Medical Memoranda

Intravenous Atropine for Peptic Ulcer

I present here a case of ulcer of the lesser curvature of the stomach in which a crater the size of a cherry diminished to one-tenth of its original dimensions after four weeks' treatment and ceased to be visible radiologically after six and a half weeks.

An ex-Serviceman aged 41 was discharged from the Army because of hyperthyroidism. In July, 1946, for two weeks he had pains in the epigastrium after meals. In October and November, 1946, the pain returned and was more severe. He was admitted to hospital on Nov. 18. The thyroid gland was slightly enlarged and a little hard on palpation. The basal metabolic rate was +11%, and there were no cardiac or ocular signs. A fractional test meal showed fasting hypersecretion with acidity 30/20 and 55/45;

FIG. 1

the highest acidity after the introduction of 100 ml. of 5% alcohol was 60/45 and 65/55. Stool examination for occult bleeding (benzidine test) was positive. A barium meal showed the presence of a niche the size of a cherry on the lesser curvature with regional gastric spasm opposite (see Fig. 1).

Under treatment the gastric complaints disappeared completely in 10 to 14 days. On the ninth day the benzidine test became negative. On Dec. 16 the ulcer niche on the lesser curvature diminished to one-tenth of its original size and on Jan. 4, 1947 (after six and a half weeks), it ceased to be visible (Fig. 2). The highest acidity shown by fractional test meal before leaving the hospital was 50/40.

The treatment consisted of: (1) slightly restricted mixed diet; (2) 1 oz. (28 ml.) of cod-liver oil before breakfast; (3) 1 dr. (4 g.) magnesium trisilicate three times daily after meals; (4) radiant heat

FIG. 2.—Ulcer niche on the lesser curvature invisible.

twice daily for 20 minutes on the upper abdomen: (5) daily intravenous injections of 1/60 gr. (1 mg.) atropine sulphate plus 10 ml. of 10% calcium gluconate. After twenty-eight daily intravenous injections of atropine and calcium they were continued every third day, so that in all the patient received 35 injections.

COMMENT

The diet in this case was not very strict and the alkalinization was not very massive. From my clinical experience it appears that cod-liver oil before breakfast favours rapid healing of a peptic ulcer, but I ascribe a great part of the therapeutic success to the intravenous injections of atropine. For many years the subcutaneous injections of 1/60 gr. (1 mg.) of atropine formed an integral part of my treatment. However, I met resistant cases in which diet, alkalis, bismuth, cod-liver oil, and subcutaneous atropine could not bring about a remission, and operation could not be performed for various reasons. I then tried atropine 1/60 gr. in 10 ml. sodium bromide or calcium gluconate (10%) intravenously. The results surpassed my expectations. I admit that it is difficult to imagine, if one does not see for oneself, how different is the therapeutic effect of atropine injected subcutaneously and intravenously. The case described is an exact replica of cases published by me in *La Presse Médicale* in 1937. In my view intravenous injections of atropine sulphate in sodium bromide or calcium gluconate should form an integral part of the conservative treatment of peptic ulcer.

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REFERENCE

Landau, A., and Hejman W. (1937). *Presse méd.*, 45, 1468.

True Knot of the Cord giving rise to Foetal Distress

True knots of the cord are fairly commonly seen at delivery, but are usually without effect on the foetus. The following case is of interest in that tightening of the knot in labour gave rise to an unexplained foetal distress in the first stage of labour.

CASE HISTORY

A primigravida at term was admitted to hospital on Jan. 18, 1947, as a case of foetal distress in the first stage of labour, with the cervical os dilated to admit only one finger. The patient had had a show at 3 p.m. the previous day, which was followed shortly afterwards by feeble and irregularly timed contractions. The vertex was presenting, engaged in the left occipito-anterior position, the foetal heart rate was 136, and the maternal pulse 64. Vaginal examination showed the head in the mid-cavity, and the cervix not dilated. No liquor amnii was draining. Labour continued throughout the night, with increasing uterine contractions, and at 9.15 a.m. on the 19th thick greenish-brown-stained liquor was passed. The foetal heart was found to be beating irregularly at 146, but subsequently fluctuated between 90 and 150. The cervix was dilated to the size of only one finger and no prolapse of the cord was palpable. Admission to hospital was requested, and this was arranged.

The progress of labour was confirmed, but no cause could be found for the apparent foetal distress. The foetal heart was observed for a while; while beating irregularly in rhythm, it remained fairly constant at about 146 beats a minute, and was not unduly influenced by pains. Morphine 1/4 gr. (16 mg.) was ordered and the labour allowed to continue without interference. The foetal heart rate varied between 120 and 148, but became more regular in rhythm during the afternoon, although thick meconium-stained liquor continued to be passed at intervals. At 4.45 p.m. the cervix was dilated to four fingers, and at 6 p.m. was fully dilated. Delivery of a mature infant weighing 5 lb. 7 oz. (2.47 kg.) followed shortly afterwards. The cord was not encircling the neck, which fact probably saved the baby's life.

The baby at birth was limp blue-asphyxiated, and covered with meconium-stained liquor. The pharynx was cleared, and the infant responded slowly to efforts at resuscitation but ultimately became of a good colour. After delivery a true knot (tightly tied) was discovered about half-way along the cord, which was 20 in. (50 cm.) in length. The placenta was normal. The neonatal period passed uneventfully, the baby subsequently being discharged fit and well.

I am indebted to the medical superintendent for permission to publish this case.

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