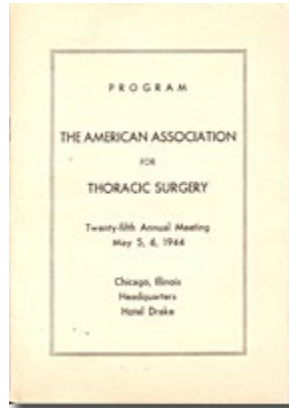


1944 ANNUAL MEETING PROGRAM



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ANNUAL MEETING PROGRAM

9:00 a.m. Business Session.

9:30 a.m. Scientific Session.

1. Corrosive Stricture of the Esophagus.

RALPH ADAMS and (*by invitation*)

WALTER B. HOOVER, Boston, Massachusetts

Two cases of neglected corrosive stricture of the esophagus are described. The methods used to accomplish recovery from suppurative mediastinitis and from the stricture are discussed in reference to the first case. The combination of esophagoscopy and surgical measures that restored esophageal function after seven years of complete stenosis in the second case are reported.

2. The Management of Benign Tumors of the Esophagus.

STUART HARRINGTON and

HERMAN MOERSCH, Rochester, Minnesota

Benign tumors of the esophagus may be very insidious in their development and attain considerable size without giving rise to severe symptoms. The more common symptoms are dysphagia, substernal pain, regurgitation of food, cough and dyspnea.

The diagnosis of the pedunculated tumors may follow regurgitation of the growth into the mouth. For the diagnosis of the others, roentgenologic, fluoroscopic and esophagoscopy studies will be needed.

Treatment will vary with the type of tumor and on its location. Some of the pedunculated ones may be removed through the mouth with the aid of a snare. The other tumors will require esophagotomy through the neck, chest or abdomen. Fifteen cases of benign tumors of the esophagus have been seen at the Mayo Clinic. In eight cases, operation was not advised. In seven, removal of the tumor was advised and done. One tumor was removed through the mouth, the other after esophageotomy. There was one operative death.

3. The Causes of Mortality Following Radical Resection of the Esophagus for Carcinoma.

JOHN OARLOCK, New York, New York

4. Current Observations on Thoracic Surgery in the Present War.

B. NOLAXD CARTER, Col.M.C., A.U.S. and
MICHAEL E. DE BAKEY, Major,M.C., A.U.S
Office of the Surgeon General, Washington, D. C.

Figures are given indicating the incidence and mortality of thoracic injury among American troops in the present war, and a comparison is made with similar figures in previous wars. Comments are made on the factors contributing to the marked reduction in mortality in chest wounds attained thus far.

A brief consideration of only the important features of thoracic surgery as they have appeared up to the present time is given under the headings: Hemothorax. Pneumothorax, Foreign Bodies, Empyema, Injuries of the Chest Wall and Abdomino-Thoracic Wounds. Only pertinent facts are considered as based on reports from the field.

5. War Wounds of the Chest Observed at the Thoracic Surgery Center, Walter Reed General Hospital.

BRIAN BLADES, Major, M.C., A.U.S. and (*by invitation*)
DAVID J. DUGAN, Captain M.C., A.U.S., Washington, D. C.

The definitive treatment of various types of war wounds of the chest will be discussed. The indications for the removal of retained shell fragments in the lungs will be considered and representative cases presented. The important causes and the treatment of chronic draining sinuses in the chest wall following gunshot wounds will be discussed. A summary of one hundred cases of hemothorax will be presented and an evaluation of the emergency treatment will be made on the basis of late complications and final results. The principal causes of incapacities following severe thoracic wounds will be considered, and the final disposition of the soldiers in this group enumerated. Lantern Slides.

Trends and Practices in Thoracic Surgery in the Mediterranean Theatre.

EDWARD D. CHURCHILL, Col.M.C., Consulting
Surgeon Allied Force Medical Section (Amer.)

Friday Afternoon May 5, 1944

DRAKE HOTEL

2:00 p.m. Scientific Session.

