TWO CASES OF INTESTINAL OBSTRUCTION.

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THE truth of Jacobsen's statement that "the advances in operative surgery have outstripped those of diagnosis in intestinal obstruction" is perhaps as strikingly exemplified in the present day as it was five years ago. To the uninitiated this may savour somewhat of a reproach upon our professional progress. It is only when one is brought face to face with practical experiences that one realises fully the formidable obstacles in the way of accurate diagnosis. Of this I am quite convinced, that there is no task in medicine or surgery where the despair of utter impotence is more often felt than in unravelling the mysteries of a case of obstruction. Turning to operative measures we find ourselves beset on all sides with difficulties. It has been truly stated¹ that "abdominal section in the treatment of intestinal obstruction, both acute and chronic, is one of the most formidable operations in surgery." According to some of the latest statistics (Curtis) a mortality of 68·9 per cent. is given in published operations since 1873 in acute obstructions. For all operations the rate of mortality would, no doubt, be much higher. Without operation Greig Smith² says that "certainly 95 per cent. die"; "the indication is clear enough—as clear as the indication to tie a bleeding carotid—operation." Treves states: "With regard to the curative treatment [of acute obstruction] the only measure is laparotomy." Immediate operation is the teaching of the progressive school. On the other hand, we have the conservative school, with its small following, crying with equal vigour for delay in operation. Hutchinson, the leader of the conservative school, perhaps the keenest observer of the present day, maintains that "these forms of strangulation are *often* in early stages effectually relieved without operation; that, in fact, cases of recovery without operation after very acute symptoms are not uncommon." Hutchinson "fully recognises the propriety of exploratory laparotomy in cases in which the symptoms have persisted after one or more persevering attempts at taxis under anæsthetics." Upon one point there can be no question, I think—viz., that laparotomy is the indication in all cases after the stage of established peritonitis. Two or three attempts at taxis and manipulation carried out in a "*bonâ-fide* and energetic manner for half an hour or three-quarters" upon inflamed intestines seems to me both irrational and unscientific. Unfortunately the diagnosis of the stage of established peritonitis frequently presents insuperable difficulties. Not long since, in a case of ovariectomy under my care, death, before the post-mortem examination was made, was attributed to septic peritonitis of adynamic type. Not a trace, however, of peritonitis was discovered, the patient having died from cancer of the gall-bladder. Taxis and manipulation in the early stages of obstruction may in Hutchinson's hands often relieve strangulation, but we have no evidence that they produce better results than laparotomy in the same stage. In certain cases where the obstruction is due to the presence of a foreign body this method may be commended, but on the whole it seems to me to be a blind, unscientific method in which the patient is exposed to the veriest chance operations. By the method of laparotomy, on the other hand, we endeavour by an intelligent coöperation of brain and senses (1) to discover the lesion, and (2) to remedy it. When laparotomy fails it is generally due to one of the following causes: (1) delayed interference; (2) a pathological condition irremediable from the first; and (3) inability to discover the lesion, which, by the way, is by no means an uncommon occurrence. The two following cases will serve to illustrate some of the points to which I have referred. I am indebted to Dr. A. W. Sheen, our house surgeon, for help in the preparation of the notes and the general management of the cases.

CASE 1. *Acute obstruction*.—A man aged sixty-five years was admitted into the infirmary on Jan. 15th, 1895. He had

been quite well till 4 A.M. on the 12th. He was suddenly attacked with pains in the bowels. The bowels were last open on the morning of the 12th, and during the morning he was sick. On Jan. 14th the vomited matter commenced to have a faecal odour. He had had hiccough all night for the two nights before admission and had kept nothing on his stomach. A medical man had been seeing him, and had given him pills, medicine, and rectal enemata. The injections were returned at once. The patient said that he had had a rupture on the right side since he was a child. This had not troubled him for years, but he had suffered vague pains in the bowels off and on for twelve months. The rupture was put back by his medical man on Jan. 12th. The patient was a thin, ill-nourished, old man, complaining of pain and tenderness at the top of the right inguinal canal. The finger met with no obstruction in the canal. The abdomen was somewhat distended. There was no dulness anywhere. There were no visible coils of intestine. The vomited matter was stercoraceous. The pulse was fine and the tongue moist; the pupils were contracted, and the patient was very dull, being fully under the influence of opium. This was evidently a case of strangulation after reduction, probably dependent upon one of two conditions: (1) damage to returned intestine, or (2) reduction *en bloc* or *en masse*. There was no second hernia, no marked distension, nothing in the ring, and no tangible swelling in the abdominal cavity; and, feeling certain that we had to deal with a damaged intestine, the patient was sent back into the ward. During the night the vomiting persisted, and as the patient seemed worse in the morning median laparotomy was performed. A loop of small intestine lying against the internal ring was pulled out. It was six inches long and of a purplish colour; the coats were thickened and it was evidently the portion of intestine which had been confined in the hernial sac. The intestinal contents could be pushed along it. The bowel was somewhat more distended above than below. It was returned into the abdominal cavity and the wound sewn up. In the after history of the case there is very little to note. The vomiting ceased after the operation, except on two occasions. Minute doses of morphia were given to control pain. The bowels acted naturally on Jan. 20th, five days after the operation. The motions were loose and frequent, and were passed into the bed. After Jan. 30th he had one motion per diem. He was taken home by his friends on Feb. 3rd, being bodily well, but mentally very defective.

