AFTER-TREATMENT OF ABDOMINAL SECTION.

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"Many men of many minds" seems peculiarly apropos of the after-treatment of patients upon whom abdominal section has been performed, and, from the exceedingly great variety of methods adopted, it would almost appear that "all roads lead to Rome." Be this as it may, it is certain that there is no one method so far superior to another as to hold a sufficiently large portion of surgeons together with the result of establishing *the right method.* Consequently, we may fairly assume that there is no single method, to the exclusion of all others, which embraces all that is meritorious. It is not at all likely that surgeons would continue in their own particular routine unless their results were satisfactory not only to themselves but to their patients, and the fact that so many different men do continue in so many different ways is sufficient proof, I think, that there are many correct ways, and in this as in so many problems in surgery lies the solution of this question of after-treatment.

What can be more diametrically opposed than one surgeon opening the bowels of his patient, by the use of a laxative and an enema within twenty-four hours after an operation, and another allowing the bowels to remain locked for from five to eight days? And yet each method has its advantage, and the results in both have been good in various hands.

What is more antagonistic than the feeding of one patient

as soon as an appetite is developed, and the practical starvation of another (on slops) for an indefinite time; the free use of morphine and its absolute prohibition; the administration of a stimulant, and its absolute refusal; the enforcement of rest in the dorsal position and the privilege of free movement; the prolonged rest in bed, and the enforced getting-up within from twenty-four hours to a week; the continued administration of drugs on every pretext, and their almost absolute withdrawal? And yet it must be admitted that all of these methods, diametrically opposed as they are, have been used with the utmost success and will continue to be so used.

Personally, I have been guilty of trying all these methods from time to time, and, if my surgical experience has taught me anything, it has taught me this, namely, in the routine case, if my surgery has been satisfactory and my patient has gone from the operating table free from sepsis, hemorrhage, and shock, the after-treatment is of little importance as far as recovering from the surgery is concerned; it is principally of importance as to the relative comfort of the patient. What to me formerly appeared of great moment is now, in the light of a wider experience, amusing and the petty details being continually threshed over seems like making "mountains out of a mole-hill."

Simplicity is the key-note of surgical work as few assistants, as few instruments, as few sponges, as it is possible to work with and work effectively. So it is in the after-treatment. The key-note here is to do as little as possible ourselves, to allow our patients to do as much as possible, as they choose; and when we do act to follow as closely as can be in the lines indicated by nature.

I have found, after the administration of ether, a patient is both thirsty and sick at the stomach, and anything placed in the stomach, even of the mildest sort, will further irritate that organ. Rest and time are the great panaceas; consequently

thirst is quenched by rectal enemas of warm water often repeated—nothing is administered by mouth, neither food, nor drink, nor ice, nor medicine. By the end of twenty-four hours nature has asserted herself, the irritation of the stomach has passed, the thirst is quenched, and the stomach is ready to digest and absorb. By this time the sting of the pain from the operation is considerably abated, and the patient is chafing under the enforced dorsal position. What is to prohibit her drawing up her knees, shifting her body or turning on her side? Absolutely nothing. She desires to do it, and if her desires are not humored she will only suffer the more, physically and mentally. Turning will do no harm, will rest, will relieve anxiety, and will often dissipate pain by encouraging peristalsis and the passage of flatus. If a patient has an appetite and desires something to eat, why deny it or why make her swallow slops when she craves solids? In all seriousness, what is there forty-eight hours after an operation in the routine case which prohibits the eating of anything a person craves? I know of *nothing* and consequently allow nature to dictate in all these matters.

Whether or not opium is harmful in full doses does not interest me much; as a very moderate dose or two in the shape of morphine relieves the primary sting of the operation; takes away the memory of the horror of the first long unending night; its bad effects, if any, are so far outweighed by its beneficial action that I like to use it.

Ordinarily most people feel well when their bowels are moved daily, and there is no exception to this when one is sick. Because one gets well and has not much tympany when the bowels are kept locked, is no reason why we should violate the laws of nature, when we know nature has at this time the extra burden of two extraneous and noxious substances, which may with benefit be thrown off—ether and opium. I see no reason why a bed-ridden person should be allowed to accumulate and absorb ptomains and noxious substances

any more than a well one. The effect of the first movement of the bowels on the patient is most marked for the better, and the earlier this is secured the sooner is the patient off the surgeon's mind.

The question of catheterization is merely one of good nursing; once or twice after leaving the operating table is the limit of allowance; multiplicity of this should mean a change of nurses.

There is probably no great advantage in keeping the routine patient in bed longer than two weeks, and there is a growing tendency toward lessening this time. As far as surgery is concerned this practice is perfectly rational. Wounds in other parts of the body heal up soundly in this space of time, and, if anything, peritoneal wounds heal more quickly. In many cases of abdominal surgery, however, there is a two-fold object to be obtained. This is peculiarly so in the class of chronic or semichronic cases so often dealt with by gynecologists. A very large percentage of these patients—especially the hospital cases—are broken-down, neurasthenic, half-starved, illy nourished, sexually abused women, and the surgery is only a first step toward their recovery. Very many of these women, especially those operated upon for cystic ovaries, displaced uteri, torsion of the tube, and chronic appendicitis, or appendical colic, would be very materially benefited by rest without an operation at all. In such cases an operation, followed by an enforced getting up in two weeks, is irrational, and in twenty-four hours is brutal. What these people need most of all is rest—physical, dietetic, and mental.

Prolonged, absolute rest in bed has no dangers attached to it in spite of the recent arbitrary dictum of surgeons. The assertions as to the dangers of thrombus or embolus and phlebitis, from the recumbent position, are absurdities not borne out in the slightest degree by my own experience, nor has any surgeon yet adduced a proof of sufficient weight

to be taken seriously. I care for no man's opinion if he is unable to accompany it by proof which appeals to my reason. I have been sufficiently interested in this subject to investigate the experience of that body of specialists who deal, to an enormous extent, with patients in a recumbent position, and who are most competent to speak on the subject,—the neurologists.

Following rest cure of from two weeks to three months and longer, Dr. Charles K. Mills has never seen a case of phlebitis; Dr. Wharton Sinkler never saw and never heard of a case; Dr. Weir Mitchell and his son, Dr. John K. Mitchell, have seen but one or two cases, and those from well-defined causes, and Dr. Francis X. Dercum has seen two cases in men, one gouty and one syphilitic.

If the recumbent position was a factor in the production of phlebitis, the observations of these gentlemen would surely have given some indication of it. It being as it is, I think we are perfectly safe in rejecting the theory that a few weeks' quiet in bed is of any serious import in the convalescence of our patients, especially when these weeks of careful feeding, nursing, and rest are productive of a very great amount of good health such as many of these people have not known for years.

I admit that a surgical case may be got out of bed and home in a week or ten days, but I deny that this is best for them, or that this means that their convalescence has been more rapid. Our aim should not be to get them home in the quickest possible time, but to give them the best amount of stored-up health and energy with which to successfully meet the future. One who has got out of bed with health fully restored is surely more competent to meet the necessities of every-day than one who has been quickly put upon his feet, with little regard to his general condition.