SECTION V—Therapeutics

Treatment of Hemorrhage Caused by Peptic Ulcer

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NOTHING is more alarming than a copious hemorrhage from an unseen source. No other catastrophe creates such a deep sense of futility in the mind of the physician who is responsible for the patient's welfare.

In hemorrhage from gastric and duodenal ulcers the source of the bleeding is both invisible and uncertain. Blood simply cascades from the mouth or from the bowel or both simultaneously. The patient becomes cold and blanched and swoons into unconsciousness. The pupils dilate and the respiration becomes slow and shallow and the victim presents almost a perfect picture of dissolution. Blood from the stomach is colored a deep dark red which distinguishes it from that which comes from the lungs. It is often mixed with particles of undigested food. It is a never-ceasing source of wonder that one can lose such apparently large quantities of blood and survive the ordeal. The burden of discretion rests very heavily upon the physician in the case at this particular point and the choice of a proper and safe procedure in the circumstances creates a serious quandary for the medical attendant. The patient presents a very dismal prospect for surgery on account of the acute anemia and its concomitant infirmities. On the other hand, it seems like unpardonable timidity merely to stand by and watch a patient bleed to death without exerting an effort toward his relief. The medical measures that we have available are so meager that they do not inspire either hope on the part of the patient or confidence on that of the physician.

We have become convinced that there is an efficient solution of the problem furnished by venoclysis when it is used sincerely and appropriately. Complete rest for the stomach is, thereby, secured and the organ contracts into a hard mass which plugs the vessels and controls the bleeding, if allowed to remain in force as much as ten days. All evidences of gastric disease disappear if the ulcer is not malignant. In support of this statement I beg to submit the following twelve cases of hemorrhage which have occurred as the leading symptoms in my series of forty-six cases of gastric and duodenal ulcer treated by venoclysis.

Case I. was a physician, age 53, of the stout and robust type. Had had his gall bladder removed and a gastroenterostomy to control hemorrhage three years previously by another surgeon. In the interval he had suffered considerable digestive trouble. Was restricted to a diet. Suddenly on Oct. 25, 1932, he collapsed from the effects of a copious hemorrhage. He lost consciousness, became pale and apparently lifeless. His body surface was cold and clammy. He vomited blood and passed large quantities per rectum. His pulse was soft and feeble and he had sighing respiration and gasped for breath. The question of moving him to a hospital was seriously debated on account of the apparent hopelessness of his condition. He was removed however and on his arrival there his blood count showed the red under two million and the hemoglobin 60%. He was immediately started on venoclysis, 10% Glucose in Ringer's Solution and 10 cc. of 10% calcium gluconate was added to each 800 cc. of the Solution.

A diagnosis of marginal ulcer had already been established by X-ray examination. In January, 1934, he had a slight hemorrhage from the bowel. With that exception he has been perfectly well to date, has been symptom-free and weighs 175 pounds: a gain of 45 pounds since his illness and is actively engaged in the practice of medicine.

Case II. H. G. E., age 52. After an indefinite period of gastric symptoms he suddenly became dizzy and nauseated and vomited blood copiously, also passed large quantities from the bowel. This began on Feb. 15, and continued through February 16 to extreme weakness and unconsciousness. On February 17, he was removed to the Deaconess Hospital and treated by Dr. R. L. McCormack who exhibited venoclysis. Continued it ten days. Hemorrhage was immediately controlled. All symptoms finally subsided and March 17 he was up and around and on April 15 he weighed 165 pounds. He since resumed his work, has been entirely free from gastric symptoms. It is now three years since his illness.

Case III. W. H. W., age 31. Admitted to St. Anthony's Hospital December 18, 1932. Symptoms began four years previously and continued with more or less severity. Two and one-half years ago patient suffered a rather severe hemorrhage followed in a few days by a second. He was temporarily relieved by a Sippy diet treatment. Venoclysis was begun on December 18, 1932, following his third and last hemorrhage. It was continued ten days. He left the Hospital January 14, 1933. He has regained his normal weight and resumed his occupation. Has remained symptom free up to now.

Case IV. W. E., age 59. Admitted November 17, 1931. Had peptic ulcer and hemorrhage ten years ago. Has had stomach trouble in varying degrees of severity since then. Present attack began on November 17, 1931. Was brought to hospital in collapse and unconscious. Pulse could hardly be felt at the wrist. Patient was cold and very pale. Venoclysis was immediately begun. There was a prompt reaction on the part of the patient. His progress toward recovery was unbroken. He left the hospital in two weeks.
Venoclysis continued five days. He has gained forty pounds and has remained well up to this time.

Case V. A. Z., age 41. Admitted March 29, 1931. Patient was complaining of "stomach trouble" the past ten years. Has had copious hemorrhages at irregular intervals during the past four years. More frequent and copious during the past year. When admitted to the hospital his R.B.C. was 300,000. Hemoglobin 18%. Venoclysis was begun immediately after his admission. On April 2, a blood transfusion with citrated blood was given through the venoclysis attachment. 500 cc. taking about four hours to give it. He immediately became very restless and became delirious and died on April 4. He had been quiet and composed until the blood transfusion was administered. No post mortem was obtained.

