POST-OPERATIVE LESIONS AND SEQUELÆ.

Their Extent, Character, and How to Deal with Them.

By JOSEPH PRICE, M.D.,
PHILADELPHIA.

It must have come to the notice of many of you that there are numbers of useless, often harmful operations. It seems a common affair for surgeons, or those passing as such, to work some little end at the expense of all the risk of a regular operation. They have only in view some temporary or peculiar benefit, without sufficient consideration of the subsequent work necessary to complete cure. Our great aid lies in the recuperative abilities of the patient; and what can one expect when her vital powers are taxed for recovery from numerous ill-judged operations? It is surely a matter for considerable caution. The excuses are few for repeated operations. We will view repeated operations from two standpoints: one is where pathological conditions and the broken-down condition of the patient are such as to render a complete operation of extreme peril to the patient. To determine this question, the extent to which procedure is safe, is one of the most serious that appeals to surgical judgment. It is only such conditions that justify leaving anything for a second operation. The other and more frequent reason for re-operation, the one least to be justified, the one a reproach upon our surgery, is the attempted work of ignorance or that which cowardice leaves uncompleted. There is an explanation of the necessity for many repeated operations, which we give with a sense of regret. The commercial element repeatedly enters in with a resistless influence; there is a money motive —this where the life of a human being is involved! The reasoning is from any other than a high professional standpoint. "This is a paying case; I will go as far in this case as is absolutely safe.

Digitized by Google

I will give temporary relief, secure the patient a brief period of comparative comfort, and when the trouble returns in aggravated form the patient will go into other hands for complete removal of the trouble, with probable if not very certain increase of some one's statistics of mortality." This is the conduct and reasoning of too many. Statistics have become too much a matter of mere advertising concern, and are therefore of little value. All of us are concerned in our mortality, all want our patients to recover; but mere recovery from an operation does not in very many instances mean a cure; the terms are not synonymous. Indeed, the condition of the patient, after so-called recovery from certain operations is worse, the suffering greater, the life in greater peril than before. Mere experiment is responsible for very many repeated operations. This experimenting is not limited to the young—those fresh from our college benches. Experience convinces me that many of our young men are more conscientious than some of their seniors. They push their special work until they have a fitness for it. This they can afford to do, for when they begin they will know how, and therein lies the secret we are all seeking.

Leaving this side-play, let us talk surgery; and permit me to say it is difficult to talk it wisely, more difficult to practise it wisely. In every case there should be a very reasonable certainty as to existing trouble, otherwise it is impossible to determine upon the method of treatment. But the error is not always of diagnosis; the operator may be moved by the craze to operate. The subjects of these unjustifiable operations—operations for slight or undefined troubles—receiving no relief, will permit a real trouble to grow until conditions become such that relief by the most skilful surgery is difficult and of uncertain result. In many of the cases of repeated operations the primary operation was unjustifiable; there was error of diagnosis; doubt and speculation in the mind of the operator as to existing trouble. The primary operation may create conditions, set up adhesions, which make the second operation difficult and dangerous. All forms of exploratory operations imply ignorance and doubt, and are responsible for much of the work which has to be repeated. It is true that there are cases where an exploratory procedure serves a good purpose, and, when done under proper surgical method and with absolute cleanliness, involves no great risk to the patient. It should be kept in mind

Digitized by Google

that all surgical procedures involve more or less risk. The tolerance of the peritoneum has tempted to a great deal of surgical nonsense, often to a carelessness or rashness which sets up pathological conditions requiring radical surgery for their correction. We will name a few of the procedures which give us a large percentage of second operations: 1. Dilatation and curettement. 2. Vaginal puncture. 3. Vaginal hysterectomy.

Then comes the operation that cures—abdominal section, the freeing of omentum and bowel, both large and small, the removal of pathological conditions, irrigation and drainage. The class of patients upon whom repeated operations are most frequently required are the well-to-do, those who can afford to go to Florida, to Paris, to travel about the world consulting specialists and all kinds of men—men with fads, some very much like those species of fish with both eyes on one side of the head, unable to see but one side of an object, that side only too frequently the financial side. The patient is advised to numerous forms of treatment, very frequently treatment which only aggravates the condition. Along with the treatment I have named, the rest cure comes in. The rest cure has its field; but when we have to deal with certain pathological conditions we must recognize that there is something more than rest needed. Rest cannot correct diseases of the pelvic viscera. In appendicitis a second operation occurs to relieve obstruction or break up adhesions which were the result of the incomplete primary operation. In many of these cases, as in others, the complications are so great and extensive that the operator, not having the knowledge and skill, or lacking courage, abandons the procedure with the entirely too common apology, "inoperative," "hopeless." The freeing of visceral adhesions in primary operations is rare, and for this reason very much work has to be gone over again with all the difficulties aggravated tenfold. Too many operators are content with the simple removal of a growth, with correcting the fixation or pathological conditions about it. A partially adherent bladder, if not freed, will remain a perpetual source of annoyance. Bands of adhesion about the ileum, if not freed, form the post-operative obstruction we see so commonly reported. The removal of remaining and irritating material, careful trimming of all ragged, fringy adhesions, clearing away of all débris and clot, and well-placed drainage at the seat of oozing, will favor a perfect

