

pedunculated fibroid from left uterine cornu, double salpingitis; abdominal myomectomy, removal of right tube; R.

130.—E.B., 49, S.; T.H.; Dr. H. E. Powell; April 26th; uterine fibroid, cystic and adherent left ovary; prolapse of rectum; abdominal hysterectomy, left ovariectomy, suspension of rectum to sacrum; R.

131.—J.S., 36, M.; C.H.W.; May 7th; uterine fibroids, small left ovarian cyst, dense bowel adhesions; abdominal hysterectomy, left ovariectomy; R.

132.—A.R., 44, S.; C.H.W.; May 7th; uterine fibroids, cystic left ovary, bowel adhesions; abdominal hysterectomy, left ovariectomy; R. Previous myomectomy, see No. 10.

133.—R.W., 44, M.; T.H.; Dr. F. J. Tresilian; May 17th; uterine fibroids with adhesions; abdominal panhysterectomy, removal of right appendages; R.

134.—A.H., 46, W.; C.H.W.; May 21st; uterine fibroids with bowel adhesions, diseased appendages; abdominal hysterectomy, removal of both appendages; R.

135.—I.C., 43, M.; C.H.W.; Dr. T. N. Kelyack and Dr. Clements; May 28th; uterine fibroid; abdominal hysterectomy; R.

136.—J.B., 42, M.; Dr. Townsend Barker; June 11th; uterine fibroids with cervix fibroid; abdominal panhysterectomy, removal of left appendages; R.

137.—M.L., 49, S.; T.H.; Dr. G. Angus Hunt; June 14th; uterine fibroids, right cystic ovary; abdominal hysterectomy, both appendages removed; R.

138.—M.P., 41, S.; C.H.W.; Dr. Thomas and Dr. Garvin; June 18th; uterine fibroids, right ovarian cyst, left hydrosalpinx; abdominal hysterectomy, removal of both appendages; R.

139.—L.H., 32, M.; T.H.; Dr. Moore; June 28th; subperitoneal fibroid; abdominal myomectomy; R.

140.—M.H., 45, S.; C.H.W.; Dr. W. W. Don; July 2nd; multiple fibroids; abdominal panhysterectomy; R.

141.—J.B., 50, M.; C.H.W.; July 2nd; uterine fibroids, both ovaries cystic; abdominal hysterectomy, double ovariectomy; R.

142.—J.S., 44, M.; T.H.; July 5th; uterine fibroid; abdominal hysterectomy; R.

143.—E.H., 33, S.; T.H.; Dr. L. P. Scott; August 2nd; uterine fibroids, cystic left ovary; abdominal hysterectomy, left ovariectomy; R.

144.—A.C., 38, S.; T.H.; Dr. David Petty; August 2nd; large uterine fibroids, double ovarian cyst, dense adhesions; abdominal panhysterectomy, double ovariectomy; R.

145.—M.R., 37, M.; C.H.W.; Oct. 1st; large red degenerating subperitoneal fibroid, dense bowel adhesions; abdominal myomectomy; R. Previous operation for right extra-uterine pregnancy.

146.—L.L., 33, M.; P.; Dr. W. Henry White; Oct. 12th; uterine fibroid; abdominal hysterectomy; R.

147.—S.T., 47, S.; T.H.; Dr. A. de Prenderville; Oct. 12th; uterine fibroids, cystic right ovary; abdominal hysterectomy, right ovariectomy; R.

148.—C.W., 57, M.; T.H.; Dr. R. Lyon; Oct. 18th; uterine fibroids, fundal fibroid adherent to abdominal wall; abdominal hysterectomy; R.; previous double ovariectomy (16 years).

149.—E.M., 34, M.; Dr. W. Love; Oct. 18th; uterine fibroid, double chronic inflammatory disease of the appendages; abdominal hysterectomy; removal of right appendages; R.

150.—K.G., 46, M.; P.; Dr. H. E. Powell; Oct. 21st; uterine fibroid, commencing cystic degeneration; abdominal panhysterectomy; R.

(To be continued.)