CASE 2. *Chronic obstruction*.—A man aged forty-two years was admitted into the infirmary on July 31st, 1894. He gave a history of having been ill for twelve months with "wind in the bowels, vomiting, and costiveness." He gave up work at Whitsuntide, and took to his bed on July 22nd. His bowels had not been opened since then, but he had passed a little flatus up to the morning of the day of admission. On July 28th and 31st he had "injections" without result. There was no blood or discharge from the rectum at any time. He had been retching and vomiting constantly, sick seven, eight, or nine times a day, the vomited matter being brown and watery. Latterly he had suffered from hiccough. Pain had been very bad for the last week, chiefly paroxysmal. He had got much thinner. He passed very little urine, which was bloody. Many years ago he suffered from right hip disease, which had left the limb much shortened. On admission the abdomen was found to be uniformly distended and resonant. Intestinal coils were visible. The patient complained of a constant pain with paroxysmal exacerbations, referred chiefly to the right of the umbilicus. There were no herniæ; the rectum was empty. There were constant retching and vomiting, the vomited matter being watery and containing bile, but not at all faecal. He hiccoughed occasionally. He had not passed urine since admission. The patient was pale, thin, with an anxious expression and evidently of a very emotional temperament. The diagnosis was chronic partial obstruction of the small intestine. We were unable to arrive at any definite conclusion as to the pathological condition. Soon after admission a scap enema was administered, and it produced a large motion of ordinary consistence. Small quantities of milk-and-water were ordered. On Aug. 1st the patient expressed himself as being much better. He had slept in the night fairly well. The urine was acid and contained no albumen. On Aug. 2nd another enema was injected with good result. He was ordered white mixture, one ounce thrice daily. On Aug. 3rd he was sick again. The white-

¹ Seenn and White: Text-book of Surgery, vol. ii., p. 703.

² Abdominal Surgery, pp. 439-440.

mixture was omitted and yolk of eggs and milk, pancreatised, ordered. On Aug. 4th the sickness was worse, the vomited matter being liquid and brown, but not fæcal. An enema was given with but little result. He complained of abdominal pain, paroxysmal, which he referred to the umbilicus. He sat up in bed and rubbed his stomach vigorously at intervals. He was extremely emotional; at one time he thought he was going to die, and at another wanted to get up. On Aug. 5th the patient had been constantly vomiting. The vomited matter was brown, liquid, and offensive, like the contents of the small intestine, but not stercoraceous. He was put on nutrient enemata and was given ice to suck. On Aug. 6th, at the request of the patient and after consultation with Dr. Wallace, I performed median laparotomy. Finding nothing in the common situations of obstruction, the intestine was carefully examined from a point steadily fixed by Dr. Wallace. There was distinct evidence of peritonitis, but we were unable to determine the seat of obstruction. The wound was sewn up and the patient was ordered only to have ice to suck. A quarter of a grain of morphia was injected hypodermically at 7 P.M. On Aug. 7th the patient slept for six hours. He had not been sick, but had had some pain in the abdomen. He was put on nutrient enemata, every four hours. On Aug. 8th the patient was very restless during the night. He had slight hiccough. He would not keep still, and got out of bed and took a large quantity of ice. He slept about one hour. There was no vomiting. On Aug. 9th the patient remained in much the same condition, notwithstanding the administration of sedatives. On Aug. 10th he was much quieter during the night, and slept at intervals. He had occasional abdominal pain. There was no distension of the abdomen, and no rise of temperature above 100° F. since the operation. On Aug. 11th the patient was very restless during the night. The nurse could not possibly keep him quiet. He was not sick. He had taken all his food. His bowels had not been moved since the operation until now, when from 4 P.M. till 9 P.M. they were opened thirteen times. A starch and opium enema was given. On Aug. 12th the patient was quieter on the whole; he slept two and a half hours in the night. The bowels were open seven times. He insisted on sitting up when using the bed-pan. He tried to get out of bed several times, and succeeded once, when he drank a large quantity of water. At 9 A.M. the patient was found to have several coils of intestine protruding from under the lower border of his dressing, which had not been touched since the operation. Chloroform having been administered, it was found that a suture had given way. The intestine was carefully washed, returned, and the wound resutured. The patient was much collapsed afterwards. A brandy enema was given and strychnine was injected hypodermically. On Aug. 13th the patient died at 2.35 P.M. The post-mortem examination was limited to the abdomen by request of the friends. The wound was somewhat unhealthy. There was recent peritonitis over the coils of small intestine beneath the wound. On removing the intestine an abscess cavity was opened lying between the liver, the hepatic flexure of the colon, and the duodenum. There were old peritoneal adhesions across the concavity of the hepatic flexure. The exact relationship of the abscess cavity could not be ascertained, but it seemed to originate from the hepatic flexure of the colon, the calibre of which was much narrowed, but not completely obstructed at one point. There were some clay-coloured fæces in the descending colon. There was no general peritonitis.