Digitized by Google

cure. It is sometimes necessary to retie old pedicles when portions of an original cyst or tumor remain in the pedicle, and cut or scrape with a short knife the dirty seat of dead ligatures and stitch healthy peritoneum over those parts. The surgery of the rectum and sigmoid from the intrapelvic side has not been written. In most repeated operations the cicatrix and ventral hernia require detail and painstaking surgery. The repair of the omentum, commonly adherent to cicatrix in pelvic viscera, is important.

Unfortunately, too many poor women continue to suffer from post-operative lesions; they are told to have patience, that the symptoms will vanish. Very frequently there is opposition on the part of the physician to reopening and correcting the mischief; some look upon visceral adhesions as necessarily fatal. A few do not consider an operation complete until all visceral adhesions have been carefully freed and repaired and left in as normal condition as possible; after the repair of viscera for the removal of growths, placing all viscera in pathological relation. A number of operators remove tumors without examining surrounding parts. When we hear of a case operated upon two or three times by the same operator we have no difficulty in forming an estimate of his surgical ability. We know that in his primary operation, in his second and probably third venture, he left something behind he should have removed; all through he was doing incomplete work. We fully recognize that too much surgery in extremely debilitated patients will kill just as surely as none at all. Methods of procedure have much to do with the necessity for repeating operation. As an illustration of this fact, I will refer to a very recent case of my brother, Dr. M. Price. There will be no difficulty in drawing conclusions from the report. The patient was referred to him for operation. It was found the woman was suffering with an abscess on the left side extending above the umbilicus; pulse 120, temperature 102°; leaking badly; septic in the extreme; uterus fixed; fluctuations in the pelvis easily determined. A diagnosis of pelvic abscess was made without hesitation. The abdomen was opened from above. The bowel, omentum, and mesentery were all firmly attached to the walls of the abscess, which extended above the umbilicus, and as adhesions were broken by the hands pus began to well up from under the sac as it was detached. The enucleation continued down to the depths of Douglas's pouch, over

Digitized by Google

the back of the uterus, and under the entire left broad ligament. The abscess wall was enucleated, torn from its fastenings, and delivered. It consisted of three distinct abscesses—an abscess the full length of the tube, a dermoid cyst (the contents of which had become infected), and a large handful of hair and dermoid débris—which occupied the space close to the crest of the ileum and well under the broad ligament. All were removed. There was thorough irrigation of the abscess cavity, and which was extended into every nook and corner where pus was likely to have worked its way, everything thoroughly washed out, and glass drainage used for two days. The patient's pulse, temperature, and septic condition rapidly changed, and she made a perfect recovery. It would have been utterly impossible to have said before operation in this case what amount of work would have to be done. It would have been impossiblle to have corrected the lesions of the bowel; to have broken up adhesions, or to have removed the sac of the abscess or pyogenic membrane; to have dealt with the dermoid, or to have treated this case in any way safe to the patient except by abdominal section and drainage from above. By the vaginal route the operation must have proved a failure.

I have used the term methods. It has become a term of rather loud use. The inventive genius of the profession of the period seems to be in the direction of "new methods." If there was less deception about results we would have less confusion and be better able to determine the value of any given surgical procedure, and our patients would be greatly the gainers. While it is digressive, I regard it as an important and profitable question to ask ourselves, Have we advanced any in the last ten years in our relative position to the men who stand to us as pioneers, who gave us our first lessons, our advanced position? If so, in what respect? Have what we have called our own advances, improved ways, lowered our mortality? In pelvic surgery Tait stood first—taught us the best we know. He has had no very close second. His disciples have not greatly improved upon his ways, but it is near home our concern lies. We can profitably inquire, What new truths have we added to the stock of our scientific knowledge—we mean that which is original with ourselves? Along this line how do we stand with our brothers across the seas? We have names we can place by the side of the great names in our science, no matter of

