

most certainly the case with this patient, but also with the desire of removing secondary permanent disabilities which may occur when the hemorrhage does not involve the capsule primarily, but only by its reactive processes and its slow extension brings about the more far-reaching results.

## GASTROPYLORODUODENOSTOMY

WITH EXCISION OF THE ULCER-BEARING AREA  
FOR ACUTE PERFORATED ULCER IN  
THE PYLORIC CANAL \*

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*History.*—C. P., man, aged 26, while standing on the sidewalk in front of his residence, May 16, 1914, talking to friends, was seized with an acute excruciating pain in the upper abdomen. So intense was the pain that it caused him to fall to the ground unconscious. The friends who picked him up and carried him into the house noticed that he vomited a small quantity of blood.

About one hour after this happening, he was seen and found still in a semicomatose condition, pulseless at the wrist, with cold, clammy sweat covering his body, the respiration entirely thoracic, his face having a very pinched and blanched expression. He was found sitting in bed with the body acutely flexed on the knees. No amount of persuasion could induce him to change this position. It was impossible to examine his abdomen carefully. He would allow no one to touch it. No information or clinical history could be obtained from him. All the facts on which to evolve a working diagnosis had to be obtained from bystanders who had witnessed the attack and knew nothing about the patient. Information obtained from relatives was no more illuminating. They said that he had always been well and had never lost a day's work. That morning he complained of a headache, but had eaten a very large meal at noon.

The diagnosis of perforated gastric ulcer instinctively fixed itself on my mind. Indeed, I could not think of a gallbladder perforation, as there would have been no hematemesis in such a condition, nor would such a perforation be likely to occur suddenly, without the occurrence of a few biliary colic pains. Of great weight, also, was the assurance received from the family that the patient had never had any acute gastric distress or acute abdominal pains before. I was also impressed by the unmistakable signs of shock and pinched expression. An acute perforated appendicitis could cause the same type of shock, but I have never seen the occurrence of hematemesis in these cases.

The patient was quickly taken to the Protestant Deaconess Hospital, a hypodermic of morphin, one-fourth grain, and atropin, 1/150 grain, was given, and a hasty preparation made for an abdominal section.

*Operation.*—A long paramedian incision was made on the right epigastric region, extending down to the right iliac fossa. When the peritoneum was opened, a large amount of blood and gastric contents escaped. From the amount of food and liquid in the abdomen, it was evident that the patient had had an excellent dinner and had certainly not lacked in wine. A careful surgical toilet was made, and the examination of the viscera was started at the stomach. Exactly in the pyloric ring and in the lower outer portion of it, a perforation large enough to admit the index finger was found. This was certainly a fortunate location for the perforation, as it enabled me to make a wide excision of the ulcer-bearing area, and it was possible to restore the pyloric end of the stomach, insuring a large pylorus, by employing the technic of Vidal, effecting a gastropyloroduodenostomy. To my astonishment, on examining the ileocecal juncture, the appendix was found to be acutely inflamed and with a cleancut perforation, with a little fecalith just extruding from it.

\* Read at a meeting of the Indianapolis Medical Society, May 4, 1915.

The appendix was removed in the usual manner. The abdomen was properly closed with adequate drainage being provided at the lower angle of the incision. An intravenous injection of physiologic saline solution had been given during the operation, and the patient left the table in a much better condition than before the operation.

The recovery was uneventful, the patient leaving the hospital after three weeks. A communication received from him in April informed me of his excellent health and absolute freedom from any symptoms whatsoever.

This case seems to me strongly to emphasize the etiologic rôle played by an appendiceal lesion in the production of acute gastric and duodenal ulcers. This case, whose final issue would have been death, in my opinion, seems to have had its basic etiology in the appendiceal lesion. I am induced to attribute to the concomitant acute appendicitis more importance than that of mere coincidence.

