TRANSACTIONS

OF THE

PHILADELPHIA ACADEMY OF SURGERY

Stated Meeting Held May 8, 1925

The President, Dr. Edward B. Hodge, in the Chair

CYST OF THYROGLOSSAL DUCT

Dr. Jessie W. Pryor presented a man, aged twenty-seven years, who was admitted to hospital complaining of a swelling in his neck. This mass was first noticed five years ago, when it was the size of a pigeon's egg; it has been growing slowly until it now in size and shape is equal to a hen's egg. The mass lies just to the right of the midline in the upper part of the neck. (See Fig. 1.) It extends to the midline, but does not cross it. It is freely movable, circumscribed, soft, no fluctuation obtained and no pulsation or bruit. On swallowing, the mass is definitely elevated and quickly descends as though attached to the base of the tongue.

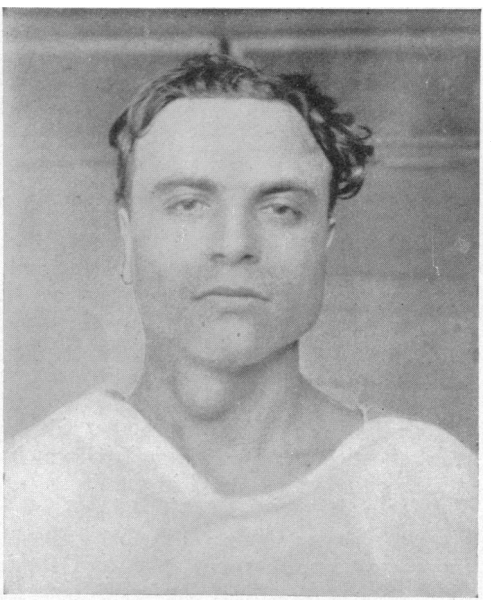

Fig. 1.—Thyroglossal cyst, anterior view.

The mass was a little too high to be a cyst of the right lobe of the thyroid. The man came to operation with three diagnoses suggested by three people: (1) Branchial cyst. (2) Lipoma. (3) Cyst of thyroglossal duct.

The definite attachment to the base of the tongue caused the reporter to stick to the thyroglossal idea even although the mass was definitely on the right side and not in the midline.

A collar incision was made in the crease of the neck through skin and platysma, crossing from the anterior border of one sterno-mastoid muscle to the anterior border of the other. The flaps were retracted up and down. The pretracheal fascia was then incised vertically and dissecting with finger and scissors a mass, the size of an egg, was freed on each side and posteriorly. The appearance of the cyst at this stage was fusiform, the upper pole was very definitely attached to the lower border of hyoid bone and the lower pole attached to upper margin of the right lobe of the thyroid.

About this stage the cyst was ruptured. It contained opaque yellowish semi-gelatinous fluid. The cyst wall was then ligated at the attachment to thyroid gland and as close to the hyoid bone as possible. The bands were cut, the pretracheal fascia closed, the platysma sutured and the skin wound closed. The recovery was uneventful.

Pathologist's Report.—The specimen consists of the wall of a cyst about the size of an almond, having a ragged lining and smooth outer surface. Externally it is attached to an elongated mass of tissue about an inch long, apparently the wall of the thyroglossal duct.

Microscopic Description.—a. The wall consists of a dense sclerotic fibrous tissue containing masses of colloid inclosed in the interstices and in what appear to be dilated luminæ.

b. Fibrous tissue structure surmounted by laminated wall, containing a system of capillaries filled with red cells, and having a homogeneous free surface. At one end is a portion of the same structure seen in colloid masses. Diagnosis: Cyst of thyroglossal duct.

