

IMPLANTATION OF URETERS INTO THE SIGMOID COLON FOR INOPERABLE VESICO-VAGINAL FISTULA

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(With permission of Lt. Col. W. C. Spackman, I.M.S.)

Indira Dattatraya, aged sixteen years, was admitted to the Sir D. M. Petit Hospital on 7th October 1939 for continuous dribbling of urine per vagina and soreness of the perineal skin.

History. The patient had a difficult and prolonged labour at home, in a village, forty-five days back. The pregnancy was normal, full term. The labour lasted for three days. Membranes ruptured twelve hours after the onset of labour. She states she had good pains. A dead child was extracted by the feet on the fourth morning by the two dais who attended her. She had no medical aid.

For the first ten days after confinement the patient had slight difficulty and burning during micturition. About the 15th day she observed urine dribbling per vagina and a foul blood-stained discharge. She gradually lost control over micturition.

The patient was examined under general anaesthesia. The skin of the perineum was excoriated. The urethra was intact and normal.

Speculum examination. The vagina was rather narrow; the cervix could not be seen. Instead, a large fistula with fixed indurated edges was visible, through which the wall of the bladder tended to prolapse.

Vaginal examination. Two fingers could be admitted through the fistula into the bladder. A wide ring of contraction could be felt at the lower limit of the fistula, and above, in a posterior direction, a prominence could be felt, possibly the mutilated cervix.

Investigations. Blood pressure 110 S. 75 D.

Blood R.B.C. 3,880,000

W.B.C. 6,500

Hg. 65%

Blood urea 21 mgm. per 100 c.c.

Fundi oculi Normal

Urine not examined as not possible to collect.

Pre-operative treatment.

Alkaline mixture.

Two tablets of Sulphanilamide t.d.s. as a prophylactic.

The day before operation.

R/ Mandelix	min. 120	Ammon. Brom.	gr. 20
Tr. Digitalis	min. 10	Chloral Hydras	gr. 5
Tr. Belladonna	min. 4	Aqua	ad oz. 1
	mft	Mist.	t.d.s.

Bowel wash.

Vaginal douche with acriflavine 1-2000.

The morning of operation. The vaginal douche was repeated, and the patient was prepared for an abdominal and vaginal operation with the usual aseptic precautions. She was given a hypodermic injection of Morphia $\frac{1}{4}$ gr. with Atropine 1/100 gr. and taken to the theatre.

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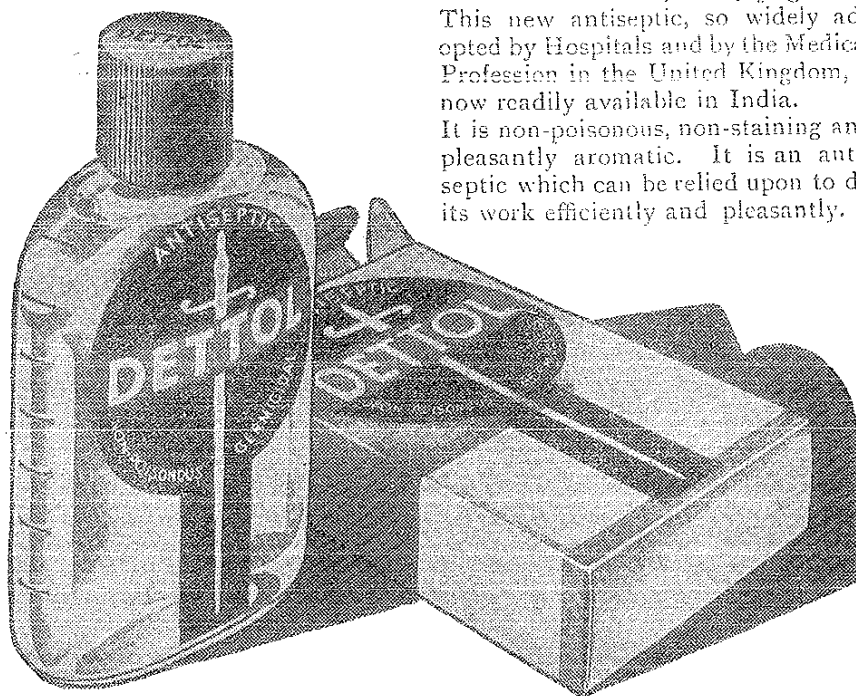
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(vide '*British Medical Journal*'

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Operation. 20-10-1939.

Anæsthesia — Spinal, Percaine 1-200, 2 c.c.

Position — Dorsal

Incision — Subumbilical median.

