GAS GANGRENE AS SEEN AT THE CASUALTY CLEARING STATIONS.

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Gas gangrene is still a very striking feature in the surgery of this War. It has from its very frequency ceased to arouse very much wonder and is I think a little in danger of being accepted as a necessary evil and treated by routine measures.

Two very interesting papers have recently appeared by D’Este Emery and Kenneth Taylor.

D’Este Emery’s views seem to be as follows: The toxin kills the leucocytes which are the natural protection of the body. To have a sufficient supply of these it is necessary that the circulation be intact. Therefore tissue devitalized by trauma, by constriction of the limb or by actual damage will favour the disease. Why, however, does the disease not stop when healthy tissue is reached? The explanation lies in the fact, that the toxin when present in large amount inhibits emigration and kills the leucocytes. If there is no free escape the toxin accumulates to such an extent that it soaks through into the healthy tissue and kills the defensive leucocyte and so the gangrene spreads.

Taylor’s view may be summarized as follows: The mechanical action of the pressure produced by the gas is usually if, not always the most important part of the infection. It brings about the death of the tissues from (a) the resulting anemia, (b) the actual mechanical fragmentation of the muscle substance, (c) the mechanical scattering of the infection. He shows in the earlier part of his paper that the experimental injection of the exo-toxin produces softening of muscle and parenchymatous degeneration of the liver cells. His experiments in vitro show the same effect on pieces of muscle: He suggests that the rapid systemic intoxication is produced by the breaking down of the muscle substance, as injection of the exo-toxin does not produce an effect comparable to that seen in the clinical course of the disease.

If one compares these two theories of the disease one finds that they mainly differ in the part played by the gas. Taylor thinks, that it plays an important part; D’Este Emery denies this and believes that the bacterial toxins are the important factor. Taylor believes that the disease is mainly one of the muscles. D’Este
Emery thinks that this is a mistake and that it is only the fact of the bacteria being able to produce gas by the aid of the muscle sugar that leads to this assumption.

These views reflect two somewhat different conceptions of the disease, but it seems probable that both observers have some right on their sides.

I have thought that a statement of some of the features of the disease as it presents itself to me may be of interest. I will commence by quoting some cases that illustrate some points that I want to emphasize.

Case 1.—A soldier (under care of Captain Anderson) was hit by a shell fragment, which made a large wound involving the adductors and hamstrings and smashing the femur in the upper third.

The superficial and deep femorals were injured and had to be ligated. The wound, which was a large open one, was cleansed and drained in the ordinary way. The limb was fixed in a Thomas's splint.

Within thirty-six hours the leg was dead, but non-tympanitic; the thigh was tympanitic over all its circumference. It was still warm, as such infected limbs often are, about the seat of the actual injury. No crepitation could be obtained by palpation, but with a stethoscope distinct crackling could be detected on passive motion of the limb and on relaxing or increasing deep pressure; the stethoscope was applied over the vastus externus. The limb was removed through the fracture, but the patient died quietly in his sleep some twelve hours later.

An examination of the ablated limb showed the following condition:

The subcutaneous tissue appeared normally yellow in its fatty layer and no gas could be demonstrated by pressure. The deeper layer immediately over the fascia lata was oedematous, but not discoloured. On incising the fascia lata, which appeared normal, a similar oedematous condition of the areolar tissue over the vastus externus was observed. No gas could be demonstrated here. The vastus externus was normal in colour and contracted in a lively manner when pinched or when cut with a knife.

The adductor longus was of a dirty brick-red colour, more opaque and less translucent than healthy muscle. It was non-contractile and gave no sign of life when pinched. It was non-crepitant to the squeezing finger and cutting scalpel.

The hamstring muscles were the same colour; non-contractile and frankly gaseous and crepitant.
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The areolar tissue was oedematous and infiltrated with blood, but not black.

Cultures were made from portions of the vastus externus and adductor longus by taking pieces from the heart of the muscle after searing the surface.

Both showed anaerobic bacteria as reported by Captain Emrys Roberts.

Pieces of muscle taken from vastus externus, adductor longus and biceps were examined microscopically by Captain McNee, Captain E. Roberts and Lieutenant Dunn.

1) The Vastus Externus.—The fibres were normal and no bacteria were to be seen in the tissues.

