

ACUTE INTESTINAL OBSTRUCTION.

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Not infrequently general practitioners are blamed for failure to recognize acute intestinal obstruction at an early stage. Sometimes they are blamed most unjustly. In the early stage there are few conditions which present greater difficulty in diagnosis; in the later stages, the diagnosis is so easy that "he who runs may read". I will mention very briefly a few of the points which are of importance.

Early diagnosis is the key to success in treatment. Severe pain of sudden onset, unaccompanied by rigidity or marked tenderness should lead us to suspect intestinal obstruction. When, in addition to pain, there is inability to pass flatus or fæces, surgical treatment is indicated. A person who is passing neither flatus nor fæces is a dying person. If this fact cannot be established from the history of the illness there are two methods of value in settling the point:—

1. The administration of two enemas at an interval of one hour usually will confirm or negative the diagnosis.
2. Although it is not an orthodox aid to diagnosis, I believe that the administration of an ounce of castor oil is not only harmless but of great value from a diagnostic point of view. My experience is that a dose of castor oil given to a patient with acute intestinal obstruction is invariably vomited soon after it has been administered. This, of course, is not conclusive evidence of obstruction, but is very suggestive.

When pain is accompanied by rigidity the symptoms may suggest perforation of a hollow viscus. We are told in our text books that the rigidity of intestinal colic is superficial and less marked than in perforation. In my experience this is not true. The rigidity of intestinal colic *may* be board-like in its intensity, but there is this important difference. In intestinal colic, gentle massage with a warm hand continued for at least five minutes will gradually overcome the rigidity. In perforation no coaxing will induce the muscles to relax their protective spasm.

In recent years it has been suggested that radiography should be employed as an aid in the diagnosis of acute intestinal obstruction. In my judgment this is a suggestion which should be condemned wholeheartedly. At the present time there is perhaps a tendency to overlook the value of the "seeing eye" and to rely over-much on laboratory-made diagnosis. I prefer the "seeing eye" of a living clinician to the scientific eye of an inanimate machine. Even if the diagnostic value of radiography in acute intestinal obstruction were more than problematical, the unfortunate patient, by the time his examination and preparation for operation have been completed, has had quite sufficient trial of his patience and endurance. In dealing with acute intestinal obstruction the surgeon should have the courage of his convictions and get on with his job.

In the treatment of acute intestinal obstruction experience has taught me three important lessons. First, the importance to the patient of a short period of rest after the preparation for operation is completed. Therefore, when the preparation has been carried out, a small dose of morphine should be administered and the patient allowed to rest for at least half-an-hour. Secondly, the importance of keeping the patient warm. In more senses than one, a cold slab is the death-bed

of the acute abdomen. Therefore a heated operation table is a vital necessity and the patient's extremities should be bandaged in cotton wool. Thirdly, in my early days, experience as an anæsthetist taught me that patients who are acutely ill will not stand prolonged operations. After half-an-hour the pulse begins to flag and after forty-five minutes this failure becomes pronounced. Therefore, the ideal to be aimed at should be the relief of the obstruction by the simplest method in the shortest possible time. Two cardinal principles should be kept in mind:—

1. No form of anastomosis or resection is permissible in cases of acute intestinal obstruction.
2. Almost invariably drainage of the bowel is advisable.

I am aware that at the present time drainage is not a fashionable procedure; indeed, by some it is regarded as a confession of ignorance on the part of a stagnant and indecisive mind. This heresy is a heritage of the War when claims were made as to the success of excision and primary suture of septic wounds which were not confirmed by those who observed the ultimate results of this method of treatment.

If the obstruction cannot be removed or if, after its removal the intestine is too paralysed to empty itself, drainage of the bowel is imperative.

Statistics prove conclusively that the mortality rate from resection is extremely high and that drainage is much more likely to be successful.

To sum up, the important points are:—

- (a) Early diagnosis and early operation.
- (b) Preparation of the patient to be followed by a short period of rest.
- (c) A heated operation table.
- (d) No resection or anastomosis.
- (e) Drainage of the bowel when necessary. Sepsis demands drainage. Surely this is one of the eternal verities of Surgery!

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