6. Difficulties in the Differential Diagnosis of Bronchogenic Carcinoma.

ROBERT G. BLOCH, WILLIAM E. ADAMS and (*by invitation*)
THOMAS F. THORNTON, J. EDMOND BRYANT, Chicago, Ill.

With mounting experience in the many clinical and pathological variations of bronchogenic carcinoma and especially with the growing desire for its early discovery, it has become apparent that a considerable number of such tumors cannot be definitely diagnosed by conservative methods of examination. Large scale routine X-ray examinations reveal an increasing number of small findings of doubtful significance and origin. In the Out Patient Department of the University of Chicago Clinics where nearly all patients undergo a fluoroscopic examination of the chest regardless of the nature of their complaint, this procedure has proved as valuable for the early discovery of neoplasms as of tuberculosis and other intra-thoracic involvements. Among the first 10,000 patients so examined 75 were found with pulmonary neoplasms. One-third of these proved to be primary bronchogenic carcinoma.

A number of cases are presented in this paper illustrating the minimal and questionable roentgen findings in really early tumors and their development into the more advanced stages. Since roentgen examination can never lead to a differential diagnosis and bronchoscopy is negative in tumors of peripheral location, surgical exploration alone can lead to a satisfactory diagnosis in many of the early lesions. A series of cases with more advanced tumors but presenting difficulties in differential diagnosis is also presented. The problem of excavating carcinoma at times was found especially puzzling.

7. Bronchia lAdenoma.

C. L. JACKSON and *(by invitation)* FRANK KONZELMAN
and CHARLES NORRIS, Philadelphia, Pennsylvania

8. BronchoscopicCinematography of Bronchial Tumors.

PAUL HOLINGER and *(by imitation)*
RALPH G. RIGBY, Chicago, Illinois

This presentation will consist of Kodachrome motion pictures taken through the bronchoscope showing the appearance of various types of bronchial tumors. Clinical data and X-rays incorporated in the film will correlate the various aspects of diagnosis, and special emphasis will be placed upon the criteria determining operability.

9. The Problem of So-Called Adenoma of the Bronchus.

EVARTS A. GRAHAM and *(by invitation)*
NATHAN A. WOMACK, St. Louis, Missouri

Its embryological origin will be discussed. Evidence of its potential malignancy, presented by Womack and Graham in 1938, will be enlarged upon with mention of the confirmation by later contributors. A correlation with "round call" and "oat call" carcinoma will be shown. Treatment will be discussed.

10. An Attempt to Evaluate the Effects of Thymectomy in the Treatment of Myasthenia Gravis.

ALFRED BLALOCK, Baltimore, Maryland

During a period of slightly less than three years the thymus gland has been removed from 20 patients with severe myasthenia gravis. Only two of these patients had tumors of the thymus. Some of the patients have shown striking improvement where as there has been little if any improvement in others. An attempt will be made to evaluate the effectiveness of this procedure.

6:30 p.m. Cocktail Party.

7:30 p.m. Banquet, Hotel Drake.

Saturday Morning, May 6, 1944

DRAKE HOTEL

9:00 a.m. Scientific Session.

11. Indications for Pericardiotomy with Special Reference to Exposure of the Infected Patent Ductus Arteriosus.

HAROLD NEUHOF, New York, New York

The customary indications are for suppurative pericarditis, constrictive pericarditis, injuries producing hemorrhage within the sac, and rarely for neoplasms of the pericardium. The indications should be broadened since pericardiotomy is an entirely safe and simple procedure. Discussion of the advantages and technique of transpleural pericardiotomy except in the presence of infection. The additional indications for pericardiotomy according to personal experience are: 1. for exploration for chronic lesions of the pericardium other than obvious constrictive pericarditis. 2. for obscure manifestations suggestive of low-grade infection of the pericardium. 3. for exploration for residual infection following drainage for suppurative pericarditis. 4. at times to determine the extent of invasion at the hilum in exploratory operations for carcinoma of the lung. 5. for relief of cardiac tamponade secondary to neoplastic invasion of or through the pericardium. 6. to determine the extent of invasion of an extrapericardial neoplasm and as a guide to the extent of sacrifice of any of the pericardium, and 7. for better exposure and easier dissection when the patent ductus arteriosus is the seat of bacterial endarteritis.

