

Clinical Notes : MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

THREE UNCOMMON ABDOMINAL CASES ILLUSTRATING SOME PITFALLS.

BY NORMAN C. LAKE, M.D., M.S.LOND., F.R.C.S. ENG.,
MAJOR, R.A.M.C.;
AND
H. K. KEVIN, L.R.C.P. & S. IREL.,
CAPTAIN, R.A.M.C.

THE following cases occurred within a short period at the Prisoners of War Hospital, Oswestry. They are recorded because of their rarity, and also indicate some pitfalls.

Traumatic Diaphragmatic Hernia.

CASE 1.—German prisoner of war, aged 20. Wounded Sept. 27th, 1918; admitted to this hospital Oct. 5th, 1918, with gunshot wound of left side of chest. Small entry mark in fourth interspace about 3 inches from mid-line; bullet felt subcutaneously just mesial to inferior angle of scapula. His field-card recorded hæmoptysis for a few days in France. Upon admission the entry wound was a mere scar; no hæmoptysis or pathological sign in the chest. On Dec. 11th he was up and due for discharge, but returned to bed complaining of pain in the left hypochondrium and constipation; he vomited once after food. No pathological lesion detected; general appearance and condition good. The following morning he was rather collapsed; abdomen considerably distended. The pain in the left hypochondrium continued; also tenderness present. Temperature 95.2° F., pulse 120; tongue dry and furred. The left chest was abnormally resonant and the heart dullness obscured. Two enemata were given without result. Provisional diagnosis was intestinal obstruction, probably due to band in splenic region.

Operation.—Anæsthesia was very difficult owing to the rapidly increasing dyspnoea. Abdomen was opened in mid-line as rapidly as possible with a view to relieving this. The distended intestines were allowed to come out of the wound. No relief to respiratory embarrassment. The transverse colon was enormously distended; the obstruction obviously lay somewhere in the region of the splenic flexure which could be felt drawn up under the left dome of the diaphragm. At this point respiration ceased entirely; all the usual means of resuscitation were employed with no response.

Autopsy.—An aperture was found in the tendinous portion of the diaphragm on the left side, admitting four fingers; a considerable coil of the splenic flexure of the colon had passed through the opening. Strangulation had occurred at the sharp edge of the aperture. The bowel occupied practically the whole left side of the thorax; lung was compressed to a small mass on inner aspect and heart displaced well to right.

The bullet in its passage had passed tangentially across the dome of the diaphragm. The scar so formed had healed only to yield later when the intra-abdominal pressure was raised by exertion.

Internal Hæmorrhage from Splenic Infarct.

CASE 2.—German prisoner of war, aged 24. Admitted to this hospital on Sept. 28th, 1918, with diagnosis of nephritis. Upon admission the urine contained a small quantity of albumin, trace of blood, no casts. The heart was enlarged; soft organic systolic bruit at apex. A little œdema was present, distributed generally over the body. He was treated for nephritis; not much improvement. On Dec. 3rd and 4th he complained of pain in the left hypochondrium associated with tenderness. The following day he suddenly became blanched, the pain meanwhile increasing, the pulse very rapid and thin; temperature subnormal. Shifting dullness in the flanks more marked on the left side was noted. A diagnosis of internal hæmorrhage from the spleen was made; cause doubtful. Two or three old and recent pinpoint hæmorrhages in the conjunctivæ were noted; retinæ normal.

Operation.—When the patient reached the operating theatre his general condition was so bad that it was decided to transfuse him before operation. Saline infusion was immediately undertaken and a donor found. Rather over a pint of blood was transfused by the citrate method, the biological test being used for incompatibility. The patient improved somewhat, and as it is in our experience better to wait a short time after transfusion before anæsthesia, the operation was delayed. He was, however, obviously still bleeding rapidly and died before operation could be undertaken.

Autopsy.—General subcutaneous œdema. The heart was very enlarged; aortic and mitral valves sclerosed and on the surface many old and recent vegetations. Both lungs were œdematous. The peritoneum contained a large quantity of partially coagulated blood. One-third of the spleen had been converted into a large infarct extending back to the vessels in the hilum. Under the capsule, which had ruptured at one spot, was a fairly recent mass of blood clot; hæmorrhage was proceeding directly from aperture in splenic artery. The kidneys were "flea-bitten" and the mucosa of stomach and intestines showed similar points of hæmorrhage.

The case was obviously one of infective endocarditis, with an infected infarct in the spleen which had ulcerated its way through the wall of the splenic artery.

Acute Idiopathic Dilatation of the Stomach.

CASE 3.—German prisoner of war, aged 25. Admitted to this hospital on Feb. 3rd, 1919, with diagnosis of "acute abdomen." On the previous day after a midday dinner he was seized with a sudden pain in the epigastrium and shortly afterwards vomited. This seemed to give some relief and the case was not thought serious until the following morning, when he began to develop signs of peritonitis. No gastric history. Upon admission the condition was serious. He was continuously vomiting large quantities of slightly blood-stained material containing recognisable undigested food from the previous day. The abdomen was considerably distended, but at the same time quite rigid. There were shifting dullness in the flanks and tympanitic resonance over the front. The case was anomalous, but a diagnosis of peritonitis, probably due to perforation of a pyloric ulcer, was made and operation immediately undertaken.

