1944 ANNUAL MEETING PROGRAM

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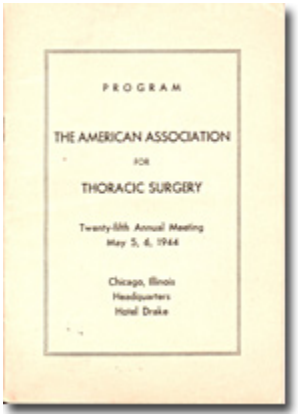

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ANNUAL MEETING PROGRAM

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9:00 a.m. BusinessSession.
9:30 a.m. ScientificSession.

1. Corrosive Stricture of the Esophagus.

RALPH ADAMS and *(by invitation)*
WALTER B. HOOVER, Boston,Massachusetts

*Abst.*ï¿½ Two cases ofneglected corrosive stricture of the esophagus are described. The methods usedto accomplish recovery from suppurative mediastinitis and from the strictureare discussed in reference to the first case. The combination of esophagoscopicand surgical measures that restored esophageal function after seven years ofcomplete stenosis in the second case are reported.

2. The Management of Benign Tumors of the Esophagus.

STUART HARRINGTON and HERMAN MOERSCH, Rochester, Minnesota

*Abst.*ï¿½ Benign tumors ofthe esophagus may be very insidious in their development and attainconsiderable size without giving rise to severe symptoms. The more commonsymptoms are dysphagia, substernal pain, regurgitation of food, cough anddyspnea.

The diagnosis of the pedunculated tumors may followregurgitation of the growth into the mouth. For the diagnosis of the others,roentgenologic, fluoroscopic

and esophagoscopic studies will be needed.

Treatment will vary withthe type of tumor and on its location. Some of the pedunculated ones may beremoved 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 beenseen 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 themouth, the other after esophaeotomy. There was one operative death.

3. The Causes of Mortality Following RadicalResection of the Esophagus for Carcinoma.

JOHN OARLOCK, New York, New York

4. Current Observations on Thoracic Surgery inthe 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.

*Abst.*ï¿½ Figures are givenindicating the incidence and mortality of thoracic injury among American troopsin the present war, and a comparison is made with similar figures in previouswars. Comments are made on the factors contributing to the marked reduction inmortality in chest wounds attained thus far.

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

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

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

*Abst.*ï¿½ Thedefinitive treatment of various types of war wounds of the chest will bediscussed. The indications for the removal of retained shell fragments in thelungs will be considered and representative cases presented. The importantcauses and the treatment of chronic draining sinuses in the chest wallfollowing gunshot wounds will be discussed. A summary of one hundred cases ofhemothorax will be presented and an evaluation of the emergency treatment willbe made on the basis of late complications and final results. The principalcauses of incapacities following severe thoracic wounds will be considered, andthe final disposition of the soldiers in this group enumerated. Lantern Slides.

Trendsand Practices in Thoracic Surgery in the Mediterranean Theatre.

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

Friday AfternoonMay 5,1944

DRAKE HOTEL

2:00 p.m. ScientificSession.

6. Difficultiesin the Differential Diagnosis of Bron-chogenic Carcinoma.

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

*Abst.*ï¿½ With mountingexperience in the many clinical and pathological variations of bronchogeniccarcinoma and especially with the growing desire for its early discovery, ithas become apparent that a considerable number of such tumors cannot bedefinitely diagnosed by conservative methods of examination. Large scaleroutine X-ray examinations reveal an increasing number of small findings ofdoubtful significance and origin. In the Out Patient Department of theUniversity of Chicago Clinics where nearly all patients undergo a fluoroscopicexamination of the chest regardless of the nature of their complaint, this procedurehas proved as valuable for the early discovery of neoplasms as of tuberculosisand other

intra-thoracic involvements. Among the first 10,000 patients soexamined 75 were found with pulmonary neoplasms. One-third of these proved tobe primary bronchogenic carcinoma.

A number of cases arepresented in this paper illustrating the minimal and questionable roentgenfindings in really early tumors and their development into the more advancedstages. Since roentgen examination can never lead to a differential diagnosisand bronchoscopy is negative in tumors of peripheral location, surgicalexploration alone can lead to a satisfactory diagnosis in many of the earlylesions. A series of cases with more advanced tumors but presentingdifficulties in differential diagnosis is also presented. The problem ofexcavating carcinoma at times was found especially puzzling.