The peritoneal cavity was opened after the superficial vessels had been ligatured. The patient was placed in the Trendelenberg position. The small intestine was packed away with warm saline sponges, exposing the ureters and the sigmoid colon. The right ureter was separated from the surrounding tissues at the level of the brim of the pelvis, after incising the peritoneum covering it. Doyen's clamps covered with rubber were applied and the ureter cut. The distal end was ligatured. A fine catgut suture was passed through the sero-muscular coats of the proximal end and with its aid a No. 12 ureteric catheter was introduced up to the pelvis of the right kidney. The distal end of the catheter was set aside temporarily. A protective towel was now arranged, isolating the sigmoid colon.

An incision of one inch was made in the colon, varying in depth, cutting the serous layer at the top, then muscular submucous and mucous layers, slitting the mucosa at the lower end of the incision, sufficient to admit a No. 12 ureteric catheter (method first suggested by Coffey). A specially devised metal tube was introduced through the rectum up to the opening in the mucosa of the colon. This tube was used as a guide to pass the distal end of the catheter along the sigmoid colon and out through the anus, thus bringing the proximal end of the ureter to lie in the tunnel prepared for it in the colon. The ureter was fixed in this oblique position by suturing the edges of the incision in the sigmoid over it with two layers of interrupted catgut sutures. A similar procedure was carried out for the left ureter, it being implanted slightly to the left of the right ureter. Patient was placed in the dorsal position. The packs were removed, the greater omentum was spread over the field of operation, and the abdomen closed in layers.

Post-operative treatment. Patient was received back in the ward, given a hypodermic injection of Luminal 3 gr. and Intravenous Glucose 25% 100 c.c.

As soon as the effects of the anæsthetic had worn off she was raised into Fowler's position.

The ends of the ureteric catheters, protruding from the anus were separately placed into two test tubes which were firmly secured between the thighs.

The flow of urine was constantly watched. When the tubes filled they were emptied into two larger receptacles, the contents of which were measured separately every 24 hours (*e.g.*, 1st day, 20-10-39, right ureter 10 oz., left ureter 8 oz.) and charted.

Treatment. Daily investigations of urine from each ureter for amount in 24 hours, specific gravity, reaction, albumen, acetone, sugar, casts, R.B.Cs., and pus cells.

Blood pressure noted daily.

Bowels opened on the 5th day for the first time, with the aid of an olive oil enema. After this the patient defæcated regularly

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about two to three stools per day. Liq. paraffin given h.s. daily. She gradually assumed control over her bowels.

The left ureteric catheter was removed on the 8th day, the right on the 9th. Sutures were removed on the 10th day.

T.P.R. were recorded four-hourly for 10 days. The temperature wavered between 98.0°F. and 98.8°F.

The usual hygienic care of all operation patients was observed, except that the care of pressure points was accentuated, as the patient was nursed on her back for 9 days.

21-10-1939. The mixture of the day before operation was restarted, i.e., R/ Mandelix etc., and continued for 6 days.

Injection of Glucose 25% 100 c.c. given daily for 5 days.

For the first four nights Luminal 3 gr. was injected as morphia was contra-indicated. Later Seconal was used as a sleeping draught when required.

Diet. For six days consisted of fluid low-residue diet, Horlicks, Ovaltine and fruit juice.

Barley-and-glucose water were given in liberal quantities.

After the 6th day semi-solid diet was commenced and much appreciated by the patient.

Her progress was very satisfactory and she left hospital 16 days after operation looking very fit.

THE LADY OF THE LAMP

May 12, 1940, was the 120th anniversary of the birth of Florence Nightingale, heroine of the Crimea, revolutionary angel of the nursing profession, one of the great women of English history. This sympathetic sketch of a strong and fascinating personality was broadcast by the British Broadcasting Corporation in the Home programmes by MRS. W. H. SALMON, who knew Florence Nightingale intimately.

I well remember May 12 as a big family event in my life—the birthday of Florence Nightingale, and on that day her room was a veritable florist's shop, every corner filled with the flowers she loved, from many an admirer. It is thirty years since she left us, but she still lives in a very real sense as the inspiration of the thousands of nurses and V.A.D.s who are dedicating themselves to the Nation's service today.

To those whose privilege it was to know and love her it is sad to find how many people think of her as a loud-voiced virago. Nothing is further from the truth; if a wrong had to be righted she allowed nothing to stand in her path, but she was essentially a womanly woman. In the hectic time of trying to bring order out of chaos in the early days of the Crimea, a Roman Catholic Sister writing home said: "She is a perfect lady in everything, never overbearing, and I have never heard her raise her voice." You did feel the iron will that lay below her gentle manner, but her musical voice was a joy to listen to, and in the family circle