TWO CASES OF INTESTINAL OBSTRUCTION IN CHILDREN.

By E. P. BAUMANN, M.D. EDIN., M.R.C.P. LOND.

CASE 1. Acute intussusception reduced by manipulation.—My first case was that of a little girl, aged nine years, the daughter of a relative, to whom I was urgently summoned on the evening of Sept. 17th, 1906. It appears that the child, who was convalescent from a recent attack of whooping-cough and in fair general health, had come home from school that afternoon complaining of "stomach-ache," the result, she said, of a fall whilst playing some game. As she complained of very severe pain and seemed ill she was put to bed and various domestic remedies were applied both internally and externally—amongst others, a dose of Gregory's powder was administered. Nothing served, however, to alleviate the condition and the child lay moaning and writhing in pain. She seemed after nightfall to become very collapsed and on measuring her temperature and finding that the thermometer registered less than 97° F. the parents became alarmed and sent for me in haste. On my arrival I found the patient in a state of collapse, with a pale face, sunken eyes, and a rapid and compressible pulse. She lay with her knees drawn up and complained of severe pain in the lower abdomen. The tongue was dry and furred. The temperature was subnormal. I ascertained, on inquiry, that there had been no movement of the bowels that day, nor had there been any vomiting. On palpation of the abdomen there was readily felt a tumour lying transversely immediately below the level of the umbilicus. The mass was cylindrical and sausage-shaped, distinctly curved, smooth, and of firm elastic consistence. Per rectum the rounded end of the tumour was

distinctly felt, forced down against the finger when the patient strained and receding when the abdominal muscles relaxed. The finger on being withdrawn from the rectum was found to be coated with blood-stained mucus. I informed the parents that an intussusception existed and urged upon them the necessity for immediate operative interference. Before taking steps to secure surgical assistance I determined, however, to assay abdominal taxis. This method, a strong plea on behalf of which was advanced by Mr. Jonathan Hutchinson in the early "nineties," consists in kneading and manipulation of the abdomen and so attempting to reduce an intussusception. Ever since first I had read of this method I had been struck by its obvious value, but I had never before had an opportunity of putting it into practice. All the cases of intussusception I had previously met with were of longer duration, more or less firm adhesions having already formed. In the present instance the condition was probably of not more than at the most three or four hours' duration, and the case was consequently a very suitable one for taxis. I was able fairly well to grasp the tumour externally with the left hand and with the tip of the right forefinger in the rectum exerted a kind of bimanual manipulation, alternately increasing and relaxing the pressure with either hand. The tumour gradually disappeared with gurgling and borborygmus, and the child professed herself instantly relieved. I then ordered an enema to be administered, with the result that a copious motion was brought away. The abdomen was now quite flaccid and no further serious pain was complained of. After ordering a small dose of morphine I left the patient for the night. Three or four motions containing blood-stained mucus were subsequently passed and the child vomited once or twice. By the following morning the patient had completely recovered her normal health. For several days I anxiously awaited the trend of events, for the possibility of a recurrence was by no means excluded. There has been, however, no recrudescence of the symptoms, and it must be concluded that the manipulative measures were completely successful.

Remarks.—Unfortunately every case of intussusception is not so amenable to treatment as this one proved to be. In the majority of cases by the time the diagnosis is made adhesions have already formed and the necessary manipulations are then, on the one hand, little likely to be successful; and, on the other, not unattended by danger from the possibility of rupture of the gut with subsequent fatal peritonitis. In reference to the causation of the lesion in this case there were two factors of speculative interest, namely—(1) the convalescence from a recent attack of whooping-cough; and (2) the history of an injury to the abdomen. The former factor not infrequently figures in the history of cases of intussusception in children, whilst isolated cases have been recorded where abdominal trauma appeared undoubtedly to be the cause of the condition. In the present case both factors may have been of influence, the one in predisposing to and the other in determining the onset of the lesion.

