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Original Communications.

APPENDICITIS—ITS TREATMENT.*

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Possibly the last word on the treatment of appendicitis has been written, but it has not been heeded by at least not a few. The ground has been covered over and over again, and yet we have almost as many different methods as we have practitioners of the healing art.

Long before the pathology of appendicitis was so ably pointed out by Fitz, in his classical paper on the subject in 1886, the profession understood that there was a disease in or around the head of the cecum that was attended with a high mortality. His ob-

*Read at Nashville Academy o f Medicine, Tuesday, June 2, 1908.

servation, based on many post-mortem examinations, revealed the fact that many cases of peritonitis had their origin in the appendix, and since then, even up to the present time, a constant warfare has been waged between the internist and the surgeon, as to whether appendicitis was or is a medical or surgical disease. It was always a subject for a heated discussion upon the floor of every medical society, no matter where convened. The internist, yielding step by step, after a bitter, long drawn out contest, until today, nearly all, if not all of our authorities concede it to be a surgical disease, and surgical only. Yet the large majority of the cases are first seen by the general practitioner, and the safety of the patient depends upon the hearty co-operation of the physician and surgeon.

Unfortunately, many of the general practitioners do not yet concede that it is a surgical disease, and they are yet firm in the belief that they can do something that will control or mitigate it, although no less authorities than Osler and Price have said that there is no medical treatment of appendicitis. And if some of the general practitioners accept this teaching they are opposed to applying it in their individual cases, until they have been driven to it by some of the later complications of the disease.

The death rate in every community is still inexcusably high, and the best way to lower it is to get these men who see a few cases each year to recognize the disease early, to appreciate the true pathology, and get them to follow the case to the operating table and observe just the true condition that produces this certain train of symptoms that they are trying to combat, and the folly of some of their methods will be apparent.

They tell us that the mortality of the surgeon is as high, or higher, than that of the internist, but they forget the character of cases brought to the surgeon, and that his mortality would have been practically nil had he seen the cases earlier. And the opportunity that I have had for the past two years of observing these different methods of treatment employed by different ones, has developed some interesting points in connection with the treatment of these cases.

But before we can treat patients suffering with appendicitis with a greater degree of success, it is of the utmost importance

to make a careful diagnosis; and fortunately, it does not require any great amount of dextrous skill or highly educated diagnostic acumen beyond what can be acquired by any practitioner, to make the diagonsis almost, if not certain, in every case. The reason that a mistake has been made is because a careful physical examination has not been made in every case in which there are any symptoms of intra-abdominal disturbance.

We are too prone to make a diagnosis of indigestion or gastro-intestinal catarrh from what the patient or the friends tell us, and not from what we actually find ourselves.

The application of the three cardinal symptoms to each and every case should never be omitted, and would often save the patient from an almost hopeless condition, by revealing his true condition ere the golden opportunity for his relief has forever passed.

The three cardinal symptoms are pain, localized tenderness and rigidity of the right rectus muscle.

The pain, in the greater majority of cases, is acute and sudden in onset and colicky in character, and is referred to the neighborhood of the epigastric region or somewhere about the umbilicus,' more frequently than it is over the seat of the appendix itself. Early it is very often diffused over the entire abdomen; but later, as the inflammation in the appendix increases and its peritoneal surface becomes involved, the pain becomes localized or intensified over the seat of the diseased organ. Localized tenderness and muscular rigidity are early, constant and important symptoms. This train of symptoms in the order mentioned are always present in more or less degree of severity in every case, and there should be no mistake in their interpretation, and upon these three symptoms we can predicate a diagnosis. Associated with these three cardinal symptoms we may have the following: Nausea and vomiting; chill, elevation of temperature, increased pulse rate, and later, tympanitis, irritability of bladder, retraction of thigh and limitation of abdominal excursion, obliteration of liver dullness.

When we get these symptoms, as enumerated, firmly in our minds, and they are not only present in every case, but usually markedly so, the differential diagnosis should be easy and cer-

tain. So much so that I will not encroach upon your time by taking up the subject for the cardinal symptoms makes the differential diagnosis.

You all well know that nearly all cases that come to the surgeon are bad and when discussing the case with the physician that had charge of it, although the diagnosis was made early, the reason they gave for the delay is one of the following: 1st. The family would not agree to an operation. 2d. I was treating the case until I was sure that pus had formed. 3d. I treated the case by the starvation method, employed by Ochsner. 4th. I was trying to get him over this attack and do the interval operation.

The first of these objections is a result of the lack of education upon the part of the public and to the half-hearted way and manner in which the operation was recommended by the doctor; also to the lack of unanimity on the part of the profession; although a diagnosis is made early, we can't agree as to what is best to be done in this individual case.

Second, none of us can tell when nor where pus is forming, and if it does form, to what extent it will be disseminated throughout the abdominal cavity. Knowing the virulence of the appendicial infection, its tendency to break through the appendix and in a few hours cause a fatal peritonitis, the man who sits idly by and deliberately waits until he is sure of pus and peritonitis, is only another case of "locking the stable door after the horse is gone."

So widespread has become the misapplication of the Ochsner method of treatment, and it is so easy to put into practice that it deserves more than a passing notice. First, it should be understood that its chief exponents, if they ever did, do not now claim to recommend it for the treatment of appendicitis itself, but for beginning, diffuse, spreading or general peritonitis.