7. BronchialAdenoma.

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

*Abst.*ï¿½ This presentationwill consist of Kodachrome motion pictures taken through the bronchoscopeshowing the appearance of various types of bronchial tumors. Clinical data andX-rays incorporated in the film will correlate the various aspects ofdiagnosis, and special emphasis will be placed upon the criteria determiningoperability.

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

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

*Abst.*ï¿½ Its embryologicalorigin will be discussed. Evidence of its potential malignancy, presented byWomack and Graham in 1938, will be enlarged upon with mention of theconfirmation by later contributors. A correlation with "round call" and "oatcall" carcinoma will be shown. Treatment will be discussed.

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

ALFRED BLALOCK, Baltimore, Maryland

*Abst.*ï¿½ During a period ofslightly less than three years the thymus gland has been removed from 20patients with severe myasthenia gravis. Only two of these patients had tumorsof the thymus. Some of the patients have shown striking improvement whereasthere has been little if any improvement in others. An attempt will be made toevaluate the effectiveness of this procedure.

6:30 p.m. CocktailParty.

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

Saturday Morning,May 6, 1944

DRAKE HOTEL

9:00 a.m. ScientificSession.

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

HAROLD NEUHOF, New York, New York

*Abst.*ï¿½ The customaryindications are for suppurative pericarditis, constrictive pericarditis,injuries producing hemorrhage within the sac, and rarely for neoplasms of thepericardium. The indications should be broadened since pericardiotomy is anentirely safe and simple procedure. Discussion of the advantages and techniqueof transpleural pericardiotomy except in the presence of infection. Theadditional indications for pericardiotomy according to personal experience are:1. for exploration for chronic lesions of the pericardium other than obviousconstrictive pericarditis. 2. for obscure manifestations suggestive of lowgrade infection of the pericardium. 3. for exploration for residual infectionfollowing drainage for suppurative pericarditis. 4. at times to determine theextent of invasion at the hilum in exploratory operations for carcinoma of thelung. 5. for relief of cardiac tamponade secondary to neoplastic invasion of orthrough the pericardum. 6. to determine the extent of invasion of anextrapericardial neoplasm and as a

guide to the extent of sacrifice of any ofthe pericardium, and 7. for better exposure and easier dissection when thepatent ducutus arteriosus is the seat of bacterial endarteritis.

12. ArteriovenousFistula of the Lung.

JOHN C. JONES, LosAngeles, California

*Abst.*ï¿½ This lesion israre but interesting, and presents a clear-cut clinical entity characterized bycyanosis, clubbing of the fingers and toes, polycythemia, increased bloodvolume with decreased oxygen saturation and a normal heart. The roentgenmanifestations are variable, but planigraphy is a definite aid in the diagnosiswhen a bruit is not present. A case of arteriovenous fistula of lung diagnosedclinically and cured by pneumonectomy will be presented. Lantern slidesillustrating X-rays, planigrams, surgical specimen, and the photograph of thepatient postoperatively. A new method of bronchial closure will be brieflydiscussed.

13. HydatidDisease of the Lung.

LOUIS R DAVIDSON, New York, New York

*Abst.*ï¿½ Hydatid disease ofthe lung has been a very rare condition in the United States. However, in viewof the fact that members of our armed forces will return from Australia, Italy,Algeria and the Mediterranean littoral in general, amongst other places, it isnot 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 surgicalexperience obtained from four cases of hydatid disease of the lung, thedifficulties confronting the surgeon were unfolded. Each case presenteddifferent problems so that a rather broad viewpoint was obtained. One of thesecases was diagnosed pre-operatively by radiography in that a definitepathognomonic sign was present. This sign and its production will be described.

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

14. Studies of the Pathogenesis, Dynamics andClosure of Tension Cavities.

H. MCLEOD RIGGINS and*(by invitation)* ROBERT P. GEARHART, NewYork, New York

*Abst.*ï¿½ Studies of tensionor positive pressure cavities in pulmonary tuberculosis have been carried outat Bellevue and Triboro Hospitals intensively over a period of several years.They have been conducted along the following lines:

1ï¿½Clinical.2ï¿½Roentgenological. 3ï¿½Serial intracavitary pressure readings by theintroduction of a needle through the chest wall into the cavity and connectedwith a water (pneumothorax) manometer. 4ï¿½Gas analysis of the air removed bytransthoracic needling. 5ï¿½Bacteriological and chemical studies of intracavitaryexudates and fluid. 6ï¿½Intracavitary injection of lipiodol and gentian violet.

