

Clinical Department.

ACUTE PANCREATITIS.¹

BY M. H. RICHARDSON, M.D., BOSTON.

THE subject of Dr. Lund's paper is one of great interest to me, and it has been presented in a most interesting manner. One can say nothing in the way of adverse criticism. Dr. Lund has had the fortunate experience of seeing one or two of these cases of acute pancreatitis recover. In all the cases that I have seen in which this diagnosis was confirmed death has followed. It seems as if the time had come when we ought not to content ourselves with leaving these cases to themselves. The occasional occurrence of disseminated areas of cicatrization in the peritoneum — the yellowish spots referred to by Dr. Lund, and which I think every abdominal surgeon not infrequently sees — seems to show that recovery follows mild cases of fat necrosis. The severe cases are essentially fatal, and are among the most terrible of abdominal emergencies. It is to be hoped that by earlier recognition, and by earlier and more thorough methods, we may reduce the almost prohibitory mortality of operations thus far performed.

I have seen a number of cases of suppuration in the epigastrium, in the lesser cavity of the omentum. My first case was one which Dr. Elliot thought had probably started from a suppurating pancreas. There was no reason to think it was the pancreas except that the woman had a large abscess in that region. She was a "fat old woman who may have had gall stones." We simply drained the abscess, and she made a good recovery. I have drained abscesses in the epigastrium in four or more instances, but I have attributed them to other causes than pancreatitis. One occurred in a girl who had been in the habit of swallowing rubber gum. I supposed that the gum had collected in the stomach and that a perigastritis had resulted. This was indeed the fact. In another case in which I operated for Dr. Dudley, of Abington, we found extensive retroperitoneal hemorrhage. The man died, and an autopsy was not obtained. I have operated in another instance for what I supposed was suppuration of the mesenteric lymph glands situated near the pancreas. The patient, a girl, recovered, but died later of pulmonary tuberculosis. I have used this case as an illustration of possible mesenteric tuberculosis and suppuration. One case was undoubtedly an acute hemorrhagic and suppurative pancreatitis. My patient was a girl of nineteen, who was apparently moribund. I thought at first that there would be no use in operating, but finally decided to open under cocaine the epigastrium where the guiding symptoms lay. We gave her chloroform finally. The wound gave exit to enormous quantities of bloody serum, and to masses supposed to be pancreatic fat. To my surprise,

the girl recovered from the operation and did well four weeks, toward the end of which time she began to cast off large masses of sloughing pancreatic tissue. She was doing fairly well, when suddenly she died. An autopsy was not obtained. On the same day a similar case was operated upon at the Massachusetts General Hospital. The patient, a man, also died at the end of about four weeks, after doing well.

I have listened to the paper with great attention and interest, and I think that the conclusions are warranted. In all obscure inflammations of the epigastrium, attended by acute sudden pain, we ought to explore. If we cannot do anything else we can at least drain. From the nature of things I do not suppose that we can save many cases. The frequency with which the diagnosis of pancreatitis has been made is suggestive. In all obscure cases of sharp pain high up in the abdomen the one who always says "acute pancreatitis" will sooner or later be right. I have said it many times, but never was right. The fact is, that the diagnosis of these obscure lesions is practically impossible unless time is taken for study, which the imperative call for operation forbids. The only case of mine in which this lesion was really found was one in which it had not been suspected. The last case in which this diagnosis was made was only two weeks ago. One of my assistants thought the lesion an acute pancreatitis; a consultant, intestinal obstruction; the rest of us made no diagnosis. Under either it was plainly an acute appendicitis — in other words, it proved to be what almost all obscure acute inflammations in the abdomen prove to be — an acute appendicitis with general peritonitis.

CASE OF RECOVERY AFTER OPERATION FOR ACUTE PANCREATITIS.¹

BY J. C. MUNRO, M.D., BOSTON.

The patient was under the care of Dr. Flanders, of Jamaica Plain, and was seen also by Dr. Jackson. When I saw her there was general abdominal pain, tenderness and spasm in both hypochondria and in the epigastrium, with a tumor in the latter region, extending into the left lumbar region. The diagnosis was some retroperitoneal infection. At that time Dr. Flanders thought of pancreatitis, but personally I did not give it much credence. There was a history of recurrent attacks of gall stone, and I thought it more likely that a large gall stone had perforated the posterior peritoneum and produced a retroperitoneal lymphangitis, extending across to the kidney. On the following day, March 8th, I operated, and found the omentum full of fat necrosis, and behind that a large tumor which increased in size towards the left. I introduced the fingers into the tumor and found that there was no pus, but that it broke up rather easily. With one finger

¹Contribution to the discussion of a paper on "Acute Hemorrhagic Pancreatitis," read by Dr. F. B. Lund before the Boston Society for Medical Improvement, November 26, 1900. See Journal, November 29, 1900.

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