by one tablet thrice daily for seven days. Urticaria, colic, and fever did not develop during his next three days in hospital or during the subsequent follow-up.

COMMENT

The symptom-complex characterized by fever, abdominal colic, and urticarial rash appeared about the same time of the day.

The absence of chill and rigor, nausea and vomiting, and profuse sweating during defervescence preclude a clinical diagnosis of malaria; but demonstration of malaria parasites in the peripheral blood film during the last attack and the complete disappearance of symptoms after proguanil therapy suggest the unitary nature of the symptom-complex. Further, it was noted that antistim did not prevent the return of abdominal colic and fever.

In the dietetic history nothing was suspected which could be incriminated for urticarial attacks; and examination of the stool revealed no pathological condition which could explain the abdominal colic.

Lastly, the association of malarial attacks with abdominal pain is a common manifestation of malignant tertian infection.

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Unusual Case of Subacute Intussusception with Spontaneous Elimination

Cases in which an intussusception has sloughed off and been passed per rectum are rare enough to be placed on record.

CASE REPORT

A child aged 2½ attended the casualty department on July 10, 1949, with vomiting and intermittent abdominal pain. She showed signs of a follicular tonsillitis and a urinary infection, but of no other abnormality. A course of sulphatriad (total 12 g.) cleared these with a temporary decrease of symptoms. However, the vomiting recurred and there was abdominal distension with some apparent constipation; she was therefore admitted for investigation.

On admission on July 20 she seemed to be in good general condition, with no wasting, but was extremely fretful. Her abdomen was grossly distended, tense, and tympanitic; no guarding was elicited and no masses were felt; a few borborygmi were heard. On rectal examination the anus appeared normal, the rectum felt empty, but some soft yellow faeces were seen on the examining finger. Other systems were normal. Her blood count was within normal limits, except for a leucocytosis of 15,000 per c.mm. with 80% polymorphs.

The child ate well and did not vomit. She had from one to four motions a day, which were normal or relaxed, contained no blood, and grew no pathogens. Her temperature was 100° F. (37.8° C.) on admission, and it never really settled till after operation. On the fourth day she passed what appeared to be a necrotic piece of tissue 15 in. (38 cm.) long, followed by a small pale stool. The child appeared relieved and was less miserable; the rectum felt empty and there was no blood on the examining finger. The following day the abdominal distension increased, and there was visible peristalsis, with a step-ladder pattern, an apparent increase in abdominal pain, but no guarding or rigidity and no palpable mass. A radiograph of the abdomen showed several fluid levels in the small intestine. A

laparotomy was decided upon, and an intravenous plasma drip was started pre-operatively, as the child had started to vomit.

Operation.—The lower end of the ileum was found to be congested and adherent to other parts of the small intestine; the caecum and appendix were normal, but about 2 ft. (61 cm.) proximal to the ileo-caecal junction a mass resembling an intussusception was felt in the lumen of the intestine. On a very gentle attempt to reduce this, the wall of the gut opened and a little faecal matter leaked out; a finger-like projection was then visible inside the intestine. Adhesions were divided and a resection and end-to-end anastomosis were carried out. The wound was closed without drainage, and sulphonamide, penicillin, and streptomycin therapy was instituted; the plasma infusion was continued for 24 hours after operation. Faeces and flatus were passed within 24 hours of operation. Post-operative recovery was uneventful, except for a rectal prolapse on the third day, which was easily replaced.

Specimens.—(1) The slough was found to consist of necrotic tissue containing some moderately large arteries and a band of collagen fibres running longitudinally, suggesting that necrotic whole gut was present, rather than mucosa only. (2) The mass within the resected intestine consisted of fatty tissue containing some rather large blood vessels, and with a covering of mucous membrane.

COMMENT

It seems probable that there was a subacute intussusception in which a portion of the mesentery was drawn into the lumen of the intussusciens; that the intussusceptum sloughed off, leaving a projection of mesenteric fat pointing into the bowel; and that the neck of the intussusceptum and the base of the intussusciens were joined by adhesions to form a spontaneous anastomosis, which broke down at the lightest touch (see illustration).

Leichtenstern (1877) reported spontaneous elimination in 42% of 593 cases; but since then few cases have been reported. Three cases of gangrenous intussusception have been reported recently (Kerr, 1949; Conway and Dawson, 1949), in one of which end-to-end anastomosis was possible; in none of them did spontaneous elimination occur. The present case resembles these in that diagnosis was made difficult by an unusual clinical picture. Although there was a story of early vomiting, there was no wasting, such as is usually found in subacute intussusception, and no blood was at any time passed per rectum.

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