

PAROXYSMAL HEART HURRY ASSOCIATED WITH VISCERAL DISORDERS.¹

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THE coincidence of tachycardia with abnormalities, both organic and functional, in the abdominal viscera has occurred in so frequent a proportion among cases which have come under my personal observation within the last three years that I venture to offer for the consideration of the profession a brief record of facts noted under conditions affording exceptional opportunities for close and continued observation, and to base thereon certain suggestions in regard to the connexion between paroxysmal heart hurry and visceral disorders, which, so far as my reading goes, have not hitherto been made by writers on tachycardia. Setting aside the slighter forms of heart hurry, which we know as "palpitations," occurring infrequently, lasting for a short time, and being distinctly arrhythmical, familiar to us all in association with flatulent dyspepsia, but which I think should not be confounded with true paroxysmal tachycardia, my small experience of this comparatively rare condition is confined to cases of more or less gravity, wherein there has been distinct disease or displacement of one or other of the abdominal organs in both sexes, or serious disturbance of the pelvic organs in females, and at the risk of appearing to argue *post hoc ergo propter hoc*, the coincidence of extreme rapidity of the heart's action occurring in paroxysms with floating kidney, dilatation of the stomach, and profuse menorrhagia at the menopause, has induced me, in default of pathological evidence to the contrary, to regard prolonged irritation of one or other branches of the abdominal sympathetic as a possible cause of paroxysmal heart hurry. It appears to me that just as irritation of the solar, renal, or other abdominal plexuses may produce pain or excite muscular action in the organs supplied by the stimulated nerve, so the stimulus may be referred from one periphery to the other; and thus intense impressions produced by disease or misplacement of the abdominal organs on the sympathetic filaments or ganglia with which they are endowed may be transferred to the cardiac branches of the sympathetic, or to the accelerator centre. Or if this be not a reasonable explanation of the morbid phenomena witnessed in these cases, it seems not unlikely that the strong and prolonged stimulation of the sympathetic nerves supplied to one or other of the abdominal viscera may result in stimulation to fatigue of the vagus centre,² and the following cases appear to afford evidence in favour of this proposition.

Mrs. —, aged forty-nine; history of cancer of the breast, for which she was operated on three years previously; had been falling off in weight and flesh for about twelve months, and especially for the last three or four months; catamenia almost entirely ceased about three months previously after a continued flow; had been in bed for seven weeks suffering from retching, nausea, flatulence, insomnia, palpitation, and breathlessness, occurring at intervals. There was fulness and tenderness of the liver, and just below the margin of the right ribs a very hard slightly nodulated swelling could be felt slipping from under the hand on pressure (right floating kidney). Mr. Knowsley Thornton saw the patient with me some ten days after I had first seen her, but failed to discover any certain evidence of malignancy; but he also detected a similar condition of stony hardness and mobility in the left as well as in the right kidney. There were no abnormal heart sounds, but on the seventh day after admission, in the evening, there was an attack of paroxysmal heart hurry lasting for twenty minutes, the pulse running up to 145; at 2 o'clock in the morning another attack lasting for nearly ten minutes; pulse 170. In the intervals the pulse ranged between 80 and 96. In two months the patient had altogether six attacks of tachycardia lasting for a few minutes each, in addition to those previously noted, but her general condition appeared to improve, and she gained in that time seven pounds, slept soundly at night, and took much more food than before, the vomiting and flatulence ceasing entirely,

the normal moisture of the mouth was restored, and there was no longer any constant attempt to expectorate viscid mucus; but no real improvement can have taken place in the patient, for eleven weeks after I first saw her she succumbed.

Mrs. —, aged fifty, whom I saw in consultation with my friend Dr. Stanley Smith in the early part of this year, had been operated on three times for a growth in the rectum; last operation two years and a half ago. Since then the patient had suffered from parametritis, and following the attack there had been more or less sleeplessness, anorexia, vertical and frontal headache, and occasional attacks of extreme rapidity of the heart's action accompanied by a sensation of faintness, followed by much exhaustion, sometimes lasting for half an hour or more. The succussion note of the stomach was distinctly elicited on a level with the umbilicus, and the limits of the organs appeared to be greatly increased; there had, however, been no actual vomiting, but great dislike for food, with an accompanying hungry pain at irregular intervals. During the ten weeks that the patient was under my personal observation she suffered from three distinct attacks of tachycardia, the first occurring immediately after the catamenial period, which had been very profuse, the other two during the second and third catamenial periods, both of which were menorrhagic in character but unattended by any ovarian or pelvic pain. The first attack occurred in the evening shortly after the patient had retired for the night, and lasted for nearly ten minutes, during which the pulse beat regularly but weakly, at the rate of 200. The breathing was 25 per minute; the face was flushed, and the countenance bore an anxious expression; the feet and hands were cold. The axillary temperature was barely 98° during the paroxysm.

