

A CASE OF

ACUTE INTESTINAL OBSTRUCTION COMPLICATED WITH PERFORATING ULCER OF THE DUODENUM; DEATH IN TWENTY-FOUR HOURS FROM COMMENCEMENT OF SYMPTOMS; NECROPSY.

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THE history of this case, which, owing to its rare occurrence so far as the perforating ulcer is concerned, may prove interesting, is as follows:—

The patient, Charles C—, a shoemaker by trade, also acting as town postman, aged twenty-eight, of very active habits, had been under my care periodically for about five or six years always complaining more or less of acute pain in the region of the epigastrium, not sufficient to invalid him. Latterly the attacks have been much more frequent, and have always assumed the character of gastric catarrh. The pain was always relieved by a simple alkaline mixture or soda-mint tabloids. On the evening of Sunday, April 27th, I was sent for to see him, when I found him in bed suffering most acute abdominal pain. He had travelled some miles in the morning of the same day upon his bicycle, and upon his return home to dinner his wife remarked that he looked "done up." He, however, was able to eat his dinner as usual, and attended church in the evening, after which he had a short walk. It may be as well to state that he had a fall from his bicycle on the previous night (Saturday), and, in fact, it is stated that he had met with several falls of late from his bicycle, but did not complain of anything more than a shaking. The acute attack commenced by his feeling, quite suddenly whilst eating his supper, a sharp, lancinating pain over the epigastrium, an inch or so beneath the ensiform cartilage; he at once desisted from any more food and went to bed. It was at this period that I saw him first. The abdominal pain was accompanied by persistent vomiting, with severe pain between the shoulders. Pulse 100 and weak. Bowels not relieved since the morning of the previous day, which irregularity was unusual for him. I prescribed an anti-spasmodic mixture and ordered hot fomentations to be constantly applied to the abdomen.

On April 28th I visited the patient at 7 A.M., when I found an aggravation of all the symptoms except the vomiting, which had abated for some hours. Pulse 120, very weak; urine scanty, abdomen tympanitic; knees drawn up in the bed, and the countenance assuming that anxious expression so well known in cases of abdominal mischief. An ounce of castor oil with ten minims of tincture of opium was prescribed; also milk and soda-water, with an occasional two-drachm dose of brandy, either in milk or soda-water, to combat the extreme collapse. Hot fomentations to be continued to the abdomen, with hot bottles to the feet. At 10 A.M. there was no abatement of the acute abdominal pain. Mouth very much parched, and patient suffering extreme thirst. No relief from bowels. Two-thirds of a grain of extract of opium was now prescribed in the form of pill, to be taken every four or six hours according to the urgency of the symptoms. At 1 P.M. an enema containing castor oil, tincture of assafoetida, and turpentine was now thrown well up the rectum, with instructions for it to be retained as long as possible. At 4 P.M. the bowels were fairly well relieved. Urine scanty and high coloured. There was now a slight abatement in the severity of the pain both in the abdomen and between the shoulders, but the symptoms of collapse and shock were as severe as ever. Pulse very quick and thread-like. Heart's action irregular. At 8.30 P.M. the patient had a return of the acute abdominal pain, the bowels had also acted slightly, the matter passed consisting of nothing more than a small quantity of mucus. The radial pulse was now quite imperceptible, face and chest bathed in a cold clammy perspiration, collapse being most complete; patient perfectly conscious of all going on around; intense thirst, relieved by milk and soda-water in small quantities. At 9 P.M. I left the patient for the night, with instructions that I should be called if occasion required. At 9.45 P.M. I received an urgent message to attend. Upon my arrival I found the patient dead. He had asked for a

small quantity of milk-and-brandy only a few minutes previously, as he felt faint, after which he fell back in the bed and expired, without any evidence of suffering.

Necropsy, conducted twenty-one hours and a half after death.—Face bore a placid expression. A good deal of post-mortem discolouration upon the face, upper extremities, chest, &c. Rigor mortis very well marked. Upon opening the cavity of the thorax, a considerable quantity of serous fluid escaped from the anterior mediastinum. The heart was perfectly healthy, as also the great bloodvessels proceeding from it. The left ventricle was perfectly contracted and quite empty, the right ventricle contained a small quantity of frothy, venous blood; both auricles were empty. The lungs presented no evidence of organic disease, but were slightly congested. Upon opening the cavity of the abdomen there was an escape of a considerable quantity of fetid gas, also a large amount of deep amber-coloured serous fluid. The stomach was dilated and contained a quantity of fetid gas, together with a quantity of grumous-looking fluid mixed with bile. Its mucous coat was more or less congested in patches, with a certain amount of thickening; there was no sign of ulceration or perforation of this organ. At some two and a half inches distance from the pyloric orifice of the stomach, on the anterior surface of the duodenum, there was a distinct perforation of the bowel, about the size of a small kidney bean, oval in shape, with smooth edges, the contents of the bowel being found effused into the peritoneal cavity in the immediate neighbourhood, the peritoneum in the vicinity of the perforation bearing distinct evidence of inflammatory action. Upon tracing the bowel downwards to about the centre of the small intestine (jejunum), a complete obstruction was found, the bowel being twisted, so to speak, upon itself, and held in its abnormal position by a mesenteric band. The bowel was of a dark-claret colour, and there was evidence of commencing gangrene, the whole intestine from this region downwards being intensely congested and discoloured, the vessels showing up of a bright-red tint. The liver was slightly congested, and of a somewhat darker colour than natural. The other abdominal organs showed no sign of organic disease.