Dieulafoy and D'Antona have held for many years that an appendiceal lesion can be the primary focus which may set up metastatically an ulcerative process in the stomach and duodenum. Indeed, they have conclusively proved that even acute gastric hemorrhage without ulcer may be produced by an appendiceal lesion.

If I am correct in assigning to the appendiceal lesion a greater importance than that of a mere coincidence, we may reasonably assume that acute appendiceal infections do play an important etiologic rôle in the production of acute gastric and duodenal ulcers, if not in those ulcers of the chronic type.

In a reasonably large number of gastric cases which it has been my good fortune to have had in the last four or five years, I have been impressed by the frequency of concomitant appendiceal lesions in my cases of acute gastric and duodenal ulcers and of their relative rarity in those of the chronic type, both of the stomach and the duodenum. Certainly this case stimulates much thought, and it has been for this reason that I have taken the liberty to report it.

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## ACUTE ARTICULAR SINOVITIS OF CRYPTIC NASOPHARYNGEAL ORIGIN

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The following case is presented as a justification of my theory<sup>1</sup> that the primary source (focus) of an infection or of anaphylaxis—whether general, metastatic, or local—is, as a rule, to be found in the nasopharynx, localized in Luschka's tonsil. The case described was one of acute poliarticular "rheumatic" sinovitis.

*History.*—The patient, a man, aged 26, had been under treatment by the usual internal and external remedies in a large orthopedic hospital with little relief. No focus of infection had been located, in spite of well-directed effort.

He had been subject to severe attacks of "lumbago" as long as he could remember. The present illness began in the right knee. Pain and a large effusion in the right knee and ankle had lasted for six weeks, while the right hip had been painful and useless a week. He came to the office on

1. Bryant, W. S.: Air-Borne Infections, Their Mode of Entrance; Preventive, Abortive and Ameliorative Treatment, Med. Rec., New York, May 16, 1908, p. 816; the Involvement of the Naso-Pharynx, and Its Clinical Importance, Am. Jour. Med. Sc., 1914, cxlviii, 61.

crutches, walking with difficulty. He said that he had always been a nose breather by day, but a mouth breather by night. Since childhood, he had had no sore throat, but he often has "neuralgia" over his eyes.

**Examination.**—When the patient came to me, he was thin, with haggard facies, and was unable to stand or walk without crutches. The right hip was very painful on motion and tender. The right knee had a very large effusion, and was painful; the right ankle was tightly distended, painful and tender. The man could bear no weight on the right leg at all, or bend the joints or sit on right hip. He could sit on the left side only. The examination showed a red pharynx. There was also nasal obstruction from a deflected septum. The tonsils were negative in appearance. Posterior rhinoscopy showed an enlarged soft adenoid which bled very readily. The left adenoid was the larger. Small lymph nodes were palpable along both jugular veins. There was no subjective symptom of the throat, however, and no obvious indication that any infection was present.

**Treatment and Result.**—The first treatment began with postnasal applications of hydrogen peroxid through the nose, followed by a 10 per cent. solution of silver nitrate and a chinosol nasal douche. The following day, the patient reported that he had felt relief in a half hour after the treatment of the previous day. When he came to my office this day, he had a good color, and his expression was no longer pinched. He said that the pain had entirely gone during repose. He was able to walk without crutch or cane, and could sit down normally. Palpation detected scarcely any fluid in the knee. A saturated solution of ferric ammonium sulphate and menthol and eucalyptol was applied.

On the fifth day of treatment, the hip had entirely recovered, and the nasopharynx also was well. The patient himself was much better and all pain was gone, both at rest and during locomotion. On the twenty-third day, after eleven treatments, there was no sign left of the old "rheumatism."

Here is a case of acute polyarticular "rheumatic" sinovitis. Under the usual hospital treatment the case was prolonged and convalescence delayed. The source of the rheumatic infection had not been located. On inspection of the postnasal adenoid or Luschka's tonsil region, the cryptic infection was discovered.

