

# PERFORATION OF THE ILEUM COMMENCING ON THE PERITONEAL SURFACE,

REPORTED BY DR. ADAMS, OF GLASGOW.

WILLIAM MITCHELL, aged 54, tolerably robust, temperate, and enjoying good health up to May 28, 1840. At ten o'clock, a.m., of that day, I was sent for, and found him affected with all the symptoms of strangulated hernia,—his scrotum filled on both sides with intestine, the left protrusion irreducible. The taxis was successful, and the urgent symptoms almost immediately relieved. At my next visit he complained much of pain in the left iliac region, which a few leeches, followed by warm fomentations, abated considerably. I heard no more of him until Saturday, the 13th of June, and at ten, p.m., on that day I was again summoned. He had enjoyed good health from the time of my last visit, thirteen days before, up to half an hour prior to the present one; however, the tenderness in the left iliac region had never entirely subsided, and was sufficiently acute to prevent his wearing other than his old bag-truss. He had been unable, also, to reduce, as formerly, the entire hernial protrusion, but that circumstance caused him no uneasiness, and his bowels were easily enough regulated. About half an hour before my visit he had, whilst indulging in the company of some friends, been suddenly seized with a violent pain in the left iliac region, accompanied with an extreme sense of weakness, followed by sickness and violent retching. At my visit the pain had become more diffused over the lower part of the abdomen, which was painful to the touch; the inferior portions of the abdominal muscles were so contracted as to feel as hard as a board; the expression of countenance was exceedingly anxious, and the features were greatly altered in appearance; the whole surface of the body was cold, and covered with a profuse perspiration; the pulse was 120, small, and thready; the sickness and vomiting still continued. With respect to the herniæ, both protruded considerably, but could be returned with tolerable facility; excepting a doughy mass, which had been felt in the left hernial sac, even after it was emptied of the greater portion of its contents. From the large size of the abdominal aperture, from the ease with which the greater portion of the hernia could be reduced, and from the statement of the patient, that it had never been more so since my last visit, I was satisfied that there was no strangulation of intestine to account for the symptoms then present. I accordingly diagnosed peritonitis from perforation of intestine. The remedial measures were turpentine embrocations to the abdomen, and, every third hour, three grains of calomel and one of opium. At ten o'clock next morning the

patient's appearance was highly satisfactory. He had slept a little during the night; the expression of his countenance was improved; there was less abdominal tenderness; the surface of the body was warmer; the pulse somewhat fuller and less frequent; his bowels were still, however, unopened, and his efforts at micturition were frequent, unsatisfactory, and accompanied with excessive pain. The calomel and opium, with the turpentine embrocations, were continued, and the catheter was used. The appearances of amendment in the patient's condition proved fallacious. At two in the afternoon, when I again saw him, he was evidently moribund. The efforts at vomiting had returned shortly after the last visit, and still continued; the pulse was imperceptible at the wrist; cold sweats again bedewed the body; the countenance was anxious in the extreme; the breathing panting, and accompanied with the tracheal rattle. The patient, who was quite sensible, said he had no pain. He died at six o'clock the same evening. Thus, the time which elapsed between the last sudden attack and its fatal termination was exactly twenty and a half hours.

## *Examination Thirty-eight Hours after Death.*

The body was plump, on many places showed livid patches, and exhaled a most offensive odour; the abdomen was very tympanitic, and the scrotum inflated to an enormous extent; on laying open the abdomen fetid air gushed out in great abundance; the large omentum was much upon the stretch, and at one point adhered strongly to the left hernial sac; on turning it over, the small intestines were seen highly injected, streaked with lymph, and in many places covered with purulent matter; they did not, however, adhere to each other, nor was any portion of them engaged in either hernial sac. In the pelvis, and the right and left lumbar regions, we found a considerable quantity of a dark-brown coloured fluid, having a most offensive feculent smell; and on examining more minutely the state of the intestines, we found, in addition to the general effects of acute inflammation already described, towards the left side, and in that portion of intestine usually considered as the commencement of the ileum, a circular perforation, large enough to admit the point of the forefinger. The appearances of inflammation were more vivid in this situation, and the quantity of lymph and purulent matter thrown out was greater than in the other parts. It was evident that the intestinal tunics were not all destroyed in an equal manner, *the destruction of the peritoneal being considerably greater than that of the mucous.* On the same portion of intestine, and within an inch and a half of the perforation, a small spot of ulceration was discovered, *confined entirely to the serous membrane.* The mu-

cous coat was throughout healthy, and even in the immediate vicinity of the perforation, showed no traces of increased vascular action. We examined most carefully the whole intestinal tract, from the stomach to the rectum, but could discover no further lesion. The mesenteric glands were of their normal volume. The case I consider to be almost unique.—*Edin. Monthly Journal*.

