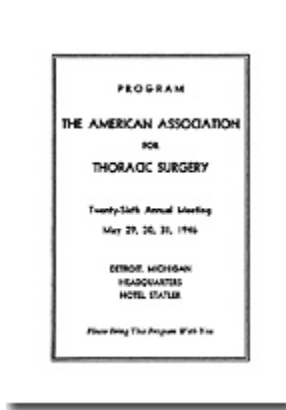


1946 ANNUAL MEETING PROGRAM

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WEDNESDAY MORNING, MAY 29, 1946

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Wednesday Morning, May 29, 1946

9:00 A.M. Business Meeting.

9:30 A.M. Scientific Session.

1. The Management of Thoraco-Abdominal War Injuries.

REEVE H. BETTS, Boston, Mass.

One of the most outstanding achievements of the Army Medical Corps during World War II was the reduction in mortality rate for thoraco-abdominal injuries from 50 to 60 per cent, as it was in the First World War, to a level comparable to straight abdominal injuries. This achievement was the result of the application of the principles and practices of civilian thoracic surgery to states produced by missiles instead of diseases. These principles and practices include: adequate anesthesia; the application of the trans-diaphragmatic approach for repair of upper abdominal lesions; amelioration of disturbed cardio-respiratory physiology, pre-operatively; provision for adequate blood-replacement therapy before, during and after surgical repair of the injury; and the realization of the importance of maintaining a clear tracheobronchial airway at all times.

During a thirty-month period in the Mediterranean Theater of Operations, fifty-one patients with thoraco-abdominal wounds were treated by the author. Of this group, forty-eight were operated upon and form the basis of this report. The mortality rate, including both early and late phases, in so far as follow-up studies were possible, was 22.9 per cent.

The author, also, was one of a group of four thoracic surgeons who reviewed the 903 thoraco-abdominal injuries treated by the Second Auxiliary Surgical Group. Some of the impressions gained thereby are incorporated in this report.

2. Crushing Injuries of the Chest.

ROSS ROBERTSON, Vancouver, B. C.

The types of crushing injuries of the chest as seen in the Royal Canadian Air Force during the war will be discussed. Death from such injuries were due to hemorrhage, cardiac tamponade or respiratory failure from mechanical asphyxia. Of these, cardiac tamponade was found to be the commonest preventable cause of death.

A clear understanding of the underlying pathological process was essential for proper treatment. Any of the following conditions could be present in an individual case: -hemothorax, tension pneumothorax, massive atelectasis, mediastinal hematoma, mediastinal emphysema, hemopericardium, diaphragmatic hernia and air embolism.

Hemothorax was aspirated only if cardiac tamponade was present and then only in amounts sufficient to relieve pressure symptoms.

Cardiac tamponade from a tension pneumothorax was relieved by water seal intercostal drainage. If due to massive atelectasis pneumothorax was induced to relieve the great negative pressure and later the bronchial obstruction cleared.

Cardiac tamponade from hemopericardium was relieved by aspiration, -from mediastinal emphysema by incision in the neck, -and from herniation of viscera through diaphragmatic defects by thoractomy repair.

Two cases illustrating most of the above conditions will be presented.

3. The Pathology of Chronic Hemothorax.

HIRAM T. LANGSTON, Chicago, HI.
and WILLIAM M. TUTTLE, Detroit, Mich.

Experience has shown that all too frequently a traumatic hemothorax is not reducible by thoracentesis. This is so, because of clotting of the pleural content. The important element responsible for this solidification of the pleural content is fibrin, from whatever source it may come. The pathogenesis of this condition is not clear, but accumulated evidence suggests that the best explanation lies in the response made by the pleura to the inciting trauma and irritating blood. This seems to be the adequate source of fibrin. The clot precipitating substances may be supplied by the wounded tissues.

Once dotting has occurred, organization follows exactly as in the case of intravascular thrombi. It is believed that minimal degrees of this process are seen, manifested chiefly by slow pulmonary expansion in cases where traumatic pneumothorax is the predominating clinical entity. This may be referred to as "deforming

adhesive pleuritis." Neglected, gross, organizing hemo-thorax will become a fibrothorax, or will eventually suppurate. This delay in suppuration is occasioned by the time required for organization of blood vessels to proceed into the fibrin mass sufficiently far to allow the leucocytes migrating from, this point to accumulate in sufficient numbers to be recognizable as pus. Obviously, neglect of this situation, or procrastination in treatment until suppuration has occurred, allows for such advanced organization along the visceral pleural surface that the lung or the involved portion thereof is encased in a cuirass of fibrous tissue so dense that expansion is not likely to ever occur, and a persistent infected intrathoracic space is the result.

