‘An operation under difficulties’ 100 years ago

In a change from recalling births, deaths or medical discoveries, this article looks at a paper published in *The Lancet* 100 years ago. Occupying a little more than a single column, its vivid description of an operation carried out successfully under primitive conditions will be of great interest.

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While searching through the bound copies of *The Lancet* of 1920, 100 years ago, in preparing my next ‘Anniversary’ article for this journal, I came across a short paper entitled ‘An operation under difficulties’. Usually, my monthly article recalls some important event in medical history – the anniversary of the birth or death of some famous clinician or medical scientist, or the announcement of some major discovery in medical science, and I go on to describe their role in the history of medicine. However, I thought that this paper, occupying a little more than a single column in that eminent journal, with its vivid description of an operation carried out successfully under primitive conditions, was of sufficient interest to readers for me to resuscitate it here, 100 years after its publication.

Under the main heading of ‘Clinical Notes; Medical, Surgical, Obstetrical and Therapeutical’ came the article ‘An operation under difficulties’. The author was listed as Nathaniel Crichlow MB, ChB Glas, Government Medical Officer, British Solomon Islands:

‘The natives of the British Solomon islands have become so accustomed to live amidst dirt, filth and squalor that they seem to become immune to septic germs. I attribute the recovery of the following case to such immunity’.

One morning I received a letter from the Father in charge of the Roman Catholic Mission informing me that, during the night, one native stabbed another native in the abdomen and that the stomach and intestines were protruding through the abdominal wound.

Although at the time suffering from an attack of malarial fever, I went immediately to the mission station. I examined the native and found that he had an abdominal wound 3 inches long in the epigastric region and running in an oblique direction. The cartilages of the sixth and seventh ribs were completely cut through. Through the wound protruded the stomach. The stomach itself had a wound 1.5 inches long and penetrating the entire anterior wall. Through this opening, the contents of the stomach were oozing. The patient was in a collapsed condition and his pulse was very soft. Ten hours had elapsed between the time he was stabbed and the time that I saw him. As the patient was not in condition to stand a trip by water, and as the hospital was some distance away, I decided to operate on the spot. Unfortunately, I had no instruments with me. I asked the Father what instruments, dressings etc. he could supply and he informed me that he could supply the following: One pair of scissors, skin suture needles, catgut, rubber drainage, wool, lint, Lysol and chloroform. I decided to operate with these instruments, with the addition of my pocket knife. The patient was lying in a native hut built of leaves and was far from clean.

Operation: I washed the protruding stomach well with weak Lysol solution and without any anaesthetic I stitched up the wound in the stomach, using the skin needles and catgut. The patient was then placed under chloroform. The abdominal wound had to be enlarged and this I did with my pocket knife. I then pushed back the stomach into the abdomen, covered it with omentum, inserted a drainage tube and stitched up the wound. Before I left, I instructed the Father with the care of the patient.

The following day I returned, fully expecting to hear of the patient’s death. Much to my surprise, I was told that he was alive and apparently much better. I did, indeed, find the patient much better. The pulse was beating strongly, there was very little abdominal pain and he was able to converse with me. Four days after, I again visited the mission station and was informed, to my surprise, that the patient was walking about. I dressed the wound and gave him 1 oz of castor oil. I left the drainage tube for a week and then removed it.

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A fortnight later the abdominal wall had quite healed and the patient was walking about and eating anything he liked. He informed me he could eat just as well as before and had no epigastric pain.

This patient was operated upon in a dirty leaf house on a dirty wooden bunk. Proper aseptic precautions could not be taken. A pocket knife, a pair of scissors, skin suture needles and catgut were the only instruments used in the operation. I had to be anaesthetist as well as operator.

The patient had very little skilled attention after his operation except that the wound was dressed every day by the mission Father. Yet, in spite of all these disadvantages, 3 weeks after being stabbed, he was walking about as well as ever and was none the worse for his experience.'

What an interesting report. Next time a young surgeon complains about the lighting in the operating theatre, or the absence of a piece of elaborate surgical equipment, perhaps he or she should have their attention drawn to this account.

Some further research through old medical directories at the Royal Society of Medicine library revealed that Dr Nathaniel Crichlow had qualified MB, ChB at the University of Glasgow in 1912 and had served as senior resident surgeon at the Dumfries and Galloway Royal Infirmary. He then served as medical officer in the British Colonial Service at Tulag, in the British Solomon islands. In addition to this case report in *The Lancet*, he published 'A brief medical guide to the Solomon Islands' in 1921 and a paper on 'Hookworm disease in the British Solomon Islands' in the *Journal of Tropical Medicine and Hygiene* in 1922. In 1929 came his paper on 'The prevalent diseases of the British Solomon Islands' in the *Transactions of the Royal Society of Tropical Medicine and Hygiene*. He was awarded the Member of the Order of the British Empire and retired to live in Trinidad.

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