

**MODERN ABDOMINAL SURGERY: THE
BRADSHAW LECTURE DELIVERED AT THE
ROYAL COLLEGE OF
SURGEONS OF ENGLAND DECEMBER
18TH, 1890; WITH AN APPENDIX ON THE
CASTRATION OF WOMEN**

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Modern Abdominal Surgery: The Bradshaw Lecture Delivered at the Royal College of Surgeons of England December 18th, 1890; With an Appendix on the Castration of Women by Spencer Wells

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SPENCER WELLS

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TO THE
PRESIDENT, VICE-PRESIDENTS, AND COUNCIL
OF THE
ROYAL COLLEGE OF SURGEONS OF ENGLAND
THIS LECTURE
DELIVERED AND PUBLISHED BY THEIR DESIRE
WITH AN APPENDIX ON
THE CASTRATION OF WOMEN
IS RESPECTFULLY DEDICATED

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MODERN ABDOMINAL SURGERY

MR. PRESIDENT AND GENTLEMEN,—Some who hear me to-day—I fear not many—may remember the condition of Abdominal Surgery in the early part of the Victorian age, forty or fifty years ago. Younger men may easily inform themselves on the subject by referring to the surgical dictionaries and text-books of the period; and all must acknowledge that the contrast with the Abdominal Surgery of our own time—with what we may call Modern Abdominal Surgery—is very remarkable. An occasional operation for strangulated hernia was almost the only piece of abdominal surgical work done in those days. The radical cure of hernia had scarcely begun to attract attention. Astley Cooper had tied the abdominal aorta, and a case of Cæsarean section, when it was heard of, was talked of by the profession and the public as a marvel. A gunshot or other penetrating wound of the abdomen was rarely met with in civil practice; and there, with the occasional formation of an artificial anus, Abdominal Surgery may be said to have reached its boundaries; for neither then nor now have operations on the rectum, nor removal of stone from the bladder until quite recently, been classed as parts of Abdominal Surgery. Take Syme's 'Principles of Surgery' as an example. In the fourth edition, published in 1856 (a book which he says in his preface is the result of thirty years' hospital experience, and has been tried by a long succession of pupils at home and abroad), the surgery of the abdomen is treated in twenty-eight pages, four of which are devoted to wounds; penetrating wounds, he says, being almost certainly fatal. One page given to tapping, twelve to hernia, and a few lines on iliac abscess complete Syme's survey of Abdominal Surgery in 1856. Compare this with the recent

work of an English provincial surgeon, Mr. Greig Smith, surgeon to the Bristol Infirmary. In the second edition, published in 1888, we find forty-six pages on the diagnosis of abdominal tumours, forty on abdominal operations generally and their after-treatment, sixty on ovariectomy, ten on the Fallopian tubes and broad ligaments, thirty on operations on the non-gravid, and sixty on the gravid uterus; 140 on operations on the stomach and intestines, fifty on the kidneys, forty on the liver and gall-bladder, and twelve on the spleen and pancreas. Then we have a few pages on omental and mesenteric tumours and intra-peritoneal cysts. A long chapter on suprapubic cystotomy follows, and then some sixty pages are devoted to wounds and injuries of the hollow and solid viscera, perforating ulcers, purulent collections, and tubercular peritonitis. It is difficult to imagine a more striking contrast than this of abdominal surgery as it was forty years ago and is now, or to contemplate without surprise the vast and rapid advance made in our own day and generation, first in this country and afterwards abroad. In systematic works for students, and books of reference for practitioners, the sections on abdominal surgery are much enlarged. You, Mr. President, were one of the earliest of the leaders in this advance. The successive editions of your own 'Practice of Surgery,' like those of Erichsen's 'Science and Art of Surgery,' confirm all that I have said, and a comparison of 'Heath's Dictionary' with that of Samuel Cooper would do so quite as strongly. We have the well-known works of Treves on 'Intestinal Obstruction' and Morris on the 'Surgery of the Kidneys;' and I am glad to be able to say that the subject has not been neglected in this theatre. Mr. Treves's Hunterian Lectures in 1885, on the Anatomy of the Intestinal Canal and Peritoneum in Man, mark a distinct advance in our knowledge, and improvements in our practice.

In 1878, as Hunterian Professor, I delivered six lectures in this College on the 'Diagnosis and Surgical Treatment of Abdominal Tumours.' Two of those lectures were devoted to the Diagnosis, and four to the Surgical Treatment of such tumours. Three were restricted to the treatment of Ovarian Cysts and Tumours, especially to Ovariectomy, and to the consideration of Antiseptics in Abdominal Surgery. The Surgical Treatment of Uterine Tumours was the subject of the concluding lecture. It was

based upon the whole of my experience up to that time. A short description of Freund's method of entirely removing a cancerous uterus by abdominal section completed the survey that I was able to take of the state of Abdominal Surgery twelve years ago. Ten years later—in 1888—in the Morton Lecture on Cancer, I entered more fully into a description of the mode of extirpating the entire cancerous uterus by the vaginal operation.

