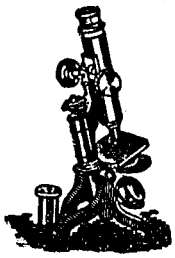
Medical Matters.

ASEPTIC SURGERY.*

DRAINAGE.



Some years ago I remember reading a paper before this Society entitled "The Abuse of Drainage of Wounds." About that time (1890) nearly every wound was drained. It is not unlikely but that the pendulum afterwards swung too far in the other direction. I suppose that to-day all septic wounds are drained with gauze, or tubes, or some other efficient device; also all wounds in which blood is liable to collect. I myself always drain wounds of the scrotum, and nearly always those of the axilla, merely to prevent blood collecting. Rubber tubes are the most comfortable for the patient, and can be sterilised with heat. Glass tubes are apt to hurt, and on more than one occasion have been known to break within the abdomen, but nevertheless they are so efficient and so easily sterilised that I occasionally employ them; gauze has advantages, but is painful to remove, even with the help of hydrogen peroxide solution. The introduction of a drainage tube increases the risk of infection. Doubtless infection from the skin—which, as we know, is septic in 25 per cent. of cases—can more easily enter when the lips of the wound are kept apart by a drainage tube than when they are allowed to adhere by immediate union. In addition, the wound has to be dressed for the removal of the tube. These considerations have led to the immediate closure of wounds made to empty psoas, lumbar, and iliac abscesses. At the worst, if the operation be aseptic, some pus may collect again and call for removal; but at this stage the abscess cavity is much smaller, and the dangers of sepsis are less. For the successful performance of this operation for emptying and then closing again these large tuberculous abscesses it is of the greatest importance to be gentle and restrained, so as not to start hæmorrhage into the abscess cavity. The neglect of this is likely to bring an excellent operation into disrepute.

In aseptic wounds, then, drainage is unnecessary unless oozing and accumulation of blood are anticipated; but in septic wounds drainage is almost invariably required. This bald statement, however, ought to be amplified, for septic *cavities* ought also to be drained. This is very clear in the case of the urinary bladder. On more than one occasion I have closed the cystotomy wound at once, being guided by the absence of bleeding and of sepsis. It is a vast gain to the patients if the suprapubic wound heals by first intention, and that they should be able to walk about at the end of the third week. But when the bladder is septic, the immediate closure of the cystotomy wound is fraught with danger. Whenever the bladder is septic I insert a Guyon's drainage tube. This admirable device has robbed this class of case of a great many of its dangers and discomforts.

Also, when the bladder is septic I perform external urethrotomy in preference to internal, in order to provide adequate drainage. The dangers of an incised wound far from the surface of the body, and frequently bathed in septic urine, are too obvious to need pointing out. The perineal wound drains well, and merely needs the insertion of a strip of gauze. When the urine is aseptic the perineal wound may be closed forthwith, with a good chance of immediate union.

The treatment of the gall bladder is ruled by similar principles. If, after cholecystotomy, it were known that the gall bladder was aseptic, and was destined to remain so, it might be judicious to suture the opening into it, and drop it back into the abdomen. But one must always be doubtful about the asepticity of a cavity which communicates with the intestinal tract by a comparatively short canal. No doubt so long as the cystic duct and the common bile duct are undilated and are lined with healthy epithelium, they prevent the intestinal bacteria from invading the gall bladder, the biliary ducts and canals, and the liver substance. But cholecystotomy is usually done when the gall bladder and the ducts have been altered by disease. It is probable that sepsis of the gall bladder is present in every case of gall-stones. Acting upon this assumption, I have never yet ventured to suture and return the gall bladder after cholecystotomy, or, in other words, to perform what has been called the "ideal operation." The systematic drainage of another cavity—the rectum—after the removal of tumours, hæmorrhoids, and for operations for fistula, has done much to diminish both the dangers and miseries of this class of operation. A small ($\frac{1}{3}$ in.) rubber tube with a packing of iodoform gauze is all that is needed. The gauze supports the drainage tube and stops the bleeding.

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* From the Lettsomian Lectures by Mr. C. B. Lockwood, F.R.C.S.

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