4. The Treatment of Organizing Hemothorax by Pulmonary Decortication.

W. M. TUTTLE, H. T. LANGSTON and *(by invitation)*
R. T. CROWXEY.

The study to be presented relates experiences in the use of pulmonary decortication in the treatment of chronic organizing hemothorax of the sterile and infected types.

Decortication is an old operative procedure which because of the poor results obtained was discarded after a relatively short-period of use. Its revival during the past war and its application to the treatment of organizing hemothorax has given uniformly good results.

Decortication was carried out in approximately one hundred and fifty instances. There were no operative deaths.

In this series approximately 25% of the patients treated had a grossly infected hemothorax. The lungs reexpanded in all instances and there were no chronic empyemas.

Its use in the uninfected hemothoraces resulted in the reestablishment of a more normal pulmonary function.

Results of the operative procedure are discussed and its usefulness appraised.

5. Total Pulmonary Decortication: Its Evolution and the Present Concepts of Indications and Operative Technique.

PAUL C. SAMSON, Oakland, Calif, and *(by invitation)*

THOMAS H. BURFORD, Mokane, Mo.

This paper will trace the origin and development of the operation known as decortication. Contributions of the surgeons responsible for its evolution will be cited. Based primarily on extensive experience with organizing hemothorax and its infections, complications following war wounds of the thorax, the authors will present the present

indications for and the technique of total pulmonary mobilization by decortication.

Consideration will be given the uses of this operation in civilian surgery and its application to the treatment of total empyemas other than those complicating a hemothorax.

Wednesday Afternoon, May 29, 1946

2:00 P.M.

6. Thoracic Neoplasms in Navy Personnel.

WILLIAM LAW WATSON, New York, N. Y.

This report is based on clinical material studied and treated on the Tumor Service of the United States Naval Hospital, Brooklyn, New York during the years 1943, 1944, and 1945. 746 cases of cancer and other allied diseases were admitted during this period and of that number there were thirty-four in which the primary growth was located in the thorax.

Eight patients with mediastinal Hodgkin's Disease and two with malignant thymoma were treated by radiation measures. A group of twenty-five patients with benign or malignant thoracic growths was treated surgically. Of this latter group fourteen patients had silent tumors discovered by chance roentgenography. This group is studied in detail.

Each case will be demonstrated by means of lantern slides showing the preoperative and postoperative chest radiographs together with slides in color showing the gross specimen removed at operation and a photomicrograph depicting the histopathology of each lesion.

7. Pulmonary Cysts.

HERMAN J. MOERSCH, Rochester,
Minnesota.

Forty-four consecutive cases of surgically proven pulmonary cysts have been reviewed. In each instance tissue was removed for microscopic examination. For purposes of study the cases of pulmonary cyst were divided into three groups. The first group consisted of twenty-five cases, and in this group the cysts were lined with an epithelial lining and the walls contained cartilage, muscle, glands and other bronchial elements in varying degree. These were classified as bronchiogenic cysts. The second group, consisting of eleven cases, had all the characteristics of the first group but the epithelial lining had been destroyed or altered by secondary infection. The third group, comprising eight cases, had marked localized dilatation of the bronchi and were designated as cystic bronchiectasis.

The group consisted of twenty-four males and twenty females. The youngest patient was seven years of age and the oldest, fifty-eight.

A review of the case histories would seem to indicate that pulmonary cysts are not always

congenital in origin and that pulmonary infection is often an important factor in their development. One case of cystic bronchiectasis is presented which clearly demonstrates the rapidity with which cystic changes in the lung may develop.

Cough, expectoration, hemoptysis and pain were the most common symptoms associated with the cases included in the present study. In seven of the forty-four cases the pulmonary cyst was found accidentally. Although the clinical history should cause one to suspect the presence of an infected pulmonary cyst, the difficulty in diagnosis is well illustrated by the fact that in twelve of the cases the condition had been previously misinterpreted.

The majority of the cysts were found to be single. The right lung was more frequently involved than the left lung. Roentgen examination was found to be the most valuable adjunct in the diagnosis of pulmonary cyst, although errors in interpretation were not uncommon. Bronchoscopy and bronchographic studies were generally found of very little value in differential diagnosis except in the cases of cystic bronchiectasis.

