ACUTE INTESTINAL OBSTRUCTION—ITS TREATMENT*

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THE successful management of acute intestinal obstruction depends as much on the treatment before operation as on the operation itself. The general practitioner usually sees the patient before the surgeon. He is called during the first few hours of the obstruction. The suffering is so intense that the patient disregards all cults and isms and early seeks medical aid. The usual surgical mortality of 30 per cent or more can be lowered to 5 or 10 per cent only by early operation, i.e., the first twelve or twenty-four hours.

THE DANGERS OF MORPHIN

Early operation is prevented by morphin. Morphin obscures the symptoms. The patient is made perfectly comfortable and no one can more than guess at the diagnosis. Obvious, pathognomonic symptoms are entirely concealed. The innocent-looking hypodermic of morphin is responsible for the death of at least twenty-five of every hundred operative intestinal obstruction cases. It seems difficult for the physician to sense the dangers of morphin in abdominal pathology. It is the duty of the surgeon to warn against its use to relieve abdominal pain. It is our opinion that each year in our land, more lives are lost to morphin than to any other cause.

SUMMARY

1. The literature regarding the problem of combined diabetes and hyperthyroidism is discussed.

2. A brief resume is given of the results in 24 thyroidectomized diabetic patients in connection with the pathological diagnosis.

3. The blood sugar curves before and after thyroidectomy in 7 patients with potential diabetes are presented with charts.

4. The blood sugar curves following dietetic treatment of two diabetic patients without hyperthyroidism are compared with the post-operative curves of the previous group.

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*Read before the General Surgery Section of the California Medical Association at the Fifty-eighth Annual Session, May 9-12, 1929.
are destroyed by the hypodermic than by automobile accidents. Pain is not in itself deadly, but its relief by morphine often results in death. Patients will endure severe pain for long periods of time and survive—for example in facial neuralgia, sciatica, tabes, arthritiis and labor. Relieve the pain of acute intestinal obstruction by morphine for forty-eight hours and the patient will likely forfeit his life. We are told that we must not give morphine for abdominal pain until we are positive of the diagnosis. Can we be certain that the cause of the pain is not intestinal obstruction? Two of our thirty fatal cases had been given morphine for two days under the diagnosis of gall stones. We shall look in vain for improvement in our death rate until the entire profession discards the hypodermic as a remedial agent in all acute surgical abdominal diseases. We do not need better surgical operations so much as less preoperative morphine. Any surgeon in any community by repeated and continuous admonitions against the use of morphine in abdominal pain can reduce his surgical mortality in referred obstruction cases 50 per cent. In 1925, we had twenty-three referred obstruction cases with three deaths (13 per cent). The mortality of all referred cases previous to 1925 was 27 per cent. The difference represents the results of a campaign of education with my colleagues against the hypodermic in colic.

**IMPORANCE OF EARLY OPERATION**

The importance of an early operation is the one point on which all writers on this subject agree. With no morphine, most cases would be operated early. Intestinal obstruction operated on within two to four days under the diagnosis of gall stones can reduce his surgical mortality in referred obstruction cases 50 per cent. In 1925, we had twenty-three referred obstruction cases with three deaths (13 per cent). The mortality of all referred cases previous to 1925 was 27 per cent. The difference represents the results of a campaign of education with my colleagues against the hypodermic in colic. We are told that we must not give morphine for abdominal pain until we are positive of the diagnosis. Can we be certain that the cause of the pain is not intestinal obstruction? Two of our thirty fatal cases had been given morphine for two days under the diagnosis of gall stones. We shall look in vain for improvement in our death rate until the entire profession discards the hypodermic as a remedial agent in all acute surgical abdominal diseases. We do not need better surgical operations so much as less preoperative morphine. Any surgeon in any community by repeated and continuous admonitions against the use of morphine in abdominal pain can reduce his surgical mortality in referred obstruction cases 50 per cent. In 1925, we had twenty-three referred obstruction cases with three deaths (13 per cent). The mortality of all referred cases previous to 1925 was 27 per cent. The difference represents the results of a campaign of education with my colleagues against the hypodermic in colic.

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