RHINOPLASTY FOR SYPHILITIC DEFECT OF NOSE

DR. ROBERT H. IVY exhibited two cases of total rhinoplasty for syphilitic defect of the nose, in which the Indian flap method, as modified by V. P. Blair, was used. A single flap is employed to form the entire external nose, its distal end being folded to form columella and lining for alæ. These cases demonstrate conclusively that by this method sufficient prominence of the lower part of the nose can usually be obtained without the use of cartilage or other supporting tissue in this region. Cartilage is only implanted in these cases where the nasal bones themselves give no prominence to the upper part of the nose, and even here it is not usually necessary. In one of the cases no cartilage whatever was employed. In the other, a small piece of costal cartilage was implanted over the depressed nasal bones, high up beneath the forehead flap.

INTRAPERITONEAL TRANSFUSION FOR MELENA

DR. J. RALSTON WELLS reported the history of a male infant, ten months of age, weighing seventeen pounds, who was admitted to hospital, October 11, 1924, on account of persistent voiding of blood per anum. Five weeks ago it first passed bloody bowel movements. Two weeks later the same blood losses occurred. The day before admission its stool was "blackish" in color and very hard. The patient was evidently in distress when passing this stool, as shown by drawing knees up and crying immediately after it. An enema seemed to relieve the pain but the baby became so cold that hot water bottles were necessary for local body application. It vomited twice on this day; no gross blood in vomitus.

When admitted the child looked severely ill and weak, but was in no acute distress. Is very pale, no flushes. Breathing is 72, with sometimes an expiratory grunt; pulse rapid, 160, and thready. Temperature 103° F.–104° F. Is most comfortable lying with right leg drawn up. Resents disturbance. Abdomen slightly distended and moving with respirations. Palpation shows generalized tenderness and resistance, especially marked on whole right side. No palpable masses nor localizing point or points of tenderness. Peristalsis active. Rectal examination gave no additional information. The general physical examination is negative except for the left thorax, which shows a slightly impaired percussion note and slight impaired resonance over the lower lobe posterior. No alteration in breath sounds. No râles. Head, heart, extremities and nervous system negative; negative urine.

Blood.—Hb. 30 per cent.; red blood cells 2,500,000.

Third Day.—Dark stool passed with large clot of blood. No vomiting but along toward evening appeared in a condition simulating collapse and some liquid dark material resembling blood was passed per rectum. Five c.c. of horse serum was given intermuscularly.

Sixth Day.—Condition improving; no more hemorrhages seen. Temperature now around 100°, respiration and pulse in proportion. No cough.

Seventh Day.—Slight hemorrhage. Temperature, pulse and respiration became practically normal at this time. Slight hemorrhages occurred October 23; November 8; December 17; December 27; January 2; January 3; quite copious hemorrhages occurred November 6; December 25. An intraperitoneal transfusion of citrated blood was first given October 19, when 100 c.c. of the blood was injected. At this date the hæmoglobin had fallen to 22 per cent. The proportion of Hb. rapidly rose after this injection until at the end of ten days it marked 55 per cent. After the copious hemorrhage which occurred November 6, it fell again to 20 per cent. Repetition of the intraperitoneal transfusions of 100 c.c. of blood November 20 was followed by the same gradual increase in the hæmoglobin index until by December 12 it reached 60 per cent. After the hemorrhage of December 17 a transfusion was at once resorted to, with again a rapid rise of the Hb. index to 65 per cent. The repeated hemorrhages late in December and during the first week in January, 1925, caused the decision to make an explorative abdominal incision. An X-ray examination had been made December 11, with the report that the plates indicated a marked narrowing of the lumen of the transverse colon for a distance of about three inches near the median portion on the right side, just above umbilicus.

The von Pirquet reaction was slightly positive.

January 7, under ether, a median incision of the abdominal wall was made. A good exposure was obtained. Nothing abnormal was detected, except some enlarged intraperitoneal glands. No free fluid. No indurations or ulcerations seen nor polyps palpated. One hundred c.c. of citrated blood was put into the peritoneal cavity, and the incision closed. The operative recovery was uncomplicated.

