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Diagnosis & Treatment



Surgery

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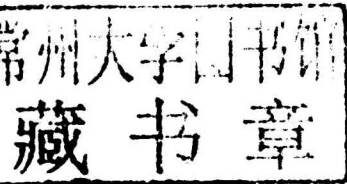
Diagnosis & Treatment Surgery

FOURTEENTH EDITION

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Current Diagnosis & Treatment: Surgery, Fourteenth Edition

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Preface

Current Diagnosis & Treatment: Surgery is a ready source of information about diseases managed by surgeons. Like other books in the Lange series, it emphasizes quick recall of major diagnostic features and brief descriptions of disease processes, followed by approaches for definitive diagnosis and treatment. Epidemiology, pathophysiology, and pathology are discussed to the extent that they contribute to the ultimate purpose of the book, which is guidance for patient care. About one-third of the book is focused on general medical and surgical topics important in the management of all patients.

The book also includes limited current references to journal literature for the reader who wishes to pursue specific additional detail. Because of the concise nature of this text, more focused exploration may be useful to gain detail in specific areas.

OUTSTANDING FEATURES

To maintain currency of the information, this text is revised and updated frequently. The most recent edition was published in 2010. With each revision, particular subjects are completely, substantially, partially, or minimally rewritten as indicated by the progress in each field. New authors and chapters are introduced for the text as needed.

This edition includes major revisions of many chapters, and entirely new chapters on:

- Infection, Inflammation, & Antibiotics
- Thoracic Wall, Pleura, Mediastinum, & Lung
- Pancreas
- Large Intestine
- Small Intestine

INTENDED AUDIENCE

- Students: This is an authoritative introduction to surgery as the discipline is taught and practiced at major teaching institutions.
- Residents: This is a ready reference for concise discussions of the diseases faced each day, as well as the less common ones calling for quick study.
- Medical practitioners: Those who have occasion to counsel patients needing surgical referrals appreciate the concise readability of this book.
- Practicing surgeons: A most useful guide to current management strategies.

ORGANIZATION

This book is arranged chiefly by organ system. Early chapters provide general information about the relationship between surgeons and their patients (Chapter 1), training and professionalism (Chapter 2), preoperative care (Chapter 3), postoperative care (Chapter 4), and surgical complications (Chapter 5). Subsequent chapters deal with wound healing, inflammation, infection, antibiotics, fluid and electrolyte management, and surgical metabolism and nutrition. The main series of body systems topics begins with the chapter on head and neck tumors and ends with the chapter on hand surgery. Further chapters on pediatric surgery, oncology, and organ transplantation complete the coverage.

MULTIPLE CHOICE QUESTIONS

Along with the customary revision of all sections as called for by changing concepts in each field covered, in this edition, multiple choice questions and answers have been added to supplement each chapter.

ACKNOWLEDGMENTS

The editor and contributors continue to acknowledge their gratitude to J. Englebert Dunphy, MD, for the inspiration to begin the first edition of this text, and his lifetime of service to the practice and teaching of surgery, and to Lawrence W. Way, the

long-time editor of editions 2 through 12, and conscience of the UCSF surgical training program. I have witnessed that same dedication to surgical students and trainees from faculty members at Washington University in St. Louis, the University of Michigan, and now at Boston University and Boston Medical Center, as well as at dozens of other universities and hospitals that I have visited. At each institution, I have appreciated the diligence and curiosity of our trainees, but I have admired none more than our present group at Boston Medical Center.

I am particularly grateful for the important contributions that the staff at McGraw-Hill has made to ensuring an accurate, high-quality text. In particular, Brian Belval has been extremely supportive and helpful. I am also grateful to colleagues and readers who have offered comments and criticisms to guide preparation for future editions. I hope that anyone with an idea, suggestion, or criticism regarding this book will contact me.

Finally, I thank my wife, Faith Cuenin, and our children Kevin and Megan for their constant love and support.