2) The Adductor Longus.—The fibres had lost their transverse striation. The muscle substance was broken up in transverse plates or presented longitudinal markings as if painted with a coarse brush. Between the fibres, which were obviously separated from one another, were bacteria in varying quantities in the interfibrillar spaces. There were some polymorphonuclear leucocytes.

3) The Biceps.—The appearances were similar to those seen in the adductor longus, but the separation of the fibres was more marked and there were more bacilli and leucocytes.

Case 2.—A man under the care of Major Cuff was hit with a shell fragment in the middle of the leg. The anterior tibial was divided and was tied. (The man was also wounded in the liver and coeliotomy performed to stop the bleeding.)

About forty-eight hours after the receipt of the injury the leg became tympanitic and died. The skin of the thigh was crepitant and the gas in the crepitant area could be displaced by pressure in the same manner that surgical emphysema can be.

An incision in the crepitant area showed normal-looking fat without oedema and the knife drawn over the deep fascia gave the typical hollow sound. The subfascia connective tissue contained gas. A culture taken from this locality remained sterile.

The leg was taken off through the knee. The thigh never gave any sign of infection, although it was crepitant. A good recovery followed.

Case 3.—Pte. B. was wounded in the thigh with a shell fragment. The femoral was exposed in the wound. The thigh became tympanitic on the fourth day and was treated with incisions which arrested the gangrene. The foot died in the following night, and the leg was tympanitic in the morning. Exploration showed that the femoral had become thrombosed. The leg was amputated.
at the seat of election. Examination of the ablated part showed the following condition:—

It was drummy, but not crepitant.

The anterior tibial muscle group was a dirty red colour and non-contractile. The posterior tibial muscle group was brick-red, but non-crepitant. The calf group was contractile and purple. The fascial planes between the muscles appeared normal. The subcutaneous tissue in the cut surface of the amputated leg was oedematous and greenish, but contained no gas.

Cultures from the subcutaneous tissue and the purple contractile calf groups both gave *Aerogenes capsulatus*.

Case 4.—A man was wounded on the flexor aspect of the forearm. He exhibited all the signs of "gas infection." The hand was warm but anesthetic. Incisions through the deep fascia arrested the disease, but the superficial flexors sloughed; otherwise the man made a good recovery.

Case 5.—A man was shot through the flexor aspect of the forearm. The bones were intact. He was admitted with a tense, swollen forearm. The hand was cold and senseless and showed a line across the back of the hand, suggesting that the outer half of the hand was about to mortify.

Incisions into the flexor aspect of the forearm and into the thenar eminences showed the superficial muscles and those of the thenar eminences in a state of "? death." That day the hand was warm and the circulation returning. The improvement was of short duration and the hand and flexor muscles were ablated. The extensor muscles were uninfected. The man made a good recovery.

Case 6.—A man was shot through the middle of the humoral biceps. He developed all the classical signs of gas gangrene. The medical officer in charge thought that amputation would be necessary. The surgical specialist (Captain Neligan), however, made a long incision over the muscle and found that the muscle was dead and gaseous in the middle at the site of the wound. The two ends of the muscle were still normal in colour and contractile. The whole muscle was ablated.

There was some doubt as to the state of the triceps, but an incision through the fascia showed that this muscle was healthy and contractile.

Case 7.—A patient hit in the buttock suddenly developed gas gangrene in this region. It was freely incised. Before death, which occurred within a few hours, the upper arm became crepitant to the finger, though there was no wound at all in this region.
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Case 8.—The case quoted by Captain Mullally and McNee in the Lancet, April 1, 1916, where gas gangrene appeared at the sites of subcutaneous injections.

Case 9.—A case quoted by Lieutenant-Colonel Gordon Watson, where the opposite thigh to that injured became distended with gas shortly before death.

Case 10.—Many cases in which after amputation one muscle is found in the stump dead and gaseous and separable from the others if the insertion or origin is divided.

Case 11.—A man was shot through the popliteal space. The leg was cold and dead, but was not drummy or crepitant. Amputation through the knee was performed. The popliteal space was full of blood. There was a large hole in the artery. A dissection of the ablated leg showed that the muscles were non-contractile, but purple in appearance. Microscopical sections showed the normal striation of the fibres which were not separated from one another.