Infected pulmonary cysts, which are invariably associated with clinical symptoms, should be promptly removed, not only for local reasons but also because they may exercise deleterious effects upon other organs.

In addition, in two of the cases carcinoma was found to be present in the wall of the cyst. The question presented itself as to whether or not the cystic changes were secondary to the carcinoma. The clinical history would seem to indicate that the carcinoma occurred secondarily in the cyst. Although surgery is the procedure of choice in the treatment of pulmonary cyst, the fact that carcinoma may develop in such a lesion makes it more imperative that surgery be undertaken as soon as feasible. The results following surgical removal of pulmonary cysts are found highly satisfactory.

8. Report of the Chest Tumor Registry.

J. E. ASH, COL. M. C. CURATOR, Army
Medical Museum.

9. A Report of 194 Lobectomies Performed at Kennedy General Hospital, Chest Surgical Center-1943-1946, with One Death.

R. H. MEADE, JR., Chicago, Ill. (*and by invitation*)

E. B. KAY and FELIX HUGHES, Memphis,
Term.

Although the majority of patients admitted to Kennedy General Hospital, Chest Center, were battle casualties their treatment presented few problems, due to the excellent care given them overseas. The bulk of the operative work was done for bronchiectasis and other non-military indications. From November 1943 to March 1946, 194 lobectomies were performed by the

staff, with one death. Three surgeons performed most of the operations but a number were done by three others. Empyema developed in 8% of the cases. Discussion will be given of the indications for operation and of the management of the patient before, during, and after operation.

10. Pulmonary Function After Adolescence Following Pneumonectomy in Childhood.

ANDRE COURNAND (*by invitation*), and CHARLES W. LESTER, New York, N. Y.

Five years ago we reported on the pulmonary function in a group of three children each of whom had undergone pneumonectomy two to four years previously. We have continued to observe these children and have added a fourth who falls in the same category. They have been studied with regard to lung volumes, maximum breathing capacity and ventilation, breathing reserve and respiratory gas exchange as was done in the first report. In addition observations have been made on cardiac output and pressure in the right ventricle using the technique of right heart catheterization. These studies indicate that there has been no development of pulmonary emphysema nor cor pulmonale and that the cardio-respiratory function has continued good during the growth of the child through the years of adolescence.

5:00-6:00 P.M. Cocktail Party-Hotel Statler.
(Members and invited guests)

THURSDAY MORNING, MAY 30, 1946

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Thursday Morning, May 30, 1946

9:00 A.M. Scientific Session.

11. The Use of Curare in Anesthesia for Thoracic Surgery.

H. BRODIE STEPHENS and (*by invitation*)
PHYLLIS HARROUN and FREDERICK E. BECKETT,
San Francisco, California.

Curare has been used routinely in patients undergoing intra-thoracic operations at the University of California Hospital since February, 1945. This paralyzing agent because of its temporary action is delivered to the patients at intervals, by intravenous route throughout the operation. Nitrous Oxide and Oxygen are administered intratracheally to provide the necessary anaesthesia. A report on the use of curare in fifty-six patients who underwent thoracic surgical operations is presented. The patients ranged in age from sixteen months to seventy-two years. The advantages of this type of anaesthesia are threefold:

1. The high frequency cautery unit can be utilized throughout the entire operation.
2. The patients demonstrate little of any physiological change from the normal during operations that averaged five hours and eighteen minutes.
3. The patients are awake and responding consciously when they reach the ward.

The report embodies the technique of administering curare to produce apnoea in thoracic surgical patients anaesthetized with Nitrous Oxide and Oxygen. The type of operations, the condition of the patients during their operations, the postoperative course of the patients are then summarized in appropriate tables. The compiled data has favorably impressed the authors and it is our impression that curare may be generally accepted as a valuable supplement to anaesthesia in thoracic surgery.

12. Surgery of the Thymus in Myasthenia Gravis.

O. T. CLAGETT, and (*by invitation*)

L. M. EATON, Rochester, Minn.

The association of abnormalities of the thymus with myasthenia gravis has been a matter of interest. We have had experience with fourteen cases of thymic tumors in individuals with myasthenia gravis. About fourteen additional thymectomies were performed on individuals with myasthenia gravis who had hyperplasia but no tumors. Complete study of the problem from the standpoint of clinical diagnosis, x-ray diagnosis, pathology, and surgical treatment will be presented, as well as evaluation of the results of surgical treatment of myasthenia gravis.

