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Original Communications.

CASE OF STRANGULATION OF THE LARGE INTESTINE, NEAR THE JUNCTION OF THE DESCENDING COLON AND THE SIGMOID FLEXURE, BY A BAND,

SUCCESSFULLY TREATED BY AN OPERATION.

By Dr. R. LAWRENCE WILDER, San Francisco, Cal.

MARCH 30th, 1868, was called to see Mr. G., aged 33, in consultation with Dr. J. D. B. Stillman. Found patient vomiting incessantly a thin, coffee-colored fluid. He had had no passage from the bowels for four days. There was some swelling of the abdomen, and considerable tympanites. Great pain on pressure; countenance pale and anxious; pulse 130, thready and irregular. There were no appearances of hernia. The patient referred his pain mostly to the *right* iliac fossa. This, with the suddenness of the attack, led us to believe that the trouble was intussusception at the ileo-cæcal valve.

Warm-water injections had been given every hour for the previous twenty-four hours, but had come away without apparently entering the colon. Insufflation was then proposed. Quite a large amount of air was pumped in, by means of a Davidson's syringe. We suffered this air to remain in for a time, in hopes that by distending the intestine gently but fully, we might be able to bring things to a normal position and condition.

The air gave the patient so much pain that in about an hour it was thought advisable to allow it to escape. On dilating the sphincter ani, no air escaped. The rectum and sigmoid flexure remained perfectly empty, while the whole extent of the colon remained distended. This turned our attention to the *real* cause of all these symptoms of obstruction, which we decided must be a stricture of the large intestine, situated near the junction of the descending colon and the sigmoid flexure. It also seemed most probable that this obstruction

was caused by a band of adhesion, suddenly inflamed; for the patient had had peritonitis about two years before, and had since, as he says, been troubled with "colic."

A long enema-tube, carefully passed up, met with a decided obstruction about eighteen inches from the anus. After several attempts to pass the tube into the colon, which were unsuccessful, the tube being stopped at the same place each time, we decided that his only hope of relief lay in an operation.

Later in the day, Dr. Calvin G. Page, of Boston, Mass., saw the patient with us, and, after a careful examination, agreed as to the diagnosis, and fully concurred with us in the opinion that an operation for the relief of the stricture afforded the patient his only chance of recovery. This statement being made to the patient and his friends, they consented to anything we might propose to do. As it was late in the day, and as the symptoms were about the same as in the morning, we determined to postpone operative interference until the next day—in the meantime to give the patient the benefit of treatment by position.

March 31st.—The previous symptoms being more marked, and the abdomen having become more tympanitic and enlarged, the operation was immediately decided upon.

Operation, by Dr. Wilder, assisted by Drs. Stillman and Page. Patient etherized and placed upon his right side. Incision made about midway between the last rib and the crest of the ilium, commencing at the edge of the sacro-lumbar and long dorsal muscles, and extending horizontally towards the umbilicus about four inches. The muscles were then carefully divided on a director, in both directions, the entire length of the incision. A large amount of fat appeared and rolled up into the opening. This I carefully dissected through with my finger and the handle of my scalpel. The distended intestine now showed itself in the aperture. I carefully passed my hand into the cavity of the abdomen, through the incision, and at the same time introduced an olive-pointed œsophageal

[WHOLE No. 2108.]

probang into the rectum *per anum*. Carefully following this, with my finger within the abdominal cavity, I passed the probang along till I arrived at the stricture, which was found to be at the junction of the colon and sigmoid flexure. The intestine below the stricture was loose and flaccid, while above there was great distention, feeling like an inflated bladder with a string tied around its neck. I felt what seemed to be a *fibro-membranous band* surrounding the intestine and constricting it. By pushing the point of the probang well up, and using my finger-nail, I succeeded in dividing the stricture. Immediately upon the division of the band, the probang slipped through into the colon; at the same time an immense amount of gas and fluid *fæces* escaped with great force from the anus. A long enema-tube was then introduced, which passed easily up the descending colon, through which more gas escaped. Drs. Stillman and Page also satisfied themselves, by an examination, that the stricture was divided, and that the tube passed freely up the descending colon. I now withdrew the tube. The flaps of the wound were brought together and the edges held by sutures. Strips of adhesive plaster and a roller were then applied.

