HISTORICAL PERSPECTIVES OF THE AMERICAN ASSOCIATION FOR THORACIC SURGERY

WYMAN WHITTEMORE (1879-1957)

Wyman Whittemore, twelfth president of The American Association for Thoracic surgery, was born in Cambridge, Massachusetts, April 6, 1879. Raised in the Boston area, he prepared for Harvard College (S.B. 1901) at St. Mark's School. He graduated from Harvard Medical School, cum laude, in 1905 and promptly received an appointment to the surgical house staff of the Massachusetts General Hospital. Two years later he began what amounted to his apprenticeship to two senior surgeons on the visiting staff of that hospital. Busy general surgeons, they were happy to leave thoracic surgical problems to their colleague Sam Robinson, who had, with the support and encouragement of his chief, J. Collins Warren, spent 4 months with Sauerbruch and Brauer in Marburg. Known for his work in positive-pressure anesthesia, and a pioneer in the management of bronchiectasis and tuberculosis, Robinson had created a clinical research environment that attracted Whittemore's interest. When, therefore, in 1912 for reasons of health Robinson left Boston for Clifton Springs and later the Mayo Clinic and Santa Barbara, Whittemore was ready to fill the gap. For the next 15 years he was the sole surgeon for the Thoracic Clinic until the summer of 1927 and Churchill's return from his Wanderjahr in Britain and Eastern Europe.

By the early twenties, Whittemore's position on the surgical staff was assured. He was highly regarded as an operating surgeon devoted to his patients' welfare. Careful and conservative by nature and training, he was willing gingerly to take on the challenges of bronchiectasis and lung abscess and cautiously to explore the possibilities of thoracoplasty for tuberculosis. He was not the innovator that Robinson had been, and his conservatism at times bothered Churchill, but Whittemore was no mere "gifted amateur."

In June 1919, at the Second Annual Meeting of The American Association for Thoracic Surgery, Whittemore read a comprehensive paper on the operative management of acute empyema, a personal, operative series of 100 consecutive patients. It is interesting to find him ready to recommend, if the patient did not appear too septic, Lilienthal's operation, which very much resembled decortication of the lung as popularized during World War II and a bold move in those pre-antibiotic days. The operation, of which Whittemore reported 14, consisted of a long, lateral intercostal thoracotomy—mechanical spreading of the ribs—removal of all pus, fibrinous debris from the pleural space, and constricting membrane from the lung—expan-

sion of the lung under direct observation—and in his hands, tight closure of the chest. Of the 14 patients, 11 fared "brilliantly;" one, an infant, died after convulsion; two had recurrences. Balanced against these 14 were 54 of 66 patients who did well after trocar thoracotomy followed by a careful program of suction and irrigation through a tightly sewn-in-place 22F catheter. Four in the trocar thoracotomy group died.

In the next 10 years, Whittemore contributed a series of well-thought-out, surgically orthodox reports on the treatment of empyema, including empyema complicated by chronic suppurative bronchiectasis and lung abscess, which added the new dimensions of invasive pulmonary sepsis and bronchial healing. Whittemore had very little to say on the subject of cancer of the lung, leaving that to Churchill, but he did involve himself in thoracoplasty and collapse therapy for tuberculosis. He believed that their benefits were so self-evident that sanatoria should develop major surgical capabilities, including a well-trained surgical staff that would allow the procedures to be carried out in the sanatoria.

When it came to the matter of resection for nontuberculous pulmonary infection and the race to develop safe lobectomy, Whittemore had his own entry, generally known as exteriorization lobectomy, less elegantly as strangulation lobectomy. An excellent sense of the frustrations that beset the race to develop safe lobectomy and pneumonectomy can be found in Mead's encyclopedic *History of Thoracic Surgery*. Every clinic had its solution to a part of the problem and a few overall successes to keep the race alive.

Whittemore presented his exteriorization lobectomy to the American Surgical Association in May of 1927. He made it clear that he was dealing with suppurative bronchiectasis limited to one lower lobe, a condition that called for limited extirpation. Amputation of a lobe within the pleural cavity, however, in his hands had carried a prohibitive mortality—one survivor among six patients operated on. For a year and a half, therefore, he had used a new strategy in five patients with *lower lobe* disease.

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Under general anesthesia, the pleural cavity was opened and the intrapulmonary disease evaluated. If disease was limited to the lower lobe and the adhesions not too firm, lobectomy was decided on. Enough ribs were removed so that the diseased part of the lobe could be delivered from the pleural cavity once the adhesions and the pulmonary ligament were divided. The lung was firmly sutured to the muscles of the chest wall with chromic catgut and heavy linen thread, taking very deep stitches into the lung tissue. A 20F catheter was placed to the root of the lung and the wound closed as tightly as possible. Nature was then allowed to take its course. In about 10 days the lobe became dry gangrene, which then gradually became a profuse, foul discharge, and in 4 or 5 weeks the whole area sloughed off, leaving a healthy, granulating stump with small bronchial fistulas. The wound was then packed daily for 3 to 4 months. In two patients of the five, complete healing occurred; one patient, aged 19 years, was able to return to work but had a persistent bronchial fistula; one

patient had been operated on only 6 weeks before the report was made and was doing well; one patient, aged 9 years, died of contralateral pneumonia 10 days after the operation. The series ends here, for at this time Whittemore had a severe head and neck injury, the result of a riding accident, which effectively ended his operating career. His successor, E. D. Churchill, was much more interested in individual ligation technique.

In 1934 Whittemore asked to be relieved of his hospital assignments. With his talented wife he retired to an old Shenandoah Valley farm, which they restored. "There are nearly a thousand acres," he wrote to his fiftieth Harvard Reunion report, "and we are all kept busy and contented producing the steaks and roasts you all like to buy." After two cerebrovascular accidents, a fractured hip, and the medical indignities of age, he died of a painless coronary infarction, January 26, 1957. He was 78 years old.

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