13. Surgical Lesions of the Esophagus Seen in an Army Thoracic Surgical Center.

EARLE B. KAY (*by invitation*), Memphis, Tenn.

During the past three years over 130 patients with diseases and injuries of the esophagus have been seen at this Army Thoracic Surgery Center. Forty major esophageal operations were performed by the staff with only one operative mortality, an incidence of 2.5 per cent. The treatment of the nonoperative cases is also discussed.

In 11 of the 14 caustic strictures, the caustic was contained in sabotaged alcoholic beverages and consumed accidentally while overseas. There were six patients with undilatable esophageal strictures, four of whom had intrathoracic esophagoplasties and the fifth an antethoracic esophagoplasty. A sixth patient has had a first stage antecutaneous esophagoplasty. One of the intrathoracic esophagoplasties was total, another approximately an inch below the thoracic inlet, and the other two at the level of the aortic arch. The other 19 strictures responded to instrumental dilatation.

There were eight benign intramural esophageal cysts and tumors. Seven of these were excised locally, and the eighth required esophageal resection and esophagogastric anastomosis. Of the five malignant tumors, three were inoperable, and two were treated by resection and esophagogastric anastomosis.

Eleven cardioplasties were performed for cardiospasm. They were completely improved by operation and there was a marked decrease in the caliber of the esophagus postoperatively.

Ten patients had traumatic injuries to the esophagus (war wounds). Eight others had large shell fragments adjacent to the esophagus, two of which had caused localized perforations or diverticuli.

Twenty patients with congenital short esophagi were seen. The complications occurring in this condition are discussed.

14. Technical Problems in Surgical Treatment of Carcinoma of Esophagus and Upper Stomach.

JOHN H. GARLOCK, New York.

In this paper the author discusses the various technical features concerned with resection of the esophagus and upper stomach. There is described a new abdomino-thoracic approach which simplifies the operation considerably. In addition, some technical changes in the operation of total gastrectomy by the thoracic route are also described.

15. Section of the Vagus Nerves to the Stomach in the Treatment of Peptic Ulcer.

LESTER R. DRAGSTEDT, Chicago, Ill. (*by invitation*)

During the past three years, section of the vagus nerves to the stomach has been performed on 60 patients. The operation has been performed through a transthoracic supra-diaphragmatic approach and by a transabdominal sub-diaphragmatic exposure. Complete division of the vagus nerves to the stomach has been found to produce a marked decrease in the secretion of gastric juice, a marked decrease in the tonus and motility of the stomach, and an immediate and persistent relief of the epigastric pain and distress characteristic of the disease. In addition, objective evidence of healing of the ulcers by means of x-ray or gastroscopic examination has been obtained in almost all cases. The implication of these findings on the concept of peptic ulcer as a psychosomatic disease will be discussed.

16. The Management of Thoracic Surgery in the Hospitals of the Veterans Administration.

BRIAN BLADES, Washington, D. C.

Thursday Afternoon, May 30, 1946

2:00 P.M. Executive Session.

2:30 P.M. Scientific Session.

Presidential Address-The Direct Approach to Cardiovascular Disease.

CLAUDE S. BECK

17. Tetralogy of Fallot: Diagnosis and Indications for Operation.

HELEN B. TAUSSIG, Baltimore, Md. (*by invitation*)

This paper will discuss the diagnosis of the tetralogy of Fallot, the different diagnosis, and give brief mention to other types of malformations which may be amenable to operation, and finally the indication for operation in the various age groups.

18. The Surgical Treatment of the Tetralogy of Fallot.

ALFRED BLALOCK, Baltimore, Md.

Approximately 90 patients with the tetralogy of Fallot have been operated on during the last fifteen months. The surgical technic and the results of operation will be considered.

19. Complications of the Surgery of Patent Ductus Arteriosus.

JOHN JONES, Los Angeles, Calif.

A discussion of the various complications arising in a series of patients operated on for persistent patent ductus arteriosus. This series includes both the ligation of the ductus and the division and suture technique of Gross.

20. "Complete Division of the Patent Ductus Arteriosus."

ROBERT E. GROSS, Boston, Mass.

In a series of 130 cases of surgically treated patent ductus arteriosus, some form of ligation was employed in 43 instances. In about 80 per cent of these the result was perfect, in about 10 per cent the ligature partly cut through and some fistula was re-established, in about 10 per cent the ligature was not tied lightly enough to close off all of the shunt. This experience has led to the development and adoption of a technique for complete division of the ductus, which has now been carried out in 87 cases. This method of division is discussed in detail and is illustrated with appropriate drawings. Some post-operative observations on these patients are summarized. The complete division of the ductus has been so satisfactory that simple ligation of the vessel has now been completely abandoned.