My attention to the existence of tachycardia as a concomitant with floating kidney was first attracted by the case of a young lady three years ago, in whom the existence of a right floating kidney had been diagnosed by two distinguished physicians, at whose instigation she underwent the rest-massage treatment under my care. For a period of six weeks the pulse was only on rare occasions under 96 per minute, and occasionally rose to 125, the highest record without apparent cause, although the increased rapidity occurred more frequently after the slight exertion of leaving the bed than at other times. A similar rapidity of the pulse was again noticed in a second case of floating kidney occurring in a gentleman aged fifty, who was under my observation for about a fortnight. No note of paroxysmal heart hurry was made during that time, save once during the night, when the pulse rose to 150. The next case coming under my notice was one to which reference has already been made at a meeting of the West London Medico-Chirurgical Society by Dr. Seymour Taylor and myself, and I have been fortunate enough to secure a succinct life-history of this patient from a perfectly reliable source which I think affords very remarkable evidence in favour of the belief that the existence of floating kidney was the original cause of the condition which eventually proved fatal. At the time I was called to see this lady in consultation with her usual medical attendant, I was totally unaware of the existence of any visceral disturbance, and until I saw her no data were afforded save that there had been absolute sleeplessness for twenty-one days and nights, the existence of this total insomnia being strenuously insisted upon by the nurses who watched her day and night. At the time of my first visit a paroxysm of heart hurry had existed without cessation for more than three weeks, during which period the heart beats, when it was possible to count them, are said to have reached 245 per minute. The patient, a stout lady aged fifty, was lying in the dorsal position with the head and shoulders raised; the countenance was livid; eyes prominent; respiration 40; pulse uncountable; heart sounds normal save for the extreme rapidity, the apex beat was just below and outside the nipple; the abdomen was enormously distended, the feet and hands were cold, and there was a clammy perspiration over the whole body. The patient was conscious and fully recognised those around her. My first visit, at which I attempted nothing, was in the afternoon. My second visit lasted from 9 P.M. until 2 A.M. For two hours I was busily engaged in attempting, by abdominal massage and the evacuation of flatus and fæces from the bowel by means of a long tube, to reduce the very remarkable distension of the abdomen, which was the greatest I have ever seen. In this I was so far successful that the walls of the abdomen, pre-

¹ A paper read at the West London Medico-Chirurgical Society, May 2nd, 1891.

² Vide Landois and Stirling, pp. 886.

viously hard and tense, became much softer and flaccid, and in the course of kneading the ascending colon I was able to detect very distinctly an oval tumour in the right iliac region close to the groin, which slipped away on pressure. This, after careful manipulation, I felt quite sure was the displaced right kidney. My diagnosis was subsequently confirmed by the gentleman with whom I was in consultation and two of our most distinguished physicians, one of whom, however, was not prepared to accept my suggestion that the floating kidney was the cause of the tachycardia. Death, due to failure of the heart's action, apparently from sheer exhaustion of the overworked heart, the beat of which even during sleep was never reduced below 180 per minute, occurred six days after I had first seen the patient. Three attacks of syncope occurred in the last twelve hours of life before the final failure of the heart's action. The following is the history given by the husband: He had heard the patient say that she first noticed some internal discomfort at the age of three, when it was reported by a relative that she threw herself on a chair, saying that she had a clock inside. As she grew older she became stronger, but was always a delicate child, and often on stooping to pick up anything heart hurry was brought on. To within a few years of death the attacks in all cases came on and passed off suddenly; for instance, on one occasion, her husband having given her a glass of champagne during an attack, before he could put the glass down again the pulse became quiet, exhaustion being the only effect noticed. On another occasion, as soon as an attack of twenty-four hours' duration ceased, there was absolute relief; and she crossed the Channel, though a bad sailor, without a recurrence. Her husband said that at the time he knew her first she had been free for some years, save from attacks lasting for half an hour only. Before the birth of her eldest son (aged thirty at the time of her death) she had a severe attack; and a month before the birth of her youngest child (aged twelve at the time of her death) she had an attack which lasted three days. Long standing brought on a paroxysm. Fourteen years before death the patient discovered that lying on the right side brought on a paroxysm. She used to say that she felt her heart fall, though her medical man never found it displaced. She could always lie on the left side, and could steady the heart by lying on the left side, and drawing up the right thigh forcibly against the abdomen. The paroxysm generally ended in a kind of "worse moment." When the paroxysm was threatening, the patient would place herself in the recumbent position on the left side. The right arm was then strongly stretched over the head, and the right thigh forcibly flexed against the abdomen. This always availed to steady the heart until the penultimate attack. Many English and French physicians and surgeons were consulted; numerous methods of treatment and drugs were employed without avail. The patient always suffered during the attack from pain and a peculiar dead sensation about the nails and tips of the fingers. Three years before death a long attack, lasting for weeks for the first time, terminated gradually instead of suddenly. Then a change in the symptoms took place. After the attacks were over, there was almost constant umbilical pain, with exacerbation of agony, lasting sometimes six hours, spreading through the back and up and down the inside of the thigh to the knee. The patient's health steadily got worse, and nervous symptoms followed on long-continued pain. A fissured anus was discovered by an eminent Parisian surgeon, who successfully operated for it. Finding that going up and down stairs brought on a paroxysm, the patient had for many years been carried upstairs, but on one occasion, having been induced to walk upstairs, an attack came on. The paroxysms became more frequent and lasted longer, and during the attack only was albumen found in the urine, but never after the cessation of a paroxysm. There was severe illness for three years before the death; a deep inspiration would bring on a paroxysm, the penultimate attack lasted fourteen days, and was followed by a month's comparative ease, when the last attack ensued, and extended over a period of nearly four weeks, terminating in the way I have already described.