#### CONCLUSION

When, in cases of acute articular inflammation, the primary infection is not obvious, a cryptic infection probably thrives in the nasopharynx. Luschka's tonsil is the most usual seat of cryptic infections that extend to the general system or form metastatic inflammations.

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#### REPORT OF CASE OF UNILOCULAR OVARIAN CYST

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The patient, Mrs. H., came from a wealthy family; a clear family history was difficult to obtain, but she had no knowledge of any other member of the family having had a similar tumor; she had smoked opium for several years, which fact she succeeded in concealing from us until after the operation, by secretly taking pills.

The tumor had been growing for four or five years; there had been no severe pain, but great discomfort. When brought to the hospital the patient was also suffering from a severe attack of diarrhea, which, however, we succeeded in getting under control before the operation.

On measurement we found the patient to be 4 feet 10 inches tall and 5 feet 8½ inches in circumference at the waist line.

With an assistant on each side, she could with great exertion walk a few steps; getting her to the operating room, which is situated on the second floor, and on the operating table was a problem. As one of the visiting physicians aptly remarked, it was a case of engineering as well as surgery. She was too broad to sit in a rolling chair or balance herself on a stretcher, so we had four coolies carry her on an improvised stretcher—a woven cane bed—and when she was finally transferred from that to the operating table, we had to put her at an angle of 45 degrees, reclining on her side, with two assistants under the tumor to support it.

An incision about 3 inches long was made through skin and peritoneum just below the umbilicus, the cyst tapped and over 100 pounds of dark brown fluid removed. The cyst with its contents weighed 139½ pounds. The incision was then extended above and below, when, on examination, the cyst wall was found to be bound by heavy adhesions to the abdominal wall, intestines and omentum, while the pelvic organs, including the bladder, formed a solid mass for the pedicle.

The bladder was carefully dissected away from the mass, although in several places the adhesions were so dense that a portion of the cyst wall had to be left, and in spite of the utmost precaution the bladder was entered. After the bladder wall was finally dissected free, the rent was sutured, the pedicle clamped and tied, and the cyst wall, including both the ovaries and uterus, removed. The stump was covered with peritoneum and dropped back into the pelvis. About a quart of normal salt solution was poured into the abdominal cavity, and the abdomen closed. In the meantime the patient was very much in shock. Gradually, as the abdominal contents were removed, she had been placed in the horizontal, and finally in the Trendelenburg position. Intramuscular and intravenous infusions of normal salt had been given, while strychnin, nitroglycerin and pituitary extract had also been administered.

Recovery was uninterrupted. In three days the patient was urinating, the bowels moved without even a laxative being given, and in five weeks she left the hospital cured of her opium habit, and with no bad after-effects from the operation.

Six months after the operation she continues in good health.

The physicians who so kindly assisted in the operation were Drs. McCartney and Freeman of our own (Methodist) mission, Dr. Sheridan of the Canadian Methodist Mission, and Dr. Post of the American gunboat *Palos*, who was then in port.

**The Physician and Health Administration.**—In a reprint in Public Health Reports of a paper read by J. W. Trask before the Tennessee State Medical Association he again emphasizes the responsibility and the opportunity of the physician with reference to effective health administration and disease prevention. He says the principal function of the federal health department is the control of epidemics and the prevention of the spread of disease from one state to another. In order to accomplish anything in this respect it is necessary to have prompt and accurate information of the occurrence of epidemic diseases from every section. For this information the service is dependent largely on local boards of health, and they in turn depend on the notification of such diseases by physicians who come in contact with the individual cases. He says that physicians are still remiss in reporting cases to their local health departments, and do not recognize as they should that they are essentially a part of the health department. He says, "The practicing physician who fails to report a case of a communicable disease thereby endangers the welfare of the community and exposes others to the danger of contracting the disease, and among those thus exposed may be others of his patients. He is neither a good physician nor a good citizen, and must be considered as opposed to the principle of the control of disease and the protection of the community for which the health department stands."