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Boston, Massachusetts
November 2014

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**Appendix: Answers to Multiple
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Approach to the Surgical Patient

J. Englebert Dunphy, MD*
Lawrence W. Way, MD

1

The management of surgical disorders requires not only the application of technical skills and training in the basic sciences to the problems of diagnosis and treatment but also a genuine sympathy and indeed love for the patient. The surgeon must be a doctor in the old-fashioned sense, an applied scientist, an engineer, an artist, and a minister to his or her fellow human beings. Because life or death often depends upon the validity of surgical decisions, the surgeon's judgment must be matched by courage in action and by a high degree of technical proficiency.

THE HISTORY

At their first contact, the surgeon must gain the patient's confidence and convey the assurance that help is available and will be provided. The surgeon must demonstrate concern for the patient as a person who needs help and not just as a "case" to be processed. This is not always easy to do, and there are no rules of conduct except to be gentle and considerate. Most patients are eager to like and trust their doctors and respond gratefully to a sympathetic and understanding person. Some surgeons are able to establish a confident relationship with the first few words of greeting; others can only do so by means of a stylized and carefully acquired bedside manner. It does not matter how it is done, so long as an atmosphere of sympathy, personal interest, and understanding is created. Even under emergency circumstances, this subtle message of sympathetic concern must be conveyed.

Eventually, all histories must be formally structured, but much can be learned by letting the patient ramble a little. Discrepancies and omissions in the history are often due as much to overstructuring and leading questions as to the unreliability of the patient. The enthusiastic novice asks leading questions; the cooperative patient gives the answer

that seems to be wanted; and the interview concludes on a note of mutual satisfaction with the wrong answer thus developed.

BUILDING THE HISTORY

History taking is detective work. Preconceived ideas, snap judgments, and hasty conclusions have no place in this process. The diagnosis must be established by inductive reasoning. The interviewer must first determine the facts and then search for essential clues, realizing that the patient may conceal the most important symptom—for example, the passage of blood by rectum—in the hope (born of fear) that if it is not specifically inquired about or if nothing is found to account for it in the physical examination, it cannot be very serious.

Common symptoms of surgical conditions that require special emphasis in the history taking are discussed in the following paragraphs.

► Pain

A careful analysis of the nature of pain is one of the most important features of a surgical history. The examiner must first ascertain how the pain began. Was it explosive in onset, rapid, or gradual? What is the precise character of the pain? Is it so severe that it cannot be relieved by medication? Is it constant or intermittent? Are there classic associations, such as the rhythmic pattern of small bowel obstruction or the onset of pain preceding the limp of intermittent claudication?

One of the most important aspects of pain is the patient's reaction to it. The overreactor's description of pain is often obviously inappropriate, and so is a description of "excruciating" pain offered in a casual or jovial manner. A patient who shrieks and thrashes about is either grossly overreacting or suffering from renal or biliary colic. Very severe pain—due to infection, inflammation, or vascular disease—usually forces the patient to restrict all movement as much as possible.

*Deceased

Moderate pain is made agonizing by fear and anxiety. Reassurance of a sort calculated to restore the patient's confidence in the care being given is often a more effective analgesic than an injection of morphine.

► Vomiting

What did the patient vomit? How much? How often? What did the vomitus look like? Was vomiting projectile? It is especially helpful for the examiner to see the vomitus.

► Change in Bowel Habits

A change in bowel habits is a common complaint that is often of no significance. However, when a person who has always had regular evacuations notices a distinct change, particularly toward intermittent alternations of constipation and diarrhea, colon cancer must be suspected. Too much emphasis is placed upon the size and shape of the stool—for example, many patients who normally have well-formed stools may complain of irregular small stools when their routine is disturbed by travel or a change in diet.

