

NOTE ON ACUTE DILATATION OF THE STOMACH
POSTOPERATIVE.*

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STUDY of the literature proves this postoperative complication to be fairly frequent, obscure in diagnosis, and unusually fatal. It is insidious in onset and yet, unless recognized early, therapeutics appears to be futile. I recall but two cases, which I report in the hope that the members may be in a position to give me information as regards early diagnosis and rational therapeutics. Likely enough, I have seen more than these two cases, but the following are the only ones recognized, and this limited experience satisfies me that our present means of diagnosis are inexact even as, in uncomplicated dilatation, our therapeutics is nugatory except when the condition is recognized in its stage of inception. Further still, it appears to me that the condition is rarely uncomplicated—that is to say, there is often an associated paresis of one or another portion of the intestinal tract, and this again shrouds diagnosis in obscurity.

CASE I.—The indication for operation here was multiple fibroids and double, sterile pyosalpinx. The cervix being diseased, total abdominal hysterectomy was performed. The operation was of about one hour duration and offered no special difficulties. The raw supravaginal region was covered with sterile plain gauze, and this was carried into the vagina. Within twelve hours the subject became tympanitic and vomiting started in

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with violence. Although the subject had received only a few ounces of water, gastric lavage removed about one quart of darkish fluid, nonodorous. The tympanites was general, and high enemata of ox-gall and later of alum failed to relieve the paresis of the intestines. Hyoscin, grain one-fiftieth, was ordered hypodermically, hourly for three doses, and gastric lavage was repeated every two hours with similar result as regards the amount of fluid withdrawn, and this fluid became blacker. At the end of six hours the intestinal spasm relaxed, and at the end of twenty-four hours the vomiting ceased and the subject made an uninterrupted recovery.

CASE II.—This subject was aged forty-two and a widow. She was a woman of large build, weighing nearly 250 pounds. Two years previously I had curetted her for metrorrhagia and had performed multiple myomectomy. My desire was in favor of complete hysterectomy, but this she declined, a second marriage being contemplated. Convalescence was uneventful. In December, 1908, the woman returned to me, still a widow, gave me a history of regular menstruation, and on examination I found multiple fibroids. She had slight rise of temperature and tenderness over one fibroid mass, which made me suspicious of probable necrosis. I urged operation as soon as feasible. She reappeared in February, 1909, the abdomen larger, with again temperature and decided tenderness over the left area. She was so exceedingly stout that accurate palpation was not possible. She was operated on within twenty-four hours. On opening the abdomen I found I was dealing with pregnancy plus fibroids. It turned out to be an instance where "women's bellies" were more to be believed than their words—to paraphrase a statement of Robert Battey's. I opened the uterus, removing a three months' fetus, and then performed a supravaginal hysterectomy, the cervix being in good condition. The operation was a difficult one, owing to the enormous thickness of the abdominal parietes, and the woman was in the Trendelenburg posture for fully one hour. She reacted well from the operation, had but little vomiting, and this more a "bubbling over"—a matter which I now think should have impressed me more. At the end of twenty-four hours she began to be tympanitic, and this yielded to three doses of hyoscin. The bowel also responded to a high glycerin enema. The vomiting, or rather the bubbling over continuing, I washed out the stomach and removed over two quarts of blackish fluid. Notwithstanding lavage every two hours, the woman went from bad to worse and died in thirty hours from exhaustion with signs of systemic toxemia.

To oppose these cases: In the one I dealt with primary paresis of the entire intestinal tract—the predominating element being intestinal. In the other there existed associated paresis of the gut, but the factor of note was the gastric dilatation. In short, in case of intestinal paresis we possess in hyoscin or in atropin

therapeusis carrying a measure of certainty, while in predominating gastric dilatation I question if it has any value. What is desirable here is earlier diagnosis and treatment of a more radical nature, perhaps surgical. We cannot order gastric lavage in every instance of postoperative vomiting, but thus we might diagnosticate very early this untoward complication. What I term "bubbling over" from the stomach, somewhat as a full bottle will run over or a baby will allow to trickle out from a distended stomach, if noted, calls for immediate and repeated lavage. Where the gastric dilatation exists for over twenty-four hours undetermined the upper intestinal tract is pouring its contents and its ferments into the stomach and then gastric lavage and drugs would appear to be nugatory. Whether we are dealing with a gastromesenteric ileus, or with paralysis of the gut from the jejunum upward, it would seem that our mainstay should be surgery—possibly a jejunostomy for drainage, rather than drug or position. But then to be of value, early diagnosis is imperative.

Finally, from an etiological standpoint, can the neurotic stomach of pregnancy enter as a factor? I have recently heard of three instances similar to my second case, operated upon by experts, where the issue was fatal. In these cases as well the women were stout and in the Trendelenburg posture for fully one hour. Pressure on the stomach perhaps leads to loss of tone, whence relaxation and dilatation with their untoward sequelæ.

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ACUTE DILATATION OF THE STOMACH AS A POSTOPERATIVE COMPLICATION.

DR. JOHN OSBORNE POLAK, of Brooklyn, N. Y., said that this complication occurred eight times in one thousand abdominal sections. There were two deaths in patients with low hemoglobin percentages, and low red cell counts. All patients were operated upon under general anesthesia. They were in the elevated trunk posture at the time of occurrence. Six had had septic processes before operation. One had previous gastroptosis. Vomiting began from twenty-four to fifty hours after operation. There was diffuse abdominal pain and thirst, with continuous and persistent regurgitant vomiting, without peritoneal irritation, thus enabling one to make the diagnosis.

Treatment consisted of lavage, starvation, the right latero-prone posture, irrigation by the Murphy method, and nutrient enemata.