My own impressions of the disease as seen at the Front and gathered from the cases above quoted and many others may be briefly stated as follows:

1. It is rare to meet gas gangrene without a muscle injury.
2. It is chiefly a disease of the muscles and is rarely dangerous unless muscle is involved.

It occurs, it is true, in retroperitoneal hematoma; but here there are wounded muscles in which it can at first obtain a lodgment, and there is in addition the blood-clot and the tissues devitalized by the extravasated blood in which it can spread.

It has been said that one of the most remarkable features about Aerogenes capsulatus is the fact that a bacillus usually but little pathogenic becomes suddenly extremely virulent.

Barger and Dale have shown that an allied bacillus—the Vibrio septique—becomes at once extremely toxic when grown on muscle. Cannot then the difference in the toxicity of the Aerogenes capsulatus depend on the nature of the medium in which it is implanted? Will not this account for the difference in the clinical course of many wounds? If inoculated in fascial tissues it finds difficulty in establishing itself, but if it gains entrance to muscle it finds itself in favourable surroundings and is at once enabled to produce such toxins as will quickly destroy its host.

3. The lesion in its early stages may be described as a longitudinal one, running up and down the wounded muscles from the seat of the lesion (see Case 6). Muscles and groups of muscles are involved while others escape.
(4) It is rare to find all the muscles of a segment of a limb involved, save in a segment distal to one in which the main blood supply has been cut off. Thus the whole leg dies and becomes gaseous when the femoral artery has been blocked in the thigh.

(5) The muscles affected are in the first instance the wounded ones. If the pressure caused by the disease is relieved, the gangrene will most probably be confined to these muscles, but if the pressure is not relieved the other muscles may so have their blood supply checked as to fall victims to the infection.

(6) Muscles contained in rigid compartments such as the anterior tibial group are especially prone to die if wounded.

(7) There is but little tendency for the infection to pass from one muscle to another. This is well shown in amputation stumps, where one muscle dies and becomes gaseous, while the rest of the cut muscles remain healthy.

(8) The infection is farther advanced in the muscles than in the intermuscular areolar planes.

In legs amputated for gas gangrene the only visible abnormality may be the brick-red colour of the dead muscles. So normal looking may be the appearance of the cut surface of the limb that I have known people unacquainted with the peculiarities of the disease express disbelief in the infection of the limb until the bacilli were demonstrated in the non-contractile muscle. Again, the internal appearance of a limb affected with gas gangrene is quite different to that of such a disease as cellulitis of the neck, in which the areolar tissue is infected and the muscles normal.

(9) The muscles become resonant from the presence of gas long before they become crepitant to the finger, though this phenomenon may be perceptible at an early date by means of the stethoscope. This was pointed out to me by Captain Maybury.

(10) The presence of gaseous crepitation does not necessarily mean microbic infection (see Case 2).

(11) Crepitation is usually a comparatively late phenomenon and is due to the escape of gas into the areolar and subcutaneous tissue.

(12) In an infected limb, a vascular lesion will be followed by the death of the muscle or muscle group, which death would not have followed in an uninfected limb. It is believed that the pressure produced by the gas so raises the tension in the limb as finally to arrest the circulation.

(13) In an infected limb there are several conditions of the muscles: (a) Normal purple red contractile muscle which may or
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may not be infected as judged by cultural experiments. (b) Dead, non-contractile, non-crepitant muscle which has a peculiar red colour and is less translucent than normal muscle. (c) Dead, non-contractile, crepitant muscle which has the same appearance as the last. (d) Brown, black or diffusent muscle.

(Muscle dead from the cutting off of the blood supply is a purplish brown and its naked-eye appearance quite different from (b) and (c).]

(14) The microscopic appearances of muscle dead from cutting off its blood supply are different to those of a muscle dead from infection. The striation is present in the former and absent in the latter.

(15) The bacteria are between the muscle fibres and not in them.

(16) Microscopical examination suggests that the gas may find its way between the muscle fibres in front of the bacterial invasion.

(17) In dead infected muscles the fibres are separated from one another. This separation is more marked in muscles that are crepitant than in those that have not yet reached that stage.

Death of a Muscle with an Intact Blood Supply.

