HISTORICAL PERSPECTIVES OF THE AMERICAN ASSOCIATION FOR THORACIC SURGERY

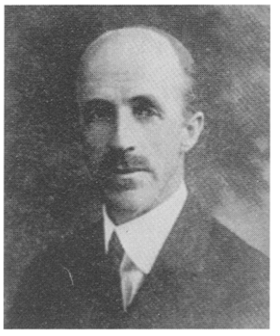
SAMUEL ROBINSON (1875–1947)

Sam Robinson, fourth president of The American Association for Thoracic Surgery, was born and raised in Augusta, Maine. After graduating from Harvard College and then Harvard Medical School in 1902, he went directly to the Massachusetts General Hospital as house pupil, followed by a junior staff appointment. His early interest in patients requiring thoracic surgery and his extra effort to work in the physiology laboratories of his contemporary Walter Cannon caught the eye of his chief, J. Collins Warren. Warren made it possible for him to spend 4 months overseas in von Mikulicz's clinic, where Sauerbruch and Brauer were doing their brilliant studies of differential pressure for open thoracotomy. Returning to Boston in 1908, Robinson was encouraged to pursue his interest in the embryonic specialty of thoracic surgery and was given responsibility for the hospital cases of empyema, bronchiectasis, chest wall tumors, tuberculosis, and "the patriarch of the surgical scrap heap," chronic empyema.

One of Robinson's urgent projects on returning home was to construct an ingenious apparatus similar to Brauer's for maintaining *positive* pressure in the lungs during thoracotomy, diametrically opposed to Sauerbruch's negative-pressure chamber. Sam Robinson enclosed the anesthetist and patient's head in a relatively small positive-pressure cabinet, thus giving the operating team much more room to maneuver than was possible in Sauerbruch's (and later Willy Meyer's) chamber. In any event, both methods soon gave way to intratracheal ventilation. Sam Robinson's box was lost without trace but not Sam, who at this time coauthored on equal terms with Sauerbruch two important papers on the technique of pulmonary resection.

Robinson's first lobectomy in 1909 for bronchiectasis was a multistaged affair completed 10 months after an initial drainage, a subsequent unroofing procedure, a first stage, and finally removal of the lobe and eventual recovery. By 1917, Robinson, then in his prime at the Mayo Clinic, had performed seven lobectomies for bronchiectasis with three deaths; this record is comparable with Howard Lilienthal's of New York—nine lobectomies with four deaths.

Robinson had other irons in the fire, most notably artificial pneumothorax in the treatment of pulmonary tuberculosis. The original credit, of course, goes to Forlanini (1882) and later to John B. Murphy and Brauer. Robinson worked closely with his medical colleagues, Cleveland Floyd and Gerardo Balboni, who was fluently conversant with the Italian literature. Their report to the Clinical and Climatological Society in 1912 is a sobering picture of tuberculosis in young people. Although only 12 of their 28 patients survived, their report is an important milepost in collapse therapy for pulmonary tuberculosis.



Courtesy of the Harvard University Archives.

When Robinson assumed clinical responsibility for the patients with diseases of the chest on his return to the Massachusetts General Hospital from abroad, of the first 51 seen, 31 had acute empyema. In their treatment he emphasized early reexpansion of the lung by simple tube and external suction, followed by open drainage of residual spaces if need be. Chronic empyema was a different matter. In 1916 Robinson reviewed the steps in its management: accurate roentgenographic diagnosis with contrast media, staged drainage, and finally obliteration of the infected space by thoracoplastic procedures including Schede thoracoplasty as a last resort.

Plagued by recurrent bouts of bronchial infection, Sam left Boston in 1912 to join his surgical mentor, James Mumford, in his move to Clifton Springs, New York. When the latter died in 1915, Robinson was granted a surgical appointment at the Mayo Clinic where he became, in effect, its first thoracic surgeon. Three years later he entered army service at Letterman General in San Francisco. However, his activities were so greatly handicapped by a recurrence of bronchopneumonia that he sought the benign climate of Santa Barbara, recognizing that "In practicing surgery in a small community, I am resigning all hopes of distinction in my profession. Better health is my consolation, however."

Robinson carried on an active practice of general surgery in Santa Barbara until his death in 1947. He played an active role in the founding days of The American Association for Thoracic Surgery and was elected its president in 1921, although he no longer took part in the thoracic surgical scene. Robinson was a brilliant writer and observer of surgical disease—imaginative, colorful, and sympathetic. Years later, reflecting on the Boston scene and his own career, Edward Churchill wrote, "If Sam Robinson had kept his health . . . the Massachusetts General Hospital [in the twenties] would have been a creative center for thoracic surgery on this continent." The irony lies in the evidence that bronchiectasis lay at the root of Sam's problem.

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