The idea has gone out that where this method was used an operation was not needed, and if an operation was done this method was of no value. The idea is to limit peristalsis, until nature can throw out a limiting wall; but given a case of perforation or beginning or diffuse peritonitis, should we wait until nature fails to limit or localize, and then deny the man an operation, just because we have stopped food, washed out the man's

stomach, given a few enemata and established rectal alimentation?

Why not be rational, and let the infected material out through an opening, even if it has spread out and filled the entire abdominal cavity with pus. And then the Ochsner routine is the best treatment that can be instituted, and fills a most valuable place in the handling of these cases.

The misapplication of this treatment, by its being used for the early cases, is responsible for the high mortality that always attends the late.

If the layman, the physician, and the surgeon could once realize that appendicitis means as early operation as possible, the mortality of the disease would be greatly reduced.

As to the interval operation, it is a wise thing to advocate in the interval; but it is sometimes a most dangerous procedure in the midst of an acute attack. For no one can tell whether the case will ever go to the interval.

To attempt to trust an acute attack until the fourth or fifth day and then be forced as a last chance to submit to the knife, will always be followed by a high mortality, and discredit surgery in the eyes of the public. But as many lives that have been lost by this waiting method, and by great odds the most dangerous one, it is not by far the one that is oftenest used, and very little is said about it, and that is something like the following: They tell you they saw the case, with such severe pain in his bowels, that they had to give several hypos. of morph. before the patient could get any relief, and then I gave him some calomel to work it off. When asked how much, usually 5 to 10 or 15 grains. It did not act, and I gave him some large doses of oil, and he vomited so much that I tried several doses of salts, but the vomiting continued, and then I resorted to enemas of every description, both high and low, till finally the bowels moved, but after doing all that for him, he did not seem to be any better at all, and then I told the family that something would have to be *done*.

In fact, there seems to be an idea among the profession that it is a condition to be relieved by purging. If the bowels would move the man would be better. If we will stop and think for

a moment of the anatomy of the part and then remember the pathology that is going on in the appendix, we will see that our remedies miss the seat of the disease from one-fourth to five inches, and not only do no good, but defeat the object we are trying to accomplish. Even if you could purge the appendix, you would not reach the point of infection, as it is in the wall of the organ. Again, every peristaltic wave defeats nature's effort to limit the focus of infection by dense adhesions thrown around the part. The very first principle of any kind of surgical treatment, rest, is violated, and the danger of perforation is very much increased and general distribution of your sepsis favored by violent peristalsis, produced by your cathartics. And, when these cases, that have been severely purged ,come to the operating table every surgeon knows that almost every chance of recovery is gone.

It is not now a case of appendicitis, but of peritonitis, with all of the open mouth lympatic glands of the peritoneal sack, drinking up the septic material that has been scattered throughout its whole extent, that will result in an overwhelming toxemia, and death.

Gentlemen, the picture is not overdrawn, and the interval not too long between such cases, and this last method of treatment is the reason for presenting this paper to this society. Not that you are guilty of this kind of treatment, but I know that you all have seen and do see, by far too many cases treated in the above manner. This hyper-purgation, with cold or hot applications to the abdomen, with morph. for the pain, seems to sum up the medical aspect of the treatment of these cases by some of the general practitioners even at this day.

Now is it rational, gentlemen, based upon the pathology of the disease in any of its stages? True, some of them will get well, but it is in spite of the treatment. If clinicians could more often observe the pathology of these cases at the operating table in all of its intensity, in some cases with mild symptomatology, and in other cases of pronounced symptoms, find the pathology limited to the appendix alone, and with almost a doubt as to its departure from the normal healthy condition, requiring a microscope to detect it, they would place less confidence upon their abil-

ity to decide which was the case demanding operation or no operation, and they would grow more tolerant to operative measures and less wedded to therapeutic agents in the inceptive stage.

This investigation will of necessity lead us to the conclusion or the universal professional belief that all patients with appendicitis should be operated upon in the first 36 or 48 hours, at the latest. Notwithstanding, eighty per cent. of all cases will get well, but who can pick out the eighty, and why lose the twenty.

This we will designate the first stage—operation. An operation done at this stage should be followed by just 100 per cent. of recoveries. Murphy lost one case in 1200, Treves two in 2000, and many surgeons, with less opportunity than the two quoted, have done many operations in this stage, with no deaths.

Price claims that a perforation or a spreading infection does three times as much harm and kills many times more patients than an inexperienced operator in an early operation. But the minimum of danger is not the only advantage to be gained by an operation in the early stage. The time for convalesence is not more than two or three weeks at the outside. Drainage is not, as a rule, indicated, and hernia is scarcely possible at all. The patient would then be relieved of his appendicitis without hazard, without prolonged illness, without the danger of unpleasant sequella, without the possibility of recurrence, and only by the timely operation in this, the first stage of the disease.

But for some good or bad excuse, the opportune time has passed; the second stage has arrived and we have the rapidly spreading or increasing inflammatory process going on from the second to the fifth day. We have the beginning or the circumscribed abscess around the appendix, the neighboring tissues and organs beginning to be inflamed with the changes of circumscribed or general peritonitis, with elevation of temperature and increased pulse rate, meteorism, intestinal paresis, with manifestations of severe auto-intoxication. Shall be operate in this stage designated by Wallace as the rapidly progressive stage?

There is, unfortunately, a difference of opinion among surgeons today in regard as to what is best to be done in this stage. Some claiming that experience and experimentation have demonstrated the fact that operative measures always increase rather