12. Arteriovenous Fistula of the Lung.

JOHN C. JONES, Los Angeles, California

This lesion is rare but interesting, and presents a clear-cut clinical entity characterized by cyanosis, clubbing of the fingers and toes, polycythemia, increased blood volume with decreased oxygen saturation and a normal heart. The roentgen manifestations are variable, but planigraphy is a definite aid in the diagnosis when a bruit is not present. A case of arteriovenous fistula of lung diagnosed clinically and cured by pneumonectomy will be presented. Lantern slides illustrating X-rays, planigrams, surgical specimen, and the photograph of the patient postoperatively. A new method of bronchial closure will be briefly discussed.

13. Hydatid Disease of the Lung.

LOUIS R DAVIDSON, New York, New York

Hydatid disease of the lung has been a very rare condition in the United States. However, in view of the fact that members of our armed forces will return from Australia, Italy, Algeria and the Mediterranean littoral in general, amongst other places, it is not difficult to believe that some of them will come down with hydatid disease, for in the countries mentioned this disease is not infrequent.

With the surgical experience obtained from four cases of hydatid disease of the lung, the difficulties confronting the surgeon were unfolded. Each case presented different problems so that a rather broad viewpoint was obtained. One of these cases was diagnosed pre-operatively by radiography in that a definite pathognomonic sign was present. This sign and its production will be described.

The question of simple and complicated cysts and the surgery to be performed in each case will be discussed.

14. Studies of the Pathogenesis, Dynamics and Closure of Tension Cavities.

H. MCLEOD RIGGINS and *(by invitation)*

ROBERT P. GEARHART, New York, New York

Studies of tension or positive pressure cavities in pulmonary tuberculosis have been carried out at Bellevue and Triboro Hospitals intensively over a period of several years. They have been conducted along the following lines:

Clinical. Roentgenological. Serial intracavitary pressure readings by the introduction of a needle through the chest wall into the cavity and connected with a water (pneumothorax) manometer.

Gas analysis of the air removed by transthoracic needling.

Bacteriological and chemical studies of intracavitary exudates and fluid.

Intracavitary injection of lipiodol and gentian violet.

SUMMARY OF RESULTS

Clinical observations have often revealed the rapid and "undue" enlargement of tension cavities *without corresponding cavitation and liquefaction of lung tissue*. Serial roentgenological studies reveal a varying but rather characteristic pattern and behavior of many tension cavities. They may rapidly increase or decrease in size, apparently close or fill partially or completely with fluid. Intracavitary pressure determinations have given evidence of the patency of the communicating bronchus. In cavities with obstructed bronchi, the injection or withdrawal of air may greatly alter their size. Gas analysis of samples from certain giant tension cavities has shown the effect of the patency of the related bronchi and possibly of the ability of the gases to diffuse through the cavity walls. Bacteriological studies show pyogenic organism variably present, but tubercle bacilli almost always present. Retention of lipiodol or gentian violet in the cavities depends on the patency of the related bronchi. $7\frac{1}{2}$ Bronchoscopic studies and examination of the related bronchi in operation and autopsy specimens show the importance of their patency. The function of the diseased and related bronchus plays an important part in the pathogenesis and dynamics and eventual closure or persistence of tension cavities.

