SOME SURGICAL HINTS.

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Never exclude the presence of a fracture or a dislocation unless you have had the patient X-rayed. Nowadays, most patients expect it, at any rate the judge and jury do so if, later on, an action is brought against you for malpraxis. If your patient does not consent to have an X-ray taken, write a letter to him strongly urging the necessity of it and keep a copy of the letter as a precautionary measure. Always control your treatment of a fracture by radiography. It is not an exaggeration to say that radiography, for the purpose of ensuring correct apposition, is of more importance than for purposes of diagnosis. If you find the bones are not in accurate position, try again. Sometimes you may have to make three or four attempts to put up a fracture before you succeed in obtaining perfect apposition. It is advisable always to give an anaesthetic when putting up a fracture, otherwise it may be very difficult and sometimes impossible to obtain a good result.

If good alignment cannot be secured after three or four attempts, the advisability of open operation must be considered. As a general rule, oblique or spiral fractures have to be plated. It is almost impossible to get a spiral or very oblique fracture into good position by ordinary manipulation, and if you succeed, it is very difficult to keep it so.

Never plate a compound fracture. The attempt almost always ends in disaster. Whatever the position, however bad it is, allow the wound to heal and see what happens. If necessary, you can operate at a later stage.

Make a point of keeping the splints on a fracture until union is firm, and remember that the periods of union are considerably longer than those usually given in textbooks. The argument advanced in favour of removing the splints early is, that otherwise there will be a stiff joint. Do not worry about stiff joints. A stiff joint is better than an ununited fracture. Personally, I think the fear of stiff joints is a bogie. I have never seen a permanently stiff joint from simple immobilization of a limb for fracture. If a joint does become somewhat stiff after prolonged rest, movement is soon recovered when the patient gets about, and with treatment by massage and passive movement.

Lastly, do not make rash promises as to the ultimate result.

Do not be in a hurry to operate without some preparation of the patient. I know of only two operations in which delay must be cut down to a minimum; they are perforation of a hollow viscus and tracheotomy. In other conditions it is, I think, wise to defer operation for six or eight hours, and in the meantime to give the patient sodium bicarbonate by the mouth, which minimizes the ill-effects of the anaesthetic, and to administer saline and glucose continuously by the rectum.

Further, if you are wise you will not allow yourself to be persuaded, on the grounds of urgency, to operate in a private house. If the patient be fit for operation, he is fit for removal to hospital or to a nursing home. The delay, if any, will be more than compensated by the greater facilities available. In cases of badly-smashed limbs, resulting from railway or motor accidents, immediate operation is usually inadvisable. It is better to wait until the patient has recovered from the initial shock. Always remember the possibility of a fractured base of the skull. In such cases an anaesthetic may prove fatal.
Nowadays, most people recognize that acute appendicitis requires immediate operation, but here again, I am convinced that the patients do better if the operation is delayed eight or ten hours, in order that adequate preparation of the patient may be carried out. When this is done it is surprising how often the symptoms subside, so that operation can be delayed for four or six weeks—the so-called delayed treatment. This, however, should never be carried out except in a nursing home or hospital, so that immediate operation can be performed if urgent symptoms recur.

Do not decide in a hurry that operation is indicated in cases of internal 
haemorrhage. Nature is a wonderful person, and often can deal with internal 
haemorrhage very efficiently if you will help her, and if you trust her 
she will fail you but rarely. So far as haemorrhage from gastric and 
duodenal ulcers is concerned, I do not believe it is ever wise to operate 
during the haemorrhage. Beware of the fallacious argument which is 
sometimes advanced in regard to these cases, somewhat to this effect: "This patient 
is bleeding—he will probably die—something must be done." Even if we admit that 
these premises are true, and that the patient will probably die, is this any reason or 
justification whatever for doing something which will make him die sooner? Such an 
argument is illogical, as you cannot be certain that the patient will die, and in many 
cases of internal haemorrhage operation may be the last straw for the patient, who, 
but for operation, might have recovered.

