A MODIFICATION OF THE OPERATION OF CHOLECYSTENTEROSTOMY.

BY

ANDREW FULLERTON, C.B., C.M.G., F.R.C.S.,
SURGEON, ROYAL VICTORIA HOSPITAL, BELFAST.

WHEN a gall bladder is packed with gall stones, when its walls have lost their elasticity and contractility, are thick, leathery, opaque, and infiltrated with micro-organisms, there is very little doubt that the best procedure is to remove it. In recent years, however, the tendency has been to remove the gall bladder even when the signs of disease in its contents or walls are so slight as to require more than moderate experience in this branch of surgery for their diagnosis.

The removal of the gall bladder is now so frequent that this organ almost rivals the appendix as an object of attack. Its retention in the body may, however, be of great service to the surgeon in facilitating the drainage of the common bile duct when for any reason the flow of bile from the common duct to the duodenum is partially or completely obstructed. The most usual cause is chronic pancreatitis. To relieve the obstruction in such a case the gall bladder has been anastomosed to the stomach, the duodenum, or even to the colon. Although success has attended some of these operations there are certain objections which may be urged against them.

1. The gall bladder and its contents are infected and may remain so. This constitutes a grave danger to the health of the patient.
2. Gall stones may form, or, if they have been removed, may recur.
3. The contents of the stomach, duodenum, or colon may regurgitate into the gall bladder.

These disadvantages may be met, to a large extent, by the following procedure: The gall bladder is opened and cleared of its contents. A light clamp is placed near the neck, and the greater part of the viscus is removed. The small remaining portion is anastomosed to the duodenum, so that when the operation is completed the cystic duct opens into the duodenum without the intervention of any sac which might harbour gall stones or regurgitated intestinal contents. Just enough of the gall bladder is left to enable the anastomosis to be satisfactorily accomplished.

The following case was dealt with on these lines.

Mrs. R., aged 55, seen with Dr. William Monypeny, had suffered for ten years from attacks of pain radiating to the back. These attacks recurred at intervals of a few months. She had lost about 2st. in weight during the last five years. The last attack occurred a few days before her admission to the Royal Victoria Hospital on April 4th, 1922. On this occasion she was jaundiced for the first time.

The patient was spare but not wasted. She complained of pain and tenderness in the epigastrium; the sclerotics were yellow, the urine was bile-stained, and the stools clay-coloured. The temperature rose in the evenings to 99.2° F., and the pulse ranged from 78 to 84. Morphine was required to ease the pain.

Operation, April 10th, 1922. Right rectus incision. The gall bladder was distended and adherent to the colon, its walls were thick and opaque, and gall stones could be felt in its interior. The pancreas from head to tail was firm and hard, almost suggesting growth, but the gland was not fixed to its surroundings. Chronic pancreatitis was diagnosed. The gall bladder was opened and seventy-six gall stones were removed. The common and hepatic ducts were clear. The main part of the gall bladder was removed and the stump was anastomosed to the anterior surface of the first part of the duodenum, using fine catgut for the sutures. Light clamps were used to prevent extravasation and bring the parts into apposition. The abdomen was closed without drainage.

Result.—Jaundice disappeared in a few days, the wound healed by first intention, and the patient left hospital eighteen days after operation quite well. After leaving the hospital she had a bismuth meal, and there is no evidence in the skiagram of any pouch connected with the duodenum.

In this case I was afraid to remove the gall bladder completely on account of the state of the pancreas, and the presence of jaundice, possibly due to the latter. The operation I have described solved the difficulty. Even if further thickening of the pancreas takes place the patient has a safety valve in the cystic duct, and she is, in addition, relieved of the greater part of a much diseased gall bladder.

The patient reported herself on May 29th. She is steadily regaining weight.

Memoranda: MEDICAL, SURGICAL, OBSTETRICAL.

ERYTHEMA NODOSUM ASSOCIATED WITH ACUTE RHEUMATISM.

THE following case seems to me of interest, especially in view of a correspondence which occurred in issues of the BRITISH MEDICAL JOURNAL during November, 1921. The case shows so close an association between erythema nodosum and rheumatism as to suggest that these two conditions are manifestations of one and the same infection.

Miss T., aged 38, was first seen on April 27th, 1922, when she complained of severe pains in the legs, arms, and back, and of sore throat. Typical erythema nodosum was present on both legs and on the right arm around the elbow. The throat was very injected; the heart, except that the first sound was of very poor quality, was normal; the joints, apart from pain on movement, showed nothing abnormal. The temperature was 100.4°.

On the following day both wrists, the right knee, and right ankle were red, swollen, and acutely tender. The temperature had risen to 101°. After thirty-six hours the joints mentioned started to clear up, and the temperature to come down to 99.2°. On May 1st, however, the right elbow became acutely inflamed, and the temperature again rose to 100.4°. By May 5th the active process in the joints was at an end, and the temperature varied between 98° and 99°. At the sites of the original eruption a dull purple stain remained; the throat was normal, and the heart up to May 19th has remained free.

Large doses of salicylates were given from the onset of the illness on April 27th.

A point of some interest is that a brother of the patient suffered with chorea as a child.

Hampstead, N.W.

HUGH WETHERBEE.

RECURRENT VESICULAR ERUPTION AFTER INFLUENZA.

W. E. B., an omnibus ticket inspector, a married man of very abstemious habits, was taken ill on January 10th with intense frontal headache, aches and pains in all his limbs and joints, cold "shivers," and a high temperature. His condition was diagnosed as influenza, and a mixture containing sodium salicylate and diaphoretics was prescribed. In the ensuing week he developed a slight degree of tonsillitis, which cleared up in a few days. Otherwise he felt quite well, the influenza having lasted three days only.

From January 14th to 18th he had been having skate for his daily dinner. Other members of the family also partook of the fish, but remained quite well. He had partaken of skate on several occasions previously, but no rash ever developed subsequently. On January 19th there appeared on the anterior aspect of the left wrist a small reddish itchy patch. This consisted of small red, raised papules about the size of a pin's head. Two days later the patch extended to the palm and fingers, and the right hand was now similarly affected, the wrist, palm, and fingers being involved. Calamine ointment was prescribed. The following day severe pains were felt on the top of the head, and the patient was of the opinion that "something was gathering under the scalp." Next morning, the hands, front and back, were very swollen and red. Intense burning and itchy sensations were felt in the affected areas, and in the course of the day small vesicles formed on the anterior aspects of the palms and wrists of both hands. A day later the vesicles ruptured and there exuded for two days a yellowish-green fluid. At the same time the skin over the inner aspects of both thighs, from the groins to the knees, was very itchy and slightly inflamed. Calamine lotion was freely applied, and the parts were covered with cotton-wool. Mist. alba, 3ss morning and evening, was prescribed.

On January 27th the patient had chicken for dinner, and three hours later an acute vesicular eruption broke out over the entire scalp, the back of the neck, and both ears. The vesicles soon broke down and discharged a yellowish-green fluid. The next day the back, the chest, and the entire abdomen were covered with reddish papules, and the itching was very considerable. The discharge from the affected areas ceased a day later, though the parts remained swollen, burning, and intensely itching. In the ensuing week good progress was made to recovery till February 5th, seven days after the previous attack. The vesicular eruption again