► Hematemesis or Hematochezia

Bleeding from any orifice demands the most critical analysis and can never be dismissed as due to some immediately obvious cause. The most common error is to assume that bleeding from the rectum is attributable to hemorrhoids. The character of the blood can be of great significance. Does it clot? Is it bright or dark red? Is it changed in any way, as in the coffee-ground vomitus of slow gastric bleeding or the dark, tarry stool of upper gastrointestinal bleeding? The full details and variations cannot be included here but will be emphasized under separate headings elsewhere.

► Trauma

Trauma occurs so commonly that it is often difficult to establish a relationship between the chief complaint and an episode of trauma. Children in particular are subject to all kinds of minor trauma, and the family may attribute the onset of an illness to a specific recent injury. On the other hand, children may be subjected to severe trauma though their parents are unaware of it. The possibility of trauma having been inflicted by a parent must not be overlooked.

When there is a history of trauma, the details must be established as precisely as possible. What was the patient's position when the accident occurred? Was consciousness lost? Retrograde amnesia (inability to remember events just preceding the accident) always indicates some degree of cerebral damage. If a patient can remember every detail of an accident, has not lost consciousness, and has no evidence of external injury to the head, brain damage can be excluded.

In the case of gunshot wounds and stab wounds, knowing the nature of the weapon, its size and shape, the

probable trajectory, and the position of the patient when hit may be very helpful in evaluating the nature of the resultant injury.

The possibility that an accident might have been caused by preexisting disease such as epilepsy, diabetes, coronary artery disease, or hypoglycemia must be explored.

When all of the facts and essential clues have been gathered, the examiner is in a position to complete the study of the present illness. By this time, it may be possible to rule out (by inductive reasoning) all but a few diagnoses. A novice diagnostician asked to evaluate the causes of shoulder pain in a given patient might include ruptured ectopic pregnancy in the list of possibilities. The experienced physician will automatically exclude that possibility on the basis of gender or age.

► Family History

The family history is of great significance in a number of surgical conditions. Polyposis of the colon is a classic example, but diabetes, Peutz-Jeghers syndrome, chronic pancreatitis, multiglandular syndromes, other endocrine abnormalities, and cancer are often better understood and better evaluated in the light of a careful family history.

► Past History

The details of the past history may illuminate obscure areas of the present illness. It has been said that people who are well are almost never sick, and people who are sick are almost never well. It is true that a patient with a long and complicated history of diseases and injuries is likely to be a much poorer risk than even a very old patient experiencing a major surgical illness for the first time.

In order to make certain that important details of the past history will not be overlooked, the system review must be formalized and thorough. By always reviewing the past history in the same way, the experienced examiner never omits significant details. Many skilled examiners find it easy to review the past history by inquiring about each system as they perform the physical examination on that part of the body.

In reviewing the past history, it is important to consider the nutritional background of the patient. There is a clear awareness throughout the world that the underprivileged malnourished patient responds poorly to disease, injury, and operation. Malnourishment may not be obvious on physical examination and must be elicited by questioning.

Acute nutritional deficiencies, particularly fluid and electrolyte losses, can be understood only in the light of the total (including nutritional) history. For example, low serum sodium may be due to the use of diuretics or a sodium-restricted diet rather than to acute loss. In this connection, the use of any medications must be carefully recorded and interpreted.

A detailed history of acute losses by vomiting and diarrhea—and the nature of the losses—is helpful in estimating the probable trends in serum electrolytes. Thus, the patient who has been vomiting persistently with no evidence of bile in the vomitus is likely to have acute pyloric stenosis associated with benign ulcer, and hypochloremic alkalosis must be anticipated. Chronic vomiting without bile—and particularly with evidence of changed and previously digested food—is suggestive of chronic obstruction, and the possibility of carcinoma should be considered.

It is essential for the surgeon to think in terms of nutritional balance. It is often possible to begin therapy before the results of laboratory tests have been obtained, because the specific nature and probable extent of fluid and electrolyte losses can often be estimated on the basis of the history and the physician's clinical experience. Laboratory data should be obtained as soon as possible, but knowledge of the probable level of the obstruction and of the concentration of the electrolytes in the gastrointestinal fluids will provide sufficient grounds for the institution of appropriate immediate therapy.

