TWO CASES OF OESOPHAGOTOMY FOR THE REMOVAL OF FOREIGN BODIES: WITH A HISTORY OF THE OPERATION

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WITH A

HISTORY OF THE OPERATION.

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INTRODUCTORY REMARKS.

THE removal of foreign bodies from the œsophagus, by external incision, has been so little treated of in surgery, that it is dismissed, by most authors, with a bare allusion, or an obscure description, as of some remote possibility, which the surgeon should know of, but which he need have no expectation of being called on to undertake.

And it has been so rarely performed, that, after diligent search, we have been able to find a record of only *fifteen* authentic cases; of which *seven* were in France, *one* in Italy, *one* in Belgium, *one* in India, and *five* in Great Britain.

The ingenuity of the surgeon has been exhausted in devising means to withdraw foreign bodies through the natural passages; an intention which cannot be too highly commended, but which has often led to irritation, ulceration and perforation of the digestive tube, by the too zealous employment of instruments, as dangerous as the foreign bodies themselves.

By reviewing the history of the operation, and by our own cases, we hope to show that, as in strangulated hernia, urinary extravasation, or croup, so in œsophagotomy, the danger is in delay. That the risks of the operation depend on skill in its performance, and not on its sequences. That if done early, it can be done safely. And that it deserves its place among operations of necessity, and not of expediency, as one which can relieve a fellow being from exquisite suffering, and from extreme peril.

ŒSOPHAGOTOMY.

CASE I.

Mr. L——, a young man of temperate habits, and strong, muscular frame, an engineer by profession, while eating a dinner of chowder, on the 9th of November, 1866, suddenly became conscious that he had a bone in his throat. Violent strangling and efforts at ejection came on, followed by vomiting. The fragment was not dislodged. A physician, having arrived, caused him to masticate and swallow some ship-bread, without moving the foreign body. His throat being violently congested, he was directed to go home, and dress it with cold water, and if trouble continued, to send for me. On the same afternoon I was sent for; but was not at home, and word was not left for me to visit him. Distress in the throat continued, and while repeatedly applying cold water, continued chills came on. He passed a bad night, swallowing only water. The next day, as bad as ever.

He now, Nov. 10th, sent for me again, and I saw him between 2 and 3 o'clock, P.M., a little more than twenty-four hours after the accident. He was in much distress at each effort to swallow; his face was suffused; his eyes congested; the palate swollen, the uvula touching the tongue, and provoking attempts to swallow an oversecretion of mucus which collected in the fauces. There was no swelling of the tonsils, or tongue. The latter was coated; the pulse a little accelerated. Pains radiated up and down the neck from a point on a level with the cricoid cartilage, on the right side. He had slept none the past night. Having placed him opposite a good light, I explored the pharynx with my forefinger. I was able to reach over and behind the larynx, and searched the base of the fauces and the folds around the epiglottis, as well as the back of the pharynx. I felt nothing. He vomited a little mucus, and expressed himself relieved. He now swallowed a whole goblet of water, without much wincing. I then left him, with directions to rub the

neck gently with a liniment containing one-third laudanum, and to wait and see whether the distress returned. We both of us had hopes that the foreign body had passed down. This was on Saturday afternoon. I heard no more from him until Monday morning, when I was sent for early, and found him worse.

It seems that the distress, on swallowing, returned in two hours after I explored the fauces on Saturday, and had continued to increase. The two nights (Saturday and Sunday) were poor ones. He could sleep only a half hour at a time, by lying with his mouth open and allowing the saliva to dribble away. As soon as it accumulated, the effort to swallow woke him up. These naps were promoted by rubbing in the laudanum, of which he had used large quantities. He had swallowed nothing but water and a very little strained broth. He could not drink milk, and could distinguish the difficulty of swallowing between it and water. His efforts to swallow were attended with violent contortions. His suffering was evident and great. His aspect was worse everyway. His tongue and throat the same as on Saturday. His pulse 116.

Having prepared a soft sponge, large enough to fill the œsophagus, and attached it to a long probang, I passed it down twice. The first time it was passed, he vomited; the second time, he fainted and declined another trial, which, indeed, I was not disposed to make. The sponge passed down almost to the sternum, and beyond the seat of pain, without meeting any obstruction. On withdrawing it the second time a single drop of fresh blood appeared on its left side, corresponding to the *right* side of the throat. No blood tinged the mucus expectorated, before or afterwards. He continued to refer the centre of pain to the right side of the cricoid cartilage. Tenderness on pressure was greater there than elsewhere, much greater than on the other side of the neck. Pain radiated down on the chest, upwards to the temple, and from the throat to the ear. It was almost impossible for him to swallow, and he would not attempt it unless urged to do so. I now gave him some morphia, directed his bowels to be cleared by a purgative enema, preparatory to using nutritive injections, and left him for a few hours.

