A C A S E
OF
ABDOMINAL SECTION
FOR
ACUTE CIRCUMSCRIBED PERITONITIS.
RECOVERY.

BY
HOWARD MARSH, F.R.C.S.,
SENIOR ASSISTANT SURGEON AND LECTURER ON ANATOMY AT ST.
BARTHOLOMEW'S HOSPITAL; SENIOR SURGEON TO THE
HOSPITAL FOR SICK CHILDREN.

Received March 3rd—Read March 10th, 1885.

J. R—, a medical student, æt. 19, was admitted into St. Bartholomew's Hospital, on December 18th, 1884, under the care of Dr. Andrew. He stated that, though subject to occasional constipation, he had been in good health till December 8th, when, having taken some aperient medicine, he was attacked with severe griping pain, and with sickness which had continued till his admission. The bowels acted several times after the medicine, but for the last three days nothing had been passed. When first seen he lay with his legs extended. The abdomen was tympanitic and distended, and slightly tender. A little below and to the left of the umbilicus there was an area about eight inches square, which was firm and resistant,

dull on percussion, painful on pressure, and yielding an obscure sense of deep-seated fluctuation. This area was slightly raised above the surrounding surface, and the skin was cedematous and presented a slight flush. As it was believed that the case was one of circumscribed peritonitis, it was on the following day determined to perform an exploratory operation. Just before the patient was removed to the operating theatre he was violently sick several times, and it was obvious that his condition was rapidly becoming very critical. When he was under chloroform, I made an incision about two inches long just outside the linea semi-lunaris, and opened the cavity of the peritoneum. As soon as this was done, from two and a half to three pints of extremely foetid pus, evidently under considerable tension, streamed out. A careful digital examination was now made, but nothing beyond distended coils of small intestine could be felt. The abscess-cavity was washed out with a solution of carbolic acid lotion (1 in 60) introduced by means of a soft india-rubber catheter, and a piece of drainage-tube eight inches long and about the size of a little finger, was inserted through the wound, the upper and the lower ends of which were brought together to avoid the danger of intestinal protrusion. Carbolic dressings were applied, and kept in place with a lightly adjusted bandage. Two hours after the operation he was cold and collapsed, and his pulse was very quick and small; two hours later, however, he had rallied considerably, and his pulse was 96, regular, and fairly strong, and his temperature was normal. He had been sick several times, but the material vomited had quite changed its character, and now consisted merely of clear, bilious liquid, derived from the upper part of the small intestine.

December 20th.—He was decidedly better. Pulse 96, temperature normal, and he had passed a good night, sleeping quietly, with a few intervals of wakefulness. He was sick occasionally till 8 a.m., bringing up about 14 oz. of bilious fluid. In the night, at 10 p.m. and at

2 a.m. a third of a grain of morphia had been injected under the skin. Discharge was profuse, and the dressings were found to be soaked through. During the day the bowels acted three times, the motions being light coloured and fluid. He was fed with small nutritive enemata, and only allowed to take, by the mouth, a teaspoonful of iced water occasionally. He complained of intense thirst during the day. An enema of starch and opium was given to check the action of the bowels. At 6 p.m. the area of dulness could be felt to extend across the middle line towards the right iliac fossa, and in this situation he complained of tenderness on pressure. The nurse was directed to keep him as far as possible on his left side.

21st.—Night rather restless. Morning temperature was 99.6° . There had been no more sickness. The abdomen was less tympanitic; the area of dulness was diminished; the bowels had acted four times within the last twenty-four hours, the motions consisting of light yellow liquid, mixed with small, solid, well-formed fæces. He was taking milk and beef tea in small quantities.

22nd.—Was improving. Temperature last night was 99.6° , this morning normal. Pulse 96. As the drainage-tube was found to have slipped out it was discontinued. Still a large quantity of purulent discharge. A piece of distended intestine protruded slightly at the bottom of the wound.

23rd.—Steadily improving. Wound looked well. Temperature ranging from 100° in the morning to 101.8° in the evening. Pulse 108, small. Was still fed with enemata. He had taken about a pint of warm milk and water, and two small cups of tea, and a little bread and milk.

26th.—Decidedly better. Abdominal distension had subsided. Discharge copious, but healthy. Free from foetor. Bowels were acting twice a day, and the motions, though in great part fluid, contained well-formed fæces. Still on liquid diet. Was occasionally taking ten minims of tincture of opium to quiet the bowels.

January 4th.—Doing well. Had minced chop for dinner. For the last four days the cavity had been washed out with a solution of 1 in 1000 of tincture of iodine introduced by means of a soft india-rubber catheter. This passed easily for eight inches or more in several directions among the coils of the small intestine.

12th.—There had been a threatening of a protrusion of the intestine through the wound, but this had been prevented by the application of a compress of cotton wool over a piece of oiled lint and a lightly applied bandage. He now spent the greater part of the day on a couch.

20th.—Doing well, but his bowels now seldom acted without an enema. The protrusion of the intestine was less marked.

February 20th.—Since the last note there had been little requiring detailed description. He had gradually improved and gained flesh and strength. His temperature had been as a rule normal, and his pulse between 80 and 90. But both on Feb. 8th and on Feb. 19th he had attacks of sickness, lasting for some hours; his temperature rose to 101° , and his pulse to 96, while at the same time there was marked increase in the amount of discharge. During the past week he had improved quickly in strength and colour. The bowels now never acted without injection. The wound was slowly closing by granulation, and was only about half an inch in length.

March 7th.—Wound now closed. Bowels still never acted without an injection. He seemed quite well.

Remarks.—Neither Dr. Andrew nor myself could form any definite opinion as to the origin of this attack; but it seemed not unlikely that inoculation of the peritoneum had occurred from the escape of pus from an abscess formed in the mesentery round old suppurated glands.

Although the case was one of circumscribed peritonitis, that it yet involved fully a third of the whole abdominal cavity was shown by the fact that the swelling and dulness not only occupied the greater part of the left lumbar and iliac regions, but was found, as distension subsided,

to extend for several inches across the middle line in the direction of the right iliac fossa. The extent of the mischief was also disclosed by the direction and distance from which pus was washed out when the catheter was introduced. It was therefore an instance of much more extensive disease than would generally pass by the name of circumscribed, and approached the characters of an example of general peritonitis. It thus has at least some bearing on the treatment of the latter affection.

At the time the operation was performed the patient was so constantly sick, and so rapidly passing into a condition of collapse, that it was the opinion of all who saw him that unless relieved he would live but a very few hours. The operation calls for no especial comment. It consisted merely in the opening and washing out of a large intra-peritoneal abscess. It may, however, be remarked that it seemed better to rest content with the evacuation of the matter which had collected than to enter into any investigation into the origin and nature of the case. To have taken the latter course would not only have involved the danger of disturbing the adhesions which were acting as a barrier to circumscribe the mischief, but also the risk of rupturing the softened intestinal coils and producing fæcal extravasation. Besides, any investigation of this kind could scarcely have led to any useful result, while it would certainly have necessitated a considerable enlargement of the wound, and increased the possibility of an escape of some portion of distended intestine.

(For report of the discussion on this paper, see 'Proceedings of the Royal Medical and Chirurgical Society,' New Series, vol. i, p. 362.)