Only one vessel was divided, and that was a small muscular branch, scarcely requiring a ligature. The hæmorrhage amounted to nothing. The depth of the dissection and the care necessary, made the operation rather long and tedious. Ordered two ounces of brandy, to be immediately given by the mouth.

9.30, P.M.—Patient rallied well. Passes gas *per anum*. Tympanitis diminished very much. Pulse 110, regular and strong. Ordered morphia sulph. gr. ss. subcutaneously.

April 1st, 12.30, A.M.—Patient comfortable. Pulse 110. Repeat morphia.

7, A.M.—Patient is very comfortable. Pulse 110, strong and regular. Tympanites still diminishing. Countenance cheerful. There has been no vomiting since the operation. Ordered beef-tea, four ounces, to be injected into the rectum. Ice to allay thirst, which is considerable. To repeat morphia.

12.30, P.M.—Pulse 96. Patient complains of pain in right thoracic region. Has previously had rheumatism. Ordered, lemon to suck. To chew beef-steak, as he says he feels very hungry. Repeat morphia, and continue ice.

6, P.M.—Pulse has risen to 110. Tympanites remains about the same. Ordered,

hop fomentations to be applied over whole abdomen. Repeat morphia.

12, M.—Pulse 120, not so strong. Some delirium. Coma vigil. Patient complains of seeing cobwebs, &c., about the room, and is wandering in his speech. Tongue dry and horny. Removed the dressing from wound. Incision entirely closed by first intention. Ordered, brandy $\mathfrak{z}$ ss. every hour; also $\mathfrak{R}$. Ferri et quiniæ citratis, $\mathfrak{z}$ ij.; syrup. aurantii, $\mathfrak{z}$ i.; aquæ fontanæ, $\mathfrak{z}$ iv. M. To take two teaspoonsful every two hours. Repeat morphia, gr. i.

April 2d, 8, A.M.—Patient more comfortable. Pulse 120. Respirations 40. Tympanites so much increased as to impede the movements of respiration. Tongue looks better. Horny feeling gone. Brandy to be reduced to two teaspoonsful every hour. Ice to suck. Morphia gr. i. repeated.

6, P.M.—Considerable delirium. Tympanites very great. Decided, on recommendation of Dr. Page, to puncture the peritoneum and let out the gas. Pulse 120; respirations 45, just previous to the operation. I introduced a small trocar in the median line into the sac of the peritoneum, just below the umbilicus. A great amount of gas rushed out, relieving the distention *below*, but not *above* the umbilicus. Another perforation was made with the trocar, about two inches *above* the umbilicus in the median line. A much larger amount of gas escaped than from the puncture below. The abdomen at once became flattened and more natural. The pulse came down to 100 per minute, and remained stronger and more regular. The respirations were reduced to 34. Repeated morphia gr. i. Ordered to continue brandy and prescription.

12, M.—Was suddenly called to see patient. Found him with delirium of an epileptiform character. Pulse 130. Pupils dilated. Ordered to discontinue morphia and the prescription also. To have potass. bromid. $\mathfrak{z}$ ij. To continue brandy.

3d.—Patient very much better. Very rational at intervals. Tongue clean and soft. Pulse 100, strong and regular. Tympanites entirely disappeared. Very little tenderness on pressure of abdomen. Wound entirely united, firm and sound. Patient seems generally very much improved. Potass. bromid. $\mathfrak{z}$ ij.