SUMMARY OF RESULTS

1ï¿½Clinicalobservations have often revealed the rapid and "undue" enlargement of tensioncavities *without corresponding cassation* and *liquefaction* of *lungtissue. 2*ï¿½Serial roentgenological studies reveal a varying but rathercharacteristic pattern and behavior of many tension cavities. They may rapidlyincrease or decrease in size, apparently close or fill partially or completelywith fluid. 3ï¿½Intracavitary pressure determinations have given evidence of thepatency of the communicating bronchus. In cavities with obstructed bronchi, theinjection or withdrawal of air may greatly alter their size. 4ï¿½Gas analysis ofsamples from certain giant tension cavities has shown the effect of the patencyof the related bronchi and possibly of the ability of the gases to diffusethrough the cavity walls. 5ï¿½Bacteriological studies show pyogenic organismvariably present, but tubercle bacilli almost always present. 6ï¿½Retention oflipiodol or gentian violet in the cavities depends on the patency of the relatedbronchi.

7ï¿½Bronchoscopic studies and examination of the related bronchi inoperation and autopsy specimens show the importance of their patency. Thefunction of the diseased and related bronchus plays an important part in thepathogenesis and dynamics and eventual closure or persistence of tensioncavities.

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

*Abst.*ï¿½ Evidenceis presented to demonstrate that:

1. A large percentage of pulmonarytuberculosis cavities are "tension cavities" and rarely close withthoracoplasty.
2. Some residual cavities are "tension cavities" which areun-effected by thoracoplasty.
3. The detection of "tension cavities" can be made only by needlingof the cavity and a recording of the intracavitary pressure.
4. Intracavitary suction drainage will reduce large "tensioncavities" to the size of a catheter; to obtain permanent closure a partialthoracoplasty is essential.
5. Negative pressure giant cavities close readily withthoracoplasty.
6. By the use of a combination of transthoracic intracavitarysuction drainage and thoracoplasty in the treatment of "tension cavities" theideal collapse therapy is attained, namely a maximum of collapse of diseasedareas with a minimum of damage to normal lung parenchyma.
7. The closure of giant positive pressure cavities can beaccomplished by an anterior stage thoracoplasty preceding suction drainage andfollowed by a partial posterior stage thoracoplasty.

A new and safe technique for needling and draining "tensioncavities" is shown.

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

JEROME R. HEAD, Chicago,Illinois

*Abst.*ï¿½ From an experiencewith 50 cases of pulmonary tuberculosis treated by means of Monaldi suctiondrainage during the last several years an attempt will be made to evaluate theprocedure from the standpoint of the results obtained.

SaturdayAfternoon, May 6, 1944

DRAKE HOTEL

2:00 p.m. Executive Session.

2:30 p.m. ScientificSession.

Pulmonary Resection in the Treatment of Tuberculosis.Introductory Remarks.

FRANK S. DOLLEY, LosAngeles, California

17. Total and Partial Pneumonectomy in theTreatment of Pulmonary Tuberculosis.

ROBERT M. JANES, Toronto,Ontario, Canada

*Abst.*ï¿½ The report isbased upon experiences gained through operating upon thirty-two patients,seventeen of whom had lobectomies and fifteen pneumonectomies. The lobectomieshave been done, for the most part, because of persistent positive sputum whichcould be demonstrated as coming from one lobe. Some had previous collapse andsome had not. The majority of the pneumonectomies have been done in patientswith stenosis of the bronchus. The results have, on thewhole, been reasonably satisfactory. Some obvious mistakes in the selection ofcases have been made and while experience is limited, it is possible to drawsome tentative conclusions as to the probable place of these procedures in thetherapy of pulmonary tuberculosis.

18. Lobectomyin Pulmonary Tuberculosis.

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

*Abst.*ï¿½ The hazard ofpulmonary resection in active tuberculosis can be reduced by the application ofthe hilar dissection technic of lobectomy, combined with

recent improvements inanesthesia and operative and postoperative care. During the past year and ahalf the author has performed lobectomy in a selected series of cases withpositive sputum. Several different types of cases have been chosen foroperation. In some instances lobectomy was performed because it was anticipatedthat collapse therapy would fail to close the tuberculous cavity. In othercases lobectomy was performed although there was no definite contraindicationto thoracoplasty. The results obtained suggest that lobectomy has a definiteplace in the therapy of pulmonary tuberculosis, and that some previously heldviews on the inevitably great hazard of pulmonary resection in the presence ofa positive sputum must be revised. A series of cases will be presented whichillustrate (1) the type of cases selected for lobectomy; (2) the immediateoperative and postoperative reaction; (3) the operative and postoperativemanagement; (4) the incidence of postoperative complications and (5) follow-upresults to date.

