REPORT OF A CASE

IN WHICH

GASTROTOMY

WAS PERFORMED FOR THE RELIEF OF OBSTRUCTION
OF THE BOWELS.

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JAMES D., a delicate boy, aged 11, had, at the end of February 1848, an attack of inflammation of the bowels. The symptoms were those usually observed; namely, pain and tenderness (principally affecting the right hypogastric region), vomiting and constipation; and these symptoms readily yielded to the usual remedies; namely, leeches and fomentations, calomel and Dover's powder in small repeated doses, and subsequently castor oil and injections.

On Saturday, the 1st of April, I was again requested to see him. He was suffering from shivering, pain in the abdomen, and vomiting of sour greenish matter. The urine was scanty and irritating, the tongue furred, and the pulse quick. He had been exposed to cold and fatigue on the Thursday preceding.

I again resorted to the remedies which I had used on the previous occasion, but not with the same success. The pain and tenderness were somewhat alleviated under the use of leeches, bran poultices, and calomel and Dover's powder in

small repeated doses ; but the vomiting continued, and the stomach rejected everything that was swallowed except the calomel and small quantities of soda-water and milk. The bowels too were excessively obstinate. Castor oil, when administered, was vomited, and injections, which were carefully used under my own superintendence, brought away only a very few small fragments of feculent matter. On Wednesday, the 5th, a lump of colourless mucus came away ; but, after this, there was no discharge from the bowels whatever. The last full evacuation was on Thursday evening the 30th of March.

From Wednesday the 5th to Saturday the 8th of April, the patient took half a grain of calomel twice daily, and at night half a grain of opium. There was no vomiting so long as only a very small quantity of liquid was swallowed ; but the bowels were still constipated. The belly was tense, but not so tender, and only in pain at intervals. The patient complained, when the belly was carefully examined, that he felt a *swelling below and to the left of the navel*, whilst the chief spot where pain and tenderness were felt, was exactly beneath the situation of one particular leech-bite, *below and a little to the right of the navel*.

On Saturday, April 8th, I thought it right to try the effect of small doses of colocynth and henbane, repeated frequently. They, however, brought on a return of most distressing vomiting ; the matter rejected being a yellow liquid of a most offensive stercoraceous smell.

On Sunday, the 9th, I had the advantage of a consultation with my friend Mr. Thomas Peregrine. The patient was in much pain, excessively exhausted, and apparently moribund ; and was still harrassed with the stercoraceous vomiting. Mr. Peregrine agreed with me in repudiating the use of purgatives, and in recommending small doses of opium to allay pain and irritation.

Monday, 10th.—The patient much easier : no vomiting since last night ; small quantities of milk and of wine and soda water are retained ; he has asked for a crust. No eva-

cuation. Tongue cleaner, and red at the tip and edges. Pulse 90, feeble. On a careful examination of the abdomen, I could recognise what appeared to be the outline of the distended stomach in the epigastrium; below, and parallel to that, the outline of a fold of distended intestine; below that, and to the left side, another. The patient still pointed to the same place, immediately under a leech-bite, a little below and to the right of the navel, as the seat of his chief pain and tenderness. I felt convinced, therefore, that at this point the tube of the intestines was obstructed, and probably by some adhesion consequent on his former attack of inflammation; but the patient's condition seemed so hopeless that any interference by operation was not to be thought of.

On the 11th and 12th the patient's condition was in most respects the same, except that his strength was rather greater. The eye was brighter; the intellect clear; the pulse from eighty to ninety, and less feeble; there had been no more vomiting, and the stomach retained small quantities of soaked crust of bread and of wine. The urine was clear and copious; the tongue cleaner and slightly aphthous; the whole body greatly emaciated; the abdomen in the condition above described. The patient was subject to fits of colicky pain, attended by faintness and sinking: these were checked by wine and two-grain doses of soap and opium pill.

On the 13th, the condition of the patient being the same as I have just described, I had another consultation with Mr. Peregrine. It appeared to us that there were three courses which might be pursued. One was, to attempt to move the bowels by injections and purgatives. But I had already, without good effect, injected as much liquid into the bowels as could be done without danger of rupturing them: and it was evident that purgative medicines, administered by the mouth, would merely bring on a return of the vomiting, and could be of no avail against a mechanical obstruction. The second was, to let the patient die quietly. The third was, to attempt relief by a surgical operation. In favour of this last plan were the facts, that the patient lived on

from day to day, slightly improving, since Sunday ; and that he pointed to one definite spot as the seat of his pain, where, in all probability, we should find a mechanical obstacle, if one existed. The parents of the boy were, therefore, told our opinion ; and it was left to them to decide whether an operation should be attempted or not ; they being fully informed that it afforded the only, although a most desperate, chance of relief.

One more valuable day was lost through their hesitation ; but on Friday the 14th, they gave their consent. On that day, therefore, having again made a careful examination of the patient's condition, and believing that he had a sufficiency of strength to justify the attempt, we resolved to perform an operation for the purpose of finding, and if possible removing, the cause of the obstruction of the bowels.