Operation.—Abdomen opened in mid-line. The peritoneal cavity contained a large quantity of blood-stained, thin, purulent fluid. The stomach was enormously distended, occupying the greater portion of the whole abdomen; small intestines collapsed and pushed well down into pelvis. Stomach wall was thin and in places hæmorrhagic; no perforation found. A gastrostomy was performed by the Kader method and several pints of stomach contents were drained off. A large tube was inserted down to the duodenal region and another into the pelvis. The abdomen was sewn up, subcutaneous saline administered, and pituitary extract in 5 m. doses every three hours. The gastrostomy tube drained large quantities of increasingly blood-stained material. Death 17 hours after operation.

Autopsy.—The peritoneum contained some blood-stained fluid. The stomach was smaller than at operation, but its walls were so thin in places as to be quite transparent. The mucosa for the most part was deeply hæmorrhagic. The distension involved the first and second portions of duodenum; otherwise intestines were normal. No perforation or stricture; all other organs quite normal macroscopically.

The case fits in with the description of acute idiopathic dilatation of the stomach, usually a post-operative complication. In addition we here have a peritonitis most marked about the stomach. There are two possibilities: 1. That the peritonitis is the primary cause and the dilatation a secondary paralytic one. 2. That the dilatation is primary and the peritonitis due to the migration of organisms through the attenuated stomach wall. The man had been eating salted herrings; large masses of the sharp vertebral spines were found in the cæcum, the spines being so sharp as to perforate the bowel wall on the slightest pressure. The suggestion arises that infection may have been carried through the stomach wall in this manner, but the peritoneum usually deals very effectively with small infections of this nature. The case must, therefore, be left under the heading idiopathic.

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A CASE OF MULTIPLE OSTEOMATA OF THE SKULL BONES.

BY C. N. SLANEY, M.R.C.S., L.R.C.P.

THE following case is recorded on account of the comparative rarity of the condition.

Account of Case.

The patient, aged 40, destitute of relations and having no recollection of his parents, mentally approximates to the cerebration of a child barely a quarter of his own age. To the best of his recollection, in 1888, when about 12, he sustained a blow on the right lower jaw from a cricket-bat; three months later he noticed a swelling (see figures, 1). This gradually increased in size, was painless, and unaccompanied

by any objective symptoms except for a sensation of cramp when he drank anything cold. This tumour was subsequently removed by operation. No evidence of fracture; right ramus of lower jaw was much thickened. In 1890 a similar small tumour (2) appeared over the left superior maxilla, attributed to a blow by a stone. It was followed in 1893 by a painless swelling (3) in the left lower jaw; no trauma. The fourth tumour developed gradually in 1895, a few months after his discharge from hospital; no trauma.



Multiple osteomata of skull bones.

Tumour 5, also in 1895, he attributes to knocking his head against a wall; it became gradually larger in size, but is now stationary. Probably the condition of the right eye is due to a tumour (6) similar to the others; no injury. He does not know when his eye trouble commenced, possibly in 1888; his vision was defective when he attended school that year. The bony outgrowths are in lower jaw bilateral. As a whole they give rise to no harmful pressure symptoms except in reference to the right eyeball.

The patient appears well nourished, is 5 ft. 1 in. in height, and weighs 109 lb. There is complete nasal obstruction, apparently due to a general swelling and turgescence of the nasal mucosa; also slight pharyngitis and hoarseness of voice. He professes to see best with a -12 D. sphere, but he prefers not to use glasses. The right pupil reacts to light and accommodation; left pupil dilated and fixed. With the margins of the orbits appearing normal, there is a small hard, movable tumour to be felt under the right upper eyelid, probably in relation with the lacrimal gland. The tissues of both upper eyelids are abnormally flaccid and overlap the cornea; an appreciable amount of the sclerotic is visible below each cornea, more marked in right eye; lacrymation is continuous. Proptosis of the right eyeball has been present since 1888; vision in both eyes more defective since 1894 and still getting worse. Some increase of tension in right eye; no apparent narrowing of visual fields. Media in both eyes hazy from *muscae volitantes*; discs and vessels smaller than usual. There are signs of old keratitis; positive Wassermann. His abdomen is protuberant and thorax rickety. There is marked indrawing of the skin with each heart-beat at its apex, apparently situated at left side of xiphisternal notch immediately below sixth costal cartilage. No dullness to right of sternum. His cranial nerves appear healthy except for loss of sense of smell. The angle of the mouth on the left side is drawn up, and he is unable to whistle. The left knee-jerk is absent.

Description of Tumours.