21. The Surgical Treatment of Coarctation of the Aorta.

CLARENCE CRATOORD, Stockholm, Sweden.

7:00 P.M. Cocktail Party-Statler Hotel.

8:00 P.M. Banquet-Statler Hotel.

FRIDAY MORNING, MAY 31, 1946

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Friday Morning, May 31, 1946

9:00 A.M. Scientific Session.

22. Decortication for Tuberculous Empyema.

FRASER B. GURD, Montreal.

As a result of the performance of a relatively large number of decortications for chronic infected open pneumothorax (chronic empyema) among Canadian soldiers following the first stage of the War, the author has had considerable experience in the performance of this operation in longstanding chronic cases. Although not invariably, it has been found that, even after compression of the lung for several years, removal of the confining membrane has resulted in immediate expansion.

Since the orthodox treatment by extensive thoracoplasty of empyema complicating pneumothorax in cases of pulmonary tuberculosis has been, on the one hand, relatively unsatisfactory and, on the other hand, has inevitably resulted in marked interference with pulmonary function, the author has during the past two years carried out decortication in three cases of this sort. It has been found possible to remove the membrane from the surface of the lung without undue difficulty and in each of the three cases, although the lung had been compressed for periods of from fifteen months to four years, immediate expansion took place with ultimate healing of the empyema cavity.

Certain technical aspects of the problem require special consideration. The chronic chest cannot be easily spread therefore it is necessary to perform thoracotomy, in stages, so that sufficient room for intrathoracic operation may be obtained. Furthermore, in the chronic chest not only must the fibrous membrane be removed from the surface of the lung but the dissection must be carried towards the hilar region if the maximum expansion of the lung is to be obtained.

23. Lobectomy and Pneumonectomy in the Treatment of Pulmonary Tuberculosis.

RICHARD H. SWEET, Boston, Mass.

In 1943 Drs. Churchill and Klopstock reported an experience with lobectomy as an elective operation applied in the treatment of six patients with pulmonary tuberculosis at the Massachusetts General Hospital. At that time, although the operative technique had been developed to the point where the operation could be performed with reasonable safety, the indications for its use were not clear and no long time observations of end results were available. It was decided, therefore, to apply the principle of extirpation in a series of suitable cases so as to have available a record of experience upon which to formulate judgment in the future. *

In order to simplify the evaluation of the procedure, reducing the number of variable factors as much as possible, routine post-lobectomy or post-pneumonectomy thoracoplasties have not been performed.

Fifty-seven cases of lobectomy or pneumonectomy have been added to Dr. Churchill's original six cases, making a total of 63 cases. The results to date are presented as an experience with the method in the

management of certain types of cases of pulmonary tuberculosis. The tabulation of these results demonstrates in general what types of cases may be expected to do well or badly. Detailed discussion will be confined to the completed paper.

24. Further Experiences in Pulmonary Resection in the Treatment of Pulmonary Tuberculosis.

RICHARD H. OVERHOLT, and (*by invitation*)

NORMAN J. WILSON, and LAZARO LANGER, Boston, Mass.

This report shall deal with the experience in approximately two hundred cases of pulmonary tuberculosis treated by resection. These operations were performed between 1934 and the present time. One section of the paper shall deal briefly with late follow-up results in the first ninety-three cases which were operated upon prior to April, 1944. In this earlier group, the patients received general anesthesia and were placed in the classical side position during operation. The major section of the paper shall deal with technical problems and present-day methods. This section of the paper is concerned with a report on the immediate results in the treatment of approximately one hundred patients treated since April, 1944. All of these patients were operated upon under local anesthesia and all except ten of them were placed in a reverse, or face-down position on the operating table. The benefits of both local anesthesia and the face-down position shall be emphasized, and the statistics of this group shall be compared with the earlier group.

25. Cavernostomy.

E. J. O'BRIEN and (*by invitation*) P. V. O'ROURKE,

F. C. TEST, and E. F. SKINNER, Detroit, Mich.

Open surgical drainage of tuberculous pulmonary cavities has been reported in the past by several surgeons, but in general the results have not been encouraging.

The authors present an analysis of about 70 cases of cavernostomy for tuberculosis, operated upon in the four years preceding September, 1945.

