

The Radical Treatment of Cancer of the Stomach

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The radical treatment of cancer of the stomach can only mean what the radical treatment of cancer implies in other parts of the body—surgical removal of the primary growth, together with any tissues that may have become secondarily affected. There is no medical treatment of cancer other than alleviation of symptoms, and even in the palliative treatment surgical intervention may be of the greatest service, as, for example, in the relief of conditions due to pyloric obstruction by gastroenterostomy, or of obstruction esophageal orifice by gastrostomy, or the establishing of a permanent channel for the introduction of nutriment into the organ.

In this paper, however, I shall try to confine myself to the consideration of that class of cases in which the safe removal of the cancer-bearing portion of the stomach is still possible...

Case 1. H. K., aged 31 years, farmer, native of Germany. Family history negative. Mother died at age 45, cause unknown, except that she had "dropsy." Patient never had any serious sickness until his present ailment began. No history of dyspepsia or colic up to that time. First examination April 29, 1904. The first symptom, noticed during the summer of 1903, was pain to the right of median line just below costal border, felt on riding. By November, 1903, he felt this pain constantly. At the same time his appetite became poor, tongue coated, the stools colorless and tough, and the urine brown. There were no attacks of severe pain. Jaundice was noticed during January or February, 1904, and lasted about four weeks, then disappeared and has not returned, and the stools have since then been of a dark-brown color. Vomiting began in November, 1903, and always occurs during the night, as a rule after he has reclined for about an hour, and never in the day-time (sic), except on one occasion about a week ago, when he had two vomiting spells in one day. At this time he first noticed that the vomited material resembled coffee grounds. He has never vomited fresh blood. As a rule there is no nausea except shortly before the vomiting...Has lost fully thirty pounds in weight. Bowels at times constipated, no diarrhea.

Present condition. The patient is a man of medium height and spare build, his highest weight during health having been 153 pounds. Skin and hair very dark, which perhaps added to the cachectic appearance, which is extreme. Sclera clear. Tongue thickly coated and breath very foul. Large, hard but movable tumor in the right half of the epigastric region extending into the right hypochondrium, just below the normal seat of the gall bladder. The tumor moves distinctly up and down with the movements of respiration; it is slightly tender on pressure and the seat of steady though not severe

soreness. The use of the stomach tube brought forth several pints of decomposing foul food remnants and secretions, of a distinctly "coffee-ground" character. Marked dilation was further shown by careful air inflation, the lower border of the stomach reaching nearly to the umbilicus. Air inflation did not alter the position or relations of the tumor. Examination after a test meal showed the absence of free HCl, the presence of lactic acid and long (Oppler-Boas) bacilli. The tests for pepsin were omitted. The blood examination showed 68% hemoglobin, 3,990,000 reds, and 11,200 whites. Urine normal. The diagnosis of cancer of the pyloric portion of the stomach, with obstruction and dilation could therefore in this case be made with a considerable degree of certainty, the only question as to the possibility of radical operation depending upon the involvement of neighboring structures; the free mobility of the large growth made this unlikely, and this view was fortunately fully borne out at the operation.

Operation May 4, 1904, at Milwaukee Hospital. Careful preparations as to diet, bowels, skin and mouth were carried out for several days previously. Rectal infusions of normal salt solution were given to fill up the blood vessels and supply the system with abundant fluid. Pulse before operation, 72; temperature, 98.2. A short incision was made close to the right of the median line midway between the ensiform cartilage and umbilicus, and finding upon exploration that the conditions were favorable for a radical operation, the incision was enlarged and more than half of the stomach removed, following with a posterior gastro-jejunostomy. The technique recently described by W. J. Mayo was followed in nearly every detail. The sections were made with the actual cautery, and celluloid thread used as suture material. About one inch of the duodenum was removed and all of the stomach as far to the left as the Mikulicz-Hartmann line. The Doyen clamps were used, no larger ones being available, and were found quite satisfactory. No special device was used for the gastro-jejunostomy, and the sutures consisted of one course of through-and-through Ford sutures and one course of Cushing's. The abdomen was closed by alternating through-and-through and figure of 8 sutures, without any drainage. The patient stood the long operation surprisingly well, and the subsequent course of the case was uneventful...

The tumor was the size of an average adult fist, nodular, hard, the entire surface ulcerating, and had caused very nearly complete closure of the pylorus. Microscopically it proved to be an adenocarcinoma, the enlarged lymphatic glands showing secondary infiltration with epithelium of the same character as that found in the tumor...

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