

pair of scissors, skin suture needles, and catgut were the only instruments used in the operation. I had to be anaesthetist as well as operator. The patient had very little skilled attention after his operation, except that his wound was dressed daily by the mission Father. Yet in spite of all these disadvantages three weeks after being stabbed he was walking about as well as ever, and was none the worse for his experience.

FOUR UNUSUAL CASES OF INTESTINAL OBSTRUCTION.

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THE four cases described below, admitted to the London Hospital within a period of 48 hours, are recorded as being of general interest.

(1) *Atresia of the Small Intestine.*

M. S., aged 18 hours, admitted on Oct. 18th, 1919. Normal labour. Since birth had vomited continuously green froth and had not passed meconium. On admission well-developed child, vomiting greenish fluid. The abdomen was distended. About $1\frac{1}{2}$ inches from the anus was felt what appeared to be an obstruction to the finger. No bulging downwards could be detected. A rubber catheter was passed and was obstructed at the same spot.

Operation.—A muscle-splitting incision was made in the left iliac fossa; the small gut was distended and ended blindly. This blind end was brought out of the wound and enterostomy performed with a small Paul's tube. The child never rallied and died about six hours later.

Post-mortem report.—Paul's tube in apparently blind extremity of distended upper 95 cm. of small intestine (7 cm. circumference). Proximal 30 cm. of distal segment of small intestine (0.7–1 cm. circumference) free from the main mesentery, greatly twisted upon itself, and bound by several band-like adhesions to the lower surface of the proximal intestine, to the sigmoid colon, and to the transverse colon. The omentum replaced by adherent bands. Notch (10 cm. long), with rounded border in mesentery, between the upper extremity of small gut and the base of the apparently blindly ending proximal 30 cm. of the distal segment. Upper segment distended with gas. Pasty greenish-black occasionally white content in lower segment. Pale greenish pasty substance in colon. No abnormality in rectum and anus. Almost complete collapse of both lower lobes of the lungs. Patches of collapse in posterior parts of both upper lobes. Ductus arteriosus and ductus venosus patent. Foramen ovale patent. Bile-stained mucus in stomach. Uratic casts in kidneys. Centre of ossification in lower end of femur. Great congestion of lips and nails. Well-developed male baby.

(2) *Acute Obstruction by Band Simulating Appendicitis.*

D. C., aged 4, admitted on Oct. 19th, 1919. This child was brought to the hospital, having been ill for 48 hours. She complained of gradual onset of pain in the right iliac fossa, where it had remained localised, incessant vomiting, and constipation. On admission the child looked very ill and her eyes were sunken. Her skin showed loss of elasticity. Tongue was dry and coated. Temperature was 99° F. and pulse was 136. The abdomen was slightly full, and the movement on respiration was markedly impaired in the lower abdomen. There were rigidity and tenderness over all the lower abdomen, but this was more marked in the right iliac fossa. On rectal examination no bulging of the pouch of Douglas could be felt.

Operation.—Under the anaesthetic an indefinite mass was felt in the right iliac fossa. A muscle-splitting incision over the mass was made, and later enlarged upwards. The small intestine was distended, and there was a considerable quantity of blood-stained fluid in the peritoneal cavity. The mesentery was studded with

tuberculous glands, and there were numerous adhesions between the intestines. On tracing down the distended gut there was a sharp kink produced by a band attached to the mesentery and to the intestine near the mesenteric border. This band was divided. The intestine about 2 feet above was also joined to this point by adhesions and the portion in between was much discoloured, had lost its lustre, and did not contract. It was not considered viable, and about 2 feet of small intestine, extending to within 6 inches of the ileo-cæcal valve, was resected. End-to-end anastomosis was performed. A drainage-tube was passed to the pouch of Douglas after the abdomen had been irrigated with hot saline. After the operation patient's temperature continued to rise, and reached 105° before she died some 12 hours later. No autopsy was allowed.

