

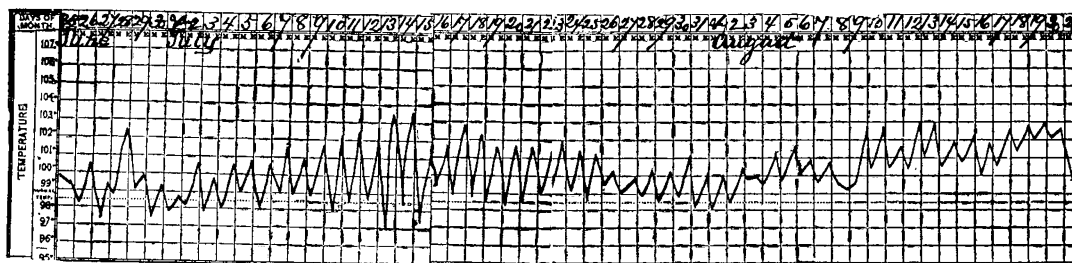
TWO CASES OF TUBERCULAR INTESTINAL ULCERATIONS AND GENERAL TUBERCULOSIS.

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REPORTED BY CHARLES W. TOWNSEND, M.D., Medical House Officer.

CASE I. P. C., aged forty-seven, entered the hospital, June 15th, 1885.—Mother and two sisters died of consumption. Patient's previous health excellent; occupation, night-watchman; habits good; no venereal or malarial history. For the last three years has had attacks of abdominal pain, at first at intervals of several months, but at less and less intervals lately, and for a week has had attacks nearly every day. The pain is diffuse and severe, lasts from half an hour to

present. Head not opened. Right pleural cavity contained one and one-half pints of clear serum; left pleural cavity nearly obliterated by old adhesions. A small cavity the size of a cherry-stone with ragged, cheesy walls at the apex of left lung. Both lungs œdematous and studded with numerous miliary tubercles. Pericardium contained six ounces of clear serum. Heart pale, normal. Peritoneal cavity contained one and one-half quarts of clear serum; a few old adhesions in left iliac and lumbar regions. Miliary tuberculosis of mesentery. Beginning ten feet below the stomach, twenty-seven large tubercular ulcers were to be counted in the small intestine, besides numerous small ones, one involving nearly the whole cœcum and one in the



several hours, and is generally preceded by the rumbling of intestinal gas and distension of abdomen. It is not relieved by pressure; never jaundiced; bowels inclined to constipation. Slight cough without expectoration for three years. Has lost fifteen pounds in weight in the last two months.

Physical examination: patient is pale, fairly nourished; tongue slightly coated; a few moist râles heard at left apex in front after cough; percussion note, voice sounds and respiratory murmur normal. No abdominal tenderness and nothing abnormal to be felt. Urine normal.

During the first two weeks after entrance, the patient had several attacks of abdominal pain, after which, with the exception of slight attacks in the first week of August, he was entirely free from pain. A symptom which does not appear in the history now showed itself, namely, a sensation of chilliness sometimes accompanied by slight shivering, about noon, followed by a feverish feeling in the afternoon without sweating, and by a rise of temperature, as shown by the chart, the highest evening temperature being 103.8° on the 14th of July. An hourly chart shows a gradual rise of temperature from nine in the morning, the maximum point being generally reached at four in the afternoon. Quinine had apparently no effect. For a month before death, the patient had from two to four loose, sometimes liquid dejections daily, uncontrolled by astringents and opium. At first able to walk about the hospital yard, the patient grew gradually weaker, but kept to bed for a week only before death.

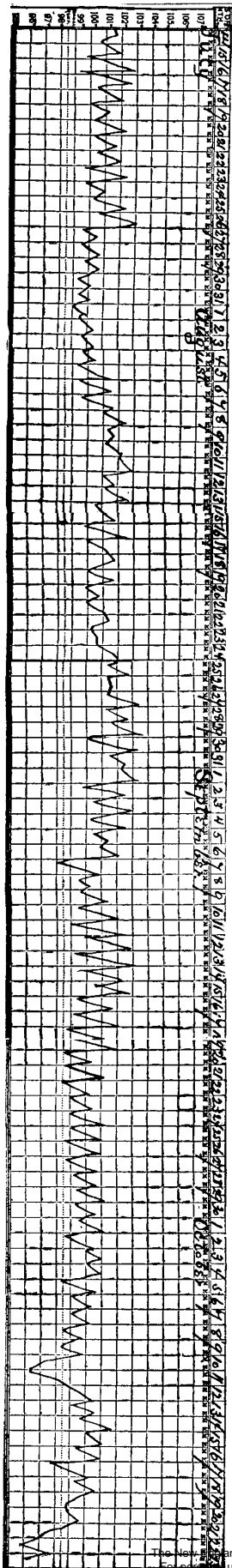
August 18th, there was slight œdema of feet and legs. Moist râles as before at the left apex, and in the lower third of both lungs, front and back. Heart sounds feeble, but otherwise normal; increased area of hepatic dullness and tenderness in right hypochondrium. On the day before his death, moist râles were to be heard in abundance throughout both lungs, and there was evidence of peritoneal fluid. Respirations became more rapid, pulse small, but consciousness was retained to the last, death taking place August 21st.

Autopsy twenty-one hours after death, rigor mortis

middle of the large intestine. Liver enlarged and fatty degenerated; spleen small; kidneys and bladder normal.

CASE II. J. T., aged thirty-four, entered the hospital July 14th, 1885. Family history good. Previous health good, with exception of frequent "colds," for one of which he was in the hospital fifteen years before, the diagnosis being bronchitis. Constant slight cough for six years, with thick yellowish-white expectoration; no hæmoptysis. Feeling poorly for three months, has had five or six watery dejections daily for the last two weeks, and a constant, dull, diffuse pain in abdomen; no tenesmus; no blood or mucus in dejections; no headache, vomiting, or chills; progressive loss of flesh and strength in the last month.