My diagnosis at this time was, that a small fragment of fish bone was imbedded in the wall of the œsophagus on the right side, opposite the cricoid cartilage, this being the line of junction of the pharynx and œsophagus. The reasons on which this opinion was based were:

1st. The history of the case; it being now the third day since the accident, and the symptoms increasing in severity.

2d. The morbid appearances in the fauces, of the palate, uvula and tongue, were not sufficient to account for the symptoms.

3d. That the foreign body was small, because the fingers, lifting forward the larynx and trachea and embracing the œsophagus, could detect nothing externally, and the probang encountered no obstruction.

4th. That it was situated opposite the cricoid cartilage on the right side, and was imbedded there:—

Because this was the narrowest part of the œsophagus;

Because this was the centre of pain and tenderness;

Because the drop of blood on the sponge corresponded to this side.

At 1.30, P.M., Dr. Buckingham saw him with me. Since I last saw him he had had a violent rigor, followed by heat and sweating. His pulse was 120, sharp and irritable; œdema of the right side of the neck had come on. His face was haggard; his eyes and skin much congested. He expressed the opinion that he could not endure his sufferings many nights and days longer. Dr. Buckingham wisely refrained from exploring the parts, in view of their œdematous condition, and the constitutional disturbance. He concurred with me in the opinion that œsophagotomy should be attempted, as the only safe course; and that the operation was imperatively demanded and could do no harm.

1st. Because, if the diagnosis were correct, and the foreign body there, it was working through the walls of the œsophagus, and could be reasonably reached in no other way.

2d. Because, if the diagnosis were incorrect, and the foreign body gone, the irritation it had excited was about to lead to abscess, which might end in suffocation, and for which the incisions of œsophagotomy must be the ultimate treatment.

The risks and chances having been detailed to the patient, he assented promptly to the operation. He was conveyed to the City Hospital, and having been kept under the influence of morphia, and stimulated by an alcoholic enema, the operation was begun at 7, P.M., with the very valuable assistance of Drs. Buckingham and Thaxter.

OPERATION.

The patient had a short, thick-set neck, with powerful muscles, and the veins were congested and full. The neck having been extended and the face turned to the opposite side, an incision was begun opposite the top of the thyroid cartilage, midway between it and the sterno-mastoid, and carried down parallel to the muscle, three and a half inches, to the sternum. This divided the skin, superficial fascia and platysma. The edge of the sterno-mastoid was now sought for and dissected out. In completing this dissection just above the top of the sternum, the anterior jugular vein, a vessel of moderate size, was divided. This, which would have been of no importance otherwise, gave rise to two consecutive sucking sounds, as if two bubbles of air had been drawn into the vein. Dr. Buckingham promptly applied his finger to the mouth of the vein, and no perceptible effect was produced in the heart's action by this accident. This vessel, although it did not bleed, was subsequently tied, as a matter of precaution; and this was the only ligature required during the operation.

The carotid sheath was next sought for and exposed with the point of a director, and then drawn outwards with the sterno-mastoid. Then the upper belly of the omo-hyoid muscle was denuded, and drawn outwards also. The edge of the sterno-hyoid next presented itself, the thyroid gland, and the side of the cricoid cartilage. A slow dissection with the director and the handle of the knife, and with the finger, was now carried on through the cellular tissue, down between the œsophagus and the carotid sheath, which in the lower part of the incision ran in contact, side by side. The side of the œsophagus having been reached, the larynx and trachea were lifted and tilted over, and the foreign body felt for, in vain.

The next step was to stretch the œsophagus from the inside, so that its walls might be presented in a single layer to the finger. To do this the tube of a stomach pump was introduced into the œsophagus by the fauces. Considerable difficulty was experienced in passing the tube into the œsophagus, as it repeatedly brought up in the larynx and trachea. The swollen state of the soft palate threw the tube forward into the glottis, and the patient being profoundly ætherized, the epiglottis did not exclude it, and he breathed through it in a rhythmical manner, and without lividity. After sundry vain attempts by myself and others, Dr. Thaxter succeeded in drawing forward the opening