

AN INTERESTING CASE OF APPENDICITIS : PERFORATION ; OPERATION ; RECOVERY.

By T. WILSON PARRY, M.A., M.D., B.C. CANTAB.

THIS case of appendicitis is interesting because the patient was only 16 months old, while the condition was otherwise unusual. Moreover, the patient when an infant five months old suffered from fistula in ano, and it is not often that a medical man is called upon to attend a patient for two rare surgical affections in the first six months of life.

The patient was a boy, who was born on June 10th, 1907. He was a posthumous child, his father dying at the age of 33 years, after a short three days' illness, three weeks before the child was born, of what was called an acute asthmatical attack. I did not attend him, but am informed that he had had a bad attack of influenza in the preceding December, from which he never properly picked up, losing flesh steadily, till this acute attack intervened, from which he did not recover. There appears to have been a history of tuberculosis. When the child was a month old the mother noticed when bathing him a thickening of about the size of a small pea situated deeply in the right ischio-rectal fossa. The child had no pain and I left instructions that it should be carefully watched by the mother and if it grew larger or altered in any way I was to be immediately informed. When the child was four months old the little place had slowly become larger, so that I was able to detect fluctuation. On Oct. 7th I cut down under an anæsthetic, evacuated a few drops of pus, thoroughly scraped the part, and expected it to heal up forthwith. It did not heal and a second "pointing" occurred, not far from the original one, but not communicating with it, which I also opened. There were now two separate sinuses for a few days till the last one that was opened suddenly closed up. Although I could not discover any opening into the rectum I naturally began to consider it to be a case of fistula in ano. Mr. G. B. Mower White, who kindly met me in consultation, confirmed my diagnosis and told me that it was the first case of fistula in ano he had seen in an infant. I passed a probe in the usual manner through the wound into the rectum, cut down upon it, scraped thoroughly and dressed in the accustomed way for fistula, and the case healed soundly in one month's time.

That fistula in ano is an exceedingly rare affection in children under two years of age there can be no question. I have been unable to find a case recorded. I have been unable to discover whether the fistula in this instance was, or was not, of tuberculous origin.

I was called again to attend the same little patient on Oct. 9th, 1908. The mother told me he had had a restless night, whimpering and tossing incessantly. His fingers had been constantly in his mouth and he appeared to be cutting one of his four remaining still uncut molars. Two months previously to this he had had a teething attack accompanied by an obstinate paresis of the bowel which had lasted five weeks, and which aperients and enemata had the greatest difficulty in overcoming. Since that time, however, the child had been in excellent health. His mother told me that his bowels had been properly opened on the preceding day, but she had given him a dose of castor oil that morning before I came. On examination the temperature was slightly subnormal, there was no sickness, and the abdomen (usually large) was neither distended nor at all rigid. In the evening the temperature rose to 102° F., but there was still no sickness or abdominal rigidity. As the bowels had not been opened I gave an enema of plain warm water and the result was good. On the next morning (Oct. 10th) the temperature was again subnormal and I may here say, as it became a point of special interest in the case, that with one exception, and that when it rose only four points, the temperature remained subnormal during the whole of the rest of the attack both before and after operation. In the evening, as the bowels had not acted, I gave another enema, but this time only with slight success, what was passed being extremely offensive. There was still no sickness, but a slight abdominal rigidity had appeared which was more marked over the right abdomen. During the next two days (Oct. 11th and 12th) sickness intervened and there

was undoubted pain in the abdomen, which, however, was much relieved by frequently applied hot fomentations. The pulse was good. In the evening of Oct. 12th when I called I found the child asleep and I was enabled to partly examine the right iliac fossa without waking the child up, only eliciting a single cry when my finger touched the bottom of the fossa. I could feel no lump and the abdominal rigidity appeared to be less, though there still existed a noticeable difference between that on the right and that on the left sides. I was now able to eliminate intussusception, no elongated tumour being discoverable, no tenesmus having occurred, and no blood or mucus having been passed per rectum. It was clearly also not a case of primary intestinal obstruction. Summing up the situation my feeling was that the trouble was appendical and this was partly confirmed on the next day (Oct. 13th), when very definite abdominal distension first made its appearance, which by the evening of that day became much increased, and I asked Dr. G. F. Still to kindly meet me in consultation.