4th.—Pulse 90, strong and regular. Patient has had three profuse alvine evacuations, blackened by the iron previously administered. Slight delirium present, which is of an epileptiform character. Patient

has been accustomed to have these attacks since his youth. To continue bromide of potass. Beef-tea and milk *ad libitum*.

7th.—Removed sutures. Union firm the whole line of the incision. Appearance of abdomen perfectly natural. Bowels regular. Delirium gone. Pulse 84, soft and compressible. Patient in every respect convalescent. There is nothing in the condition of the abdominal parts to prevent a rapid recovery.

The case above narrated by Dr. Wilder terminated fatally a few days after the conclusion of his report, death occurring from pyæmia.

There are two points in the case that should go upon the record. The first is, that the patient was subject to occasional attacks of epilepsy and had suffered some years previously from a fall through a scuttle, a distance of three stories, since which accident he had had frequent attacks of abdominal pain in the region of the liver. The *post-mortem* appearances in this region showed old peritoneal inflammation, with adhesions to the diaphragm, and a recent deposit of lymph and pus over a surface of several inches, but entirely confined to that region.

The second point is, the great relief given by puncturing the peritoneum with the trocar and allowing the accumulated gases to escape. I examined the peritoneal points of puncture *post mortem*, and found no trace of inflammation. The intestines were not touched by the trocar.

The intestine at the point of stricture showed an ecchymotic line an inch long by one fourth inch wide, but was otherwise healthy. There was considerable pus found behind the peritoneum, between it and the line of incision, which had closed by first intention. It would, perhaps, have been better to have kept the most dependent part of the wound open, so that this pus could have escaped.

CALVIN G. PAGE.

PELVIC CELLULITIS.

By H. O. MARCY, M.D., Cambridgeport.

INFLAMMATION of the cellular or areolar tissue of the pelvis occurs so rarely, except in connection with the puerperal state, external violence, or uterine disease, that cases of idiopathic character are of more than ordinary interest. The obscurity of diagnosis, and departure from the usual prescribed rule of surgical non-interference,

have caused me to feel that the following case was worthy of record.

Mrs. S. K., aged 33; first seen in October, 1867. Mother died of ovarian tumor. Father living. In early life, healthy. Menstruated at 16; married at 17. One child, 12 years old. Severe labor. Delivered by turning. Sick for weeks. Troubled at times with prolapsus. Has worn supporters. Never pregnant since.

In January, 1867, had pneumonia. During attack suffered from severe pain in lower part of bowels; later, noticed a swelling in left iliac region, size of an orange; quite tender and painful. Tr. iodine was applied externally by attending physician. It was thought to have disappeared, but some time later was again noticed, and has been constant since, gradually increasing in size up to the present.

In May had a discharge of several ounces of very foetid pus by rectum. Pus has been discharged several times since from rectum, each time preceded by increased suffering. Has occasionally noticed fæces covered with pus.

Present condition, October, 1867. Pale, anæmic; much loss of flesh and strength. Appetite good, bowels inclined to diarrhoea. Sleeps poorly; complains of much pain about the tumor, shooting down leg. At times compares the suffering in severity to that of labor. Dull heavy pains in entire pelvic region.

By abdominal examination there can be distinctly felt above the pubes on left side, a hard non-fluctuating mass, rounded in outline, not differing much in size from a child's head at birth. Os uteri enlarged, thickened, rough, admitting finger.

Posteriorly and apparently continuous with the fundus uteri is felt the tumor above described, dipping down into the pelvic basin. The uterus above the cervix seems lost in the mass.

Examined from the rectum, that portion within reach feels softer, is partially separated from the mass above, by constricting fibrous bands, giving it a bilobulated appearance. Has menses quite regularly, but excessive menorrhagia, usually from two to three dozen napkins.

The patient "has been the rounds of the Doctors." The larger number have not hesitated to pronounce it cancer, and advised non-interference.

At my request the patient consulted my friend, Dr. H. R. Storer. His diagnosis was fibroid tumor of the uterus—that pressure and irritation were the probable causes