHOLECYSTOSTOMY

Dr. Edward B. Hodge reported the case of a woman, a patient of Dr. A. B. Gill, who was admitted to the Presbyterian Hospital July 12, 1916, with history of removal by Doctor Gill of a subacute appendix four years before. For the past ten months there had been attacks of pain in the epigastrium, radiating into the back and right shoulder at times, nausea, vomiting, and epigastric tenderness. When seen a week before, there was slight jaundice. No fever in this or previous attacks. A diagnosis of cholecystitis had been made and operation decided on when jaundice subsided. Although this was still present, pain was so severe as to demand relief.

Under gas-ether an enlarged, rather thick-walled gall-bladder was exposed. It was adherent to the omentum. Stones were felt in the gall-bladder but not in the common duct. The foramen of Winslow was open. The gland at the junction of the cystic and common ducts was enlarged as also the pancreas. The stomach and duodenum were normal. Difficulty in relaxing the patient prevented good exposure, so drainage rather than removal of the gall-bladder was done. There were many dark green stones and the mucous membrane was moderately inflamed, but not of the " strawberry " type. A tube was placed in the gall-bladder and a cigarette drain to the kidney pouch.

For forty-eight hours she did well. In the first twenty-four hours there was drainage of more than a pint of bloody mucus and bile, later

becoming green. For the first fifteen hours of the second twenty-four there was no drainage. On the evening of this day, the fourteenth, drainage became free again, and by evening of the fifteenth amounted to 70 ounces (2100 c.c.) of turbid fluid with some flakes in it. Temperature was 100°, abdomen soft, passing flatus, stomach a little unsettled, and pulse weaker and 120. She was beginning to feel very weak and prostrated. The weather was extremely hot.

From this evening to the next morning the amount of drainage was 1050 c.c. of the same character. Her condition was now alarming with small weak pulse, extremities cold, clammy and bluish, face yellowish, but lips a good color, breath not bad, and no acetone in urine which had become very scant in the last twenty-four hours. Stimulation was increased and saline given under skin in addition to the glucose-sodium bicarbonate solution that had been used by rectum. At this time Doctor Jopson saw her in consultation. The question of attempting to check the excessive drainage from the gall-bladder was discussed, since her condition seemed to be largely due to great loss of fluid by this channel. A clamp was placed on the tube and from that time no fluid came from or around the tube.

By the next morning the patient's condition was decidedly improved, she had had a restful night and felt better. She had passed only 6 ounces of urine in the last twenty-four hours, but this was entirely negative. The tube was removed four days later and replaced by a gauze strip. There was thereafter no leakage. She was discharged from hospital two weeks from operation and has remained in excellent health since.

Colon bacillus was cultured from the gall-bladder at operation. The laboratory report on the yellowish, turbid, flaky fluid at the time of the greatest amount of drainage showed unexpected findings. Tests for bile acids and bile were negative. The fluid did not digest egg albumin or starch and therefore contained no pancreatic ferment. Quantity not sufficient for lipose test.

It is readily seen that the unusual features in this case are the amount and the source of the drainage. The amount of discharge, if from the liver, far exceeded anything he had found recorded in the literature or in the experience of those with whom he had discussed it. The normal daily production of bile is usually given as from 700–900 c.c. In this case there was once 2100 c.c. and again 1020 c.c. for some fifteen hours.

In the absence of positive findings for bile and bile acids, we are led to seek other possible sources. There was no evidence at operation of communication between gall-bladder and stomach, duodenum or colon. Nor was there any reason for post-operative development of such communication. Back flow from the duodenum through a relaxation of the common duct sphincter also seemed ruled out by the laboratory findings. Of one thing we can be sure—the drainage came through a tube sutured into the gall-bladder. In the reporter's opinion the drainage had its

origin in the liver, even though for some reason the ordinary tests for bile were not positive.

ANHYDROUS COCAINE SPINAL ANÆSTHESIA

DR. JAMES RALSTON WELLS read a paper with the above title, for which see page 504.

ULCERATIVE CYSTITIS

DR. FLOYD E. KEENE read a paper entitled "Circumscribed Pan-mural Ulcerative Cystitis," for which see page 479.

DR. JOHN G. CLARK paid a tribute to Dr. Guy Hunner for having discovered and brought this unique pathologic entity to our knowledge. As the report of these cases from the Gynæcological Department of the University Hospital will show, they have all been of chronic standing and the patients have suffered in many instances so excessively that they have become chronic invalids, the dysuria and frequency of urination being so great as practically to confine them to their homes. All surgeons in years past have persistently treated cases of this type under the diagnosis of chronic cystitis, and yet neither the cystoscopic picture nor the urinalysis bore out this diagnosis. The case that brought this type of pathology to his cognizance was the first one to which Doctor Keene alluded, of a woman who had been under observation for fifteen years for an extensive cystitis following an abdominal operation. Gradually all of the characteristic clinical findings of cystitis disappeared but the symptoms persisted and even grew worse. After several ineffectual operations of various types and the employment of every manner of treatment the patient fell into Doctor Hunner's hands, who promptly made a diagnosis of solitary ulcer, and, after she had undergone the operation which he has devised for this condition, she regained her health completely.

These cases in their variation between acute exacerbations and temporary quiescence are suggestive of the manifestations of a duodenal ulcer. Also, the symptoms are out of all proportion to the diminutive lesion which one discovers on cystoscopic examination. The lesion, therefore, is an extremely small one, but the symptoms are decidedly major in severity. When one views these small ulcers and contemplates the major operation necessary to relieve the patient the therapeutic procedure unquestionably appears to be out of proportion to the existing pathology. Nevertheless, as the results have demonstrated, there is no series of patients more grateful for their relief than these, and count the operation of small significance when they have experienced complete relief. It is to be hoped that the time will come when some other form of treatment may be instituted which may obviate so extensive an operation. Nevertheless, Hunner has given these cases the most painstaking and skilful attention, and finally through failure of local treatment to achieve favorable results, he was compelled to resort to operation. In view of

the fact that Hunner has so well defined and described this condition, there need be no great difficulty in naming the condition. We have chosen, therefore, to designate this as the Hunner Ulcer, for we feel that through his careful work he deserves this identification.

DR. ALEXANDER RANDALL said that since his attention had been drawn by Doctor Keene to this type of bladder ulcer he had been looking for it in the male, but had not thus far met with it. He had asked Doctor Keene as to the possibility of the condition being tuberculosis. The ulceration of the bladder, the sterile urine cultures, and the chronicity highly suggest tuberculous origin. He replies that in repeated examinations cultures in guinea pigs have been negative as well as studies of section of excised tissue. He cannot, however, help feeling that search should be continued along this line, because as pointed out by Pelouse there has been obsrved another unusual form of tuberculosis in this region. Surgeons are still very much in ignorance of the actual pathology and physiology of the bladder itself, especially as regards infections.

MALIGNANT DISEASE OF THE LUNGS

DR. GEORGE E. PFAHLER read a paper with the above title, for which see page 472. The paper was illustrated by lantern slides.