Under chloroform we were both able to feel, on bimanual examination, abdominally and rectally, a thickening between the examining fingers a little to the right of the middle line, which we both decided was more than probably an inflamed and swollen appendix. Surgical aid became imperative and Mr. H. Stansfield Collier who had been summoned cut down a little to the right of the middle line, over the spot where the thickness had been felt, and found a faecal concretion, rather larger than a cherry-stone, lying loose in the abdominal cavity. He then carefully separated the appendix from the bladder, to which viscus it had become adherent, and removed it. It measured two inches in length, was large and club-shaped at the distal end, and was perforated about half an inch from the extremity. Further, an incision was made in each flank for the purpose of drainage and a rubber drainage-tube was inserted also into the operation wound anteriorly. The operation was performed at 9.30 P.M., after which an enema of one drachm of brandy in two ounces of water was given. At midnight an enema of one drachm of turpentine in six ounces of soapy water was given without any result and the child was fed entirely on panopepton (one drachm to an ounce of water) given in teaspoonfuls and half-spoonfuls at carefully appointed intervals. The child was continuously restless all night, but kept down what food was taken till 12.40 P.M. on the next day (Oct. 14th), when vomiting again returned. This occurred at three other times during the day. At 2 P.M. the tube in the operation wound was removed and a six-ounce enema of turpentine and soapy water was given per rectum when some flatus was passed. At 4 P.M. a quarter of a grain of calomel was given and at 9.30 P.M. another injection of turpentine and soapy water was administered, but with no result. On Oct. 15th the child vomited eight times. At 9 A.M. I gave three enemata consecutively, each consisting of a drachm of turpentine, a drachm of ether-soap, and six ounces of water, but there was still no action of the bowels. In spite of this last-mentioned fact abdominal distension was markedly less, so much so indeed that a drainage-tube in the right flank became bent at an angle, the skin moving downwards fully three-quarters of an inch. As the tube was now rendered useless by virtue of the kink produced I removed it. I now put the child on one-eighth of a grain of calomel every two hours to endeavour to create a peristalsis, and these powders were continued until a full grain of the salt was given. The result was excellent. After the second powder had been given the vomiting ceased, and when at 6 P.M. I again repeated my three consecutive enemata of the morning a fairly good motion with much flatus was passed. At 1.30 A.M. on the 16th the child was very restless and in much pain, but the passing of a rectal tube liberated a large quantity of flatus and gave immediate relief. An enema was again given at 4.30 A.M., but without success; but at 6 A.M. a small motion was passed naturally. At 4.30 P.M. another enema was given and this time a good result was obtained. I now took the child off panopepton and put him entirely on two drachms of Theinhardt's food with one and a half ounces of milk in six ounces of water. Flatus was now passed frequently. On the 17th the milk was increased by half an ounce in each feed of six ounces. The bowels acted twice slightly and once well. On the 18th I removed the third tube. The discharge from the wounds was now not nearly so offensive. The wounds were dressed twice a day

and the discharge, when thick, scanty, and offensive, was thinned and increased by lightly packing the wounds with ribbon gauze soaked in a 2 per cent. solution of both citrate of soda and sodium chloride. From this time forward the child made an uninterrupted recovery. By the end of the third week the wound in the left flank was entirely healed, while those in the middle and in the right flank were reduced to small healthily healing sinuses. At the end of the month all the wounds were sealed.

True appendicitis is a rare disease in children under two years of age. Before the year 1897 no cases were recorded in the epitome of diseases to be found in the annual reports of the Hospital for Sick Children, Great Ormond-street. In that year there was a case in a child, aged 22 months, which passed off successfully without an operation. In 1902 there was a child, aged four months, with appendicitis in a hernial sac; an operation was performed and the child recovered. In 1903 a child, aged 21 months, suffering from some other disease, had a passing mild attack of appendicitis while in the wards of the hospital and got well without an operation. In 1905 there was a child, aged eight months, who had a ruptured appendix with general peritonitis; an operation took place, but the child died. In 1907 there were three cases of appendicitis, but all of them in hernial sacs, and these were all operated upon successfully. Summing up, then, since 1907 there were seven cases in all of appendicitis occurring in children under the age of two years. Of this number four of the cases were ones of appendicitis in hernial sacs. Of the remaining three cases, two of them appear to have been under physicians and did not pass into the hands of the surgeon, while the last one—the only one of this kind operated upon—died. This case of mine, therefore, in relationship to these statistics, stands alone, as it is the only case of a child under two years of age who, suffering with acute appendicitis not in a hernial sac, has been operated upon successfully and has lived. I happen to have heard privately of one other case similar to this one now published. The child was 14 months old and made an excellent recovery. Mr. Collier was the surgeon in this case also.

Crouch End Hill, N.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF ECLAMPSIA.