A muscle deprived of its usual blood supply, or with a restricted supply, falls an easy prey to the gas bacillus. Muscles with an intact blood supply seem liable to die, but the method of their death is not quite clear. Cultures show that normal looking and contractile muscle may be infected. What proportion of such infected muscles would ultimately die if left untreated is not known. Nor is the way in which the infection spreads known.

Case 6.—Shows that the infection and death spreads in both directions from the seat of injury, for in this case the centre of the muscle on both sides of the wound was dead but the extremities were still living and contractile. Small bomb or shell wounds which would not affect the main blood-supply are followed by gas gangrene, and experience shows that if left untreated such infection will spread rapidly and compass the death of the wounded muscle. Incisions will save this spread of gangrene. It seems, therefore, that pressure is a great factor, but whether it wholly acts by cutting off the blood supply or by allowing the gas to penetrate the muscle and produce an anaemia of the fibres, or by favouring the penetration of the yet living muscle by the toxins derived directly or indirectly from the bacilli, is yet undetermined. In the first instance, the infection is possible because the local damage affords
a medium in which the bacteria can grow and multiply. The extension is brought about in two ways.

(1) The Toxins produced by the Bacteria.—One of the most striking things seen in microscopic sections of muscles dead of gas infection is the loss of striation and the breaking up of the muscle fibre substance. These appearances are quite different from those seen in uninfected dead muscle. There must be some cause for this difference.

In some microscopic sections of an infected muscle one can see all stages of the change from normal striated fibres to the totally disorganized. The appearances are seen in sections in which the bacteria are scanty or absent and in which the amount of the separation of the fibres—presumably by gas—varies in great degree. The change in the muscle fibre may, therefore, be due either to some toxin produced directly or indirectly by the bacteria.

Both D'Este Emery and Taylor seem disposed to credit some action to this source. Taylor is of the opinion that the bacterial exo-toxin is not powerful enough to account for the constitutional symptoms and suggests that these are due to toxin produced by disintegration of the muscle substance by the bacterial toxin. He does not suggest it, but it seems possible that the toxic muscle substance produced in the traumatized portion of the muscle may be carried into the more distal parts of the muscle and cause its death.

(2) Parts played by the Gas.—These may be divided into two categories: (a) The part it plays within the limb; (b) the part it plays within the muscle.

One of the most striking and most important signs of gas infection is the tense and tympanitic state of the limb and the rapidity with which this condition is reached.

There is nothing but the rapid evolution of gas that could bring about such a condition in so short a time. An incision into such a limb shows that the increased tension is caused by the swelling of the muscle due to the gas within it. There may be gas in the areolar planes, but this is not usually the case to any degree. It has been pointed out that a muscle may be dead and full of gas and yet not crepitant to the finger; if, therefore, crepitation is taken as the criterion of gas infection a mistake may be made and a gaseous muscle passed as a non-gaseous one.

When the gas is present in the areolar tissue it follows the path of least resistance and finds its way along the intermuscular planes and around the vessels. It will disseminate itself into the subcutaneous tissue a considerable way from the wound.
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It has been stated above that in a segment of a limb that has been wounded it is only the wounded muscles that yield to the infection in the first instance. The injured muscles will induce a deleterious effect on the uninjured one by raising the intrafascial pressure of the limb, and thus causing pressure on the blood-vessels and consequent checking of the circulation. Even if the areolar planes are grossly infected they cannot influence the pressure in the limb, since the muscle sugar is necessary for the production of gas.

Taylor is of the opinion that the pressure of gas within the muscle itself leads to disintegration of the muscle-fibre substance.

The pressure produced by the gas will in addition tend to drive the toxins into the circulation, and thus be a factor in the production of the systemic poisoning and lowering of the resistive power of the body.

D'Este Emery, in combating Taylor's contention that the gas production plays an important part in the disease, says: "Gangrene may occur and the patient may die without the formation of any gas in the tissues." This statement is opposed to what is seen of the disease in the Casualty Clearing Station. The great sign on which reliance is placed is the swollen and tympanic condition of the limb, usually preceded by constitutional symptoms. What can cause such sudden swelling unless it be gas? In such cases there is no crackling or crepitation to the finger palpating the skin. An examination of the muscles that have suffered the "red-death" may even yet reveal no crepitation, but microscopic sections of such non-crepitant muscles show the fibres separated from one another and the spaces often free from leucocytes and bacteria.