Having taken care to have the apartment raised to a good temperature, and the patient having emptied his bladder of half a pint of healthy urine, I made an incision about two inches and a half in length over the linea alba, between the umbilicus and pubes, and cut carefully down to the peritoneum. This being opened, and found not to be adhering to the bowels, we passed in our fingers to the spot indicated by the patient ; and, after separating a few slight and loose adhesions, and one tolerably broad and firm adhesion of adjoining folds, we came to a distinct band passing tightly over a portion of the intestines. Having, therefore, enlarged the wound upwards and downwards to the extent of about four inches, we proceeded cautiously to draw the constricting substance into view ; when we found it to be a band—smooth, having a glistening peritoneal envelope, dense in its texture, and appearing to be either an unnatural appendage or else a very old adhesion. It was about three-quarters of an inch long, of the size of a common piece of red tape, and passed from one fold of intestine to another, binding down a certain portion of the intestine under it. Having satisfied ourselves as to its nature and passed a finger under it, we divided it. But now, whilst we were beginning to congratu-

late ourselves on having attained our object, we were dismayed at perceiving a stream of yellow feculent matter pouring up from the bottom of the peritoneal cavity. This complication, the cause of which was not obvious, convinced us at once that the case was hopeless. We deemed it our duty, however, to look for the aperture from which the feculent matter proceeded, and after a long and difficult search we found a large ulcerated opening which had evidently just given way. This was secured by a needle and ligature; the bowels, which we had caused to protrude in our search for the aperture, were returned, and the wound closed by sutures, plaster and bandages.

The patient began to sink shortly after the operation, and expired in two hours and a half. We did not use the chloroform, because the patient was subject to epileptic fits. The amount of pain suffered was very trifling, till the feculent matter came into contact with the peritoneal surface of the bowels.*

Post-mortem examination.—On Saturday the 15th, I examined the body, in the presence of Mr. Peregrine, and of Mr. Goodwin under whose care the patient had formerly been.

On laying open the peritoneal cavity, we found evident traces of inflammation, which had at some distant period affected the viscera on the right side. The omentum on the left side did not descend an inch below the great curvature of the stomach: on the right side it came down nearly as low as Poupart's ligament, and was connected to the peritoneum over it, and to the ascending colon behind it, by loose cellular adhesions. Similar adhesions connected the convex surface of the liver to the adjacent peritoneal surface. The gall-bladder, which was much distended, was connected by long and loose cellular bands to the ascending colon. Having next, on a

* The patient's mother says, that in the course of the last eight years he had suffered from distinct and severe attacks of illness, of which the prominent symptom was pain in the right side of the abdomen. These were generally healed by powders (probably calomel) and castor oil.

cursory inspection, noticed that the upper part of the abdominal cavity was occupied by the stomach, which was much distended, and the remainder by the convolutions of the small intestines, the transverse arch of the colon being quite contracted, and lying behind the greater curvature of the stomach, we proceeded to make a most careful scrutiny of the intestines. The rectum, the descending, transverse and ascending colon, were pale, contracted and perfectly empty. There was a web of very fine loose cellular adhesions surrounding the caput coli and vermiform appendage, and the last two or three inches of the ileum. The terminating portion of the ileum, for the extent of about twenty-five inches, was as pale, contracted and empty as the colon; but all the rest of the ileum and the jejunum, up to the duodenum, was reddened, enormously distended, and filled with liquid yellow feculent matter. The junction between the contracted and distended portions was well-marked and abrupt. At two points of the ileum, one of which was about a dozen inches above the contracted portion just spoken of, and the other about as much higher up the tube, we found the remains of the constricting band which we had divided during the operation. At one part, where probably we had divided the broadest band, the bowel looked as if a portion of the peritoneum had been stripped off. In two or three places near these, the bowel was roughened by very slight effusion of lymph. We next examined the ulcer which had given way during the operation. It was situated in the ileum, not far from the lower attachment of the divided band; and in the immediate neighbourhood we observed two or three other ulcerated patches. The mucous membrane around these was thickened, but there were no adhesions externally.

The liver and kidneys were tolerably healthy. The chest and head were not examined.

I think the above case shows clearly the possibility of forming a tolerably correct diagnosis of the situation of an obstruction to the intestines, and of reaching and removing it

without any very great difficulty. I very much regret that the operation was not performed a week earlier. If it had been, the ulceration would probably not have advanced so far, and the result might not have been so unfortunate. But I confess that as the case began with what appeared to be purely inflammatory symptoms, and as the patient had so recently recovered from an apparently similar attack, I looked upon the constipation at first as the ordinary accompaniment of inflammation; and it was not till after the inflammatory symptoms were mitigated, that those of mechanical obstruction became palpable.

I have requested my friend, Mr. Peregrine, to submit this case to the Royal Medico-Chirurgical Society, as a humble contribution to the series of similar cases, which have been brought before the Society by Mr. Curling, and Dr. Golding Bird and Mr. Hilton.