LOCAL DISCOLORATION OF THE ABDOMINAL WALL AS A SIGN OF ACUTE PANCREATITIS.

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In 1912 I was asked to see a big stout woman, 54 years of age, suffering from an acute abdominal illness of three days' duration. I was at once struck by the appearance of the abdominal wall surrounding the umbilicus. In this neighbourhood there was an area of discoloration about 6 inches in diameter, of a bluish colour, very like the early post-mortem staining seen on the abdominal wall, or the appearance of the skin in a late case of extravasation of urine. The area was slightly raised, and pitted on pressure. In this case (Reg. No. 5323) the patient suffered from acute pancreatitis, with much effusion into the peritoneal cavity. She lived nine days after operation, and the post-mortem examination disclosed a sloughing pancreas with much fat necrosis.

I did not observe this sign again until September, 1917, when an old soldier (Reg. No. 9536), 53 years of age, tall and of spare build, came under my observation. He had previously suffered from attacks of abdominal pain, but they had always been of short duration. On Sept. 17 he had a seizure like his old attacks, but so severe that it caused

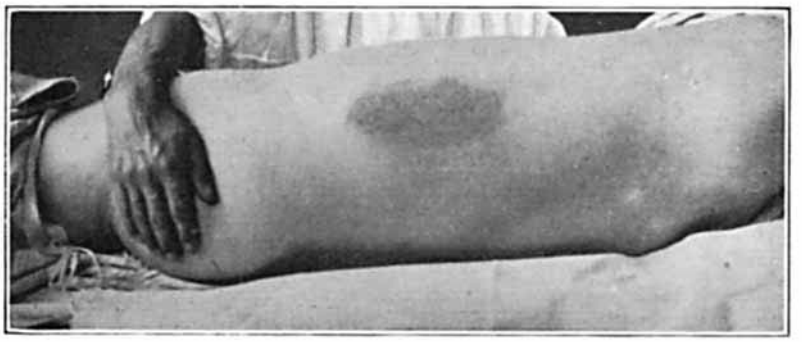

Fig. 365.—Photograph of a case of acute pancreatitis, showing the area of discoloration referred to in the text.

profuse clammy perspiration, and was only partially relieved by ¾ gr. of morphine hypodermically. Next day the pain was easier, but there was some tenderness over the gall-bladder region. On the 19th the abdomen was beginning to be distended. On the 20th the pain was still better, but there was more distention, and the pulse was now over 100. The attack was recognized as being much more severe than any from which he had previously suffered. On the evening of this day I first saw the patient. He looked very ill and distinctly toxic. The tongue was dry, the pulse 112, and the temperature over 100°. The abdomen was generally distended, and he was very tender and rigid in the right hypochondrium. No mass could be felt, and no superficial discoloration was noticed, although it was not especially looked for. The next day the patient was more comfortable generally: the pulse was still 112, though the temperature had come down, and he had passed considerable flatus. The tenderness over the gall-bladder region was very marked, and I now noticed two large discoloured areas in the loins. They were about the size of the palm of the hand, slightly raised above the surface, and of a dirty-greenish

colour. There was a little œdema, with pitting on pressure, but there was no pain or tenderness. The urine was found to be full of sugar. A diagnosis of acute pancreatitis was made; and this was confirmed by an immediate operation. The peritoneal cavity contained a moderate amount of dirty-brownish fluid, and there was a good deal more on passing the fingers down towards the pancreas. There was very extensive fat necrosis of the omentum. The gall-bladder contained large numbers of small calculi. Incisions were made into either loin over the areas of discoloration. The superficial tissues were markedly œdematous, and there was a considerable quantity of thin, dirty fluid from the retroperitoneal space. The subcutaneous and retroperitoneal fat showed areas of necrosis.

The patient stood the operation very well, and for a day or two he improved; but at the end of about a week he began to lose ground, suffering from vomiting, air-hunger, inability to sleep, and steady wasting. Death occurred five weeks from the date of the operation. At the post-mortem examination the pancreas was found converted into a slough, and there was a direct track leading from it to the incisions in either loin. There was also extensive fat necrosis, but the peritonitis had recovered, and the abdominal cavity was clean.

The illustration (*Fig.* 365) is from a photograph taken just before the operation, and accurately represents the situation and size of the patch in the left loin, that on the right side being exactly similar. The condition is clearly due to the direct action of the pancreatic juice, which escapes via the retroperitoneal tissue, and passes by the most direct route to the surface. In the case in which the discoloration was only noted round the umbilicus, the secretion may perhaps have reached that area via the round ligament of the liver.

In a cursory examination of the voluminous literature on pancreatitis I have not observed any mention of this sign.