Comments

If the population of Middlesex be taken as 2,000,000 it can be calculated that there are approximately 1,200,000 persons in the 14-55 age group. Allowing that the age distribution of the females in the above survey is very skew, being excessively overweighted at ages 14-24, it appears that there are probably some 3,000 undiagnosed cases of pulmonary tuberculosis in the county in need of treatment, and that half of these cases are without symptoms.

REFERENCES

- "Mass Miniature Radiography of Civilians" (1945). Med. Res. Cncl. Sp. Rep. Ser. No. 251, London.
 Trail, R. R., *et al.* (1944). *Brit. J. Tuberc.*, 38, 116.

A CASE OF LEFT-SIDED APPENDICITIS

BY

J. W. L. HADDON, M.B., Ch.B.

Resident Surgical Officer, Beckett Hospital, Barnsley

Although left-sided appendix is by no means rare, the following case is interesting in that a full examination was possible later in the post-mortem room and an unusual condition found.

Case Report

A soldier aged 19, three months convalescent from a subtotal thyroidectomy for Graves's disease, was admitted to hospital on March 21, 1945. He was in a very nervous and toxic state, and gave a history of severe abdominal pain, which had started suddenly 36 hours previously and become progressively worse. The pain was continuous in character, and was at first generalized and was accompanied by nausea, but had since become localized to the hypogastrium and medial side of the right iliac fossa; he had vomited twice just before admission. There was no history of dysuria, and the bowel actions had been normal. Previous history did not give any indication of gastro-intestinal disease.

Diagram showing the abnormal position of the abdominal viscera, with the restrictive band.

Abdominal examination showed slight distension, with rigidity over the whole lower half of the abdomen; and acute tenderness localized to the hypogastrium and right iliac region. Auscultation revealed a "silent abdomen." Per rectum, he was tender anteriorly, high up. His general state was poor, with dehydration and a rapid pulse which showed occasional extrasystoles. A diagnosis of early diffuse peritonitis, secondary to a perforated inflamed appendix, was made, and operation arranged accordingly.

Operation.—The abdomen was opened through a right gridiron incision as there was no clinical indication of an abnormal situation of the appendix, and purulent fluid escaped. On inspection neither the appendix nor the caecum could be seen, and their absence was confirmed by finger exploration—the right iliac fossa being apparently filled with distended coils of small gut only. The incision was closed and replaced by a right lower paramedian incision; this revealed a long gangrenous appendix lying obliquely across the left lower abdomen, from left to right, with the tip reaching the recto-vesical pouch. The caecum was occupying the left iliac fossa, together with the sigmoid colon, and it was ascertained that the liver was in its normal situation; but, apart from this, no further exploration was attempted, in view of the patient's critical state, and appendectomy with suprapubic pelvic drainage was carried out. Intravenous infusion was started, and an attempt was made to institute continuous duodenal suction; but the man proved most intractable and refused to tolerate either form of treatment, repeatedly pulling out both Ryle's tube and intravenous cannulae.

He became progressively worse, developing paralytic ileus and dying on the fifth day. Permission for a "limited" necropsy was granted.

Post-mortem Findings.—On opening the abdomen the small bowel was found to be entirely confined to the right side, with the caecum and ascending and descending colons occupying the left. The ascending colon passed obliquely upwards and to the right to join the transverse colon at a normally situated hepatic flexure, the ascending colon being maintained in its abnormal site by a thick band, 2½ in. broad, between its middle third on the left side and the transverse mesocolon. The appendix arose from the right side of the caecum, and the ileum entered it towards the right side on its postero-lateral aspect. The jejunum started at its junction with a vertically descending third part of the duodenum, on the right-hand side of the superior mesenteric artery. No other congenital abnormalities were found. (See Diagram.)

Commentary

I could not find any evidence of inflammatory adhesions, and there were no enlarged or calcified mesenteric glands, so it must be presumed that the band from the ascending colon was of congenital origin; further close inspection of the band showed fairly large vessels coursing in its substance, derived from the right colic artery and distributed to the colon, suggesting that it was a contracted right mesocolon.

A so-called "wandering caecum," due to excessive rotation of an unduly mobile caecum, was excluded by the position of the appendix and ileo-caecal valve on its right side; and further proof of the congenital origin of the condition was supplied by the abnormal site of the duodeno-jejunal flexure to the right of the superior mesenteric artery.

From these findings it is suggested that the case described is a failure of rotation of the mid-gut loop, which normally takes place at the beginning of the tenth week of foetal life during the process of reduction of the "physiological umbilical hernia"; the colon and caecum, with the attached post-arterial mesentery, being allowed to enter the abdominal cavity first, instead of the normal mid-gut and pre-arterial mesentery—probably as a result of a lax umbilical ring. As a result of this mechanism, the later return of the mid-gut loop tends to displace the vitelline artery and hind-gut, with its post-arterial mesentery, to the left and dorsally, thus accounting for the left-sided position of the large bowel. Some attempt at normal fixation of the mesenteries had taken place, as is shown by the hepatic flexure occupying its normal position, in contradistinction to the more usual U-shaped transverse colon of non-rotation of the mid-gut loop, and this partial fixation probably prevented the marked tendency to volvulus around the superior mesenteric pedicle in early infancy, of which Dott describes two cases (*Brit. J. Surg.*, 1923, 11, 251).

An unusual feature of the clinical findings was the presence of signs and symptoms in the right iliac fossa, at a point remote from the actual position of the appendix; but its deep pelvic situation might have accounted for this.

I am indebted to Dr. Ponder, county medical officer for Kent, and Mr. J. W. D. Buttery, medical superintendent of the Royal Victoria Hospital, Folkestone, for permission to publish this case.

A. Louis (*Thèse Paris*, 1945, No. 98), who records an illustrative case in a girl aged 19 months, came to the conclusion that the best treatment of Still's disease at the present time consists in intramuscular injection of gold salts.