Remarks.—The diagnosis in this case when I was first called in upon the Sunday evening was somewhat obscure; but on the following morning I felt convinced that there was intestinal obstruction, notwithstanding the fact that the vomiting had never assumed a stercoraceous character, and subsided entirely about eight hours from the commencement of the symptoms. The temperature was never to any appreciable extent above the normal. The extreme collapse and shock, terminating so rapidly in death, could only be accounted for by the perforation of the bowel.

Clare, Suffolk.

SPASMODIC TORTICOLLIS TREATED BY NERVE LIGATURE;

COMPLETE AND PERMANENT RECOVERY.

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As there are few cases on record where surgical interference has resulted in more than temporary benefit in spasmodic wryneck, I hasten to publish the following case in the hope that the same treatment may be the means of bringing relief to other sufferers. Nothing is known worth repeating of the pathology of this affection, consequently up to the present the treatment has been entirely empirical. Drugs of various sorts have occasionally done good, and nerve-stretching and resection have been resorted to in most cases with but temporary benefit. In dealing with the following case it occurred to me, looking at the facts of the case—namely, an excessive intermittent and irregular discharge of energy along the spinal accessory nerve—that by the introduction of increased resistance in the course of the nerve, and possible deflection of some of this energy into structures other than the sterno-mastoid and trapezius muscles, an abatement or cure of the trouble might result.

A. W—, a fairly healthy-looking girl aged twenty-one, daughter of fruit growers in Kent, was brought to me in January, 1889, by Dr. Sutton of Sittingbourne. She was

a well-developed, intelligent girl, with a family and personal history remarkably free from any neurotic or other complaints. Her affection dated from 1883. It had gradually supervened, and culminated in a most distressing state of things, the head being so extremely rotated as to bring the left ear with sudden jerks into a line with the sternum. This took place every few seconds, not altogether ceasing, although less violent during sleep. With regard to treatment, she had been dosed with drugs innumerable, galvanised, blistered, her tonsils removed, and the galvanocautery applied to the back of the throat, without beneficial results. I sent the case to St. Thomas's Home, and there, with Drs. Edmunds and Sutton's valuable assistance, had little difficulty in finding the spinal accessory nerve emerging from the outer border of the sternomastoid muscle. Taking the nerve as a guide, I tunnelled through the muscle for some distance, using a moderate amount of traction on the nerve, but avoiding injury as far as possible to the muscle. This done I placed a loop of silver wire round the nerve as high as I could reach, just twisting the ends to ensure slight compression. The wound was treated in the usual way, the ends of the loop protruding. On recovering from the chloroform the spasms had entirely ceased. The wound subsequently healed by first intention, without pain or discomfort in any way. After a fortnight the patient returned to her home in Kent. At the end of three months she visited me, still without the smallest return of the spasms, and much improved in health. Nothing seemed amiss with the sternomastoid or trapezius; she could rotate her head, and retain it in any position. I cut off the ends of the loop as close as possible, so as to allow the skin to grow over them. I have not seen the patient since, but learn from time to time from Dr. Sutton that she remains perfectly free from a return of her troubles. I append a letter lately received, indicating her present condition.

"Chesley, Newington, April 5th, 1890.

"Dear Mr. Collier,—I thought you might like to know how I am progressing. Am pleased to say I am feeling quite well, and have just returned from Cranbrook, where I have been on a visit for the last three weeks. I have also been to several dances this winter. So you see I am much stronger, and can keep upright.

"Believe me, yours sincerely,

"A—W—.

"Mr. Collier."

New Cavendish-street, W.

A Mirror OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. THOMAS'S HOSPITAL.