### VEGETABLE ORIGIN OF PORRIGO DECALVANS.

PORRIGO decalvans is a disease of the skin, usually of the scalp, producing a falling-off of the hair from the parts affected. It is characterised by rounded spots or patches, the surface of which is usually covered with small dry scales, or a white bran-like powder. If this powder be examined with the microscope, it will be found to consist of minute *cryptogamic* plants. The hairs that have fallen off are observed to be encrusted on all sides with these singular growths, and to form a veritable vegetable sheath, which invests them from their point of emergence from the skin to the extent of three or four millimetres. M. Gruby (the discoverer, we believe, of this pathological curiosity) has denominated the fungus by the appellation of *microsporon Andouini*, in compliment to M. Andouin, whose inquiries have done so much to illustrate the nature of the parasitic plants, which infest the tissues of living animals.

This porriginous fungus commences its development on the surface of the hairs, at the distance of one or two millimetres from the epidermis; the first sign of its existence being that the tissue of the hair is observed to lose its transparency, in consequence of the formation of excessively minute molecules on its surface.

The altered tissue exhibits the appearance of having distinct fibres, and of cells larger than the fibres of the hairs, elongated and situated parallel to their axes. It is in this part that the *microsporon* is first perceived. By its gradually extending in all directions, the adjoining hairs are quickly affected in a similar manner, and the morbid growth advances until patches of the affected hair fall off, and leave the skin nearly quite bald.

These fungi are developed and multiplied with surprising rapidity, and hence the extension of the diseased patches is sometimes very sudden. The hairs usually break off at the point where they are invested with the vegetable covering. The thickest hairs resist the invasion of the disease the longest. The vegetable nature of *porrigo decalvans* is a fact that speaks for the contagiousness of the disease. How far any of the other varieties of this scalp-affection are traceable to a similar origin has not yet been ascertained. The first step to the cure of a disease being to understand its nature, we may fairly anti-

cipate that the discovery of M. Gruby will have a therapeutic, as well as a physiological, interest.—*Med. Chir. Rev.*, Jan.

\* \* We have recently been enabled to confirm the observations of M. Gruby. *Porrigo decalvans* is, in many cases, very intractable, but we have found it yield to local applications, in some instances, of sulphate of iron. Others we have treated successfully by tincture of cantharides, combined with castor oil.

### BRITISH MEDICAL JOURNALS.

IN another page (556) of this week's LANCET will be found an analysis of a case (originally published in the London and Edin. Monthly Journal), which is not very often met with, viz., one of *ulceration of the peritoneum*. Serous membranes resist this action in a remarkable manner, and rarely become, in the first instance, the seat of the destructive process in question. Some few cases, however, are recorded by Scoutetten, Portal, and other authors. Dr. Stokes has related an instance in which the pleura was the seat of ulceration. These, taken in connection with the present well-marked example, seem to us to place the fact of its occurrence beyond all doubt.

Serous membranes do not differ essentially, in their structure, from the cutaneous and mucous textures. All are composed of a layer of extravascular, epidermic, or epithelial scales, placed over a vascular network. When serous membranes become the seat of inflammation, lymph, a highly-organisable substance, is produced. When cutaneous, or mucous tissues, on the other hand, are inflamed, a less organisable matter is effused, and ulceration is a frequent result. Let us suppose, then, this organisable matter to be absent, owing to the extremely acute character of the sub-serous inflammation, destroying the surface which should yield it. Or let us have this matter less capable of organisation than usual (not a very unfrequent occurrence), and what may we expect to find? Nothing more or less than what the present case shows us, namely, abrasion, or ulceration, of the peritoneal, or of any similar serous surface. Dr. Adams' remarks on this case are applicable and not too extended. The style, however, of his communication is not particularly clear, and we could wish that Dr. Adams had rendered the case complete by describing the appearance presented by the ulcerated surface.

ERGOT OF RYE IN RETENTION OF URINE.—The following is an outline of a case related