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AFTERMATH OF ABDOMINAL EXPLORATION

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The indications for abdominal exploration have changed greatly over the years and the purpose for which the operation is used continues to change. Exploratory laparotomy, without any further designation, at one time appeared frequently on operative schedules. If a diagnosis was difficult, an exploration offered an easy way out. Improvements in techniques and addition of new methods, particularly in the field of radiology, have increased the percentage of correct pre-operative diagnosis and proportionately diminished the need of exploration for the purpose of diagnosis. Consequently, the liberal use of exploratory laparotomy has been gradually restricted. A plausible reason for each operation performed may be had by an earnest attempt to make at least a provisional pre-operative diagnosis.

The pendulum swung too far towards no exploration. Today the practice is far too prevalent to open an abdomen for one specific purpose such as to remove a gallbladder, or an ovary, without regard to the other viscera. In spite of a thorough clinical investigation, some intra-abdominal anomalies and lesions are without signs or symptoms. These otherwise obscure lesions may be found if exploration is adopted as an auxiliary procedure to an abdominal operation. The importance of the discovery of these silent lesions varies from the detection of an early cancer to the slight displacement of an organ. Some of the findings are vital to the patient while others have only a casual interest.

It has always seemed to me that to serve the best interest of the patient the whole abdomen should be explored whenever feasible at the time of laparotomy. This practice I have always followed. In order to determine the value of this procedure my operative records were reviewed for a ten year period 1941-1951 inclusive. The findings were reported at the Academy of Obstetrics and Gynecology in 1952 and published later (1). That report included the contraindications to exploration such as the presence of infection. Also a systematic method of exploration was emphasized.

The total number explored during the ten years was 1142. Among that number some complication was found in 530 or 46.4 per cent. Some of the lesions were diagnosed before operation and the exploration was merely confirmatory. Other lesions might have been diagnosed pre-operatively. Many of the lesions gave no evidence at all of their existence before their accidental discovery.

The report (1) stated that “The gallbladder was found to be more frequently involved than any of the other viscera. The most common lesion was chronic cholecystitis. The criteria for making the diagnosis were thickening of the wall of the gallbladder, adhesions, and enlargement of the lymphatic glands along the bile tract. If two of these changes were present the diagnosis was considered positive. In this manner cholecystitis was diagnosed in 172 patients or 15 per cent of all those explored. Gallstones were palpated in 115 patients or 10 per

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cent. Adhesions not included in the cholecystitis group were found in 48 or 4 per cent.

"No attempt was made to classify the gallbladder according to size although some were small and contracted about a stone, while others might be considered hydropic. Since the filling and emptying of the gallbladder is influenced by the ingestion of food, pre-operative medication, and anesthesia, any statement regarding the size of the organ would have little value unless all of these factors were considered."

"Adhesions to the gallbladder must be distinguished from a mesentery that extends to the tip of the organ. The distinction is not always easy by palpation alone. Doubtful cases were assumed to be a mesentery. At times the adhesions were so extensive that the exact relation to the gallbladder could not be determined."

"Inability to palpate stones is not proof that they are not present. One patient was reported to have a normal gallbladder but shortly after her operation she developed gallstone colic and the gastroenterologists demonstrated stones."

In order to test the significance of the operative findings, the hospital records of the patients who were operated upon in 1942 were recently reviewed. The year 1942 was selected because it was the first of the ten-year survey and therefore gave ample time for a follow-up. Among the 61 patients explored 15 had gallstones, 7 had chronic cholecystitis not associated with stones and 12 had adhesions. The figures indicate that more than one half of the patients explored were found to have some complication of the gallbladder. The relevant material of the individual patients follows:—

Mrs. E. P. was age 42. Eight years previously she had experienced gastrointestinal distress and a diagnosis of gallstones was made. In 1941 an operation for ovarian cyst was performed. When the abdomen was explored gallstones were found in the gallbladder and cystic duct. In 1942 hysterectomy was done and the gallbladder removed at the same operation. After convalescence she was not seen again at the hospital.

Mrs. V. G. was age 49. She was referred by her family physician for the removal of an ovarian cyst. At the time of her pelvic operation, 1942, exploration showed gallstones and a chronic cholecystitis. She also had pruritis and leukoplakia of the vulva for which she was operated upon in 1945. She was hospitalized in 1952 with the diagnosis on discharge of arteriosclerosis, angina pectoris, bundle block, myocardial infarction and cholecystitis with gallstones. In the interim between hospital visits she had some indigestion but no definite gallbladder attacks. She was told about the gallstones after the first operation and advised to arrange to have them removed. She chose to wait until some definite symptoms from the stones developed. In retrospect it is difficult to determine how much the stones contributed to her other illness, but apparently it was not clear whether the upper abdominal symptoms were all cardiac or partly from the gallbladder.