Since 1878 the development of Abdominal or Peritoneal Surgery has been wide and rapid. When, in 1885, I published, in a condensed form, a small book on the 'Diagnosis and Surgical Treatment of Abdominal Tumours'—which might be called a fourth edition of that published in 1865 on 'Diseases of the Ovaries'—I had to describe the wide spread of the domain of Abdominal Surgery; to make many additions which naturally arose out of the growth of the subject, and to include the operative treatment of various kinds of tumours—splenic, renal, hepatic, mesenteric—and describe other operations hardly noticed in the earlier editions.

No intelligent student of the history of our science and art can doubt that ovariectomy was the starting-point in the modern advance of Abdominal Surgery. The first extension was to uterine tumours, and to partial and complete extirpation of the uterus. Although I have formerly alluded to these subjects in the Hunterian and Morton Lectures, experience has accumulated so rapidly of late years, that I may perhaps offer for your consideration a few remarks suggested by later modifications of these uterine operations, and upon some other of the more recent developments of Abdominal Surgery. But I will first allude to some practical questions which are still waiting for a decided answer, and which apply to nearly all surgical operations.

ANÆSTHESIA

The first question is, Which is the safest and best anæsthetic? Is it chloroform, or ether, or a combination of the two, or the mixture of alcohol, chloroform, and ether known as the A C E mixture, or bichloride of methylene, or laughing gas, or anything else? Beyond all doubt chloroform is still the usual and favourite anæsthetic. But I was from the first afraid of it.

The only death I ever witnessed of a patient under an anæsthetic was from chloroform. This was in 1848, and the surgeon was Maligne. The first year I was at the Samaritan Hospital, in 1854, I amputated a small breast, and the patient very nearly died from the chloroform. For a time we thought she was dead, and it was only after prolonged artificial respiration that she recovered. In several of my earlier cases of ovariotomy I was very uneasy about the effects of the chloroform during the operation, and in more about the vomiting which I thought it set up after operation; and twice, when Clover administered from his bag the vapour diluted with air, I had to stop my work while a patient was resuscitated. Whether chloroform was given by lint and a towel, or by Skinner's mask, or by some inhaler, I was always much more anxious about the anæsthetic than about hæmorrhage or any other operative detail; so that when, in 1867, Dr. Richardson explained his views as to the causes of danger of death from chloroform, and his belief in the greater safety of methylene, which he was then introducing, I was quite prepared to give the newer liquid a fair trial.

To my mind, the result of the first case was most satisfactory, and I have repeatedly made known what my experience of methylene has been. I have been surprised that, in the face of the reports of deaths from chloroform repeated week after week in the newspapers and Medical Journals, we have not yet had to defend one of our brethren against a verdict of manslaughter on the ground that an anæsthetic, well known to be dangerous, had been administered when others, equally efficacious, were known to be safer. I should not at all like to be tried on such an issue, for I fear the defence would be very difficult. I am sorry I cannot enter more fully into this question, but there are others which demand more time than I have at my disposal, and I must be content with explaining that some of the reasons urged against the use of methylene may be completely answered. It can be made by any manufacturing chemist in the manner described in his first paper by Dr. Richardson. Its chemical composition shows it to differ from chloroform only in containing one equivalent less of chlorine.

	Composition	Specific gravity	Boiling-point
Bichloride of Methylene	CH_2Cl_2	1320	128°
Chloroform	CH_3Cl	1480	142°

It is not so easy to procure pure methylene as pure chloroform ; for, in spite of the greatest care, a little chloroform, from which methylene is reduced by the action of zinc, occasionally passes over during distillation ; but the quantity is too small to be of much consequence. Still I trust the makers will be able to guard against this accidental admixture. Even as now sold, if it is administered sufficiently diluted with air, as it may be from Junker's inhaler by any intelligent student, or even, in cases of emergency, by a nurse, I believe any surgeon who will try it on my recommendation (after more than twenty years' experience of its use in a very large number of operations, some of them exceptionally long and trying), will be freed from much unnecessary anxiety, and may escape censure which some might think to be not quite undeserved. I am sorry I cannot devote more time to this important discussion now ; but I have some reason to believe that the whole subject may be treated fully, either in this theatre or in the Examination Hall of the two Colleges, in a full course of Lectures on Anæsthesia by Dr. Richardson, including all the substances described in his synopsis of anæsthetics in the second volume of the 'Asclepiad.'

Let me now pass on and ask you to consider for a few minutes the question of

DRAINAGE,

which, with or without *flushing* of the peritoneal cavity, is one of the more recent additions to the practice of Abdominal Surgery. First introduced and practised by Peaslee in 1855, rather in the treatment of septic peritonitis *after* ovariectomy than as one of the steps of the operation, it has been followed extensively in America, in this country, and in Germany. Some surgeons attach great importance to it, and adopt it almost as a general rule, even where there has been no escape of fluid or oozing of blood into the peritoneal cavity. Koerberlé and Keith first used glass tubes $\frac{1}{4}$ to $\frac{1}{2}$ an inch in diameter. Since then smaller tubes of vulcanite have been preferred, and various modes of syringing, attaching waterproof protectors or sponges, have been used to carry off fluid and to prevent the entrance of septic matter into the cavity. In my own work, I have from the first looked upon drainage as a practice to be avoided if possible, and have only put in a tube when I knew I had not been