ABnormally Long Vermiform Appendix

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The average length of the appendix, as stated by different authors, has varied from 3 to 11.5 cm (3 to 4 1/2 in.), with a mean of 9.2 cm. (Kelly, Ribbert and Berry place it at about 8.3 cm., 3 1/4 in.), or between 3 and 3 1/2 inches. Abnormally long appendices have been noted by J. D. Blake (24 cm.—9 1/2 in.), Lafforge (24 cm.—9 1/4 in.), Luschka (23 cm.—9 in.) and Lenzmann (22 cm.—8 5/8 in.). Below we report a case in which we removed an appendix 20.9 cm. (8 1/4 in.) in length, about two and one-half times the normal length.

History.—The patient was a mulatto woman, aged 31 years, having what we diagnosed clinically as a myoma of the uterus and an ovarian cyst (left).

Operation.—On Dec. 3, 1908, under ether anesthesia, a pedunculated myoma 13.5 cm. by 13 cm. (5 1/2 by 5 in.) was removed by tying and cutting the pedicle. A large ovarian cyst, together with the Fallopian tube, was removed from the left broad ligament. A small cyst was removed from the right ovary.

On looking for the appendix, the complete absence of the mesoappendix was noted. The appendix lay in the second most frequent position, ascending vertically behind the cecum and first portion of the colon, and partially attached to the dorsal wall of the large intestine. The tip extended to the level of the upper pole of the kidney. Considerable difficulty being experienced in freeing the appendix, its peritoneal coat was incised at the cecal junction and the appendix then stripped and dissected free from this covering. The stump was ligated and inverted into the cecum by the usual purse-string method. The uterus was then suspended and the abdomen closed without drainage. The patient made an uneventful recovery and left the hospital 12 days after the operation.

This appendix had apparently given no symptoms. It was probably drawn into the ascending position by the formation of early adhesions between the appendix and the other organs lying posterior to the cecum at the time of its descent, as suggested by Kelly. Removal was undertaken because of the more frequent occurrence of inflammation in appendices lying in this position.

204 Conti Street.

TECHNIC IN TRANSFUSION

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In experimental work in the laboratory, in which I have had the assistance of Dr. W. Lassiter, we have found the use of the fine tenacula of the Elsberg outfit advantageous in doing transfusion experiments on the lower animals with the Cire tube. The tenaculum is thrust through the Cire tube, hooks the artery by the circumference, and draws it through more quickly and with less traumatism than when sutures are used for the purpose. The artery is then drawn through a second tenaculum suffices to cuff the extremity over the Cire tube. Here the cuffs may be secured with a ligature over one of the grooves or, if desired, it can be held in place with the two tenacula while with two more the recipient vessel is drawn over the cuffed donor vessel and a single ligature used to hold both over the tube.

The advantages are ease of performance, a minimum of traumatism, and economy of time.

506 Morris Building.

ACUTE MILIARY TUBERCULOSIS FOLLOWING RENAL TUBERCULOSIS, SECONDARY TO OLD HEALED BILATERAL APICAL TUBERCULOSIS

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The following case may be of interest to many as bearing to a great degree illustrative of the relations of cause and effect in the mobilization of tubercle bacilli after an apparent cure has been effected. In the case reported here no knowledge of the primary disease was obtained until the autopsy, the patient having died from general dissemination. A point of special interest is the intermediate route chosen by the tubercle bacilli, and their temporary halting place in the right kidney before spreading to the body at large.

Patient.—I was called on July 19, 1909, to see Mr. J. C., aged 28, a farmer from Kentucky, who had been in Asheville three weeks. Data were obtained from his wife.