I think this case will be recognised as one of the most remarkable examples of paroxysmal tachycardia yet recorded. The history is undoubtedly authentic, and appears to me to bear out the opinion I had formed before I had heard it, that the condition of the heart depended upon the irritation of the abdominal sympathetic produced by the renal dislocation. The sensations of

the patient, the seat of pain, and the flatulent distension of the stomach and intestines; the loss of peristaltic power in the bowels, resulting, as I should have stated on two occasions in constipation lasting for some days; the existence of albuminuria and casts only during the attacks, the initiation of the paroxysms by deep inspiration, by stooping, and by unusual exertion; the fact that they had been frequently relieved by adopting a peculiar posture, which is precisely that which would favour auto-reposition of the kidney,—all seem to point to the closest connexion between the existence of floating kidney and paroxysmal tachycardia. The cases previously narrated, three of which I had seen before this one, afford corroborative evidence in support of the view I venture to put forward, that paroxysmal heart hurry may frequently be found to coexist with lesion of the abdominal sympathetic, and possibly oftentimes results therefrom; and I cannot help thinking that other such cases as I have recorded may have occurred and been overlooked from omission to make a systematic examination of the abdomen in cases of heart hurry.

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ON SOME COMPLICATED CASES OF ABDOMINAL SECTION.¹

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IN the autumn of 1887 I endeavoured to demonstrate that the cause of death following an abdominal section is not infrequently some obstructive condition of the bowels, and that in many cases of this kind the fatal result has been erroneously attributed to peritonitis or to septicæmia.² Further observation has confirmed me in this opinion, and I now relate the following cases in illustration of these views.

CASE 1.—On August 23rd, 1888, in the absence of Mr. Knowsley Thornton, I operated, at the request of Dr. Murphy of Twickenham, on a patient from whom Mr. Thornton had removed an ovarian tumour on May 9th of the same year. The history was one of increasing difficulty with the bowels, commencing soon after the ovariectomy. When I saw the patient obstruction was complete. There was a prominent tender swelling, resonant on percussion, and fixed in the lower part of the right side of the abdomen. The finger in the vagina could just reach this swelling. The rest of the abdomen was soft and flat. The temperature was 99.2° F.; the pulse 100 and losing strength. It seemed to me probable that some adhesion resulting from the first operation was the cause of the difficulty with the bowels. On opening the abdomen I found some inflammatory adhesions matting the parts together behind the cicatrix and in the pelvis. Two tensely distended coils of intestine lay parallel to each other and extending from the brim of the pelvis on the right side towards the right loin. I could not empty the distended gut by pressure in any direction, nor could I make out the cause of the obstruction. I therefore inserted a trocar into one of the coils, and removed a quantity of flatus and liquid fæces. It then became obvious that the obstruction was due to the presence of a neoplasm springing from the posterior abdominal wall just above the lower end of the ileum. I estimated the mass to be about the size of a Tangerine orange, and the bowel involved was evidently a portion of the jejunum close to its upper end. The nature of numerous minute points which had been noted scattered over the peritoneum was now made clear. It seemed useless to make a fistula, while, in view of the widespread character of the disease, any operation for making a communication between two portions of the gut seemed equally futile and more than likely to end in the death of the patient on the operating table. I therefore sewed up the trocar wound, and that of the abdominal wall, and in doing so discovered several other foci of new growth, from the size of a pea downwards, amongst the adhesion. The patient rallied from the immediate effects of the operation, but gradually sank and died in about thirty hours. In this case, judging by her previous convalescence, there was every reason to suppose that under favourable circumstances recovery

¹ A paper read before the Harveian Society, May 7th, 1890

² The Condition and Management of the Intestine after Abdominal Section, Med. Chir. Trans., vol. lxxi.