

Medical Notes on a Trip Abroad

NZMJ, 1926

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In selecting for discussion this evening a few from the many experiences of my recent trip, I have aimed to deal with subjects which are of interest alike to physicians, surgeons, and general practitioners. No doubt little of what I shall tell is new to you, but my summary may perhaps serve to crystallise your ideas and define what I conceive to be the present views on the few subjects with which time permits me to deal.

The greater part of my time was spent in London. It was formerly very different for those who had not received their education in a London hospital to arrange satisfactorily for post-graduate work. There is, of course, a great deal of most excellent work to be seen in London. The difficulty in the past was to know where it was and how to get it. These difficulties have been overcome to a very great extent by the Fellowship of Medicine. Any qualified practitioner may join this institution on payment of 10s. per annum. It is located in the Royal Society of Medicine, No. 1 Wimpole St, and, amongst others, offers the following facilities :—(i) Lists of operations at all hospitals in London are posted there the day before. (ii) The fee entitles one to visit many associated hospitals. These, however, do not include the regular teaching hospitals. (iii) Lectures are given at the rooms and elsewhere from time to time. These are of a practical nature and given by specialists in their subjects. (iv) Courses are arranged in special subjects at special hospitals, *e.g.*, Neurology, Gynæcology, Proctology. There are also mixed courses intended for general practitioners.

A subject upon which I was anxious to clarify my views was the surgical treatment of gastric and duodenal ulcer. Opinion appears fairly unanimous that posterior gastro-enterostomy is satisfactory in duodenal cases. This is frequently combined with inversion of the ulcer—Moynihan does this as a routine. The treatment of the less common condition of gastric ulcer is the subject of the widest diversity of opinion, not only in regard to operative detail, but also as to the general principles

which should govern surgical intervention. In view of this I have endeavoured to make a few generalisations which I have summarised as follows :—

1. It is typical of gastric ulcer that there are periods (often long) of complete remission of symptoms, and this even without any treatment whatever. This is so to a degree practically unknown in any other abdominal condition. Gall-stones and chronic appendicitis frequently have subacute exacerbations in the intervals the patient is never entirely free from symptoms. It is clearly recognised that these remissions are not due to a healing of the ulcer, though the attacks are probably coincident with an extension of the ulcerative process. The importance of these remissions from a surgical point of view is that the patient rarely comes under surgical consideration until the ulcer has reached some size. This may to some extent explain the radical measures adopted by some surgeons as a routine. The usual history of these cases is that of an attack of gastric symptoms for which the patient undergoes medical treatment with apparently satisfactory results. After a period of some (perhaps many) months, the symptoms recur with similar result, and this process is repeated over many years until the increasing brevity of the remissions, severe hæmorrhage, perforation, or the onset of carcinoma demand more radical treatment. I think it was Dr. Charles Mayo who said he had never operated upon a case of gastric ulcer which had not been “cured” at least nine times. I have recently seen a case in which another ulcer has been present many years with the typical remissions. The ulcer is on the greater curvature, an unusual site, but one in which I think it is particularly liable to carcinomatous change. The patient, whose age is about 50, is under medical

treatment and is gaining weight and losing his symptoms—conditions under which it is unlikely he will submit to surgical treatment.

2. It is generally agreed that the gastro-enterostomy alone is inadequate for the following reasons :—(i) Large chronic indurated ulcers probably do not heal. (ii) Gastric ulcers have actually developed after gastro-enterostomy performed for duodenal ulcer, which implies that so far from being sufficient to enable the healing of an ulcer it may not even suffice to prevent its onset. (iii) Disasters, such as severe hæmorrhage from and perforation of the ulcer, have occurred after gastro-enterostomy. (iv) Carcinoma may be grafted on an ulcer left after gastro-enterostomy.

The frequency of carcinoma developing upon gastric ulcer is a matter of diverse opinion and is much too wide to discuss this evening. Moynihan found that 18.5 per cent of ulcers removed, and agreed by all present to be simple, showed early carcinomatous change on microscopic examination. The Manchester Pathological Society recently investigated this question and came to the conclusion that the microscopic changes, regarded pathologists in Leeds as early carcinoma, were, in many cases at any rate merely aberrant, glandular epithelium cells, included in fibrous tissue during the partial healing of the ulcer. It is notable, however, that those who have most opportunity for observation are of the general opinion that the sequences of carcinoma upon ulcer is extremely common; amongst these are Moynihan, the Mayos, and Sherren.

3. There is therefore general agreement that some local treatment of the ulcer is necessary in addition to or in place of gastro-enterostomy. It is in the nature of this local treatment that the diversity of opinion becomes most manifest and varies from simple excision of the ulcer, even without gastro-enterostomy, to partial gastrectomy, involving three-fourths or more of the stomach. The procedures which are utilised may be enumerated as follows :—(i) Balfour's operation, *i.e.*, cauterising the ulcer with posterior gastro-enterostomy, is apparently not now so much practised as formerly. (ii) Local excision with posterior gastro-enterostomy is in favour with many in cases where the condition of the ulcer permits it. (iii) Sleeve resection is used by some. This often requires a free mobilisation of the duodenum which is unobtainable. It is said by some to impair gastric peristalsis. (iv) Gastrectomy.—This operation is gaining increasingly in favour and is the one employed by the majority of surgeons who most largely practice abdominal surgery when the ulcer is of any size and chronicity. With some it is the routine treatment. The operation most generally used is the Polya, either pre- or retro-colic. On the Continent the Bilioth I. is used a great deal, and has been facilitated by a special clamp introduced by Schumaker. Bilioth II. is not done, as it requires too much stomach. I have seen three-fourths of the stomach removed for an ulcer no larger than the tip of one's little finger. This would appear to be carrying operative radicalism to a fantastic extreme.