

THE USE OF THE FOOTBALL BLADDER IN SURGERY.

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CLINICAL CONDITION.

On the evening of the 2nd August, 1947, a male Fijian of about 65 years was admitted to Levuka Hospital, Fiji. He complained of lower abdominal pain plus retention of urine with overflow. The retention with overflow had existed for two months. His general condition was very poor, with a drying tongue.

The bladder was very much distended, extending up to the level of the umbilicus. P.R. examination revealed an enormously enlarged prostate. Diagnosis—Carcinoma of the prostate. Several attempts at catheterization failed to penetrate the prostatic urethra. I then informed the Medical Officer, who instructed me to perform a suprapubic puncture.

The puncture was made in the mid-line, two inches above the pubis. The needle was pushed into the bladder in an oblique direction backwards and downwards. A small lumbar puncture needle was used. The protruding end of the needle was attached to rubber tubing which was connected to an empty Soluvac bottle. The bottle contained a little antiseptic, was tied to the side of the bed, and the urine drained into it.

The use of a small hollow needle is desirable in such cases because the bladder must be evacuated very slowly, being a gradual decompression of the bladder.

The needle was left in situ over-night. It was removed next morning, but later in the evening the puncture had to be repeated. The needle was re-introduced half an inch below the first puncture so as to avoid leakage and extravasation of urine into the cave of Retzius.

See PLATE No. 1.

OPERATION.

On the following day the patient was taken into the operating theatre for a suprapubic cystotomy. A local anæsthetic was given, but when the rectus sheath was opened ethyl chloride and light open aether were administered. The site chosen for the incision was infiltrated with procaine 2 per cent solution. An incision about three inches long was made in the mid-line, a little above the pubis. The rectus sheath was opened near the mid-line and the fibres of the rectus muscle were split and separated with the handle of the scalpel. The cellular tissue and muscle fibres were retracted exposing the bladder. A puncture was made with the point of the scalpel (a narrow pointed blade being the best kind to use). The mushroom end of a Malecot catheter was introduced with a probe (in the absence of an introducer), but a Spencer Wells' seven inch artery forceps is more suitable for this purpose. This part of the operation was unsatisfactory, as the puncture was a little too large for the catheter and urine gushed past the sides of the catheter. The wound was thoroughly mopped out and sutured with the catheter in place. Sulphanilamide powder and closed elastoplast dressing were applied.

AFTER-TREATMENT.

Silver nitrate 1-8000 irrigation b.d. Sulphadiazine 4 tabs (2 grams) stat. and 2 tabs (1 gram) 4 hrly. to a total of 30 grams. Mist. Pot. Cit. half an oz. 4 hrly. Copious fluids. Tube connections as in suprapubic puncture. Stilboestrol 5 mgm. t.d.s. p.c. N.B: The use of hormone therapy in the treatment of carcinoma of the prostate as described by Professor C. C. Huggins of the University of Chicago is not intended as a radical cure. It is stated that although this line of treatment does not cure the condition, it reduces the percentage of cases requiring radical operation. Stilboestrol allays the pain and the other bladder symptoms in carcinoma of the prostate. Its beneficial effects may last a year or even longer. It was prescribed in this case because radical operation was contra-indicated.

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In spite of all the complications that might have developed after the operation, such as purulent cystitis, pyelonephritis, cellulitis, etc., the patient made an uneventful recovery. He was allowed to get up on the 12 day after operation. Then a problem arose. How was he to get around without undue discomfort? The use of a football bladder solved the problem. A football bladder purchased locally was connected to the catheter by a 2 inch glass tube, the urine draining into it. Whenever full, the football bladder is disconnected from the catheter, emptied and then reattached to the catheter. This is easily done by the patient. In order to support the weight and prevent it from slipping off the catheter it is supported by a bandage, the end of which is wound round the patient's neck.

Patient was discharged on the 21st August, 1947, looking very well and feeling fit. Urine draining well to football bladder.

Seen again at O.P. one month later, quite happy and contented. Still taking stilboestrol 5 mgms. t.d.s.p.c.

NOTES.

(1) Suprapubic puncture with a lumbar puncture needle may be of interest to A.M.Ps. in out-lying districts, but one must bear in mind the danger of repeated puncture—the possibility of leakage and subsequent cellulitis, peritonitis or purulent cystitis. Its use is to give temporary relief only, when the catheter fails. The method should only be used as a temporary measure to tide the patient over until admission to a hospital with surgical facilities.

(2) The operation described is actually what was done in this case. More detailed descriptions can be obtained in surgical text books.

(3) The use of the football bladder seems of novel interest. Other receptacles can be used, but will not be as convenient and completely comfortable. The football bladder is the ideal thing.

REFERENCES.

- Medical Annual, 1946.
Bailey's "Emergency Surgery" 1945.
Bailey's "Pye's Surgical Handicraft" 1946.
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A use for the football bladder in surgery.