(3) *Strangulated Sciatic Hernia with Pregnancy.*

C. P., aged 27, admitted Oct. 20th, 1919. Married, no children, no miscarriages; 18 weeks pregnant. Seven days before admission she had sudden acute pain in umbilical region, and vomited watery material. The attack subsided, and she was perfectly well in a few hours. Three days later she was seized with a similar acute pain in the umbilical region which radiated down the right leg and into the pelvis at times. The pain was colicky, and came on two to three times an hour. It was accompanied by persistent vomiting and much retching. The vomit was brownish in colour, but was not foul-smelling. Since this second attack of pain there had been absolute constipation. On admission: A well-nourished woman with anxious expression. Temperature normal. Pulse 112. Tongue dry and coated. The abdomen moved well with respiration, but was definitely distended, particularly in the hypogastric region. No visible peristalsis was seen. There was no rigidity or tenderness, except a slight degree over the lower part of the right rectus. The uterus could be felt reaching to within two inches of the umbilicus. No dullness was elicited in the flanks. On vaginal examination the os was patulous, but the fornices were very tender and difficult to examine. The pouch of Douglas appeared to be empty. On rectal examination a few hard scybala were felt which were washed out by two enemata. These were returned without relieving the obstruction.

Operation.—An incision was made in the mid-line below the umbilicus and the recti separated. The small intestine came into view and was markedly distended. A portion of collapsed gut was also found and the two were traced respectively downwards and upwards. They were found to meet in the right side of the pelvis where the intestine was firmly fixed. On attempting to bring up the obstruction to the wound the gut was inadvertently torn. About three inches of gut was then resected, including the tear, which was seen to have been through the constriction ring of a Richter's hernia. End-to-end anastomosis was performed. On examination of the pelvis there was found to be a hernial opening passing into the right sciatic notch above the pyriformis. The sac admitted the tips of two fingers for about half an inch, and in this the strangulation had taken place. A drainage-tube was passed into the pouch of Douglas and the wound closed in layers. The patient was nursed in the Fowler position. There was some difficulty in getting the bowels to act at first, but afterwards she made an uninterrupted recovery.

She was discharged on Nov. 19th. Her wound was well healed and her pregnancy undisturbed. The uterus reached to within one inch of the umbilicus. On vaginal examination the os was still somewhat patulous and there was still some tenderness in the right fornix, which bulged slightly.

(4) *Acute Obstruction by a Band in an Elderly Man.*

J. W., aged 56, admitted Oct. 20th, 1919. This man was admitted complaining of gradual onset of pain in the umbilical region of the abdomen for four days. The pain was not severe, but was dull and aching in character. Since the onset he had vomited repeatedly, and had returned everything that he had taken. The vomit consisted merely of the food he had attempted to

eat or drink. It was not brown in colour. His bowels were opened on the first day, and there was a constipated result to an enema on the second day. Since then the constipation had been absolute. He had never had diarrhoea or been troubled with his bowels in any way. His right hip was ankylosed and he had been treated for tuberculous disease about five years previously. On admission: Temperature 97° F. Pulse 80. Tongue slightly coated. The abdomen was distended and showed a definite ladder pattern with visible peristalsis. There was no ascites. The liver was not enlarged and no lump could be felt in the abdomen. On rectal examination scybalæ could be felt. An easily reducible left inguinal hernia was present. There were numerous scars over the right hip, one of which was discharging yellowish pus.

Operation.—An incision was made over the left rectus below the umbilicus, the muscle was split, and on opening the abdomen a small quantity of straw-coloured fluid was found. The small intestine was distended, but the cæcum was empty. The intestines were matted together by old fibrous adhesions. On tracing the distended intestine down a sharp kink was found, produced by a thick fibrous band attached to the mesentery and to the intestine midway between the mesenteric and the anti-mesenteric borders. This band was divided and the gut above emptied itself gradually past the stricture. The wound was closed in layers.

The patient died about 24 hours later with symptoms of ileus.

Post-mortem report.—Hæmorrhagic partial necrosis, in places almost perforated, of a knuckle of ileum (6.5 cm. long) situated 183 cm. above the cæcum. This portion of gut lies free in the peritoneal cavity. Great distension and a few submucous hæmorrhages in small intestine above strangulation. Very slight fibrinous adhesions between coils of gut throughout abdomen, but no evidence of tuberculosis in these adhesions. Large indirect inguinal hernial sac left, reaching to bottom of scrotum and containing an easily reduced portion of pelvic colon. Collapse of large intestine. Great acid digestion of lungs with congestion. A few fibrous scars producing puckering of pleura apex of left lung. No fibrous pleural adhesions. No tuberculosis of mesenteric glands. Brown atrophy of the heart. Numerous puckered scars, some of them with shallow ulcers covered by scabs, around the right hip-joint. Considerable mobility in the joint.