► The Patient's Emotional Background

Psychiatric consultation is seldom required in the management of surgical patients, but there are times when it is of great help. Emotionally and mentally disturbed patients require surgical operations as often as others, and full cooperation between psychiatrist and surgeon is essential. Furthermore, either before or after an operation, a patient may develop a major psychotic disturbance that is beyond the ability of the surgeon to appraise or manage. Prognosis, drug therapy, and overall management require the participation of a psychiatrist.

On the other hand, there are many situations in which the surgeon can and should deal with the emotional aspects of the patient's illness rather than resorting to psychiatric assistance. Most psychiatrists prefer not to be brought in to deal with minor anxiety states. As long as the surgeon accepts the responsibility for the care of the whole patient, such services are superfluous.

This is particularly true in the care of patients with malignant disease or those who must undergo mutilating operations such as amputation of an extremity, ileostomy, or colostomy. In these situations, the patient can be supported far more effectively by the surgeon and the surgical team than by a consulting psychiatrist.

Surgeons are increasingly aware of the importance of psychosocial factors in surgical convalescence. Recovery from a major operation is greatly enhanced if the patient is not worn down with worry about emotional, social, and economic problems that have nothing to do with the illness itself. Incorporation of these factors into the record contributes to better total care of the surgical patient.

THE PHYSICAL EXAMINATION

The complete examination of the surgical patient includes the physical examination, certain special procedures such as gastroscopy and esophagoscopy, laboratory tests, x-ray examination, and follow-up examination. In some cases, all of these may be necessary; in others, special examinations and laboratory tests can be kept to a minimum. It is just as poor practice to insist on unnecessary thoroughness as it is to overlook procedures that may contribute to the diagnosis. Painful, inconvenient, and costly procedures should not be ordered unless there is a reasonable chance that the information gained will be useful in making clinical decisions.

THE ELECTIVE PHYSICAL EXAMINATION

The elective physical examination should be done in an orderly and detailed fashion. One should acquire the habit of performing a complete examination in exactly the same sequence, so that no step is omitted. When the routine must be modified, as in an emergency, the examiner recalls without conscious effort what must be done to complete the examination later. The regular performance of complete examinations has the added advantage of familiarizing the beginner with what is normal so that what is abnormal can be more readily recognized.

All patients are sensitive and somewhat embarrassed at being examined. It is both courteous and clinically useful to put the patient at ease. The examining room and table should be comfortable, and drapes should be used if the patient is required to strip for the examination. Most patients will relax if they are allowed to talk a bit during the examination, which is another reason for taking the past history while the examination is being done.

A useful rule is to first observe the patient's general physique and habitus and then to carefully inspect the hands. Many systemic diseases show themselves in the hands (cirrhosis of the liver, hyperthyroidism, Raynaud disease, pulmonary insufficiency, heart disease, and nutritional disorders).

Details of the examination cannot be included here. The beginner is urged to consult special texts.

Inspection, palpation, and auscultation are the time-honored essential steps in appraising both the normal and the abnormal. Comparison of the two sides of the body often suggests a specific abnormality. The slight droop of one eyelid characteristic of Horner syndrome can only be recognized by comparison with the opposite side. Inspection of the female breasts, particularly as the patient raises and lowers her arms, will often reveal slight dimpling indicative of an infiltrating carcinoma barely detectable on palpation.

Successful palpation requires skill and gentleness. Spasm, tension, and anxiety caused by painful examination procedures may make an adequate examination almost impossible, particularly in children.

Another important feature of palpation is the laying on of hands that has been called part of the ministry of medicine. A disappointed and critical patient often will say of a doctor, "He hardly touched me." Careful, precise, and gentle palpation not only gives the physician the information being sought but also inspires confidence and trust.

When examining for areas of tenderness, it may be necessary to use only one finger in order to precisely localize the extent of the tenderness. This is of particular importance in examination of the acute abdomen.