15. The Determination and Treatment of Pressure Cavities in Pulmonary Tuberculosis.
Moving Picture Demonstration.

ARTHUR M. VINEBERG and *(by invitation)*
WALTER E. KUNSTLER, Montreal, Quebec

Evidence is presented to demonstrate that:

1. A large percentage of pulmonary tuberculosis cavities are "tension cavities" and rarely close with thoracoplasty.
2. Some residual cavities are "tension cavities" which are un-effected by thoracoplasty.
3. The detection of "tension cavities" can be made only by needling of the cavity and a recording of the intracavitary pressure.
4. Intracavitary suction drainage will reduce large "tension cavities" to the size of a catheter; to obtain permanent closure a partial thoracoplasty is essential.
5. Negative pressure giant cavities close readily with thoracoplasty.
6. By the use of a combination of transthoracic intracavitary suction drainage and thoracoplasty in the treatment of "tension cavities" the ideal collapse therapy is attained, namely a maximum of collapse of diseased areas with a minimum of damage to normal lung parenchyma.
7. The closure of giant positive pressure cavities can be accomplished by an anterior stage thoracoplasty preceding suction drainage and followed by a partial posterior stage thoracoplasty. A new and safe technique for needling and draining "tension cavities" is shown.

16. An Evaluation of the Monaldi Suction Drainage of Tuberculous Pulmonary Cavities.

JEROME R. HEAD, Chicago, Illinois

From an experience with 50 cases of pulmonary tuberculosis treated by means of Monaldi suction drainage during the last several years an attempt will be made to evaluate the procedure from the standpoint of the results obtained.

Saturday Afternoon, May 6, 1944

DRAKE HOTEL

2:00 p.m. Executive Session.

2:30 p.m. Scientific Session.

Pulmonary Resection in the Treatment of Tuberculosis. Introductory Remarks.

FRANK S. DOLLEY, Los Angeles, California

17. Total and Partial Pneumonectomy in the Treatment of Pulmonary Tuberculosis.

ROBERT M. JANES, Toronto, Ontario, Canada

The report is based upon experiences gained through operating upon thirty-two patients, seventeen of whom had lobectomies and fifteen pneumonectomies. The lobectomies have been done, for the most part, because of persistent positive sputum which could be demonstrated as coming from one lobe. Some had previous collapse, and some had not. The majority of the pneumonectomies have been done in patients with stenosis of the bronchus.

The results have, on the whole, been reasonably satisfactory. Some obvious mistakes in the selection of cases have been made and while experience is limited, it is possible to draw some tentative conclusions as to the probable place of these procedures in the therapy of pulmonary tuberculosis.

18. Lobectomy in Pulmonary Tuberculosis.

HERBERT C. MAIER and *(by invitation)*
ROBERT KLOPSTOCK, New York, New York

The hazard of pulmonary resection in active tuberculosis can be reduced by the application of the hilar dissection technic of lobectomy, combined with recent improvements in anesthesia and operative and postoperative care. During the past year and a half, the author has performed lobectomy in a selected series of cases with positive sputum. Several different types of cases have been chosen for operation. In some instances, lobectomy was performed because it was anticipated that collapse therapy would fail to close the tuberculous cavity. In other cases, lobectomy was performed although there was no definite contraindication to thoracoplasty. The results obtained suggest that lobectomy has a definite place in the therapy of pulmonary tuberculosis, and that some previously held views on the inevitably great hazard of pulmonary resection in the presence of a positive sputum must be revised. A series of cases will be presented which illustrate (1) the type of cases selected for lobectomy; (2) the immediate operative and postoperative reaction; (3) the operative and postoperative management; (4) the incidence of postoperative complications and (5) follow-up results to date.

19. Primary Upper Lobectomy Versus Modern Selective Thoracoplasty in the Treatment of Tuberculosis.

J. MAXWELLCHAMBERLAIN, Oneonta, New York

The treatment of pulmonary tuberculosis by primary upper lobectomy *instead* of a selective thoracoplasty appeals to both patient and surgeon, because of the (1) "quick cure" and (2) the better respiratory reserve. But these points are debatable, and we are inclined to agree with those who believe that lobectomy should usually follow the thoracoplasty failure.