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A FEW months ago I reported in these columns a case of eclampsia in which the convulsions at once ceased on the production and completion of labour, the morphia treatment having apparently failed. The following case, an example of the fact that some source of irritation to the system—viz., the pregnant uterus—is not by any means a necessary element in the causation of this terrible complication of labour, would, however, point to the great efficacy, in certain cases at least, of hypodermic injections of morphia in the control of the fits, even though the kidneys may be markedly deranged.

The patient, a young primipara, aged 21 years, had noticed that for about a month prior to her confinement her face in the morning had been somewhat puffed and she had been troubled with almost intolerable irritation of the skin. I was called to her confinement at about 9.30 o'clock one evening finding full dilatation and the pains weak. Progress being consequently slow I delivered with forceps. All went well till the placenta, &c., were passing the vulva when (at 10.15 P.M.) there came on a severe eclamptic fit and in the course of the next ten minutes two more occurred. I at once administered a hypodermic injection of half a grain of morphia and had the patient wrapped in a hot wet pack. At 10.45 P.M. a fourth fit came on and 35 minutes later a fifth. From this time to 7 A.M. on the next day the patient had no recurrence of the fits, and though at times she was restless and very sick she continued in a very heavy, dazed state. At

7 A.M. a sixth fit occurred, whereupon I gave the patient a hypodermic injection of a quarter of a grain of morphia and one-sixtieth of a grain of strychnine. At 9.30 and at 10.15 A.M. the seventh and eighth fits respectively occurred. I now, in addition to the hot packs that had been kept up throughout, gave the patient a saline injection of four pints (together with two drachms of bromide of potassium, 20 grains of chloral, one ounce of sulphate of magnesia, and one ounce of solution of acetate of ammonia) high up into the bowel. Until 1 P.M. no fit recurred, the patient lying absolutely motionless; at 1 o'clock, however, she had her ninth fit, half an hour later a tenth, followed shortly by the eleventh, each being as severe as the first. I then gave another hypodermic injection of half a grain of morphia. By 9.30 P.M. the patient had much improved and had become sufficiently sensible to be induced to drink two glasses of milk and some diaphoretic and bromide mixture. A very good night followed, the patient taking milk at intervals, and by the next morning she was able to recognise those tending her. During the day urine was passed freely, which on examination was found to contain much albumin. Whether on the second day of her illness the patient passed any urine it is hard to say since she was constantly in the hot wet pack. All albumin had disappeared by the fourth day.

Whilst taking precautions to produce abundant perspiration and free action of the bowels my experience in five at least out of six cases has been that hypodermic administration of morphia is a most valuable method of treatment in eclampsia whether occurring before or after labour. I only regret that in the case just described I did not push the morphia more.

Swindon.

A CASE OF VENTRICULAR HÆMORRHAGE SIMULATING ECLAMPSIA.

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I WAS called out early on Nov. 16th, 1908, to attend a multipara, aged 43 years, for a "fit." The friends gave a history of headache and lassitude for 10 days, culminating in a general convulsion lasting a few minutes. The patient was found to be six months pregnant but the foetal heart was not audible. She was semi-conscious; the conjunctiva reflex was present and the pupils were equal and small; there was intermittent clonic twitching of the left shoulder muscles and purposive movements were retained; both knee-jerks were absent but no paralysis was discoverable. With the fit there had been no cry, no biting of the tongue, and no incontinence. The tongue was fairly clean and the pulse was weak and rapid. After staying with the patient for some time she recovered full consciousness and understood what was said to her, but could not speak. She was moved into the infirmary, where she recovered speech. The urine was found to be half solid with albumin, which only very gradually decreased under treatment. On the day after admission the patient got out of bed as she saw imaginary people in the ward; on the whole she was lethargic, but would speak when roused. She suffered intermittently from paralysis of the bladder and the bowel, necessitating catheter and enema; occasionally these functions were normal. Sensation was of the disordered type seen in hysteria, with no true anæsthesia. The patient was sometimes able to talk to her husband, though not to me. Five days after admission she gave birth to a six months partly macerated male foetus, the skin peeling off it in places. The general condition slightly improved after labour, which was absolutely painless, and a confident diagnosis was made of eclampsia, with a large super-added functional element, accounting for her retention, disordered sensation, and intermittent aphasia. The patient continued in much the same state for three more days, when the pulse-rate went up to 130. On the next evening she had a fit after an enema. There was a general tonic spasm, followed by restless movements; the left pupil was dilated and fixed, oval in shape, with the long axis vertical. The right pupil was normal and the conjunctival reflex was preserved on that side. She soon became fully conscious