

In our case the growth was probably already present in the mucous membrane at the time of the first operation, but was obscured by the œdema and blood extravasation which had infiltrated the bowel wall.

AN UNUSUAL FORM OF VENTRAL HERNIA.

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THE following is a description of an unusual form of ventral hernia that came under my care some months ago:—

Mrs. E. B., aged 61, was admitted to the Great Northern Central Hospital on the night of April 12th, 1919, complaining of vomiting, pain, and the protrusion of a "piece of intestine" from the site of an artificial anus made four months previously at another hospital. This was at the umbilicus, and had worked well during that time. Examination showed a condition of acute obstruction, and what appeared to be a loop of bowel about 10 inches long protruding through an opening in the belly wall, just as if a loop had been forced through a stab wound. The constriction was so tight that its edges could not be defined, and I was at a loss to account for the condition, except on the hypothesis that the junction between bowel and belly wall had broken away in part, leaving a rent, through which a loop of intestine had been forced.¹

As the condition was obviously one for immediate operation, I opened the abdomen in the mid-line below the protruding bowel and extended the incision upwards to relieve the constriction and ascertain the exact condition. This condition was interesting. It showed that the previous operation was a colostomy, made about 6 inches above the cæcum. Part of the wall of the colon had been forced through the colostomy opening, and by stretching and turning inside out, formed the sac of a hernia, the content of which was a loop of gangrenous small intestine 10 inches long. What I had taken for the peritoneal coat of the "protruded loop" was really mucous membrane of colon, but so stretched and shining as to be indistinguishable from peritoneum. The gangrenous contents of the sac were readily removed when relieved from constriction and were resected. A lateral anastomosis was made, the colostomy returned to its normal position, and a tube placed in the pelvis.

The previous history of the patient was obtained later from the surgeon who had performed her former operation. He states:—

"She was seen by me on Nov. 25th, 1918, with symptoms of acute obstruction of three or four days' standing. Three years before she had had an operation for radical cure of an umbilical hernia. An umbilical hernia was present on this occasion, and I cut down upon it in the central line. A piece of distended bowel presented, but it was firmly adherent all round, and I could not demonstrate the peritoneal cavity at all. Her condition being bad, I tied in a Paul's tube, evidently into large intestine. Later, as her appearance was a bit suggestive of malignant disease, but she was otherwise doing very well, I determined to 'leave well alone.'"

The patient did very well for nine or ten days. Then her pulse began to get weaker and rapidly failed, and on the twelfth day she died.

Post-mortem examination showed a clean anastomosis and abdominal cavity. The large intestine was normal. There were three calcified fibroids in the uterus, one as large as a man's fist. The heart was flabby. Nothing else abnormal was found.

I think this case shows well the need for avoiding the mid-line for colostomy; for whereas in other situations abdominal muscular action tends to

close such openings, in the mid-line the reverse must happen, and this appears to have been such a case.

A PSEUDO-PARATYPHOID CARRIER.

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PARATYPHOID infections came into great prominence during the war—especially the question of carriers, as it is a well-known fact that the organisms of this group, being more long-lived than typhoid, persist longer outside the body. From some cases organisms have been isolated resembling the members of the paratyphoid group in so far as the biochemical reactions are concerned, but altogether atypical in their specific serum reactions. The latter is a very important matter, as the ultimate diagnosis is based upon serological test, and the only chance of diagnosing rightly in such cases is by isolation of bacilli from excreta or blood (patients' serum giving no reaction with standard stock cultures of typhoid-paratyphoid A or B). Since some time back four cases of pseudo-paratyphoid were reported from Cairo district,¹ the following case of a carrier coming from the same area is interesting:—

The patient, an Indian, was admitted to hospital suffering from facial paralysis. He was well nourished and seemed all right, except for a tendency to obesity. Four months before admission he had pyrexia, which was diagnosed as (?) malaria. He had traces of albumin in his urine, which was sent to the laboratory for examination of casts. From the urine a motile Gram-negative bacillus was isolated, which gave the sugar reactions of paratyphoid group, but failed to be agglutinated by any of the stock sera; the patient's serum, however, showed a strong agglutination up to 1 in 400 dilution, and a weak one up to 1 in 900 dilution. The serum failed to agglutinate any of the stock cultures of paratyphoid A, B, or typhoid, even in dilution of 1 in 10.

My personal belief is that the pyrexia diagnosed as (?) malaria was an infection with pseudo-paratyphoid, and that since then the patient has become a chronic carrier. The patient's serum of the above did agglutinate the pseudo-paratyphoid from the carrier described by Captain Paton up to a dilution of 1 in 80, and gave similar sugar reactions.

Twice before I have come across similar organisms in urine; one of the cases was suffering from liver abscess, and the organism was obtained from the liver pus.² That such organisms are pathogenic can be easily understood from the cases noted by several French observers³ and others in the late epidemic in Cairo Prisoners of War Hospital recorded by Captain Paton.

I am indebted to Colonel Jennings, O.C., No. 45 Indian General Hospital, for permission to publish the above case, and to Captain Paton for giving me a subculture of the organism isolated by him from a carrier at No. 2 Prisoners of War Hospital, Cairo.

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¹ THE LANCET, 1919, i., 1072.

² Brit. Med. Jour., March 29th, 1919, p. 378.

³ Typhoid and Paratyphoid Fevers, by Vincent and Maratet, p. 117.

LITERARY INTELLIGENCE.—Messrs. J. and A. Churchill will shortly issue a new book by Dr. A. T. Schofield under the title of "Modern Spiritism: its Science and Religion." The publishers' profits will be given to the British and Foreign Bible Society.