INVERSION OF THE UTERUS, DUE TO A LARGE POLYPUS; SUPERFICIAL NECROSIS OF BOTH UTERUS AND TUMOUR; SUDDEN EXTRUSION OF THE ENTIRE MASS THROUGH THE VULVA; REMOVAL OF TUMOUR, WITH SUBSEQUENT REDUCTION OF THE INVERSION; REMARKS.

(Under the care of Dr. CULLINGWORTH.)

THIS is an excellent example of the reduction of old-standing inversion of the uterus by the elastic repositor, after the removal of a fibroid tumour on which the inversion depended. The account is given at some length because of the unusual character of the case. For references to the literature on the subject we refer our readers to the remarks appended to it.

A married woman, aged forty-five, was admitted to St. Thomas's Hospital on April 9th, 1890. She was extremely blanched and in a state of collapse, the pulse at the wrist being scarcely perceptible. Protruding from the vulva was a large solid mass, ulcerated and suppurating over its whole surface, and giving off a highly offensive odour. The tumour, vulva, and inner parts of the thighs, as well as the clothing, were covered with discharge mixed with blood. The account was that sixteen months previously she was told she had cancer of the womb, that she had had a foul discharge ever since, and that three days

ago, whilst walking in the street with a child in her arms, she was suddenly seized with severe pain low down in the abdomen, felt something force its way out of her body, found herself drenched with blood, became faint and giddy, and had to be taken home in a cab. For some months she had been aware that there was a lump, for she had been able both to feel it and see it; but until this occasion it had never become completely extruded. A doctor endeavoured to replace the procident mass, but without success. During the three days that had since elapsed there had been continuous loss of blood. The resident officer on duty (Mr. Low), after washing the extruded mass with a solution of mercuric perchloride, returned it within the vulva, and subsequently admitted her.

On admission, her temperature was subnormal, 96°; her pulse 136, very small and feeble. Next day she had rallied somewhat, and the following additional particulars of her history were obtained. The catamenia commenced at the age of twelve; the patient had married at twenty, and had borne five children, of whom the eldest was twenty-five years of age, the youngest nineteen. She had had no miscarriages. Her present illness began three years ago, with irregular and profuse hæmorrhage. She became weak and pale after the attacks, and frequently suffered from pain around the loins and down the legs. About eighteen months ago there commenced to be a continuous watery, fetid, blood-stained discharge. About the same time the patient began to suffer from pains, like labour pains, and a constant sensation as of "something wanting to come away." She was examined by her own doctor, who told her there was something hard in the womb that ought not to be there. Shortly before Christmas, 1888, she applied for admission at a hospital for women. The doctor who examined her said that she was suffering from cancer. She was taken to the Middlesex Hospital, but left of her own accord in three days, before any examination had been made.

Dr. Cullingworth saw and examined the patient on the day following her admission. Finding the mass in the vagina smooth, comparatively soft, and lobulated, he placed her in the dorsal position on the operating table, and, seizing the tumour with two volsellæ, drew it outside the vulva for inspection. It presented the appearance of an oblong tumour, the surface of which was ulcerated and covered with an extremely fetid purulent discharge. At its base of attachment it seemed to be continuous all round with the walls of the vagina, without any intervening groove or sulcus. The upper portion of the mass was somewhat softer, and of a more livid hue than the lower, the division between the two being marked by an ill-defined and very shallow groove which ran all around the mass, at about the middle of its length. A nodule of firm consistence projected from the lower end of the mass on its left side. This nodule had a diameter of five-eighths of an inch. The diagnosis was: Complete inversion of the uterus, with a fibroid polypus attached by a broad base to its fundus, the exposed surface of both uterus and tumour being in a state of superficial necrosis. On bimanual examination, with one finger in the rectum, the body of the uterus was found to be absent from its normal situation. A sound introduced into the bladder could be felt distinctly by the finger in the rectum immediately above the vaginal roof. Passing from the vaginal roof upwards and outwards on each side was a thick tense band, evidently consisting of the broad ligament put greatly on the stretch. The roof of the vagina was not depressed. By means of a scalpel a transverse incision was there and then made across the tumour, about half an inch below the shallow groove already mentioned, and, as the interior was found not to be very vascular, the incision was carried completely through it, and the greater part of it thus removed. The outer covering of the remaining half-inch of the growth was now peeled up, and the base enucleated from the fundus uteri by means of the fingers. At its centre a band of tissue less than half an inch in diameter passed from the growth directly into the fundus; this stalk was divided with scissors, and the capsule which had been peeled off from the base of a tumour was also cut away. The inverted uterus was now left free from the growth. To check the oozing from the raw surface four silk sutures were passed beneath it and tied, so as to fold it upon itself. This at once stopped the bleeding. The vagina was then douched with a weak solution of corrosive sublimate. The uterus, still inverted, was replaced within