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

J. MAXWELLCHAMBERLAIN, Oneonta, New York

*Abst.*ï¿½ The treatment ofpulmonary tuberculosis by primary upper lobectomy *instead* of a selectivethoracoplasty appeals to both patient and surgeon, because of the (1) "quickcure" and (2) the better respiratory reserve. But these points are debatableand we are inclined to agree with those who believe that lobectomy shouldusually follow the thoracoplasty failure.

Pulmonary tuberculosis is a *bilateral* problem orshould be considered so even though the scattered minor foci are inactive andnot visible by X-ray. If this premise is correct then only the major focus canbe excised (lobectomy) or collapsed (thoracoplasty) and our

attention isdiverted immediately to the remaining healthy lung and its potential foci.Therefore, the procedure of choice (lobectomy or thoracoplasty) must have a dualobjective: (1) it must *permanently* control the major focus; and (2) itmust *permanently* protect the remaining parenchyma.

In controlling (permanently) themajor focus the modern selective thoracoplasty has earned an enviablereputation. The morbidity and mortality rates are lowï¿½the results good. In thefew reported primary upper lobectomies insufficient time has elapsed forevaluation of the final results. To protect the remaining parenchyma (afterlobectomy or thoracoplasty) we must consider not only the (1) pathologicalaspect (reactivation or spreads) but also the (2) physiological one (lungfunction). Relaxation has always been a cardinal therapeutic principal in thetreatment of tuberculosis. In this respect the modern selective thoracoplastyis the operation par excellence. By tailoring the thoracic cage to fit theremaining healthy lung, it controls the major focus and thru relaxation of theremaining parenchyma, improves function (bronchospirometry) and preventsreactivation. Primary upper lobectomy controls the major focus without alteringthe thoracic cage and by *acute* over distention of the remainingparenchyma may encourage reactivation or in time reduce function (emphysema).

Indications, technicalhazards and complications will be briefly discussed as experienced in the NewYork State Tuberculosis Hospitals.

20. TheUse of Whole Blood Transfusion in Resections of the Lung.

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

*Abst.*ï¿½ Several recentreports have stressed the danger of massive blood

transfusions. Most of thecaution has emphasized the possible deleterious effects of sodium citrate.Gibbon has shown that another factor may be present; viz., that pulmonary edemamay occur following lung resection if large transfusions are given.

A clinical study ofapproximately 25 cases of lobectomy and pneumonectomy who received fairly largetransfusions is presented. In addition 4 groups of experiments were performedon dogs.

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

21. Studiesin Oleothorax.

PAUL D. CRIMM and *(byinvitation)* VERONICA F. MARTOS andJ. J. WESTRA, Evansville, Indiana

*Abst.*ï¿½ 1. TheBacteriostatic Action of Oils on the Tubercle Bacillus. The bacteriostatic actionof peanut oil, cod liver oil and gomenol for the H37 strain, and bovine andavian types of M. tuberculosis was studied. It was found that peanut oil wasinhibitory 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, bovineand avian types of M. tuberculosis in 1.0 per cent concentration. Gomenol isbacteriostatic 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 humanstrain with peanut oil, cod liver oil and gomenol does not alter the virulenceor the acid fastness of the organisms, although the colony morphology isaltered. It is suggested that the oils adherent to the cells inhibit the growthof 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 Lungin Tuberculous Empyema. The use of irritant oils in oleothorax brings about amarked change in the clinical picture of the patient by reducing the toxiceffects of the tuberculous infection. The oil inhibits the growth of thetubercle bacillus and stimulates the production of exudate which seals over thefocus of infection in the pleura. By its irritant action the oil aids in theformation of an obliterative pleuritis which re-expands the lung. Of twentycases of tuberculous empyema undergoing treatment, six up to date have hadre-expansion of the lung without thoracoplasty being indicated for either theempyema or the infected lung.

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ARCHIBALD R. JUDD, Hamburg,Pennsylvania

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