The little patient was retained in the hospital for four months longer, slowly improving, but with a gradual fall in the hæmoglobin index. When the child was finally sent home, May 17, it weighed eighteen + pounds, and its Hb. index was 35 per cent.

DR. CALVIN SMYTHE presented a chart which Doctor Sweet and he worked up some five or six years ago when they were making some studies on intra-abdominal absorption. Using the red blood-cells as an indicator in lymph collected from the thoracic duct and watching how quickly it came through. They found that the invariable result was that in 20 to 30 hours they would get lymph which was absolutely colorless, then a faint trace of color and straight on until they got fluid which was similar to venous blood. It could be seen that it contained red blood-cells. On dogs which were afterwards post-mortemed they invariably found the pleural surface of the diaphragm to contain large amounts of blood, as if there had been hemorrhage. Since Superstein and Stanby wrote their paper on intraperitoneal infusion, he had used the method about twenty-five times in the past year and had found it an excellent one, especially in children. It is relatively painless and gives excellent results. One does not get an immediate effect, but it seems to be more lasting than intravenous injection. He had had no trouble with it. Another point in its favor is that one does not have to type the blood. They were able to use a donor in many cases that for the purposes of intravenous

injection would not have been the correct type. In this method they used 500 c.c. of the blood with no deleterious effects.

DEPRESSED FRACTURE OF THE SKULL INVOLVING SPEECH CENTRE

DR. JOHN S. RODMAN reported the history of a man, thirty-one years of age, who three days prior to admission to the hospital was intentionally struck by a thrown rock in his left temporo-parietal region. He fell to the ground and was momentarily unconscious. Was picked up at once, regained consciousness, but was dazed and had no memory of what had struck him when taken to the accident ward of a local hospital about fifteen minutes later. He was given first aid there, but then allowed to leave, and went to the police station and made a report of his injury. He remembers leaving hospital in a machine and being driven home. Had a good deal of headache and confusion. Vomited after reaching home and at intervals during night. On following day headache continued and vomited once that morning, was restless and complained of continual headache, pain in left arm, shoulder and jaws. Following day about same. He was admitted to hospital on the morning of the third day following accident as his physician felt that he was not improving and that he should be under surgical observation.

The following additional information was obtained from his brother upon admission: There had been no unconsciousness, no incontinence of fæces or urine, no paralysis noted. Very restless, keeps hands to head and complains of light hurting eyes. Asks continuously for water but will not eat solid foods, largely because of pain in jaws. Confused, perception slow and speaks with difficulty. Several attempts before right word is found. Does not sleep but does not notice what goes on around him.

Physical examination made three days after accident. Eyes—pupils equal, react to light, sluggishly to accommodation. Tongue protrudes with difficulty because of stiffness of jaws. No apparent tendency to protrude to one or to the other side. On showing teeth right side of face seems to lag a little and this side of face seems to be smoothed out. Apparently has more power in left than in right arm. No difference in lower extremities. Tendon reflexes diminished. No clonus. Tests for sensation unsatisfactory owing to patient's mental condition, as he is conscious but irritable and mentally dull. Blood-pressure 118-78; P. R. 60; temperature 98. The diagnosis arrived at was extra-dural hemorrhage with fracture of vault. X-ray showed a fracture apparently not depressed, in the left temporo-parietal region.

Operation revealed a circular fragment of skull driven inward over left temporo-parietal region. No extra-dural clot. Dura not opened. The depressed fragment was elevated.

The man, after remaining about same for four days as before operation, began to improve; his mentality cleared; speech returned to normal. He was discharged well, ten days after operation.

To Contributors and Subscribers:

All contributions for Publication, Books for Review, and Exchanges should be sent to the Editorial Office, 145 Gates Ave., Brooklyn, N. Y.

Remittances for Subscriptions and Advertising and all business communications should be addressed to the

ANNALS *of* SURGERY
227-231 So. 6th Street
Philadelphia, Penna.