Mrs. F. W. was age 44. At the time of a pelvic operation in 1942 the gallbladder was distended and a single large round stone was palpated. Cholecystectomy was advised, but was refused. She was not seen at our hospital after her convalescence. She died of cancer of the breast at another hospital.
Mrs. A. B. was age 70. The original complaint of this woman was backache which she thought was due to her pelvic organs. She did have a slight descensus but the most important feature of her examination was the presence of gallstones with a story of recent colic. A cholecystectomy was performed in 1942. Exploration of the pelvis confirmed the diagnosis of descensus and no other pelvic lesions. Palliative measures were used for her descensus and her symptoms were partly relieved. Arteriosclerosis, hypertension and nephritis have incapacitated the patient for several years. She is now 83 years old and quite feeble. No further gastrointestinal symptoms have been noted since her cholecystectomy.

Mrs. A. G. F. was age 54. A cervical polyp was removed in 1941. At that admission her gastrointestinal symptoms were investigated and a diagnosis of gallstones and amebiasis was made. The gallbladder was removed in 1942. A vaginal hysterectomy was performed in 1953 for prolapse. No gastrointestinal symptoms were recalled by her after her cholecystectomy.

Mrs. E. H. W. was age 44. The presence of gallstones was known for 10 years. Cholecystectomy was done at the same time as hysterectomy. Her convalescence was satisfactory. There is no further record of her after her immediate recovery.

Mrs. S. P. was age 37. Exploration at the time of hysterectomy in 1942 revealed gallstones in the gallbladder. She had gastrointestinal symptoms until her gallbladder was removed in 1943. During the next 10 years the patient was seen at frequent intervals for functional nervous disturbance with vague gastrointestinal symptoms.

Mrs. V. L. was age 38. Cholecystitis and cholelithiasis were diagnosed in 1941. Pregnancy began in February 1942. During the fourth month of her pregnancy her gallbladder was removed on account of an exacerbation of her symptoms. Exploration confirmed the diagnosis of a 4 months pregnancy. Her pregnancy proceeded to a normal termination. In 1948 and 1949 she had recurrences of pain in the gallbladder region over a period of 6 months. There have been no further abdominal symptoms since then.

Mrs. S. P. was age 42. Exploration at the time of hysterectomy in 1942 revealed gallstones in the gallbladder and calcified glands along the bile tract. Her convalescence was stormy but there was no indication of gallbladder complication at that time. A virus pneumonia prolonged her recovery. After her discharge from the hospital in 1942 she was reported by her family to be in good health, though she was not seen by us again. A request came to send her record to another hospital in 1953. Her physicians reported that she was acutely ill with high fever and pain characteristic of gallstone colic. After several days of observation the gallbladder was removed. It contained stones and free pus. Pancreatitis was suspected but not demonstrated. Her postoperative convalescence was satisfactory and she has been reported to be well ever since her operation.

Mrs. B. H. was age 52. Exploration at the time of hysterectomy in 1942 revealed gallstones in the gallbladder. Hypertension was present. No previous history of gallbladder disturbance could be obtained. She was advised to have the gallbladder removed but she did not return to our hospital again. In 1950 she was admitted to another hospital with a diagnosis of acute pancreatitis. After preliminary treatment she was able to have a cholecystectomy. At that operation
the pancreas appeared normal. For the last 3 years she has been in and out of cardiac failure.

Mrs. J. M. F. was age 21. An out of town patient came because of gastrointestinal disturbances. She was 4 months pregnant. X-ray showed gallstones. They were removed. Exploration at the time of cholecystectomy confirmed the diagnosis of 4 months pregnancy. There has been no further report from her family physician.

Mrs. E. E. was age 62. Exploration at the time of resection of the rectosigmoid for carcinoma revealed the presence of gallstones. This patient has returned for follow-up almost every year up to the present time. There has been no evidence of return of the cancer and she has not had gallbladder disturbance.

Mrs. L. M. was age 40. Gallstones and fibroids were diagnosed before operation. The uterus and the gallbladder were removed at the same operation. Convalescence was satisfactory. In 1947 she had a questionable cholangitis and pylorospasm. She has been well since.

