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## Original Communications.

### GASTROSTOMY FOR MALIGNANT STRICTURE OF THE OESOPHAGUS: A CASE.

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Eliza S., aged 41, first consulted me in April, 1886. Her family history was good. She had always been healthy, though not very strong; her digestion was always weak. About Christmas, 1885, she began to complain of pain in the chest, behind lower part of sternum and in the mid-dorsal region; it was almost constant, and not increased by food. During March and April she was unable to take solid food, and fluids were swallowed with increasing difficulty, part of them being often rejected, without nausea, as soon as swallowed. Large mouthfuls of clear mucus were thrown up at short intervals. On exploring the oesophagus early in May, the sound was arrested at 11 inches from the upper dental arch, showing stricture just below the level of the left bronchus. A No. 10 catheter passed fairly easily, causing some pain, and afterwards a No. 12. By the middle of May she was wholly unable to swallow anything, even a teaspoonful of water returning almost immediately, and the amount of mucus thrown off increased; it was often tinged with blood; both evidently came from the oesophagus. A catheter was introduced into the stomach three or four times daily for

the purpose of giving nourishment, a funnel into which the food was poured being attached to the catheter. The introduction of the catheter always caused pain, but she was fairly well nourished and gained somewhat in flesh and strength. The stricture rapidly contracted, so that by June 1st only a No. 8 catheter could be used, and the pain from the introduction so greatly increased that it was evident she could not continue to take nourishment much longer by this method. Rectal alimentation could not be continued for more than a few days, on account of the severe colicky pain induced. As she suffered from hunger and thirst, especially the latter, gastrostomy was proposed, the risks and disadvantages being fully explained to her. After some hesitation she decided to have it performed, and the first stage of the operation was done on June 11th. There were present and assisting Drs. Machell, Carveth, Cameron, Nevitt, Duncan, Foster and J. Caven. An incision, three inches long, was made three-quarters of an inch below, and parallel to, the costal cartilages of the 8th and 9th ribs, beginning nearly an inch to the left of median line. On opening the sheath of the rectus the direction of the incision was changed to that of the fibres of that muscle, so as to secure the benefit of any sphincter action that the rectus might subsequently exercise. On opening the peritoneum the liver and stomach came into view, the latter much contracted and overlapped by a fold of the lesser or gastro-hepatic omentum. The stomach walls were thick and of the usual pinky red color, but to make certain that it was