Three main types of lesion were selected for cavernostomy:

1. Solitary large cavity without acute or progressive exudative disease, in patients with too limited a cardio-respiratory reserve to allow collapse therapy.

2. Large solitary cavity with minimal surrounding infiltration, located in the lower lobe, without active disease of the upper lobe.

3. Residual cavity beneath an optimal thoracoplasty collapse, in the absence of acute progressive exudative disease.

As was to be expected in a group mostly composed of "salvage" cases, post-operative morbidity and mortality were high. Results, however, in groups 2 and 3 especially, were sufficiently encouraging to warrant further evaluation of cavernostomy as a procedure applicable to certain tuberculosis patients unsuited for any other surgical measures.

Friday Afternoon, May 31, 1946

2:00 P.M. Scientific Session.

26. Surgical Removal of Foreign Bodies from the Heart.

(Moving Picture Demonstration)

DWIGHT E. HARKEN, Boston, Mass.

27. Cardiac Resuscitation.

MERCIER FAUTEUX (*by invitation*), Boston, Mass.

The usual methods, (massage, adrenalin, electrical shocks), utilized to resuscitate the heart following cardiac arrest or primary ventricular fibrillation secondary to various causes have been studied in a considerable number of dogs. Even when applied during the brief period of safety which follows complete stoppage of the circulation, they are not always successful in reviving the cardiac functions definitely.

Some of the essential causes of failure are: (1) hyperirritability of the heart, (2) absence of cardiac tone, (3) increase of the myocardial temperature, (4) peripheral circulatory failure.

The value of novocain, barium chloride, cold solutions, and intracardiac perfusions of dextrose, Ringer, and blood to control these causes of failure has been investigated.

The results obtained indicate clearly that these measures, when properly employed and in conjunction with two, usual methods for revival diminish considerably the incidence of failure.

28. Traumatic Diaphragmatic Hernia.

FELIX HUGHES, EARLE B. KAY (*by invitation*)

and R. H. MEADE, JR. and (*by invitation*)

T. R. HUDSON and JULIAN JOHNSON

An analysis is made of twenty-three traumatic herniae, of which four were on the right side. Acute symptoms of obstruction developed in two cases while under observation. Resection of the colon was necessary in one case admitted with evidence of obstruction.

All herniae were repaired by a transpleural approach. This gave excellent exposure of both the abdominal and thoracic organs. The phrenic nerve was crushed in most instances. The chest wall was closed without drainage, except in the case that required resection of the bowel, and no complications occurred.

The possibility of a diaphragmatic hernia occurring in all patients having combined thoracic-abdominal wounds or injuries to the diaphragm should be considered. Since many diaphragmatic injuries occurred during the war, there is the probability that this condition will be seen more frequently in the future.

29. Thoraco-Gastric Fistula Caused by Surgical Mistreatment of Herniated Stomach.

(Report of Two Cases)

G. E. LINDSKOO, and E. A. LAWRENCE (*by invitation*)

New Haven, Conn.

The authors have had the opportunity of treating two cases in which a herniated intrathoracic stomach had been inadvertently drained surgically (by other surgeons) under the misapprehension that a left pyothorax was present. The first case developed a chronic peptic ulcer at the site of previous catheter drainage, with erosion of an overlying rib and repeated hemorrhage from the intercostal artery. Successful treatment consisted of partial gastric resection, reduction of herniated viscera, and repair of the diaphragm.

The second case presented with a massive pyopneumothorax and gastric fistula following a similar contrecoups, was treated by thoracotomy for drainage, jejunostomy for feeding and subsequent reduction and repair of the herniated stomach.

Both cases had a definite history of previous chest trauma, which was the clue to proper diagnosis and treatment. In view of the large number of war wounds of the chest returning to civilian life, it is well to call attention to the possibilities of misdiagnosis in this connection, and the method of handling complications following ill-advised surgical intervention.

30. Congenital Eventration of the Diaphragm: Surgical Management. Case Report.

DEWEY BISGARD, Omaha, Neb.

Congenital eventration is a rare condition; at least, it is rarely recognized and probably mistaken in some instances for other lesions which cause dyspnea and cyanosis in infants.

The paper will include a discussion of the literature dealing with this subject and a report of a six weeks old infant with eventration of the right diaphragm which was cured by plication of the diaphragm through an introthoracic approach. Dyspnea and cyanosis present at birth increased so that survival was possible only in an oxygen chamber prior to operation. The infant has remained well and free of symptoms and has developed normally to the present, eighteen months following operation.

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