

TRANSACTIONS
OF THE
PHILADELPHIA ACADEMY OF SURGERY

Stated Meeting Held February 6, 1922

The President, DR. JOHN H. JOPSON, in the Chair

BONE TRANSPLANTATION FOR CYST OF TIBIA

DR. JAMES K. YOUNG presented a young woman, age eighteen, who at the age of six was kicked in the left ankle; two months later the lower end of the tibia was swollen. No surgical treatment until three years ago, when patient was operated on, the lower end of tibia being scraped. She came under the reporter's observation three years ago. X-ray showed a bone cyst of the lower end of the tibia. She was subjected to operation June 5, 1920, at the Polyclinic Hospital. The cortex of the tibia was found thinned out, resembling an egg-shell. Wall lined with thick capsules. The walls of the tibia were equally distended in all directions. A bone-graft from the opposite tibia was implanted. There was no post-operative hemorrhage and no pain since operation. One year after the first operation, the tendo Achillis was subcutaneously divided. Since that time there has been a perfect result. Recent X-rays show the bone transplant in place.

DISARTICULATION OF THE HIP-JOINT FOR PERIOSTEAL SARCOMA

DOCTOR YOUNG presented a boy, aged sixteen years, who was admitted to hospital December 15, 1920, for pain in knee. No history of trauma. When operated upon, January 10, 1921, periosteal sarcoma was found in the middle of left femur involving the soft parts and the shaft above the internal condyle. Complete disarticulation of hip and amputation was done. Assisted at operation by Doctors Elmer and Cooperman. Laboratory diagnosis: spindle-cell sarcoma, some giant-cells, extensive necrosis, some highly malignant cells. Examination of the lung, November 8, 1921, no evidence of metastatic sarcoma, no evidence of disease about the shoulder-joint. On account of malignancy one tourniquet was applied at the upper border of the tumor, a long rubber tube was also applied above the pins. The femur was sawed off below the trochanter; amputation, no deep sutures were used. The time of operation was reduced, patient had no shock at operation, but two and a half hours later he had shock, but after the first six hours his convalescence was uneventful. He is now in perfect health.

DR. A. P. C. ASHHURST asked why Doctor Young sawed the diseased bone through first and then enucleated the upper end, instead of taking it out in one piece. By Doctor Young's procedure there was danger of contamination of the wound; his own experience had been that in patients where there is danger of spreading infection, tumors, or gas gangrene, it

was better not to use the Esmarch band, but to amputate by dissection. This was not as hard as it seemed, if one cuts down anteriorly, then ligates the common femoral, just below Poupart's ligament, and then ligates the superficial and deep femoral just below and divides the arteries between the ligatures. If the patient is kept in the Trendelenburg position all this time, the venous blood will run down the limb into the trunk. The common femoral vein can then be ligated and the joint opened. Then, as to diagnosis, there were some things he would like to ask. As to the diagnosis of "spindle-cell sarcoma," there were some sceptics like Bloodgood, Ewing and Codman, who have been making a registry of all these bone sarcomas. They want reports of all cases of bone sarcoma that are now alive; they want sections sent them, X-ray reports, etc., and they supply a form which can be filled out and which gives them the information they desire. He desired to know whether these observers agreed with Doctor Young that this was really a case of sarcoma.

DOCTOR YOUNG replied that he had sent all the information mentioned to Dr. E. A. Codman, of Boston, that a slide had been sent, also a specimen. He sawed through the bone first because he thought it simplified the operation considerably. He has always been impressed with the great ease and safety of the secondary operation, *i.e.*, secondary amputation of the hip-joint, which he believes is far superior to the primary amputation. He remembers the paper of Morton, published in the transactions of the Pennsylvania Hospital, with photographs of three patients sitting side by side, each having had amputation of the hip-joint. He was impressed when he found out that these were all secondary amputations. It is the removal of the bone which gives the shock; if one can divide the operation in two, it shortens the time of operation and diminishes the shock. In regard to spreading malignancy, he tried to prevent this by using the extra Esmarch band, which saves a little blood; also the long tube above the pin was very satisfactory. He thought the ideal operation to be amputation high, dividing the bone, and then disarticulating.

At one time since operation patient had tuberculosis of one lung. He spent a number of months in the pines of New Jersey, since which time there had been no evidence of the disease.

WILLEM'S TREATMENT OF SEPTIC KNEES

DR. MORRIS BOOTH MILLER presented a man, thirty years of age, who about thirteen months ago ran a needle into the outer surface of the leg, just below the knee-joint. The needle was broken off. In the attempts to remove it the wound became infected, and a few days later the joint surfaces became involved in a streptococcic infection of considerable severity. The treatment consisted of bilateral free incisions into the joint followed by systematic mobilization. He was in the hospital about three months. The case is presented as showing perfect functional recovery. There is full range of motion, full strength of the limb, and no resulting painful phenomena.