Mrs. F. H. was age 44. At exploration at the time of hysterectomy in 1942 gallstones were found in the gallbladder. Fifteen days later cholecystectomy was performed. After 12 years there has been no history of further gastrointestinal disturbance.

Mrs. A. L. was age 45. Exploration at the time of hysterectomy in 1942 revealed gallstones in the gallbladder. She was seen during the next few years for metabolic disturbances. In 1948 she had an acute exacerbation of her gallbladder trouble and a cholecystectomy was done. After her convalescence there is no further record.

A review of the fifteen records of patients who had gallstones shows that gallstones were diagnosed before operation and the diagnosis confirmed in 7 patients. The diagnosis was not made before operation in 8 patients. Cholecystectomy was done as a separate operation in 9 patients. Cholecystectomy was combined with the pelvic operation in 3 patients. Cholecystectomy was advised but the advice was not taken by 3 patients. One of these was a woman age 62 who had a resection of a carcinoma of the sigmoid. She insisted that she would not live long enough to make the gallbladder operation worth while. She is living 12 years afterwards. One patient developed carcinoma of the breast soon after her gallstones were discovered. She was treated at another hospital for her carcinoma and died from the carcinoma. The third patient who did not follow the advice had extensive arteriosclerosis which made it difficult to reason with her.

The age at which gallstones were first discovered ranged from 21 to 70. They were distributed as follows:—third decade one, fourth decade four, fifth decade six, sixth decade two, seventh decade one and eighth decade one.

The records show that 5 of the patients were not seen or heard from after convalescence from the cholecystectomy. No gastrointestinal symptoms after the cholecystectomy were reported for 5 patients. One patient had vague abdominal symptoms and functional nervous disturbance. Two women had attacks similar to those experienced before cholecystectomy. Two of those who were advised to have cholecystectomy postponed their operation until serious complications arose.
When gallstones are present it is assumed that there is an associated cholecystitis. In addition to the 15 patients with stones and cholecystitis there were 7 classified as having chronic cholecystitis. The records indicate that cholecystitis without stones is far less significant than when stones are present. Mrs. C. H. was age 38. She had thickening of the gallbladder and a few adhesions at the time of exploration. She has been seen regularly for 12 years for cancer follow-up and has not complained of any symptoms referable to the gallbladder.

Mrs. M. had thickening of the gallbladder and enlarged glands, but when she was explored 5 years later these had subsided.

Miss C. R. was age 41. There was evidence from biliary drainage and from operation in 1942 which suggested chronic cholecystitis. At another operation in 1950 the gallbladder appeared normal.

Mrs. B. F. was age 47. Several operations were performed including one for volvulus in 1926 and umbilical herniotomy in 1927. At the time of these operations the gallbladder was normal. A normal pregnancy in 1928 was without abdominal symptoms. Cholesystectomy was performed in 1942 for acute cholecystitis and cholelithiasis. She has been seen frequently since then for a variety of complaints but none of these have been referable to the gallbladder.

Mrs. C. H. was age 38. At exploration in 1942 thickening of the gallbladder wall and a few adhesions were noted. She has been seen regularly every year for cancer follow-up and no symptoms referable to the gallbladder have been noted.

Mrs. S. B. was age 48. At exploration in 1942 thickening of the wall of the gallbladder and enlarged glands were noted and a diagnosis of cholecystitis was made. In 1949 she had a coronary occlusion and since then arteriosclerosis has developed rapidly. No symptoms have been suspected for the gallbladder.

Two patients with evidence of chronic cholecystitis have moved out of the city. Their follow-up has been inconclusive.

Since none of the patients who were assumed to have a chronic cholecystitis have had further symptoms one wonders if the criteria for the diagnosis are adequate. Did they really have cholecystitis? The number of these patients reported is too few to justify any conclusions.

The group of patients who had only adhesions is difficult to summarize because the character and extent of the adhesions varied so much. Several had previous cholecystectomies and the area from which the gallbladder had been removed was covered with adhesions. In other patients the adhesions were only a part of generalized adhesions throughout the abdomen. In the follow-up no symptom or complaint could justly be attributed to the adhesions.

Although this report is limited to the abdominal explorations for one year and includes only gallbladder lesions, the value of exploration is demonstrated. Above all the menace of gallstones is emphasized. There is no medical treatment for gallstones. They should be removed. Many of the thousands of deaths annually in this country could be prevented. Abdominal exploration followed by proper advice regarding the lesions discovered is good preventive medicine.