CASE 2. Subacute intussusception simulating dysentery.—The second case was that of a female child, aged 15 months, whom I saw in consultation with Mr. W. Eddowes at Norwood, an outlying suburb of Johannesburg, on the night of Nov. 5th, 1906. The child had been ill for 72 hours with diarrhoea, the stools being loose and containing mucus and a considerable quantity of blood. A diagnosis of dysentery had been made and treatment administered in this direction without diminishing either the frequency or the unhealthy character of the motions. The temperature had at no time risen above the normal and tended rather to be subnormal. I was struck at the outset by the large amount of blood contained in the stools; the napkins looked like handkerchiefs used for a bleeding nose. With so much hæmorrhage considerable ulceration of the bowel must exist, and if there were much ulceration one would expect pyrexia at least at some stage of the illness. The stools varied in character, from a green and unhealthy to a yellow and natural colour, in the various diapers shown to me, and all contained blood and mucus. On inspection the child appeared to be fairly comfortable in spite of the frequency of the motions and she appeared to be in pain only at intervals when the legs were drawn up and there was evident intestinal colic. On examination the abdomen was found to be flaccid; in the left iliac region there was felt a small mass, about one and a half inches long and a finger's breadth in diameter. This mass, which was distinctly tender to palpation, by no means corresponded to the typical sausage-shaped tumour described in the preceding case; its presence very strongly suggested an

intussusception, but I had to confess that it might have been occasioned by an enlarged and inflamed gland, or even by a faecal accretion. Rectal examination proved negative. I expressed my suspicions but did not meet with much credence, the more so as another member of the family, a boy, aged three years, had also that night passed a blood-stained motion. Now, the firmest adherent to the doctrine of the necessity for suspecting the existence of an intussusception in every unexplained abdominal derangement cannot conscientiously assert that this lesion occurs in an epidemic form in families. I was reluctantly compelled, therefore, tentatively to acquiesce in a diagnosis of dysentery. This I did the more readily in view of the fact that the treatment adopted—frequent doses of sodium sulphate by the mouth, together with high rectal injections of astringent solutions—was not directly inimical to either condition. Two days later, on Nov. 7th, I again saw the patient with Mr. Eddowes. No change had yet occurred in the frequency and character of the motions but the child was distinctly losing ground. There was no vomiting now or at any other stage of the illness. On abdominal examination I was unable to discover the mass which had been present at my first visit, but Mr. Eddowes informed me that he had distinctly detected it a few hours before my arrival. Now this alternating presence and absence of the tumour, accompanied by frequent bloody and mucous stools of an otherwise not decidedly unhealthy texture, is so characteristic of the condition that I with more firmness declared that in my opinion the case was one of subacute incomplete intussusception for which an immediate exploratory incision was indicated. Once more my dictum was rudely shaken by the discovery that the elder child, before mentioned, had also that morning voided a blood-stained motion. On the previous occasion his stool had been pale, loose, and distinctly blood-stained, leading one to fear that he might be at the beginning of an attack of dysentery; this time the motion was healthy and well-formed, containing only a streak of blood such as is not uncommonly produced in children by a rectal polypus. I performed a rectal examination with a view to discovering a growth of this character but the result was negative. I next suggested that the original patient, the baby, should be examined in a similar quest. A whiff of chloroform was consequently administered and a careful rectal examination undertaken, both digitally and by inspection through a speculum; the result was *nil*. Abdominal palpation also proved negative. On Nov. 9th Mr. Eddowes telephoned to me to the effect that the child was slowly sinking. On ascertaining that the elder boy was perfectly well and had passed no further blood in his stools I once more declared my views as to the existence of an incomplete intussusception. This time I decisively asserted my opinion, insisting that in immediate operative interference lay the only possible hope of saving the life of the patient.

On the following morning, the ninth day of the illness, Dr. G. A. E. Murray of Johannesburg was summoned to perform a laparotomy, which I witnessed. On opening the abdomen in the middle line coils of distended small intestine at once protruded. On tracing the gut downwards it was found to grow narrowed and its walls were seen to be discoloured, the congestion becoming more intense until, about the upper third of the ileum, a very small enteric involution was met with. The intussusception was readily reducible and the mesentery at this point was then anchored by a stitch or two to the peritoneum of the anterior abdominal wall. The whole operation occupied not more than some 20 minutes, the greatest haste being necessary in view of the extremely collapsed condition of the patient. Hot bottles, stimulants, and subcutaneous injections of normal saline solution were energetically employed, but without avail, for the child never rallied and death supervened two hours later.

