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.

LEEDS GENERAL INFIRMARY.

TWO UNUSUAL CASES OF INTUSSUSCEPTION.

(Under the care of Mr. LAWFORD KNAGGS.)

IT is only within recent years that laparotomy has been considered admissible in the treatment of intussusception, but a few cases are on record in which this operation was performed with success even in pre-antiseptic days. Such a case was recorded in 1835 by Dr. J. R. Wilson¹ of Mississippi; but none of these cases occurred in infants, in whom shock after abdominal operations is so very marked. Laparotomy was, however, recommended many centuries ago by Praxagoras. Though it is true that inflation or injection may be followed by recovery in a certain proportion of cases, as among the 103 cases collected by Dr. F. H. Wiggin² of New York there were 16 recoveries with this treatment, but in the same series there were 23 deaths in cases in which inflation or injection had been employed. After laparotomy 21 patients recovered and 43 died, but in most of the fatal cases injection or inflation had previously been employed in vain. In the former of Mr. Lawford Knaggs's cases recorded below, the very youthful age of the patient, three months and a half, was greatly against success, though recovery has occurred at a very slightly greater age, as in a case under the care of Mr. E. W. Roughton³ in which the age was four months. An early record of a retrograde intussusception is that described by Spry.⁴ One of the most curious suggestions for the treatment of intussusception is that made by John Hunter, who recommended emetics, as he thought that the reversed peristalsis supposed to occur in vomiting might draw out the prolapsed bowel. For the notes of Case 2 we are indebted to Dr. C. H. Greenwood, house surgeon.

CASE 1. *A double intussusception; laparotomy; reduction; death.*—A female child, aged three months and two weeks, was admitted into the Leeds General Infirmary on August 6th, 1899, suffering from an intussusception. The symptoms were the usual ones—viz., vomiting, blood-stained slimy evacuations, and a tumour in the left iliac region. The two former had been present for six days. The apex of an intussusception could be felt in the rectum two inches from the anus. Two days before admission "the seat" had come down, and after three or four minutes went back by itself. This was the only occasion on which this had happened. The patient's general condition seemed to be fair.

The case was at once handed over by Dr. A. G. Barrs for surgical treatment, and soon after admission the patient was anæsthetised and the abdomen was opened. The reduction of the intussusception was begun from the lower end within the abdomen. The apex was gradually pushed up until the empty rectum could be brought into the wound, but it was soon discovered that no real progress was being made. The tumour was therefore brought outside. It was then found that a retrograde and secondary intussusception was present. This had formed from a folding downwards of a portion of the outer layer of the primary intussusception. Its length was between four and five inches, and its neck showed as a ring of pale gut encircling the tumour firmly about its middle (A). Reduction of the retrograde invagination was commenced from above. Its accomplishment was easy at first, but there was considerable difficulty in unfolding the last three-quarters of an inch owing to the swelling that had taken place at the apex (B). When the ascending invagination had been unrolled the primary one was dealt with, reduction being

readily accomplished from below in the usual way. The ileo-cæcal valve was the presenting part and was the most difficult to reduce. On examining the bowel before closing the abdomen the peritoneal covering was found to be the subject of many longitudinal splits, and there were considerable thickening and a good deal of local peritonitis about those portions of the bowel that had formed the apices

S.I., Small intestine. A, Neck of secondary intussusception. B, Apex of secondary intussusception. C, Ileo-cæcal valve. V, Anus.

of the primary and secondary invaginations. The child died suddenly four hours after the operation during an act of vomiting when apparently she had rallied satisfactorily and was going on well.

CASE 2. *Enteric intussusception caused by an intestinal lipoma; laparotomy; reduction; removal of tumour; recovery.*—A woman, aged 29 years, was admitted into the Leeds General Infirmary on April 16th for symptoms of intestinal obstruction. Her illness had begun suddenly five weeks before with intense pain in the left iliac region accompanied by diarrhoea and vomiting. This subsided, but from that time she had "bilious attacks" with vomiting every other day. About 10 days before admission she became much worse and a medical man was called in. She was very bad with vomiting, diarrhoea, and pain on April 13th, was about her work on the 14th, and bad again the day before admission. Her motions had contained slime and a tarry-looking substance.