HARELIP AND CLEFT PALATE DEFORMITIES

RESECTION OF THE SMALL BOWEL FOLLOWING A GUNSHOT INJURY

DR. W. ESTELL LEE reported the case of a boy, fifteen years of age, who was admitted to the Pennsylvania Hospital, January 1, 1922, complaining of a bullet wound of the abdomen.

On the anterior wall of the abdomen there was a small bullet wound about two cm. to the left and one cm. below the umbilicus which traversed the left rectus muscle. The abdomen was quite tender in this region, but there was no definite rigidity. No peristaltic movements could be heard by auscultation. There were no evidences of either free fluid or air in the peritoneal cavity.

The boy was not uncomfortable and there were no definite signs of shock. Three hours after the accident had occurred, an exploratory laparotomy was done by Doctor Lee.

A modified left rectus incision was used, excising the track in its central portion. On opening the peritoneal cavity a small loop of gut which was directly underlying the penetrating bullet wound was exposed. It proved to be a portion of the ileum in about its middle third. In this loop a total of eight perforations had occurred all within the distance of seven inches. Most of the perforations had been fairly well walled off by omentum and there was little or no soiling of the peritoneal surfaces. No other injury to the bowel or other viscera was found and the bullet wound of exit from the peritoneal cavity was not located.

Resection of this portion of perforated gut was done. A piece of ileum twelve inches in length was removed and an end-to-end anastomosis done. The abdomen was closed without drainage.

Subsequent Course.—One week following the operation the boy started to run some temperature and shortly afterwards a small mass developed directly beneath the operative incision. This was opened and a small amount of pus evacuated. Apart from this, his recovery was uneventful and fairly rapid. He was discharged from the hospital in good condition twenty-five days after admission.

SPONTANEOUS LATERAL VENTRAL HERNIA

DR. JACKSON K. HOLLOWAY read a paper with the above title, for which see vol. lxxv, page 677.

HARELIP AND CLEFT PALATE DEFORMITIES

DR. W. B. DAVIS read a paper on the above subject, for which see August number ANNALS OF SURGERY.

DR. JOHN B. ROBERTS, in discussing Doctor Davis' paper on harelip and cleft palate deformities, approved of early operative treatment, followed by careful training in speech by some one experienced in developing the proper use of the palatal and pharyngeal muscles. A long period of such instruction by the mother aiding the teacher may result in overcoming to a considerable extent the disability, due to the shortness of the soft palate even after the cleft is closed by operation. This will occupy years and should be started in infancy. He would like to have heard Doctor Davis tell how he closed the double clefts of soft and hard palate and lips. These are

the cases which have given Doctor Roberts great trouble. He usually closes first the alveolar process with wire and later the lip with silkworm gut. He is rather inclined to leave the palate itself until the child is a few months old, using then for the hard palate the Langenbeck method, the Lane upset-flap method or modifications of these operations. It is essential to separate from the posterior edge of the hard palate the nasal mucosa and the fibrous sheet of attachment, to let the velum drop towards the tongue.

The parents dislike the conspicuous part of the deformity so much that he likes to get the nose, lip and alveolus corrected early, even if they will require subsequent modelling later.

The protrusion of the intermaxillary bone should be corrected first of all in complicated clefts of lip and palate. This usually requires osteoplastic

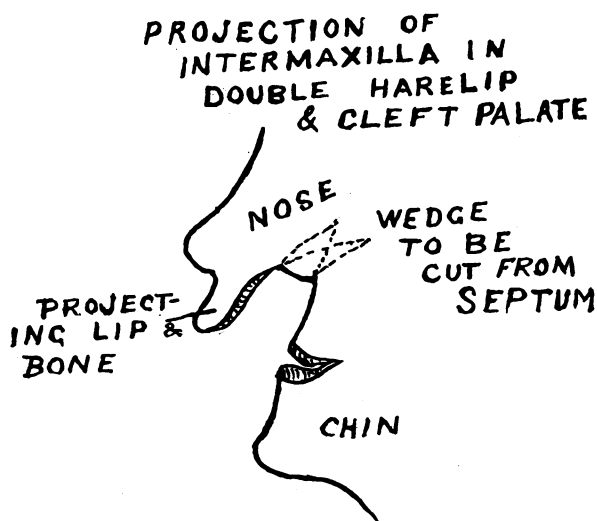


Diagram 1
Replacement of Intermaxilla.

replacement. The intermaxilla should never be removed; it must be retained and replaced to restore the dental arch.

When the hard palate is closed there is sometimes left a small opening behind the incisor teeth running from the mouth into the nose. Lane, he believes, sometimes anticipates this event by allowing the pieces trimmed from the edges of the labial cleft attached at the nostril. These two strips are turned under the lip of the baby, sutured together, and tucked up to close the floor of the nostril back of the incisor teeth. The fissure in the upper lip is then sutured; and the small nodule behind it is of service, when the uranoplasty is performed later to close the roof of the mouth.