Remarks.—This case appears to me to present many features of unusual interest which seem to render it worthy of the detailed description I have given of its course. In the first place, there is the fact of the comparative rarity of these cases of incomplete intussusception in which the occlusion of the bowel is incomplete and the passage of faeces continues unimpeded, whilst there is little or no vomiting. These cases may last for weeks or become chronic and exist for months or years, death in most instances being due to exhaustion. Secondly, there was the considerable amount of hæmorrhage from the bowel. Usually, in subacute or chronic intussusception the catarrhal changes at the neck of

the involution are comparatively slight and the stools are characterised only by small hæmorrhages. Thirdly, there was the similarity to a case of dysentery—superficial, it is true, yet sufficiently exact to obscure the diagnosis. In a paper on chronic intussusception published in the *Transvaal Medical Journal* of November, 1905, I drew attention to the frequency with which diagnostic difficulties of this character arise. Fourthly, there were the disappearance and reappearance at intervals of the abdominal tumour. According to Treves, a tumour is felt on abdominal examination in only 50 per cent. and rectally in only 32 per cent. of these cases, and in the paper already quoted I have drawn attention to the recognised fact that the tumour, once it has been felt, may disappear from time to time. For this reason it is essential that the examination of the abdomen should be undertaken both thoroughly and repeatedly. Fifthly, the fact that another child of the same family should also, and at about the same time, have passed blood-stained motions was perhaps the most perplexing factor of this difficult case. Had it not been for this fact I should have insisted upon operative interference on the occasion of my very first visit, when the patient was still of comparatively good health and the prospects were favourable. In the circumstances we had to await developments in the second child and in the meanwhile lost valuable time. Mr. Eddowes has since informed me that a few days after the death of the patient a native servant of the same household had developed undoubted dysentery, for which he was successfully treated at the Johannesburg Hospital. The question thus arises as to whether it is possible that both children had also suffered from dysentery, the baby developing her intussusception as a sequela to this disease. If so, one would expect the elder child to have been constitutionally affected, whilst apart from his blood-stained motions he appeared throughout to be in perfect health. The parents themselves attached little importance to his condition and the mother informed me that all her children from infancy had been known occasionally to pass blood in their stools whilst enjoying perfect health. Lastly, the fact of the situation of the intussusception in the course of the ileum is of interest, the enteric being one of the rare forms of intussusception.

Johannesburg.

A CASE OF PNEUMOCOCCAL CEREBRO-SPINAL MENINGITIS SIMULATING "SPOTTED FEVER."

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THE following case appears to be of especial interest at the present time in view of the prevalence of epidemic cerebro-spinal meningitis in various parts of the United Kingdom. The patient, a man, aged 24 years, was an architect's assistant and had been working in the vicinity of Hampstead for some months. He was a well-built young fellow of considerable prowess as an athlete. His previous health had been good, but there was a history of a slight attack of influenza about a month ago, and he is said to have had a severe attack of "sunstroke" (fever, severe headache, and vomiting) about eight years ago, when he was in bed a week. The patient's mother's brother is said to have died from meningitis some years ago after an illness of 36 hours.

The patient's illness began on Feb. 12th, when he returned from work in the evening complaining of headache and pains in the limbs. He vomited three times during the night. On the next day he got up for a few hours; he was "dull and heavy" but did not sleep. The temperature was 100.2° F. He took a dose of cascara and had several loose motions. During the night he apparently had a fit. On the 14th he was seen for the first time by us. In the morning the temperature was 100°, the pulse was 108, the respirations were 46, the tongue was dry and coated with brown fur, and the throat and pharynx were dry and glazed; there was no enlargement or ulceration of the tonsils. He was in a semi-comatose condition and could only with difficulty be roused. The heart and lungs were normal except that there were some dry rhonchi at the