

fistula intact, owing to the adhesions. The gall-bladder was therefore separated from the duodenum, and the opening in the latter closed by two layers of sutures. Cholecystectomy, though perhaps the ideal procedure, was not considered justifiable, so that the stones, two in number, were removed from the opening in the gall-bladder and the latter drained in the usual way. The stones, though not as large as that removed from the intestine, would undoubtedly have caused obstruction had they entered the intestine.

The patient made an uninterrupted recovery.

Remarks.

Although such a complication as that recorded in the first case appears very unusual, its possibility must always be borne in mind in operating on cases of gall-stone ileus, or where recurrence of pain and vomiting after operation point to some further obstruction. In this patient a rather too easy acceptance of a diagnosis of peritonitis from failure of the intestinal suture—in spite of a note to the effect that the stone removed was faceted—prevented a further laparotomy, which would in all probability have saved life. It would therefore seem a sound practice to search the distended portion of intestine for a further stone, and also to palpate the gall-bladder, especially if the gall-stone is faceted. In spite of thickening and adhesions in this region, any stone capable of producing further obstruction on entering the small intestine could probably be recognised. This examination could be carried out through the original incision. In cases where no further stone is evident nothing further is required. Where, however, a further stone or stones exist in the gall-bladder their removal must be considered. In some cases the patient's general condition may be such that immediate removal of the further stones may be attempted. Considering, however, that the subjects of this condition are mainly females past middle life, often stout and usually gravely ill, it would undoubtedly be safer in most cases to postpone any attempt at removing further stones until convalescence is established.

A NOTE ON THE DIFFERENTIAL DIAGNOSIS OF ACUTE APPENDICITIS AND ACUTE RIGHT SALPINGITIS.

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In a recent work¹ on the diagnosis of acute "abdominal emergencies," it is admitted that the difficulty of distinguishing between acute appendicitis and acute inflammation of the right Fallopian tube may be very great. This statement, and the fact that the point made below is not mentioned in text-books on surgery or gynaecology, prompts the following note. Sherren long since pointed out that in acute appendicitis pain is usually felt first in the region of the umbilicus, and only later in the right iliac fossa. This important diagnostic point, not yet fully appreciated, corresponds with Mackenzie's dictum,² that lesions of the small intestine cause pain, which is usually referred to the midline, round the umbilicus. In acute right salpingitis, on the other hand, pain is felt almost invariably, and from the first, on the right side. In addition, the pain is usually referred down the right thigh, anteriorly, sometimes as far down as the knee. It is to be noted that other lesions of the Fallopian tube, such as ruptured pyosalpinx, ruptured ectopic gestation, or twisted ovarian cyst, will cause pain having a similar distribution. This point, however, must be made—with inflammation of a retro-cæcal appendix, the pain is usually felt from the first, in the right iliac fossa.³

In none of the numerous cases of acute appendicitis examined personally, and verified by operation, has pain ever been complained of in the right thigh,

in contradistinction to cases of right salpingitis, in which this sign has usually been present. Occasionally right salpingitis and appendicitis have coexisted, and in these cases pain has been felt round the umbilicus, in the right iliac fossa, and in the right thigh.

The distribution of pain in the two conditions is explained by the fact that the Fallopian tube is developed as a lateral organ, and is represented in the spinal cord by the eleventh and twelfth dorsal and first lumbar segments (Head), while the appendix is mesial in origin, and is represented by the tenth and eleventh dorsal segments. On these facts alone, and apart from all other considerations, a correct diagnosis can often be made. In acute appendicitis pain usually starts in the mid-line and rarely passes below the groin, while in right salpingitis the pain starts laterally and usually radiates down the right thigh.

I wish to thank the honorary staff of King Edward VII. Hospital, Cardiff, for permission to examine their individual cases, the result of whose investigation is embodied in the above note.

NOTES OF TWO CASES OF EPILEPTIFORM CONVULSIONS DURING ANÆSTHESIA.

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THE following cases, in which epileptiform convulsions took place during anæsthesia, may be found of some interest. In each case there was no sickness during anæsthesia and recovery was quite normal.

CASE 1.—A male pensioner, aged 39 years. The operation (16/1/22) was amputation of the right little finger, under chloroform (open ether sequence adopted): First stage quiet; second stage boisterous and prolonged; third stage normal; inspirations deep, quiet, and regular; facial colour good, conjunctival reflexes absent, corneal reflexes sluggish, pupils moderately dilated.

The operation having been in progress seven minutes, and the digit having been separated at the metacarpophalangeal joint, I ceased giving the anæsthetic (ether), the patient being sufficiently under for completion of the operation. One and a half minutes after ceasing the administration I noticed spasmodic contractions of eyelids and masseter muscles, slight suffusion of conjunctivæ, and slight cyanosis of lips and lobes of the ears. Pupils moderately dilated prior to this attack, contracted somewhat at the onset. The convulsive movements affected the arms, legs, and abdominal muscles. The attack lasted altogether 40 seconds, and on its subsiding the anæsthesia continued normally.

CASE 2.—M., 25 years, an epileptic since childhood; the last convulsive attack occurred three weeks before operation (17/8/22) for tuberculous knee-joint ankylosed in a bad position of flexion. Anæsthetic adopted, closed ether. The first stage quite normal; second stage prolonged, rigidity of extensor muscles of the neck being pronounced; third stage normal. After four and a half minutes of natural breathing, the airways being perfectly free from obstruction, with pupils on the small side, corneal and conjunctival reflexes present, though sluggish and colour good, I noticed slight suffusion of the conjunctivæ, with contracting pupils and slight blueness of lips and ear lobes, accompanied by slight twitching of lips and epileptiform convulsions of the right upper extremity, other parts of the body being unaffected. Pallor of skin and profuse perspiration followed the attack, which lasted 47 seconds. The anæsthetic was continued as before. When about 20 minutes had elapsed after the attack some slight rigidity of the extensor muscles of the neck was noticed; this quickly passed off, no other symptoms being present.

LONDON DERMATOLOGICAL SOCIETY.—A clinical meeting of this society will be held at 4.45 P.M. on Oct. 17th, at St. John's Hospital, 49, Leicester-square, London, W.C. 2.

THE Society for Constructive Birth Control and Racial Progress ("C.B.C.," 61, Marlborough-road, Holloway, London, N.) is opening a second session of general meetings and lectures on Thursday, Oct. 19th, at 8 P.M., at Essex Hall, Strand, W.C., when the presidential address will be given by Dr. Marie Stopes on the Ideals and Present Position of Constructive Birth Control.

¹ Cope, Z.: The Early Diagnosis of the Acute Abdomen, 1921, p. 85.

² Mackenzie, James: The Interpretation of Symptoms, third edition, pp. 169 and 172.

³ Cope, Z.: Op. cit., 63.