upon lead us to suggest that selective observation can be applied effectively and safely to the management of gunshot wounds of the abdomen. The percentage of patients who will be spared laparotomy will be smaller for gunshots than for stabs (60% vs 18%). Nevertheless, two-thirds of the 138 patients in this series who had a negative exploration would have been spared an unnecessary laparotomy had a policy of selective observation been in effect.

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Discussion

Dr. Gerald W. Shaftan (Brooklyn): My former Chief, Dr. Clarence Dennis has long insisted that operation was but a part of surgery; that the surgeon was a well-trained physician who also knew how to operate. It is not too chauvinistic, therefore, to suggest that the general, pediatric, cardiovascular, and thoracic surgeons each know at least as much about the disease processes they see as their internist colleagues. I feel it is reasonable, therefore, to make a plea for not treating civilian penetrating type injuries of the abdomen, even gunshot injuries, by dogma or dictum, as if we were mere surgical technicians.

The better shield, however, is hard facts. We agree entirely with Dr. Nance, and with other authors, that gunshot wounds are comparatively easy to evaluate clinically, and that the decision to operate can be made rapidly and accurately on these grounds alone.

In this earlier study we only operated upon two thirds of the patients with gunshot wounds. Our current reappraisal is not dissimilar in age and ethnic background from the author's series, and gunshot wounds have become a prominent part of our local battle casualties.

I read in *The New York Times* on Sunday that our outgoing Mayor has complained that the "Saturday night special" factories in Florida, Georgia, South Carolina and Virginia have put a least a quarter of a million illegal handguns into service in New York City; so that, while in 1960 out of 390 total homicides only 19% were due to bullet wounds, in 1972 handguns accounted for 49% of 1691 homicides.

Our injury rate follows suit. In 1960, one in twelve penetrating type wounds was gunshot. In 1973, five out of nine were due to bullets. Despite this increase, on average we are operating on a smaller percentage than in our previous series, and we still have no morbidity or mortality in those treated without operation.

The operated percentage varies, of course, from year to year, but on the whole New Yorkers, obviously, are just poor shots. Perhaps, however, our local gun club is getting better, because so far this year we have operated on 92% of the gunshot injuries that we have seen.

The point that Dr. Nance has modestly suggested, and which I exhort, is to examine each patient and think. I do not suggest that each of you jump into it with both feet, but that the first time that you find your clinical judgment correct, you will be

hooked. You will no longer operate just because there is a penetrating-type wound. You will operate because as a well-trained clinician you know that the patient requires your surgical skills.

DR. FRANCIS C. NANCE (Closing discussion): I have one slide to show of our experience since June in a series of patients with gunshot wounds who have been observed. (Slide) These are the eight patients since June who have been observed with gunshot wounds on a prospective basis. None of them has suffered a serious complication, although one patient did have a fever associated with a right pleural effusion.

I'd also like to bring you up to date on a patient that we have been following now for the last eight years. This is a patient who was residing in parish prison in New Orleans, and discovered that if he stabbed himself, he would be explored at Charity Hospital and have five or six days of comfort in a Charity Hospital bed. And as you can see, on the 12th of June, 1966, he stabbed himself with an ice pick and was explored, with no indications; two weeks later, again an ice pick, and again explored, no indications; a month later, again no indications. And six times within six months he stabbed himself, got six explorations. At no time was there an indication for surgery. The last two times the small bowel was injured by the surgeon taking down the adhesions from the previous operations.

We then initiated our protocol, and managed to shortstop him in the accident room twice. We pulled a weapon fashioned from a coat hanger out twice. But since then he has appeared three times in our accident room and has persuaded the house staff that he needed an exploration. Again he got his small bowel injured getting adhesions taken out.

On his last admission he appeared at our Charity Hospital in Baton Rouge and caught the boys unaware with a coat hanger sticking all the way through his abdomen. They explored him, and did find that he had finally penetrated a piece of small bowel with the coat hanger.

This fellow has provided us with 1% of our total experience with stab wounds.