Physical examination: Patient is pale, fairly nourished; tongue slightly coated; numerous moist râles heard at the left apex, both in front and behind; percussion note, respiratory murmur and voice sounds not modified at this place as compared with opposite side. Abdomen soft, not distended, slightly tender on pressure in right iliac and epigastric regions; gurgling detected. Patient was put on milk diet, with the addition later of stimulants, given opium for diarrhœa, and kept in bed. The diarrhœa continued unchecked, pain in abdomen was only occasional and slight, and emaciation rapidly showed itself. During the latter part of September, he was able to be up and about the ward part of the day, and was allowed to have soft solids besides liquids at frequent intervals, but his temperature still continued to go up to 102° or 103° at night, as shown by the chart. For three weeks before death, he frequently complained of a feeling of rawness in the back of his throat, and of the occasional regurgitation of liquids through his nose. His voice became husky. October 10th, about noon, he complained of considerable diffuse abdominal pain, his skin became cold and clammy, his temperature falling to 96.4°, pulse 120, very small and thready. Notwithstanding the use of heaters and stimulants, his temperature did not reach normal till the evening of the next day. From this time till his death, he was delirious at night;



the dejections, previously four or five daily, now increased to eight or ten, liquid, dark-colored, and very offensive. He was nearly free from pain, the frequency of the dejections being the chief complaint. Consciousness was lost during the last twenty-four hours, death taking place, October 23d.

Autopsy by Dr. R. H. Fitz, Twenty-one hours after death.

"Body much emaciated, abdomen collapsed, rigor mortis present. Dura mater showed a delicate, pale, yellowish-brown false membrane on the inner surface, with numerous patches of recent hæmorrhage. Pia mater oedematous, slightly more opaque than usual, otherwise normal. Brain, nothing abnormal. Pericardium contained two ounces of pale-yellow fluid.

"Heart normal in size; right side distended with freshly clotted blood, left side comparatively empty. Two adjoining aortic valves adherent throughout nearly one-half their free edges by old adhesions; other valves normal. In the left ventricle a reddish-gray thrombus as large as a pea; another beneath the insertion of the mitral valve. Aorta, thin, narrow, and elastic, with slightly irregular distribution of lumbar arteries.

"Lungs. A few old adhesions at apex of left lung posteriorly, and at the base. In upper part of left upper lobe rather posteriorly and deep-seated, was a round nodule the size of a walnut of soft, cheesy material, enclosed within a dilated and occluded bronchus. A similar nodule, smaller in size, at the upper part of left lower lobe posteriorly, the containing wall being irregularly pigmented and puckered; surface of lung corresponding to these nodules irregularly depressed, and containing but little air. Throughout the left lung, numerous miliary tubercles, for the most part, isolated. Right pleural cavity obliterated by old adhesions. Extensive gray miliary tuberculosis throughout right lung.

"The abdominal cavity contained a quart of clear yellow fluid; the intestines firmly united to each other and to the atrophied omentum and abdominal walls by old adhesions. Surface of peritoneum studded with submiliary, translucent, gray granules.

"Spleen adherent to surroundings; increased in weight chiefly from increase in thickness. On section, surface studded with minute gray granules, and occasional large, projecting tubercles. Follicles and trabeculae rendered indistinct from delicate swelling.

"Left kidney slightly diminished in size, slightly anæmic. Right kidney showed a patch of anæmic necrosis as large as a beech-nut, slightly depressed below the surface, also diminished in size, but deeply injected. Suprarenal capsules, bladder, and testicles normal.

"Liver diminished in size, firm on section, the central parts deeply injected; occasional miliary tubercles. Tongue posteriorly and tonsillar region on both sides the seat of an extensive indurated ulcer, in the base of which numerous cheesy tubercles were to be seen. Vocal cords oedematous, and on the right posteriorly, a superficial ulcer three lines in length. Mucous membrane of stomach thickened and of a light-blue color.

"Intestines so matted together that the localization of numerous transverse ulcers with indurated base and injected margin could not be made. The ulcers showed cheesy points in the base, the induration extending nearly to the peritoneum, through which the reddened base of the ulcer appeared. Throughout the greater part of the large intestine, especially in the cæcum, extensive ulcers, resembling those previously described, occupied most of the mucous membrane, leaving occasional patches of unaltered membrane. The most extensive destruction of mucous membrane was in the cæcal region, and the peri-cæcal regions were indurated. Ileo-cæcal lymph glands cheesy and moderately enlarged.

"In the rectum, the ulcers extended to just above the third sphincter, and were associated with small, rounded ulcers, apparently of follicular origin.

"Diagnosis: Acute hæmorrhagic pachymeningitis; chronic aortic endocarditis; cardiac thrombosis; chronic cheesy bronchitis and bronchial dilatation. Acute miliary tuberculosis of lungs, spleen, liver, and peritoneum. Anæmic necrosis of kidney. Chronic tubercular ulcers in intestine. Chronic catarrhal gastritis."

Reports of Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

E. M. BUCKINGHAM, M.D., SECRETARY.

NOVEMBER 23d, 1885, the President, Dr. F. W. DRAPER, in the Chair.

Dr. W. C. B. FIFIELD read a paper on

THE PRESENT SYSTEM OF APPOINTMENT OF MEDICAL EXAMINERS BY THE STATE OF MASSACHUSETTS.¹

Dr. G. K. SABINE replied that it seemed to him that Dr. Fifield's paper is rather an attack upon the medical examiners than upon the system of their appointment. The position of medical examiner is, for many reasons,

¹ See page 577.