Men who die of the effects of gas gangrene in the casualty clearing stations die before there is any marked suppuration. It may be that the suppuration and involvement of the fascial planes is seen after the patients have left the Front, being a later manifestation of the disease.

The Path of the Infection, when an Unwounded Segment of a Limb from which the Blood Supply has been Cut Off Becomes Infected.

When a muscle has been wounded the method of infection is obvious. The path of the infection is not so obvious when there is no wound. For instance, the leg below the knee will become infected when the femoral vessels are occluded, although there is
no wound in the leg proper. There seem to be three possible avenues:

(1) Direct extension.
(2) Extension along the blood-vessels.
(3) Systemic infection.

(1) The anatomical appearances do not favour this route. The only muscular tissue that crosses the knee is contained in the two heads of the gastrocnemius. It has been pointed out above that direct extension to an intact muscle is rare, and as a matter of fact the soleus and gastrocnemius are the last muscles to become infected and die. The appearance of the fascial planes does not suggest them as the path.

(2) Possibly the infection travels inside the vessels—just before or after the circulation has ceased, the open ends of the vessels on the infected wound being the starting point. H. Dunn has found the aerogenes bacilli in the clotted vessels in the brain after a wound of the carotid artery.

(3) Mullally and McNee have pointed out that gas formation may take place at the sites of subcutaneous and saline injections, the slight trauma being sufficient to afford a resting-place for the bacteria circulating in the blood. Case VII and Case IX above quoted point in the same direction. It is, therefore, possible that bacteria in the blood are implanted in the distal segment of the limb before the circulation is quite brought to a close. It may be that they first gain a footing in the muscles mostly affected by the cutting off of the main blood supply and by the production of gas within them finally and completely arrest the blood-stream.

Conclusions as regards treatment.

(a) The circulation should be helped in every way. It is unnecessary to insist on the bad effects of tight bandages and tourniquets—they are appreciated now by all. Tension in a limb due to blood effusion should be relieved, no matter how small the wound. Bleeding from a small branch may produce pressure on the main vessel and even without this may cause such pressure as to embarrass the circulation. In cases where haemorrhage into a limb is continuing there is no doubt as to the advisability of finding the bleeding point. If the artery is a main one an attempt should be made to suture instead of to ligate the vessel.

Suture also would seem to be worth trying when a main vessel is locally thrombosed from the effects of trauma. If there is
difficulty in bringing the cut ends of the vessel into apposition a
Tuffier's tube may be tried.

Injuries of the popliteal artery are so uniformly followed by
gangrene, if the vessel is ligated, that every means should be tried
to re-establish the lumen, even if for a few hours.

In the case of circumscribed arterial haematoma accompanying
a small wound of the limb, time alone can show if an attempt to
suture the artery is good. One should most probably be guided
by the state of the circulation in the distal portion of the limb.

(b) In dealing with gas gangrene in a wounded segment of a
limb and deciding on the advisability of amputation, it should be
borne in mind that it is usually only the wounded muscles that
become gaseous, and that incision or ablation of such muscles is
often sufficient to arrest the disease and stop the infection (see
Case 6).

In the case of the thigh the ablation of muscles may present
difficulties, but in the leg this part of the limb can often be saved
by the ablation of the anterior tibial group, and the same applies
to the muscles of the forearm. The brick red colour and the non-
contractility will show at once which muscles are past saving.

(c) When gas gangrene occurs in a segment of a limb distal to
the segment wounded it nearly always means that the main
artery is blocked and amputation of the gangrenous segment is the
only course.

(d) The presence of crepitation in tissues apart from other
signs is of no special importance. A limb should not be sacrificed
on account of crepitant skin (see Case 2). The state of the muscles
and the number dead should be ascertained before amputation is
performed, otherwise a limb or a very considerable portion of its
length may be sacrificed unnecessarily.

The disease is the great bugbear of the surgeon at the Front.
It involves much labour and complicates the evacuation of the
wounded. It occurs in all sorts of wounds, whether small or large,
and with all sorts of projectiles. There is no wound, however
insignificant, that one can feel happy about if not opened up. It
is true that the disease is not so dangerous now as it used to be,
because of the universal opening up of wounds, but the amount of
trouble that it entails, and the amount of disturbance that it is
necessary to inflict on a grievously wounded patient, makes one long
for some remedy other than surgical interference.