History.—Mother and several brothers died of pulmonary tuberculosis. Patient well as a child; no past illnesses; was an athlete at college. About a year before this illness he had had "attacks" consisting of severe pain in the region of the bladder. These attacks came on after hard chills. At this time he had worked very hard building a house. The pain caused vomiting. These attacks recurred several times, and finally stopped. About six months before the present illness he had "stomach trouble" (nature very obscure), and his home physician said he had "tubercle" in the gaster, jalu, which was counteracted by an alkali. Three months before the present illness the patient began to run an irregular temperature and to lose weight and strength. For the past two months the temperature had been constant, ranging from 99 to 102. At no time had there been actual cough; there had been transient expectation described as "cattarrh." The patient was examined in April, 1909, and was told that his lungs were weak but that the physician did not think it was tuberculosis. It was understood from what could be elicited from his wife that a Moro cutaneous tuberculin test was given—result not positive. The patient had been kept in bed for a month at home and had been sent to Asheville. While here he was constantly in bed, growing steadily worse. His bowels were somewhat loose; he was said to be voiding a normal amount of urine.

Examination (July 19).—Patient poorly nourished, sallow and pale; dorsal decubitus; expression anxious. Evidently much loss of weight. Pupils equal, reacting both to light and accommodation somewhat sluggishly. Tongue heavily coated. Throat apparently normal.

Chest: Note over all normal save for possible hyperresonance over the upper lobes. Breath-sounds normal all over. A few subcrepitant rales heard on deep breathing and on coughing in first right and left intercostal spaces. Also a few rales on left side in anterior and mid-axillary lines down to about the eighth rib. No adventitious sounds below.

Abdomen: Tender over all. Liver, spleen and gall bladder not palpable. Some tympanites; no rose-spots. In hypogastric region there was a large tumor half the size of an adult head, sharply defined, smooth, tense, flat on percussion. It was in the region of the bladder and very tender to pressure. Patient voided about 12 ounces of urine on request. This was examined and found to be acid, sp. gr. 1.016, trace of albumin, moderate amount of pus, no other abnormality. Patient semifeculent for past three days—cerebration slow.

Tried to get out of bed.

Course of Disease.—Owing to the inaccessibility of the patient's house and to lack of proper facilities for caring for him, he was brought to the Asheville Mission Hospital on the morning of July 20. During the night of the 19th he was given morphin gr. 3/4, which kept him fairly quiet. The next morning, July 20, he drove three miles and was admitted to the hospital at 11:45 a.m. He was delirious; At 1 p.m., the abdominal tumor persisting, and having seemingly increased in size, he was catheterized and 53 ounces of urine
withdrawn, the tumor promptly disappearing. He was catheterized again at 9:30 p.m. the same evening and the large amount of urine withdrawn (84 ounces). The patient was given suiphonethylmethylanum (trional) gr. 10 and passed a restless night semidellious, trying to get out of bed and fancying that he saw many people around him. He was again catheterized at 2:30 p.m. on July 21 and 70 ounces withdrawn. I then called Dr. Charles L. Minor of Asheville in consultation. The patient was semi-dellious, quite dyspeptic, not cyanotic, abdomen slightly distended, signs in chest as stated above. Dr. Minor and myself made a tentative diagnosis of acute general miliary tuberculosis, based on the following points: Probability of tuberculosis from the history; continued temperature for two months; marked cerebral involvement; abdominal symptoms; decided dyspepsia with but insignificant chest findings; rapidity of pulse (120). An Arnett blood picture was made, giving the following result: H. III. IV. V. Index. Leukocytes count 16,000.

Dr. W. L. Dunn of Asheville also saw the patient, agreed with our diagnosis and did a Widal reaction which was wholly negative in a dilution 1:30.

Patient was again catheterized at midnight on July 21 and 58 ounces withdrawn. Bowels being constipated, 2 drams of a saturated solution of magnesium sulphate were ordered every hour until bowels moved. Other treatment was simply supportive, strychnin and digitalis being given. At night the patient was given morphin, gr. ½, which kept him fairly quiet. July 22 patient catheterized three times—total of 64 ounces withdrawn. July 23 the patient had ten involuntary bowel and bladder evacuations; the pulse grew weaker, respirations shallower, the abdomen became more and more distended, and the patient died at 9:45 on the night of July 25. At no time was he rational, and during the last three or four days but rarely recognized those round about him. During his stay at the hospital his temperature ranged from 100.2 to 102.4, with the exception of a drop to 98.3 on the morning of July 21.

