

## REPORT OF CASE

**History.**—A. S., farmer boy, aged 14, one of several children, had had good health until he became sick with measles in February, 1909. The attack was of unusual severity with marked gastrointestinal complications, dysentery persisting after the usual symptoms had disappeared. The dysentery ultimately ceased and was soon followed by symptoms consisting of pain, increase in size of abdomen, nausea, fever, and constipation, which seemed to the observer to indicate intestinal obstruction. I was called by the attendant on March 5 to operate for a supposed intestinal obstruction.

**Examination.**—Patient's temperature was 104, pulse 120; appearance indicated sepsis; abdomen was enormously distended; there was complete dullness from one iliac crest to the other, and from umbilicus to pubes.

The examination did not suggest intestinal obstruction to me. The boy's condition being critical and the nearest hospital sixty miles away, I undertook the operation amid very dirty surroundings, two other children being sick of measles in the same house, which contained three small rooms.

**Operation.**—After such preparations as were possible, the boy was placed on the kitchen table, and after the usual toilet of the operative field the abdomen was opened by a median incision, which was followed by the discharge of huge quantities of pus and fecal matter. The abscess cavity, however, was well walled off. After cleansing the cavity a ragged hole was seen in the sigmoid, large enough to admit two fingers. The opening in the bowel was surrounded by an indurated area, such as one finds in ulcer. On account of the considerable destruction of tissue, and for fear of disturbing the adhesions, no effort was made to suture the bowel. The cavity was wiped clean and drainage established.

**Postoperative History.**—The patient was put to bed in good condition and placed in the Fowler position. The subsequent history was uneventful, the bowels moving normally on the second day. The after-treatment was left to the attending physician. I saw this boy about three weeks after the operation, the abdominal wound was practically healed, bowels moving normally and general health good. It is now over eight months since the operation; the patient is in perfect health with no symptoms of cicatricial stricture of bowel which I feared might occur. The apparent rarity of bowel perforation in measles prompts the report of this case.

4263 Morgan Street.

## DIVERTICULUM OF THE STOMACH

JOHN M. LITTLE, M.D.  
BOSTON

In a clinic characterized by a large percentage of digestive disturbances, I have found it easy to distinguish a certain number in which the symptoms were due to gastric or duodenal ulcer. This statement I make, because in all cases in which operation has been performed on this diagnosis, I have demonstrated the ulcer on the table. The following case is reported because of the definiteness and simplicity of the symptoms, their difference from the symptoms of the more usual conditions, and their complete explanation by the pathologic findings at operation. These last may be briefly described as narrowing of the pylorus and diverticulum of the stomach caused by stretching of its wall, the whole being due to the scar of an old ulcer completely healed.

**History.**—A. B., aged 56, fisherman (Hosp. No. 457), was subject to indigestion for some years but two years ago began to have severe pains in epigastrium after eating. At times he would vomit, very bitter substance; and the vomiting gave immediate relief. Otherwise the pain would last perhaps from fifteen minutes to half an hour. Since then he has eaten only liquid food. The eating of anything solid always causes this pain, which is unbearable. He has always been well and healthy in every other way.

**Physical Examination.**—A well-developed and nourished healthy looking man. Physical examination shows nothing abnormal. He shows the epigastrium to be the seat of the pain and says there is tenderness there at the time the pain is there. There is now no tenderness on deep pressure.

**Operation.**—Oct. 18, 1909, after the usual preparation, the patient was operated on under ether anesthesia. The stomach, the capacity of which was normal, was washed out on the table. A four-inch incision was made in midline between ensiform and umbilicus. With the exception of the following condition, the abdominal contents were normal. There was a whitish-looking scar running from the upper part of pylorus downwards and to the left along the anterior stomach wall. To the right of this was what I took at first to be the duodenum but which turned out to be a diverticulum of dilated stomach wall, lying in front of the duodenum and capable of holding about six ounces. There were no adhesions or palpable thickenings of the walls. The stomach was opened by an inch incision on its anterior aspect. The finger carried forward, toward the pylorus, entered a ring of tissue which just admitted it. Feeling around, the finger entered another ring, which just barely admitted it. This latter turned out to be the pylorus lying behind and above the former, which was the opening into the diverticulum. Inspection showed no ulceration of the mucous membrane, which looked normal. With a finger in the pylorus, an incision an inch and a half long was made in the pylorus extending (longitudinally to axis of stomach) from the duodenum across the pylorus into the diverticulum. This incision was then sewed up transversely to the axis of the stomach. This pyloroplasty caused, at the same time, enlargement of the pylorus and drainage of the diverticulum. The hole in the anterior wall was then closed in like manner by an over-and-over stitch through all layers, followed by a continuous Lembert suture. The abdominal wall was closed by layers.

Recovery was uneventful. The patient has been on ordinary diet and has had no symptom since.

317 Dartmouth Street.

## APPENDICITIS DUE TO THREADWORMS

T. H. CULHANE, M.D.  
ROCKFORD, ILL.

The patient, a married woman aged about 21, suffered with intense pain at McBurney's point, together with intense nausea. She had no desire for food and, when food was taken, it was immediately rejected. On Sept. 8, 1909, about two weeks after I first saw the patient, I operated, removing the diseased appendix. The contents of the appendix were forcibly expelled on my finger, and live worms could be seen crawling therein. The appendix contained about eighteen threadworms. The mucosa of the appendix was congested and thickened, and contained many punctate hemorrhagic spots. The patient made a good recovery.

1025 South Main Street.

## APLASIA OF THE UTERUS

CHARLES L. PATTON, M.D.  
SPRINGFIELD, ILL.

Several years ago I reported<sup>1</sup> a curious malformation of the internal genitalia in a child, classifying the malformation as either pseudohermaphroditism masculinus externus or bilateral inguinal hernia of the ovaries with aplasia of the uterus. Since reporting this case I have seen two other cases in which I was unable to detect a uterus. Neither of these presented the condition found in the labia majora in the reported case, but both gave evidence of a marked interference with the development of the internal organs of generation.

1. Patton, C. L.: Case of Malformation of the Internal Genitals with the Reproductive Glands in the Labia Majora, *Am. Jour. Obst.*, October, 1904.