On examining the abdomen the left rectus was at once noticed to be more prominent than the right, and at times was raised markedly above the general surface of the parietes. On manipulation a large elongated tumour could be felt extending from several inches above the umbilicus down into the pelvis. It was covered chiefly by the left rectus and when palpated it became hard and more defined and the seat of pain, and these changes were accompanied by gurgling. The tumour was not tender and the resonance over it was impaired. On rectal examination what was thought to be the apex of an intussusception was readily felt through an intervening fold of mucous membrane.

On April 17th the abdomen was opened in the median line and a large intussusception of the small intestine was found lying beneath the left rectus. The apex lay at the bottom of the pelvis and the neck deep down in the upper part of the abdomen. This could only be brought to the surface towards the completion of reduction, which was easily accomplished by taxis applied at the lower end in the orthodox manner. It was then found that the presenting part of the intussusception had been an elastic, firm, and nodulated tumour as big as a hen's egg, which, though attached to the wall of the bowel, was freely moveable within the intestine in the vicinity of its anchorage. There was no congestion of the invaginated bowel or inflammation of the opposed serous surfaces, but there was a general hypertrophy of the intestinal walls both above and below the tumour.

¹ Transylvania Journal of Medicine, 1835.

² THE LANCET, August 28th, 1897, p. 525.

³ THE LANCET, Feb. 23rd, 1895, p. 483.

⁴ Medical and Physical Journal, No. 11.

The usual precautions having been taken a longitudinal incision one inch long was made in the gut over the tumour and opposite to the mesenteric attachment. Through this the tumour was delivered and found to have a pedunculated attachment as thick as a thumb. The mucous membrane was divided all round the pedicle with scissors and the tumour was clipped away at its base. A small portion of fat, which proved to be a part of the tumour, was left in the bowel wall. This was easily picked out. The bleeding was stopped, the aperture in the mucous membrane was sutured, and then the incision in the intestine was closed with a double row of sutures. A suture was also applied externally over the site of the attachment of the tumour, which was in the immediate neighbourhood of the mesentery. The operation was then concluded. The patient made an uninterrupted recovery and left the hospital on May 15th.

The tumour proved to be a mass of lobulated fat covered by intestinal mucous membrane. At one part there was superficial ulceration over an area as large as a shilling and the mucous membrane around it was congested and thickened. This had evidently been the presenting part of the tumour and of the intussusception.

Remarks by Mr. LAWFORD KNAGGS.—Cases of double invagination are sufficiently uncommon to justify putting the above instance (Case 1) upon record. In the history it will be noticed that the apex of the intussusception protruded from the anus two days before admission, but only upon one occasion. It is probable that the folding downwards of a collar-like roll of the outer layer by which the retrograde invagination was constituted occurred at this moment. The formation of the secondary intussusception, though it would not diminish the length of the primary one, would prevent its further increase which, it is well known, takes place at the expense of the sheath. That layer would become immoveable as a consequence of the inability of the secondary invagination to unfold itself when once the swelling and congestion at its apex had set in. The absence of any subsequent protrusion from the anus, which under ordinary circumstances might have been expected, is probably to be accounted for by this alteration in the conditions. It is interesting to note that the congestion which occurs at the apex of the primary invagination is also met with at the apex of the secondary one and may constitute the chief difficulty of reduction in each instance.

The interest of Case 2 depends not so much upon the fact that an intestinal tumour led to the formation of an intussusception, for an intestinal growth is a well-recognised exciting cause of that condition, but upon the nature of the tumour itself. Quite recently Mr. J. Bland-Sutton has recorded a case of intestinal lipoma and drawn attention to the probability that such tumours originate by the protrusion of mesenteric fat through the intestinal muscular tissue.⁵ It will be seen that this case is all in favour of that view and, indeed, it was feared at the time of the operation that the fat seen in the bowel wall was a portion of mesenteric fat which appeared in consequence of a wound in the intestinal wall made when cutting away the tumour. That idea was dismissed when no aperture could be discovered and when the tumour was found to be a lipoma.

⁵ THE LANCET, May 19th, 1900, p. 1437.

UNIVERSITY OF WALES.—The annual collegiate meeting of the Court of the University of Wales was held at Cardiff on Nov. 23rd under the presidency of the Senior Deputy Chancellor (Dr. Isambard Owen). The Court adopted a resolution of sympathy with the family of the late Professor A. W. Hughes. Afterwards there was a special congregation of the University, when 100 candidates were admitted to degrees.