Remarks.—The regional diagnosis was fairly accurate. The obstruction was too near the beginning of the large intestine to permit of stercoraceous vomiting. What was the cause of the kinking of intestine and the abscess cavity? With clear evidence of old tuberculous joint mischief, a justifiable diagnosis would be tuberculous mischief of a mesenteric gland with kinking of intestine by old inflammatory adhesions. In the course of conversation with the patient he told me that he was in the habit of walking with the aid of a stick, and that he always leant forward and pressed his abdomen against his hand and stick at the point where the pain was chiefly felt—that is, in the immediate neighbourhood of the hepatic flexure of the colon. Is it not possible that this long-continued pressure may have been the cause of his abdominal trouble? May not this constant irritation have been the determining factor in establishing the tuberculous gland mischief?

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THE PSYCHOLOGY OF ANÆSTHESIA.

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IN THE LANCET of March 23rd Dr. Wyld has suggested that from the collection of psychological experiences of persons when under anæsthetics "most important facts may be arrived at as to the construction of an experimental psychology." In the annotation on the subject in the same issue doubts are expressed as to the feasibility of the suggestion, whilst the interest in the study of such dreams is admitted. I not only share these doubts, but fear that actual harm may result from the promulgation of Dr. Wyld's views. The habit of auto-intoxication by means of inhalations is already practised. Patent inhalations containing chloroform and eau de Cologne are sold to the public as cures for headache and neuralgia. Should the idea gain ground that the secrets of mental science may be divulged to those under the influence of anæsthetics inquests may soon be heard on journalists hard up for "copy" who have sought inspiration by such means. It is even conceivable that etherisation may replace hypnotism at drawing-room *séances*; that the burning social and moral questions of the age may be discussed under chloroform instead of Chian, as at the Socratic symposium, but possibly with more disastrous results than attended the feast at the house of Agathos the Athenian. It is doubtful whether any scientific result can be obtained from the record of the hallucinations, illusions, and delusions of those under the influence of drugs beyond that which the well-known phenomena of ordinary sleep supply. Natural sleep is probably dependent on the accumulation of ptomaines—the products of digestion and exercise—in the circulation, which dull the intellectual and motor centres of the brain. Anæsthetics and other soporific drugs only differ in action from the home-brewed articles in that they produce a state of mental and sometimes bodily exaltation which precedes sleep. Profound natural sleep is dreamless, so also is the sleep of one heavily drugged. Dreams are the result of impressions both internal and external in a half-awakened brain, which distorts and exaggerates them into a seemingly connected tale. A knock at the sleeper's door weaves itself into what seems to him a lengthy series of events, yet the knock both occasions the dream and wakes him up. It is common experience that the dreamer awakes at the most exciting incident in his dream. It is not the dream which wakes him, but the impression which gave rise to it. In a dream one may be tried, condemned, tortured, executed, and buried by Inquisitors or Red Indians, and wake to find an ache or pain the cause. The distressing paralytic nightmare, in which one is pursued but cannot stir, is perhaps due to some uncomfortable posture of the legs which has caused them to "go to sleep." The clergyman dreams that he is preaching in his night-dress because he is conscious in a half-awakened state of actually wearing nothing else. Dreams under anæsthetics resemble the ordinary kind in that they are produced by partially felt impressions at the moment of awakening. A lady was once anæsthetised in my presence in order to have two teeth extracted. She came round immediately after the removal of the second wailing, "What is the use of it all?" Afterwards she explained that she had dreamed she died in great agony (tooth No. 1), that she had also been born again in equal pain (tooth No. 2), and that her remark was a protest addressed to the Deity. The whole period of extraction lasted less than twenty seconds. My own experiences illustrate the fact that dreams under anæsthetics are instigated by partially felt internal and external impressions. Once I had some post-mortem warts scraped from my hands under chloroform. I thought I was myself giving the anæsthetic whilst someone kept anxiously inquiring through a telephone, "Is he all right?" until I was in an agony of fear lest he might not be so. I thought that my hand was restrained (it was doubtless the case) whenever I attempted to give more chloroform. I heard the sound of the sharp spoon on the warts, but felt no pain, and thought they belonged to my patient. Afterwards I learned that my breathing had become embarrassed, and that the words, "Is he all right?" referred to me. The telephone was doubtless suggested by the sound of a musical rhythmical hammering