Doctor Roberts with lantern slides then showed irregular methods of making flaps and closing the hard palate. These he had found useful in his own work.

"APRON" FLAP FOR LENGTHENING SHORT VELUM OR CLOSING CLEFTS, USING INTRANASAL SUTURE

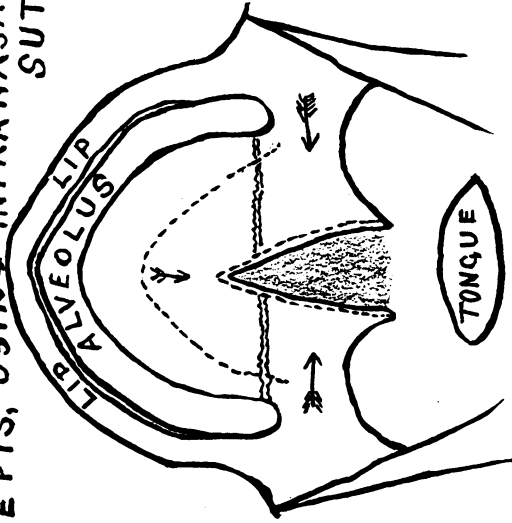


Diagram 3
Incisions for Double Cleft of Velum.

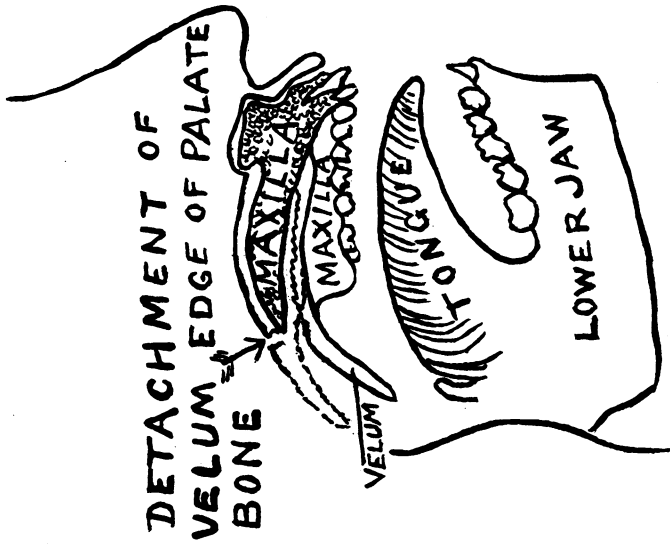


Diagram 2
Cutting Velum from Edge of Palate Bone

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 "A PROX FLAP & INTRANASAL SUTURE

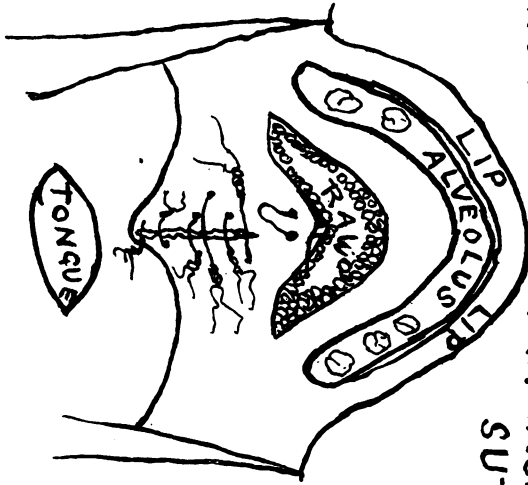


Diagram 4
 Operation for Double Cleft
 of Velum

An Unusual or
 "BRIDGE" CLOSURE
 WITH ANTERIOR AND
 POSTERIOR FLAPS

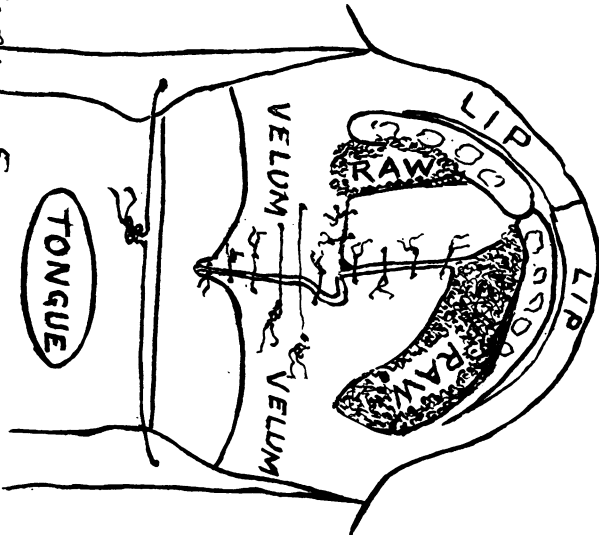


Diagram 5
 Closure of a Right Cleft