On examination of the several tumours the following points are observed:—

1. There is a linear operation scar 9 cm. in length along the lower margin of the mandible on right side from angle of jaw to symphysis; this scar is adherent in places to the underlying bone. The inner aspect of the lower jaw is smooth and regular, and appears normal on both sides; the

lower margin of the right mandible appears roughened, probably as a result of the operation. The alveoli and teeth are normal in position and regular in line; enlarged lymphatic glands in submental and submaxillary regions. The outer aspect of the lower jaw appears normal on the right side from the symphysis to tumour 4. No signs of recurrence. This tumour was stony hard.

2. There is a faint linear vertical operation scar on left side of nose about 1.5 cm. in length; also on the superior maxillary bone at this site a slight prominence, neither painful nor tender, but hard and bony.

3. This tumour extends from 1 cm. from symphysis to within 2 cm. of angle of left jaw. It envelops the lower margin of the mandible and extends upwards to just above a horizontal line level with angle of mouth. It is painless, hard, irregular in outline, circumscribed, and sharply defined; skin not adherent; it moves with the jaw and does not interfere with deglutition; no impediment to free movements of mandible. Observed from inside the mouth there is the appearance of a hard tumour growing from the outer plate of the mandible below the alveolar margin; there is no so-called expansion of the bone, but a tendency to fullness is noted over the upper part of the vertical ramus in the region of the parotid gland, but this fullness is not bony in character. He believes that this tumour is increasing in size.

4. This tumour extends from 4.5 cm. behind the angle of the right jaw to within 6.5 cm. of the symphysis; it does not envelop the lower margin of the bone, but extends up to the zygomatic arch; it is well defined, both anteriorly and posteriorly and at its lower margin, but seems to shelve off into the surrounding tissues at its upper part. It is hard, irregular in outline, and the margin of the lower jaw with its angle can be felt below the tumour, which has the appearance of growing from the outer plate of the bone below the alveolar margin, more or less in an upward and backward direction. The tumour moves with the jaw and the skin is not involved. He believes also that this tumour is increasing in size.

5. The tumour resembles those mentioned, is hard and bony, and painless. It appears as a circumscribed irregular swelling on the left side of the frontal bone 3 cm. above the orbital process; it is conical in shape, with its apex projecting upwards, outwards, and backwards, resembling a horn 3 cm. in diameter and 1.25 cm. in height. This tumour is stationary in growth, he thinks.

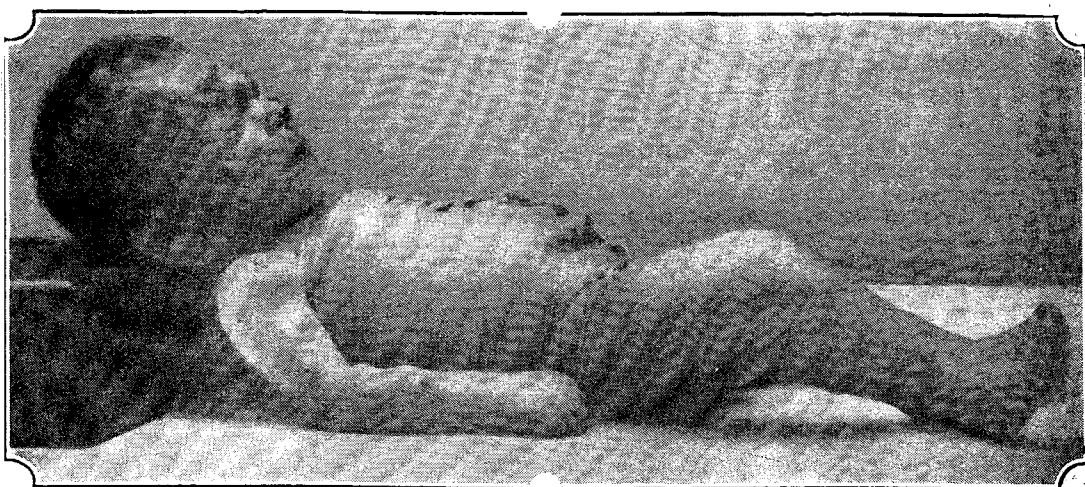
Parkhurst, I.W.

A CASE OF CONGENITAL MULTIPLE SARCOMATOSIS.

BY J. A. PERCIVAL PERERA, L.R.C.P., M.R.C.S.,
LATE SENIOR HOUSE SURGEON, CHILDREN'S HOSPITAL, SHEFFIELD.

THE following case is of interest, on account both of its rarity and of the wide dissemination of secondary growths.

The patient, a full-term male baby a fortnight old, was admitted into the Sheffield Children's Hospital, under the care of Dr. H. Leader. Multiple rounded and nodulated tumours were scattered throughout the body—e.g., head,



Case of congenital multiple sarcomatosis.

thorax, abdomen, upper and lower extremities. These tumours, present from birth, were of varying sizes, from $1 \times 1 \times 0.5$ cm. to $4 \times 5 \times 1$ cm. There was superficial ulceration in the larger tumours; one or two on cheek and legs had started to fungate. The consistence ranged from jelly-like softness in the more superficial ones to more or less bony hardness in ones attached to the long bones, ribs, and skull.

The child weighed 10 lb. on admission, and was well nourished. He was then suffering from diarrhoea and also