Pulmonary tuberculosis is a *bilateral* problem or should be considered so even though the scattered minor foci are inactive and not visible by X-ray. If this premise is correct then only the major focus can be excised (lobectomy) or collapsed (thoracoplasty) and our attention is diverted immediately to the remaining healthy lung and its potential foci. Therefore, the procedure of choice (lobectomy or thoracoplasty) must have a dual objective: (1) it must *permanently* control the major focus; and (2) it must *permanently* protect the remaining parenchyma.

In controlling (permanently) the major focus the modern selective thoracoplasty has earned an enviable reputation. The morbidity and mortality rates are low the results good. In the few reported primary upper lobectomies insufficient time has elapsed for evaluation of the final results. To protect the remaining parenchyma (after lobectomy or thoracoplasty) we must consider not only the (1) pathological aspect (reactivation or spreads) but also the (2) physiological one (lung function). Relaxation has always been a cardinal therapeutic principal in the treatment of tuberculosis. In this respect the modern selective thoracoplasty is the operation par excellence. By tailoring the thoracic cage to fit the remaining healthy lung, it controls the major focus and thru relaxation of the remaining parenchyma, improves function (bronchspirometry) and prevents reactivation. Primary upper lobectomy controls the major focus without altering the thoracic cage and by *acute* over distention of the remaining parenchyma may encourage reactivation or in time reduce function (emphysema).

Indications, technical hazards and complications will be briefly discussed as experienced in the New York State Tuberculosis Hospitals.

20. The Use of Whole Blood Transfusion in Resections of the Lung.

W. E. ADAMS and (*by invitation*) T. F. THORNTON, JR.,
J. EDMUND BRYANT and LEFFIE M. CARLETON, JR.
Chicago, Illinois

Several recent reports have stressed the danger of massive blood transfusions. Most of the caution has emphasized the possible deleterious effects of sodium citrate. Gibbon has shown that another factor may be present; viz., that pulmonary edema may occur following lung resection if large transfusions are given.

A clinical study of approximately 25 cases of lobectomy and pneumonectomy who received fairly large transfusions is presented. In addition, 4 groups of experiments were performed on dogs.

No untoward reactions were noted in our clinical patients. In does pulmonary edema was noted only in some of the dogs who had bilateral lobectomy in one stage and a large amount of blood. We feel that whole blood may be given in an amount sufficient to replace operative blood loss without untoward effect.

21. Studies in Oleothorax.

PAUL D. CRIMM and (*by invitation*)

VERONICA F. MARTOS and J. J. WESTRA, Evansville, Indiana

1. The Bacteriostatic Action of Oils on the Tubercle Bacillus. The bacteriostatic action of peanut oil, cod liver oil and gomenol for the H37 strain, and bovine and avian types of M. tuberculosis was studied. It was found that peanut oil was inhibitory for H37 and other virulent human strains in a concentration of 5.0per cent. Cod liver oil was found to be bacteriostatic for the human, bovine and avian types of M. tuberculosis in 1.0 per cent concentration. Gomenol is bacteriostatic for both human and avian types of M. tuberculosis in 5.0 percent concentrations. Complete inhibition of the bovine type occurred in 1.0 percent concentration. Prolonged incubation of the H37 strain and a virulent human strain with peanut oil, cod liver oil and gomenol does not alter the virulence or the acid fastness of the organisms, although the colony morphology is altered. It is suggested that the oils adherent to the cells inhibit the growth of the tubercle bacillus by a physical, rather than by a chemical action.
- 2.The Use of Oils in Disinfection Oleothorax and in the Re-expansion of the Lung in Tuberculous Empyema. The use of irritant oils in oleothorax brings about a marked change in the clinical picture of the patient by reducing the toxic effects of the tuberculous infection. The oil inhibits the growth of the tubercle bacillus and stimulates the production of exudate which seals over the focus of infection in the pleura. By its irritant action the oil aids in the formation of an obliterative pleuritis which re-expands the lung. Of twenty cases of tuberculous empyema undergoing treatment, six up to date have had re-expansion of the lung without thoracoplasty being indicated for either the empyema or the infected lung.

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