Digitized by Google

what land or nativity. While we welcome from any and all sources new truths—all those results of research which advance our science—we do not want foreigners to do our thinking for us any more than we want them to make our laws for us. In the line of our professional literature we want less foreign importation and better and more home production. Above all, let us be more American ; as doctors, think and act with the spirit of Americans. Yet another important inquiry: How much do these associations do for us by way of stimulating in our profession the spirit that is American? How much in the direction of making us our own teachers, investigating and inventing for ourselves? How much to make false the reproach of being foreign-taught? If we desire to act in the genuine honest American spirit we must admit we have been stealing very much from our foreign brothers and proclaiming it as peculiarly our own. We have, in a degree, been following a bad foreign example in *grabbing* and claiming very much that was not our own. We have done our *grabbing* very much as if it was one of the privileges guaranteed to us by the Declaration of American Independence. In this grabbing game it is very true that we have followed closely the example of our English brothers, who believe that the great English Magna Charta blankets the world. As Americans we need to go forward. In this forward movement each one of us is one of the procession. We can add our enthusiasm, cheer, and strength. Our courage should be strong; we want great masters in our science to grow up among us. Frequently some one of our medical or surgical brothers comes running out of the bushes, crying, "I have found something." It is usually a bug and antitoxin or a new method. There are few more potent factors in the mid-direction of our surgical efforts than the importunities of our subjects for immediate bodily relief or comfort. The idea has, I am sure, much influence with the younger practitioners anxious to please and show their resources. This brings up the important fact that a clear judgment as to methods for the eventual welfare of the patient must be uninfluenced by any consideration of present desire. Of course, we would not bar any harmless comfort, since we aim always at a favorable condition of mind ; but there can be no doubt that even a quick sympathy will urge the physician to hesitancy or a rash performance. He must be far above any effects of the patient's talk.

Digitized by Google

There is little reason in speaking of conservatism in connection with surgery. It is not a business which exhibits such a phase. There are corporations which affect to deal conservatively in stocks, nothing but gilt-edged securities; but when you consider surgery as clinging solely to well-defined treatments and operations, practised only in cases of undoubted precedent and by methods of certain establishment, you suppose a regulation of diseases which would be comfortable. But surely such a condition is not considerable for a moment. True, we report such a number of cases of appendicitis, perforating typhoid ulcer, tubercular ulcers, fixation of pus-tube at the head of cecum, as successfully treated in such manner. Yet we are sure that exactly the same troubles are never encountered in any set of patients whose diseases take the same names. And how do we prosper if we are not radicals? There is radicalism which means sure progress. The physician is foremost, best, and most helpful to us who clubs his way through the sceptics. There is surely enough slowness and dulness abroad to excuse a little radicalism. The valuable aids in our work are bold—not too bold, but it takes a considerable over-confidence to be successful in our difficult operations. Not haste, not sloth, not timidity, but of all things thoroughness.

Talk to men who have searched all things in their line and are completely prepared for work, and such men are duly prepared to be radicals. We note the men who have an intuitional advantage and peculiar power individually. They have it pre-eminently by experience, by work, and are far from conservatism; they do not cling to things to which the mosses and lichens cling; they are not idolaters of fossils. There can be nothing, to my mind, more discouraging than a great series of doubts and speculations attached to various cases treated. They start thought decidedly in hindering directions, and possess undeniably hurtful influences on young practitioners who read carefully much of the work of their elders. There is more hesitation and lack of confidence in the work of the younger men than need be. As to moral hesitation, I will quote, for they have a general application, the words of the greatest general surgeon in America, one pure and splendid in his motive, heroic and successful in his work—Dr. Nicholas Senn: "I am free to confess that I have never been able to muster my courage to attempt to attack the skull of a poor microcephalic child,

Digitized by Google

because I have always regarded the operation as useless in promoting brain development. The responsibility of the surgeon is not limited to the defective mental development of the child, nor the importunity of the parents in demanding an operation at all hazards. The surgeon should stand guard over such a charge. Mindful of the limits of surgery, have we a right to estimate human happiness? The drivelling idiot has many enjoyments that you and I know nothing about. His responsibilities to God and man are limited, and his existence on earth is a long, happy dream, which only ceases when the soul leaves the imperfect body and returns whence it came, where mental distinction is unknown."

These words, gentlemen, go out to the world, showing there is great conscience in our surgery. They go with the imprint and authority of the name of one who is every day busy. As we age, as our experiences crowd upon us, our science, with all its mysteries, becomes a clearer science; and the more weighty grow our responsibilities, the more enlarged our conceptions of duty, we feel the more keenly the issues we carry in our hands—there is sensitiveness to all breathing about us.

Digitized by Google