TYPHOID FEVER

CONVALESCENCE; SYMPTOMS OF PERFORATION;
LAPAROTOMY; NO LESION FOUND; RECOVERY

BY

W. P. HERRINGHAM, M.D.

AND

A. A. BOWLBY, F.R.C.S.

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PERFORATION of the intestine in or after typhoid fever is without doubt usually, and in the opinion of most physicians almost invariably, fatal. But a good many cases have now been recorded in which, though the symptoms which indicate perforation have occurred, the patient has recovered. That any free escape of liquid, or even of gas, into the general peritoneal cavity from the intestines is invariably fatal will probably not be disputed, and in the above cases of recovery it has been supposed that the poison has been limited by adhesions to a small part of the peritoneum. The localised plastic peritonitis that one occasionally finds opposite the ulcers of typhoid fever certainly renders this view possible. But the evidence must needs, in patients who recover, be very inconclusive, and in an able and exhaustive paper upon the subject Fitz ('Trans. Assoc. Amer. Phys.,' vi, 200) has argued strongly against it. He points out that

sudden pain, vomiting, collapse, and fall or rise of temperature are but signs of peritonitis, and he maintains that the absence of hepatic dulness, even when it has been known to be present before, and the abdominal murmur which some physicians have noted, are signs of doubtful meaning and of inconstant occurrence. But peritonitis, he says, may be due to other causes; and after enumerating many, he goes on to argue that from the symptoms mentioned it is probable that most of the recorded cases of recovery have been cases of appendicitis, caused by typhoid lesion of the vermiform process. His proof of this, however, is weak, and we need more records of the state of the appendix in typhoid fever than we now possess before this theory can be accepted.

In January of this year a case fell to our lot, which shows that the same group of symptoms may occur not only without perforation, but even without peritonitis.

CASE.—Jane P—, aged 13, was admitted to Mary Ward in St. Bartholomew's Hospital, under Dr. Hensley, on January 2nd, 1896. She was a healthy-looking girl, but had been feeling tired and had had a cough since December 18th, 1895, and had been in bed since December 25th. When admitted she had some bronchitis, the heart was natural and the pulse fair, the abdomen was rather full, the spleen was not palpable, and there were a good many typhoid spots.

The temperature fell very soon after admission, and was normal on January 9th, which was probably the twenty-second day of her illness. The motions were then solid, the tongue clean, and the pulse 80. The abdomen remained a little full.

On January 15th the patient was very well. Her temperature had been subnormal for seven days, she had been allowed bread and milk for the last two days, and had been taking food well. The bowels had been open on January 4th, 6th, and 7th, but not again until January 14th. They had not been open on the 15th. At 5 p.m. on that day she suddenly complained of acute abdominal pain,

which caused her to cry out constantly. The pain gradually became worse. She vomited frequently. Her pulse was 140 and small. She was given $\frac{1}{4}$ grain of morphine subcutaneously, which relieved her for rather more than an hour; but the pain then returned as badly as before. She was given an oil enema, but without effect in opening the bowels. The abdomen was then full and tense; its walls were rigid, and scarcely moved with respiration; the liver dulness was natural. There was marked tenderness on palpation, especially near the umbilicus, and it was to this region that the pain was referred. The temperature had remained stationary. There was a general aspect of considerable collapse. At 8.30 p.m. we saw the case together, one of us being at the time on duty for Dr. Hensley. The symptoms had in no way improved. The child lay with the thighs drawn up, and screamed with pain on the slightest movement. The abdomen was rigid, and so tender that no complete examination could be made. Retching was almost constant, though but little was now actually vomited. The pulse was still rapid, the hands and feet were cold and clammy.

As it was considered that these symptoms indicated perforation, and as the patient had previously been in good condition, it was decided to open the abdomen.

The patient was placed under the influence of chloroform, and the abdomen was opened in the middle line below the umbilicus. There was no gas or fluid in the peritoneal cavity, and an examination of the cæcum and the last two or three feet of the small intestine showed no evidence of inflammation or perforation. The whole of the colon contained scybalous masses. The abdominal wound was sutured, and a soap and water enema was administered before the patient recovered from the anæsthesia. The bowels were freely open at once. When the patient again became sensible she complained of but little pain, and such as there was quickly yielded to small doses of opium. The bowels were difficult to

move for several days, but became more regular under treatment by glycerine enemata and cascara sagrada. Recovery was uneventful and complete.

This was apparently, therefore, a case of mere colic. Yet it gave rise to symptoms like those which accompany peritonitis, sudden and severe enough to lead us to believe this condition to be present. We have no doubt that our diagnosis would have been confirmed by most physicians. If peritonitis existed, then, although other possible causes deserved consideration, yet, under the circumstances, perforation was far the most probable. If perforation existed the chances were very greatly against recovery if the case were left to itself. On the other hand, the patient had been without fever for seven days, so that we believed the gut would not be swollen or rotten, but sound and fit to heal after a wound, and she was in good case and well able to bear the shock of the operation. Agreeing that had she been in the acute stage of the fever we should have thought an operation almost hopeless, we agreed also that in her actual condition it had a good chance of success.

We record the case partly as a singular and, as far as we can find, unique instance of simulated perforation; partly to show that a recent attack of typhoid fever need be no bar to opening the abdomen should circumstances require the operation.

(For report of the discussion on this paper, see 'Proceedings of the Royal Medical and Chirurgical Society,' Third Series, vol. ix, p. 42.)