NOTES OF A SECOND CASE OF
ABDOMINAL SECTION
FOR
INTUSSUSCEPTION INTO THE COLON,
WITH
REMARKS ON THE DETAILS OF THE OPERATION.

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A SECOND case of operation for intussusception, which occurred to me a few weeks ago, gave me the opportunity of acquiring additional experience as regards some points of detail which it is, I think, of importance to bring before the profession.

The patient was an infant, aged 6 months, under the care of Dr. Madge, by whom I was asked to see the case on the fourth day of the illness. The symptoms had from the first been well-marked, the child having experienced frequent attacks of painful straining with the passage of bloody mucus. The invaginated part could be easily felt in the left flank by manipulation through the

abdominal wall, and also by the finger introduced into the rectum. It had not been actually extruded, but its lower end was often within an inch of the anus. Dr. Madge had fully diagnosed the case before I saw it, and the usual measures of treatment by injection, &c., had been carefully employed. An infant sister of the child had died of the same lesion about a year previously. When I saw the infant it was evident that there was no time to be lost, for it had rejected all food for three days. It was very weak and did not seem likely to live many hours; we therefore persuaded the parents to allow us to perform the operation at once. I found the operation, as perhaps might be expected at so early an age, much more difficult of accomplishment than in my former case, and it is chiefly to these difficulties that I wish to ask the attention of the Society. The abdominal wall was thick, being loaded with fat, and the space between the umbilicus and pubes was very short. Having made an incision in the *linea alba*, just sufficient to admit two fingers, I was able easily to reach the neck of the intussusception, but I found it so slightly moveable that I could not by any means hook it into the wound. I was very anxious not to allow the intestines to escape through the wound, and finding that I could draw the bowel out to a certain extent between the tips of my two fingers, I spent some time in trying to accomplish reduction in this manner, hoping to complete it without exposing the bowel to view. At length, however, I became convinced that this was impracticable; only a certain length could be drawn out and then it became firmly fixed. I was obliged, therefore, to enlarge the wound freely above the umbilicus, and to allow the intestines, much distended with gas, to escape. It was only when the abdomen was almost empty that I could bring the neck of the sac into view in the wound, and I then made repeated attempts to draw the bowel out, but without success. That there were no adhesions was proved by the fact that an inch or two could be easily drawn out; the impediment was clearly due to the

ensheathing bowel being thrown into folds by traction, and thus constituting a series of strictures which gripped its contents. In this dilemma, and when almost in despair as to whether I should accomplish the reduction, it occurred to me to seek the lower end of the invaginated part, and try to hold the ensheathing layer so as to prevent its being drawn into folds. This led to the discovery that it was only the neck of the invaginated tract that was in any degree fixed (by its mesentery); the lower part, consisting of the sigmoid flexure of the colon much elongated, lay in loose folds on the rim of the pelvis, and was hooked out of the wound with the greatest ease. The attempt to hold the ensheathing layer straight at once revealed the true method of reduction, for by pulling this downwards, instead of trying to pull the involved part upwards, I accomplished the replacement with the greatest ease. The *appendix vermiformis* came out last, just as the reduction was completed, proving that the intussusception had begun at the cæcum. The operation had been protracted and the infant was almost pulseless, but there still remained the task of replacing the intestines within the abdominal cavity. I had some difficulty in accomplishing this, and several times after their return, portions escaped again before I could close the abdominal wound. Under these circumstances I was induced to prick the distended small intestine at two or three places with a harelip-pin to allow the escape of flatus. To my chagrin, however, just as I was closing the abdominal wound I observed that one of the punctures in the bowel was bubbling, and that there was a stain of feculent matter on the peritoneal surface; this was carefully wiped away and the wound closed. The child, although in extreme collapse when the operation concluded, rallied subsequently, became warm, took the breast, and passed a feculent motion. Death, however, took place in the night, about eight hours after the operation.

At the *post-mortem* next day we found no trace of any

further escape of fæces, but there was almost universal peritonitis, the coils of intestine being glued together by lymph. It became of interest, as one of the child's sisters had died with precisely the same condition, to ascertain whether there was any congenital peculiarity which might account for its occurrence. We found the parietal peritoneum in the right flank quite smooth and entire, whilst the cæcum hung very loosely attached by a long mesentery. This had probably been much stretched in the process of invagination, but there could I think be no doubt that the cæcum had been loose congenitally. No reproduction of the invagination had occurred.

It is my impression, judging from my experience of this case, that in future operations the lower end of the invaginated tract ought always to be first sought, and that reduction ought to be accomplished by squeezing it or pulling the sheath downwards rather than by attempting to pull the contained tube out. I am not at all sure that in some cases this might not be accomplished without bringing the parts into view; should this not be found practicable, however, it is probable that the operator will find it much more easy, in cases of intussusception into the descending colon, to bring the lower part into the wound than the upper one. It is the more necessary to draw attention to these points because they are both probably unlikely to occur of themselves to the operator's mind.