ACCESSORY OR ABERRANT PANCREAS. WITH REPORT OF A CASE

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While an accessory pancreas is not very rare, still it is unusual enough to warrant the report of another case. This case, like Opie's, is an accessory pancreas entirely separated from the normal pancreas and adherent to the intestine, with numerous branches of the duct of Wirsung through the section, and it is, of course, natural to conclude that the main duct must have eventually opened into the intestine.

Fig. 1.—Relation of pancreas to the intestine. A, peritoneal surface of small intestine; B, aberrant pancreas inclosed by a slight capsule of connective tissue; C, mucous membrane of small intestine. Low-power lens.

Fig. 2.—A section of pancreas showing general lobular arrangement of the organ.

Among the other cases reported are those of Klob, who demonstrated and cited two examples, viz., one embedded in the wall of the stomach, while in the other case it occupied the wall of the jejunum. Zenker collected six examples in which in every case the tumor had a duct entering the intestine through overlying mucosa. One was 16 cm., another 48 cm. One of Zenker's cases of

special interest was an aberrant pancreas with a finger-shaped diverticulum of 5.5 cm. length, 44 cm. from the ileocecal valve. In these cases the coats of the accessory pancreas varied; i. e., microscopic examination showed tissue resembling pancreas, save that the interlobular tissue was frequently more abundant. Zenker diagnosed these tumors as embryonic rudiments. Luttile, in 200 autopsies, found five cases of aberrant pancreas. Wright described one example of the anomaly in which the tissue

Fig. 3.—Same as Figure 2. High-power lens. Shows cellular structure of the organ.

Fig. 4.—Section of intestine attached to the tumor: a, peritoneal surface of small intestine, showing longitudinal and circular muscular coats of intestine beneath; b, submucous coat with its blood vessels and lymphatics; c, mucous membrane of small intestine.

contained glandular tissue as well as islands of Langerhans. Hilly suggests that part of the primitive growth is separated from the remainder and later acquires an independent duct. In the *Index Medicus* of 1910, report of only one case was found—Nazari's case of aberrant pancreas in Meckel's diverticulum.

REPORT OF CASE

History.—A well-developed, robust-looking Italian, male, aged 34, was brought into the hospital with a penetrating bullet wound of the abdomen. At autopsy all organs were found normal except the peritoneum, which showed extensive peritonitis. The intestines were matted together owing to the same condition. In the intestine 75 cm. from the pylorus two perforations were found, i. e., wound of entrance and wound of exit. About 15 cm. from the sigmoid flexure in the descending colon another perforation was seen. About 30 cm. from the pylorus a flat tumor mass was found in the intestinal wall, on its free border, opposite the mesentery. It was yellowish-gray, about the size of a quarter, markedly defined from the surrounding tissue, and slightly protruding into the lumen of the bowel. The tumor and part of the intestine for about 7 cm. on each side of it were removed and sent to the College of Physicians and Surgeons, Baltimore, for microscopic examination. Dr. William Royal Stokes reported the tumor to be an accessory pancreas, or, as some may call it, "aberrant or supernumerary pancreas." On section the organ had the same yellowish gray color as the pancreas. Sections of it showed that it was enclosed on one side by peritoneum and some muscular tissue, and on the other side by the submucous coat and the mucous membrane.

Dr. H. W. Stoner made the photomicrographs here shown (Figs. 1-4).

To the embryologist, physiologist, and pathologist this condition must surely be of some interest as to its correlation with the true pancreas in health and disease. Interesting queries can be evolved from such an anomaly, as, for instance, whether the presence of such a tumor could prevent diabetes in a patient in whom the islands of Langerhans of the true pancreas were affected. Or whether in a diseased condition of the pancreas, would the accessory pancreas undergo sympathetic degenerative changes or hypertrophy and take up the function of the true pancreas?

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A PLASTER SUPPORT FOR GASTROPTOSIS

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I have employed for some time with good results, a useful method of securing abdominal support, with zinc

Fig. 1.—Pattern for plaster support for gastroptosis.

oxid adhesive plaster on moleskin. It is adapted to cases of gastroptosis and enteroptosis requiring some mechanical support in the various wasting diseases, especially chronic tuberculosis, in which digestive disturbances are so common and so important to correct.

A patient in bed will often experience relief and benefit from the constant wearing of a light plaster support of the abdomen, although it is generally assumed, on theoretical grounds, that the sagging viscera require no support at such times. Elastic belts for abdominal support are often not comfortable or effective in the lean individual with a flat abdomen, even with an extra pad inserted under the belt, and holes cut in the elastic

Fig. 2.—Plaster support applied.

to ease up the pressure over the bony prominences at the sides. The plan herewith presented consists of a plaster pattern, with eyelets at the sides for lacing, as now generally used in surgical dressings, when it is desired to avoid a change of plaster at each dressing.

The shape and size of the plaster apron will vary, of course, with each individual. The general outline is shown in Figure 1.

The plaster should extend from the umbilicus to the symphysis pubis, and in order to include the side tongues in the same piece with the apron, the 7-inch wide plaster will be necessary. (Fig. 2.)

The strap for the back should be $3\frac{1}{2}$ inches wide, cut straight, or slightly curved toward the ends; the length must be about 3 inches shorter than the actual measurement, leaving the space of $1\frac{1}{2}$ inches on each side, for the uplift traction on apron ends and lacing. (Fig. 2.)

The edge of the plaster along which the holes are punched for eyelets should be faced underneath with an extra narrow plaster strip, so as to make a double thickness to give the eyelets a better staying grip. Less traction on the plaster will be required, when it is laced up, if the patient assumes the recumbent position, which will relax the abdominal muscles and allow the viscera to lie in a more natural position.

The advantages claimed for this pattern and lacing are evident:

1. Quick relief is afforded by unlacing, when the abdomen distends with gas.
2. The single thickness of plaster over the abdomen obviates the necessity for an overlapped edge which often causes a sore ridge on the skin, in the methods requiring a three- or four-piece pattern.
3. There is a small economy of plaster over other methods.