Case VI. H. A., age 59. Admitted February 22, 1930. Died two hours after admission. Gastric hemorrhage. Diagnosis Peptic ulcer. This patient had a perforation of his ulcer three weeks previous. Was treated by venoclysis and apparently recovered. At that time he had considerable peritonitis which was very low in vitality and a surgical operation did not seem advisable. He apparently recovered and was home about one week when he was suddenly seized with abdomen and vomited large quantities of blood from the bowels. He was taken to the hospital immediately but his condition was so grave on arrival that active measures did not seem justified. Venoclysis therefore was not begun. This case is included because three weeks previous venoclysis had been employed. No post mortem was obtained.

Case VII. J. E., age 25. Admitted June 11, 1929. Sent to hospital on account of gastric hemorrhage. Seven hours after admission he had a copious hemorrhage from the bowels and for a time pulse could not be felt at the wrist. Venoclysis was begun immediately and continued until June 19. Had return of epigastric pain June 20 and 21. Venoclysis again exhibited and continued until June 25. Patient left the hospital June 27 and has remained well and symptom free to this date.

Case VIII. Geo. S., age 27. Admitted September 21, 1931. Severe gastric hemorrhage. Diagnosis peptic ulcer. Since May, 1931, patient has had numerous hemorrhages accompanied by much nausea and vomiting. Has had retinal hemorrhage in both eyes. Venoclysis used seven days. November 17, 1931, patient was dismissed from the hospital. Patient has remained well since that time and now seems normal in every way.

Case IX. Leo M., age 30. Admitted June 2, 1934. Very severe gastric hemorrhage two days before admission. Diagnosis: Peptic ulcer. Pain in epigastrium for the past year. Pain and nausea appear soon after he takes food. Has noticed tarry stools on numerous occasions during the past three months. Symptoms have increased recently both in frequency and severity. He was discharged from the U. S. Navy on account of T. B. pleureisy. He uses alcoholic drinks to excess. This is the only case in this series in which the X-ray failed to show evidence of lesion. The clinical symptoms were so positive that I can not escape the conclusion that he had an ulcer. Venoclysis was begun June 3, 1934, and discontinued June 11, 1934. He left the hospital June 16, 1934. Although he has resumed his drinking habits, he remains free of symptoms and has gained thirty pounds. I predict from him an early relapse of symptoms.

Case X. P. K., age 48. Admitted February 28, 1929. Diagnosis: Peptic ulcer. Has had gastric symptoms seven years. Has epigastric pain which occurs one to one and one-half hours after meals. Ingestion of food or soda gives relief temporarily. Pain occurs frequently at night about an hour after going to bed. Has had copious hemorrhages from the bowels in the past four years. The last one occurred one year ago and was the most severe of all. Drinks alcoholics to excess. Gets on protracted sprees, when he can obtain the money. He had venoclysis from March 1, 1929, to March 7, inclusive. He left the hospital March 15. His symptoms were relieved. However, he resumed his drinking habits and died two years later of dilirium tremens and pneumonia combined, having had several intestinal hemorrhages in the meantime.

Case XI. F. S., Louellen, Ky., age 43. Mine Supt. Treated at Harlan Hospital July, 1934. Referred by Dr. W. M. Martin. Without warning this patient was taken suddenly ill with violent hematemesis. I saw him about twelve hours later, he was then unconscious, very pale and pulse could scarcely be distinguished at the wrist. Venoclysis was immediately begun and I returned to Louisville after giving explicit instructions in regard to the management of the case and the conduct of venoclysis. The patient made steady progress toward recovery and later regained his weight and resumed his occupation and has remained well since then.

Case XII. Mrs. M. L., age 66. Admitted January 4, 1930. Nurse by profession. Severe hematemesis. Peptic ulcer diagnosed. Vomited a large quantity of blood, some of it clotted. Venoclysis immediately exhibited and continued five days. Hemorrhage promptly controlled and general improvement was established and she left the hospital January 20. Resumed her occupation as professional nurse. She appeared to have made a complete recovery. February 17, 1935, five years after her treatment, she called me to her, where I found her prostrated from a severe gastric hemorrhage. She was immediately removed to the hospital and venoclysis begun. She had some bleeding the first day. Then all bleeding stopped. Her temperature assumed high peaks, 104-105-106; venoclysis was discontinued on the third day. The patient died five days after admission. Post mortem disclosed an ulcerating cancer and her intestinal tract filled with clotted blood.

COMMENT

In all cases 10% Glucose in Ringer's Solution or normal Salina was the solution employed. Diluted in 2 grain doses was used as needed for its quieting effect.

The four deaths occurring in this series might be analyzed as follows: Case XII, was 66 at the time of the first treatment, was free from symptoms five years and died at 71, from cancer of the pylorus and hemorrhage.

Case X, lived three years and died of alcoholic excess and pneumonia.

Case V, was bled down to 18% hemoglobin and less than a million red cells when admitted.

Case VI, was beyond human aid when seen and did not have venoclysis.

The other eight cases so far as I can determine are restored to their normal state of existence.

Although I have done so previously, it might be appropriate at this juncture to offer an explanation in regard to venoclysis. I quote the following from my paper read at the annual session of The American Medical Association, June 26, 1930:

"Venoclysis is a term which I have employed to designate for the biologic and continuous administration of physiologic and therapeutic solutions directly into the blood stream." My experience with this "means of grace" covers almost the entire range of surgery. We have been able to support life and maintain a fair degree of physical prosperity for as much as three weeks at a time, to the exclusion of all other sources of nutrition. We have used it for the treatment of forty-six cases of gastric and duodenal ulcer which includes the twelve cases herein reported. In this series we had only one death besides those reported in this paper and that particular patient proved to be a cancer instead of an ulcer.