There is nothing more difficult to diagnose than acute intestinal obstruction in 
itself early stage; nothing easier than in its later stages. Often the general practitioner 
is blamed most unjustly for not recognizing it earlier. When a patient 
is seized with acute abdominal pain and vomiting, you should always 
suspect intestinal obstruction. Above all, remember that a patient who 
can pass neither flatus nor faeces is a dying person. As regards 
operation for intestinal obstruction, the position is rather different from that in internal 
haemorrhage. Acute obstruction, if left untreated, is inevitably fatal, therefore surgical 
intervention is justifiable even in the most desperate cases. It is right to take a big 
risk, even if it consists in merely opening the abdomen and draining the bowel, because 
relief of the obstruction is the only hope of saving the patient's life.

Beware of operation on a patient with jaundice. Operation is hazardous on 
account of the difficulty in controlling the excessive oozing of blood. Jaundice due 
to gall-stones may clear up, temporarily at any rate; if the jaundice is 
deep and persistent, it may be due to malignant disease, in which case 
operation will do no good and may have a fatal issue. In cases of doubt the best 
policy is "Wait and see."

Whenever possible, radical operations for malignant disease are best performed in 
two stages. The vitality of patients suffering from cancer is low, and 
they do not bear severe operations well. The two-stage operation 
greatly lowers the mortality rate.

In cancer of the stomach, a preliminary gastro-jejunostomy may be followed by 
a partial gastrectomy in four weeks. Usually, the patient improves in health and puts 
on weight after gastro-jejunostomy; if not, the probability is that there are secondary 
growths somewhere.
Never perform a radical operation for cancer of the bowel when there is obstruction. Drain the bowel by a caecostomy, and resect the growth at a later stage.

 Patients with a malignant stricture of the oesophagus die more often from lung complications than from starvation. The commonest cause of death is not starvation, but broncho-pneumonia. This being so, it may be argued that gastrostomy is not of much value. I believe that when a patient has difficulty in swallowing, he is made more comfortable and life is prolonged by a properly performed jejunostomy. I advise jejunostomy as an operation far preferable to gastrostomy in the treatment of carcinoma of the oesophagus. If any operation is to be done, it should be performed early, as soon as the diagnosis is certain. It is useless to wait until the patient is weakened and emaciated by inability to take sufficient nourishment.

 Do not be in a hurry to operate for the removal of a ureteral calculus, because it is probable that sooner or later the calculus, if it be a small one, will be passed. If you do decide to operate, be sure that the calculus has not been passed in the meantime. A skiagram should be taken as near as possible to the time fixed for operation, and all urine passed after the X-ray examination should be filtered through muslin, so as to be sure that the stone has not been passed subsequently. I have known a stone passed between the taking of a skiagram at 11.30 a.m. and 2 p.m., the time at which it was intended that operation should be performed.

THE USE OF CATHETERS.

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Probably the oldest catheter in existence is the bronze one which was found in the "House of the Surgeon" at Pompeii, and is now in the Museum at Naples. The details of the eye, and the general finish, show that the maker not only possessed great skill, but was accustomed to work of this nature. The instrument has a curious open curve, resembling that of the old-fashioned "long S." Incidentally a modern gum-elastic catheter, if tied in the urethra for a few days, will usually have a similar curve on withdrawal.

I merely mention this instrument to show that 2,000 years ago catheters were a recognized part of the surgeon's armamentorium.

Modern catheters are usually classified according to the material from which they are made, and we speak of them as metal, soft rubber or gum elastic. They are also classified by their curve, or the details of their beak or eye.

Metal catheters were formerly of silver, but are now made from brass tubing, and are nickel plated. They are easily sterilized by boiling, have a large lumen in comparison with their size, and last indefinitely. They have the disadvantage of being rigid, and are therefore more difficult to introduce than the flexible ones. In unskilled hands they may do serious damage to the urethral wall, and should never be recommended for self-catheterization. In the older instruments, the eye was often a narrow slit in the lateral wall. It was shaped thus in order to prevent injury to the urethra during introduction. With a