Auscultation, once thought to be the exclusive province of the physician, is now more important in surgery than it is in medicine. Radiologic examinations, including cardiac catheterization, have relegated auscultation of the heart and lungs to the status of preliminary scanning procedures in medicine. In surgery, however, auscultation of the abdomen and peripheral vessels has become absolutely essential. The nature of ileus and the presence of a variety of vascular lesions are revealed by auscultation. Bizarre abdominal pain in a young woman can easily be ascribed to hysteria or anxiety on the basis of a negative physical examination and x-rays of the gastrointestinal tract. Auscultation of the epigastrium, however, may reveal a murmur due to obstruction of the celiac artery.

▶ Examination of the Body Orifices

Complete examination of the ears, mouth, rectum, and pelvis is accepted as part of a complete examination. Palpation of the mouth and tongue is as essential as inspection. Every surgeon should acquire familiarity with the use of the ophthalmoscope and sigmoidoscope and should use them regularly in doing complete physical examinations.

THE EMERGENCY PHYSICAL EXAMINATION

In an emergency, the routine of the physical examination must be altered to fit the circumstances. The history may be limited to a single sentence, or there may be no history if the patient is unconscious and there are no other informants. Although the details of an accident or injury may be very useful in the total appraisal of the patient, they must be left for later consideration. The primary considerations are the following: Is the patient breathing? Is the airway open? Is there a palpable pulse? Is the heart beating? Is massive bleeding occurring?

If the patient is not breathing, airway obstruction must be ruled out by thrusting the fingers into the mouth and pulling the tongue forward. If the patient is unconscious, the respiratory tract should be intubated and mouth-to-mouth respiration started. If there is no pulse or heartbeat, start cardiac resuscitation.

Serious external loss of blood from an extremity can be controlled by elevation and pressure. Tourniquets are rarely required.

Every victim of major blunt trauma should be suspected of having a vertebral injury capable of causing damage to the spinal cord unless rough handling is avoided.

Some injuries are so life threatening that action must be taken before even a limited physical examination is done. Penetrating wounds of the heart, large open sucking wounds of the chest, massive crush injuries with flail chest, and massive external bleeding all require emergency treatment before any further examination can be done.

In most emergencies, however, after it has been established that the airway is open, the heart is beating, and there is no massive external hemorrhage—and after antishock measures have been instituted, if necessary—a rapid survey examination must be done. Failure to perform such an examination can lead to serious mistakes in the care of the patient. It takes no more than 2 or 3 minutes to carefully examine the head, thorax, abdomen, extremities, genitalia (particularly in females), and back. If cervical cord damage has been ruled out, it is essential to turn the injured patient and carefully inspect the back, buttocks, and perineum.

Tension pneumothorax and cardiac tamponade may easily be overlooked if there are multiple injuries.

Upon completion of the survey examination, control of pain, splinting of fractured limbs, suturing of lacerations, and other types of emergency treatment can be started.

LABORATORY & OTHER EXAMINATIONS

▶ Laboratory Examination

Laboratory examinations in surgical patients have the following objectives:

1. Screening for asymptomatic disease that may affect the surgical result (eg, unsuspected anemia or diabetes)
2. Appraisal of diseases that may contraindicate elective surgery or require treatment before surgery (eg, diabetes, heart failure)
3. Diagnosis of disorders that require surgery (eg, hyperparathyroidism, pheochromocytoma)
4. Evaluation of the nature and extent of metabolic or septic complications

Patients undergoing major surgery, even though they seem to be in excellent health except for their surgical disease, should have age-appropriate laboratory examination. A history of renal, hepatic, or heart disease requires detailed studies. Medical consultation may be helpful in the total preoperative appraisal of the surgical patient. It is essential, however, that the surgeon not become totally dependent upon a medical consultant for the preoperative evaluation and management of the patient. The total management must be the surgeon's responsibility and is not to be delegated. Moreover, the surgeon is the only one with the experience