His pulse ranged between 108 and 140. The apparently great polyurias was difficult to explain. The following theory has suggested itself to me: For three weeks the patient had been very sick with no skilled attendant about. His wife, though willing, was not qualified to observe keenly. As he passed urine, she believed that all was well, and paid no heed to the quantity. Owing to his sluggish mental condition, he passed but a small portion of the urine that was in the bladder. As a result, the bladder gradually lost its tone and became greatly dilated. Shortly after systematic catheterization began, the bladder regained its tone, and far less urine was obtained than at first. I am therefore led to believe that the polyuria was far more apparent than real. Clinical diagnosis: Acute general miliary tuberculosis; dilatation of bladder.

Autopsy (July 25, 1909, 11 p.m., one and one-half hours after death).—Body that of a large emaciated man. Pancreas adiposus very slight. On opening the abdomen (which was done first in this ease), the intestines were found to be enormously distended. Save for some congestion in the ileum, they were normal throughout their whole extent. Peritoneum normal. One enlarged mesenteric gland. Pancreas normal.

Left Kidney: Scattered through the cortex and medulla were several (15 to 20) gray masses, slightly elevated above the surface of the kidney substance and of denser consistence. These areas were about three times the size of a pin-head and resembled gray tubercles. In some the center appeared degenerating caseous generation.

Right Kidney: Half the normal size. Color normal in central portion, yellowish-gray at each end. Capsule stripped off easily, showing at both poles a collection of waxly yellow matter raised above the surface of the kidney. The surrounding tissue was pale. Section of the kidney along its convex border opened into two cavities, one at each end lined with caseous matter one-third of an inch in thickness and containing some detritus. These cavities opened into the pelvis of the kidney. The cavities were irregular in outline. The central portion of the kidney was nearly normal save for a few scattered tuberculous areas. The pelvis was not affected.

Spinal: A few areas, suggestive of miliary tubercles.

Liver: Normal.

Heart: Small, considerable fatty deposit. Heart muscle and valves normal. Pericardium normal.

Lungs: Unduly pale (countryman?), and both showing strong adhesions of moderate extent at the apices, but none elsewhere. Both apices showed somewhat pigmented depressed scars, 2 inches each, surrounded by emphysematous areas. On section apices showed old healed tuberculous scars with considerable fibrous tissue formation. Beginning outside these areas the whole of both lungs from apex to base was studded with millions of gray miliary tubercles. At the left base a few were going on to caseation. The lungs as a whole felt as though full of shot.

Brain: Not examined.

Anatomic Diagnosis: Old healed bilateral apical pulmonary tuberculosis; bipolar caseous tuberculosis of right kidney; beginning tuberculosis of left kidney; possible tuberculosis of spleen.

The chronologic order of events seems to have been as follows: An old healed apical tuberculosis; mobilization of the beginning of physical effort when house-building; lodgment of bacilli in right kidney with establishment of renal tuberculosis and appearance of bladder symptomatized, referred to in history of case; spread of infection to left kidney; breaking down of areas in right kidney and discharge into a vein giving rise to general dissemination throughout the lungs and without doubt throughout the central nervous system as well.

33 Haywood street.

A NEW TONSIL-SPARE

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I have been using with much satisfaction for the past two years the tonsil-snare shown in the accompanying illustration. I claim nothing original for this instrument, as it is simply a modification of the Krausmuller-Peters snare with the Vedder tip, but the modification is such and the instrument is so solidly constructed that it can be used in the same manner and with the same degree of lateral pressure as the Mathieu tonsillotome.

The thumb-ring is very broad to prevent injury to the thumb; there is also an extra thumb-hold in case both hands should be required for the écrasement. The instrument is used in exactly the same manner as the Mathieu tonsillotome, except that the tonsil, after being thoroughly freed from all adherences, must first be seized with a long tenaculum hook which is entrusted to the assistant who makes gentle traction while the operator handles the snare and the tongue-depressor; in case both hands are required in the écrasement the tongue-depressor can be laid aside as soon as the base of the tonsil is well engaged by the wire loop.

The construction of this instrument is so simple that it can be easily taken apart for cleaning.

247 Bull Street.

* Read in the Section on Laryngology and Otology of the American Medical Association, at the Sixtieth Annual Session, held at Atlantic City, June, 1909.