Medical Memoranda

Subserous Jejunal Haemorrhages During Mecamylamine Therapy

In the treatment of hypertension with ganglionic blocking agents, one of the most frequent complications is constipation. This may progress to a paralytic ileus if not dealt with immediately, and can present as an acute abdominal emergency. Bourne and Hosford (1951) describe a case which was operated upon during hexamethonium bromide therapy, when the findings at laparotomy were a grossly distended oedematous small bowel, with no evidence of mechanical obstruction. Similar cases have been described by Goldstone (1952) and McCalla *et al.* (1953), where again the operative findings were simply small-bowel distension with no obvious cause of obstruction. Grant and Boyd (1957) reported a case of ileus due to mecamylamine ("inversine"), where the small bowel was distended and no tumour or cause of obstruction was found. The following is the description of a case of hypertension on treatment with mecamylamine, presenting as an acute abdominal emergency in which the jejunum showed subserous haemorrhages.

CASE REPORT

A head mistress aged 42 was admitted to hospital on December 13, 1957, as an acute surgical emergency. She complained of severe, generalized, colicky abdominal pain of 18 hours' duration, which did not radiate through to the back. She had vomited many times, the material being food and bile at first, becoming brown and offensive later. Her bowels had been opened normally two days previously, and micturition was normal.

Twenty-two years ago she had had an appendicectomy for acute appendicitis with peritonitis. Since March, 1956, she had been under the care of one of us (J. R. H. T.) for hypertension, and had been having mecamylamine for just over a year. At the time of admission she had been taking mecamylamine, 10 mg. t.d.s., and "raudixin," 50 mg. t.d.s., for two months.

On examination she was pale and nervous, and was having severe abdominal pain. Her pulse rate was 100, temperature 99.2° F. (37.3° C.), and blood pressure 190/135 mm. Hg. The abdomen was slightly distended, with generalized tenderness and rebound tenderness to the left of the umbilicus. Rectal examination revealed tenderness in the pouch of Douglas. A plain vertical film of the abdomen showed some small-bowel fluid levels and a distended loop of jejunum to the left of the midline (Fig. 1). A diagnosis of "mecamylamine ileus" was made, so her stomach was aspirated hourly through an oesophageal tube, and she was given 5% glucose in normal saline intravenously.

Six hours later the pain and tenderness were still present, and, in view of the previous operation and the possibility of a strangulated loop of small bowel as the cause of the condition, a laparotomy was carried out.

Operation.—The abdomen was explored through a right central paramedian incision. The peritoneal cavity contained a moderate amount of pale-yellow clear fluid. There was no evidence of intestinal obstruction in either the small or the large bowel. In the lower jejunum about 3 ft. (90 cm.) of the small bowel was very noticeably covered with numerous bright-red subserous haemorrhages (Fig. 2). The affected bowel was not distended and only slightly

FIG. 1.—Plain vertical radiograph of the abdomen, showing small-bowel fluid levels and distended loop of jejunum.

FIG. 2.—Photograph of affected loop of jejunum at operation, showing subserous jejunal haemorrhages.

thickened, there being no palpable mesenteric glands. This being the only abnormal finding, the abdomen was closed in layers.

Post-operative examination of the blood showed a normal count, clotting-time, and bleeding-time; the platelet count was 169,000, with normal platelet morphology.

The patient made an uneventful recovery and was discharged home 10 days later.

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