ROYAL ALBERT HOSPITAL, DEVONPORT.—The annual meeting of the subscribers of the Royal Albert Hospital, Devonport, was held on Nov. 22nd under the presidency of Admiral Lord Charles Scott. The report showed that during the past year 721 patients had been admitted, against 669 in the preceding year. The daily average number of in-patients was 43. 1512 casualty patients were treated in the out-patient department and also 770 ophthalmic out-patients. 136 women were treated in the lock ward. 179 patients were sent to the Pearn Convalescent Home. The total cost of maintenance of the hospital had been £4775 as against £4375 in the previous 12 months. The balance due to the treasurer was £576, as compared with £239 last year.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Suggestions for a Possible Improvement in the Method of removing Stones and Morbid Growths from the Interior of the Bladder.—Median Perineal Urethrotomy and Cystotomy through a Transverse Superficial Incision (after Celsus).—Exhibition of Specimens.

A MEETING of this society was held on Nov. 27th, Dr. F. W. PAVY, the President, being in the chair.

Sir THOMAS SMITH read a paper entitled, *Suggestions for a Possible Improvement in the Method of removing Stones and Morbid Growths from the Interior of the Bladder*. The object of the paper was to raise the question whether in the operation of suprapubic cystotomy for the removal of stones or morbid growths from the bladder it was possible to improve the present method of procedure. In view of the greatly diminished risk of interference with the peritoneal cavity Sir Thomas Smith suggested that in cases where it was desirable to obtain immediate union of the bladder wound it might be worth consideration as to whether the operation should be intra-peritoneal, so as to take advantage of the facility with which opposed surfaces of peritoneum unite after suture. A short statement was made of the precautions which would have to be adopted to suit the requirements of an intra-peritoneal operation and of certain modifications in the routine method of performing suprapubic cystotomy. These modifications included the adoption of the Trendelenburg position, the distension of the bladder with air rather than with fluid, the opening of the abdomen at a higher point than that usually selected, the immediate closure of the bladder wound by suture, and the adoption of an after-treatment such as was usually employed when traumatic rupture had occurred.—Mr. CLEMENT LUCAS thought that the value of communication would have been enhanced if cases in which the operation had been performed had been submitted. As regarded the operation of suprapubic cystotomy it must be remembered that it was quite a different one from what it was originally when Sir Henry Thompson revived it. At that time the bladder was torn and drainage was accomplished above the pubes, but now the bladder was cut. It was a great thing to clear out the bladder thoroughly but he could not see the advantage of going through the peritoneum. It was not possible to exclude septic matter from the bladder. After giving due consideration to Sir Thomas Smith's suggestions he thought that there was a considerable risk of infecting the peritoneum.—Mr. W. BRUCE CLARKE remarked that in the circumstances referred to the surgeon was generally called upon to perform the operation on a septic bladder and he would want to hear more arguments before favouring the idea of opening the peritoneum under these circumstances. There were, of course, advantages in cases where there was a very large stone or a large tumour, in which the surgeon would be willing to take certain risks, but for ordinary purposes he did not think the suggestions that had been made were justified.—Mr. P. J. FREYER remarked that the subject opened up the question of suprapubic lithotomy. It was in the ease and simplicity of this operation in which its danger lay, but it really must be gauged by its mortality and this was very great.—Professor H. GILBERT BARLING had published statistics which he had collected from six London hospitals and six provincial hospitals, and out of 180 cases of suprapubic lithotomy the mortality had been 20 per cent., whereas the mortality for lateral lithotomy was 5 per cent. The mortality for litholapaxy was about the same. Suprapubic lithotomy was an operation essentially for large stone or tumour, but how people could undertake the operation in ordinary circumstances he did not know. It seemed to him that Sir Thomas Smith's proposal to abandon the extra-peritoneal method was a very dangerous one. The suggestion of distending the bladder with air was not a new one, but he did not think it was practicable. One of the great advantages of the suprapubic method was that the surgeon could introduce his finger, and this could not be done if air were used. Moreover, one of the advantages was to be able to wash out the debris from the bladder, and this was not