ABSTRACTS OF CURRENT LITERATURE.

SURGERY.

LAVOCHE, BRODIN, RONNEAUX: *Chronic Appendicitis*. "La Presse Medicale." 8th April, 1922.

THERE are few diseases which have been the subject of such vigorous discussion as chronic appendicitis. The most diverse clinical types have been described. Such as the enteritic, dyspeptic, pseudo-ulcerous, etc. At the same time, many have protested that its frequency is greatly exaggerated. In view of these conflicting discussions, the authors have thought that radiology might be of use in solving one of the most difficult problems in pathology.

Functional and general signs, which make up many of the clinical types referred to, are of little value beyond directing attention to the appendix. Only local signs can be relied upon in making the diagnosis, and these are muscular defence, and pain on palpation. The former is a good sign when present, but it is sometimes transient, and frequently absent. Pain is the fundamental sign of the disease, and by this is meant not spontaneous pain, but pain on pressure. Many different points of tenderness, all described with the patient recumbent, have been noted, *e.g.*, those of McBurney, Munro, Lanz, and Claudio. Of these points, which embrace a fairly extensive quadrilateral zone, that of Lauz (junction of outer and middle thirds of line joining antero superior iliac spires) most frequently corresponds to the base of the appendix. It is clear that the seat of appendicular pain is not absolutely fixed, but varies with the situation of the appendix while the contact of an inflamed appendix with other organs, *e.g.*, ovary, tube, bladder, may make the diagnosis very difficult. Appendicular pain may be confused with ureteral pain; thus the ureteral point of tourneaux corresponds practically to Lanz's point, and the sub-intra-spinous point of pasteau to that of McBurney.

Palpation of the appendix is only possible in very exceptional cases, and one is more liable to mistake for it, omental cords or adhesions.

In the employment of radiological methods most authors seem to have directed their attention to rendering the appendix visible, and drawing conclusions from its filling or non-filling, but agreement on this question is far from being complete. According to some authors the normal appendix always fills, once or oftener, in the course of the passage of an opaque meal, and they regard its non-filling as patho

logical. The authors have often seen the appendix, without employing any special methods beyond a liquid meal, but in a relatively small proportion of cases, about one in ten. They regard seeing it filled as a happy chance, so that no conclusion should be drawn from the fact that it is not seen. Other authors, on the contrary, regard the appendix as diseased if it is visible. Finally, to some, the fact that the appendix continues visible after the evacuation of the cæcum, is the result of a pathological state of the appendix, while to others this has no significance.

The insufficiency of the ileo-cæcal valve has given rise to equally contradictory opinions. The radiologic visibility of the appendix, therefore, can have only relative importance, and even a notable change in the shape of the organ, which is rare, does not give any precision to the diagnosis, since many diseased appendices give shadows indistinguishable from those of the healthy organ. In the author's opinion, more precise information is to be obtained from radiosopic examination, combined with palpation under screen, the importance of which only French authors have indicated. The latter permits one to investigate the points, or rather the zones of tenderness, while at the same time it gives information on the movability of the cæcum, and on the neighbouring organs. An important point in the technique, which is fully described, is that the patient should be examined both in the erect and in the recumbent position. The fact of finding a painful zone at the level of the ileo-cæcal region and of the implantation of the appendix, a zone which accompanies the cæcum in all its displacements, constitutes for them a sign of the first order, in fact they regard it as the most reliable sign of chronic appendicitis.

CHARLES MACAULEY.

JULLIARD (Minerva). *Appendicitis and the Menopause.* [Nev. Med. a.e. Suisse Rom. March, 1922. 129-147.]

APPENDICITIS, at all ages, can be very deceptive in its appearance. At certain ages, *viz.*, onset of puberty and menopause, painful abdominal crises, due to physiological engorgement may easily provide a chain of symptoms in which a differential diagnosis is not easily established at first appearance.

The appearance of appendicular phenomena during the menopausal period, does not seem to have received any particular study in the literature. Julliard has been led to a consideration of this subject, by having come in contact with eight cases in the past eight years, where the decision for or against operation was arrived at only after much uncertainty. The difficulty lies, not so much in the cases of appendicitis with frank abscess formation, or well-marked peritoneal reaction, as in the "sub-acute" or "chronic" forms, where the symptoms

can be shown on operation to be due to a genuinely pathological condition of the appendix.

To begin with, appendicitis is not common after the fortieth year, DeBovis' statistics (in nearly 3,000 cases) show only 12 per cent. in both sexes between 40 and 60 years; he further demonstrates that the frequency of chronic appendicitis in this period is only eight per cent., as compared with 40 per cent. in younger subjects.

The whole question revolves round the possibility of confusion between a pathological condition (appendix) on the one hand, and a physiological state (menopause) on the other; operation is indicated in the former, and is definitely contraindicated in the latter.

Amongst the general troubles met with in women about the period of menopause onset, we have to note: (1) *pain*; this is frequently complained of in the lower abdomen, or even in the right iliac fossa, lasting two or three days, often sufficiently severe to keep the patient in bed. It is not infrequently accompanied by (2) *nausea*, and *vomiting*, and (3) moderate fever may be present. Vaginal sensibility may not always differentiate the lesion, and abdominal rigidity is often missing in the chronically inflamed appendix. A genuine appendicitis may exist in a woman of this age, and may even have its onset concomitant with the monthly period; cases with identical symptoms on operation may disclose a healthy appendix. How is one to establish a differential diagnosis?

A history of pre-existent crises, prior to the menopause, points to the appendix as the seat of trouble; fever, too, is in favour of appendicitis. Pain, of a rhythmical type, synchronous with the onset of the period, and of monthly repetition, inclines the diagnosis to menopausal origin; this will be confirmed by the cessation of the recurrence of pain on the definite establishment of the "age critique."

Julliard sums up his own attitude as follows:—"It would seem that a patient who has already had several pre-existing attacks of 'appendicitis,' recurrent at each period, should be operated upon. A woman who has had *one* attack of apparent appendicitis, with pain persisting between the periods, should also submit to operation, even if the diagnosis be in doubt. If one is called to see the patient during her *first* attack, it is better to wait for time to establish the diagnosis. A patient under the observation of a watchful physician who is on his guard, will always find a surgeon to intervene should his colleague consider the symptoms have altered or developed sufficiently to justify operative intervention."

The question is one for further observation and record on the part of surgeons and gynaecologists.

WM. DOOLIN.