Remarks on Cases.

The points of interest in these cases are: (a) The varying ages of the respective patients; (b) the unusual nature of the causes of obstruction; (c) the impossibility of diagnosing the actual cause of obstruction before operation; (d) the length of the history in the last three cases; (e) the fact that in Case 3 apparently a previous strangulation had reduced itself three days before.

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A CASE OF CORNEO-SCLERAL CYST.

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THE case is remarkable for the size of the cyst, which, being situated in the upper half of the right eye, extended across almost the whole length of the palpebral aperture, and caused very marked lagophthalmos.

J. C., a boy aged 9 years, fell on the spout of a kettle three years ago. His right eye was cut, and he was

taken to a hospital where the eye was stitched next day. He was in hospital for three weeks, and on leaving it could only see shadows, but no swelling was noticed for over two years. When admitted to hospital he complained of no pain, but only of the discomfort and disfigurement that the swelling caused. He could still see shadows.

The cyst was roughly crescent-shaped and occupied the upper third of the cornea and the sclerotic above

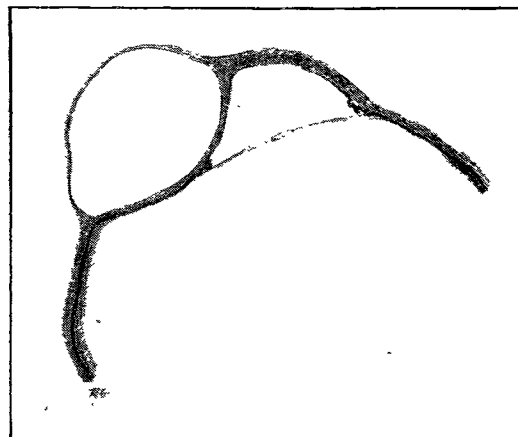


FIG. 1.—Showing general arrangement of cyst.

this and on either side. It measured 25 mm. in the horizontal direction and 12 mm. from before backwards at the point of its greatest depth. The upper lid barely covered the cyst. There was no ulceration present. There was no anterior chamber and no pupil was visible. The tension was +3. No movements were seen in the cyst.

The eye was removed on August 14th, 1919. On section the cyst was found to contain clear fluid. It had the characteristics of an implantation corneo-scleral cyst. The iris was stretched in the vicinity of the cyst, but in

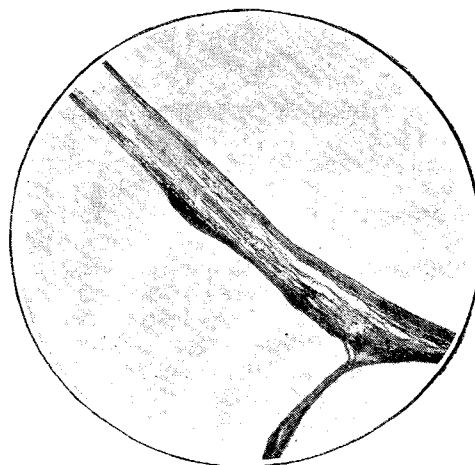


FIG. 2.—The corneal wall of the cyst, showing the corneal epithelium on one side and the epithelium lining the cyst on the other. A projection of the epithelium into the cavity of the cyst is shown.

front was firmly adherent to the cornea. The posterior chamber was deepened, especially near the cyst, and pigmented bands of organised lymph could be seen in front of a small and fibrous lens. No communication could be made out between the cyst and the posterior chamber. The optic nerve was cupped. The cyst was lined with squamous epithelium, which in places sent down projections which formed imperfect septa.

The sections here illustrated were made by Dr. Gorst at the Thompson Yates laboratories.

WEST CORNWALL INFIRMARY, PENZANCE.—At the annual meeting of the subscribers to this institution, which was recently held, it was decided to make a public appeal for the erection of a children's ward. The cost of the scheme is estimated at £12,000, being £5000 for the building and £7000 for maintenance. It was reported that the late Mrs. D'Esta Oliver had bequeathed £3000 to the funds of the charity.