A CASE OF CHRONIC INTESTINAL OBSTRUCTION DUE TO TUBERCULOUS CICATRICIAL CONSTRICTIONS OF THE JEJUNUM.

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THE patient, a man aged 35, when admitted to hospital on December 26th, 1913, was suffering from intense pain over the greater part of the abdomen, of which the respiratory movements were somewhat restricted. There was no visible peristalsis. On palpation there was some tenderness. No tumour could be felt. The temperature was 101.4° F., and the pulse 120. The only history which could be obtained from the patient was that of occasional fever and great abdominal pain, frequently relieved by vomiting half an hour after food, during the previous six months.

On the morning after admission the temperature was normal and the pulse 100. During the next eight days the temperature varied daily 0.5° F. on either side of the normal line, and the pulse ranged between 100 and 108. On the evening of the following day the temperature ran up to 104.5° F., the pulse reaching 120. Next morning the temperature was normal and the pulse 96, but in the evening the temperature was again 102.5° F., and the pulse 112. During the next two days the temperature was normal, the pulse varying between 114 and 102. Since admission the patient had frequently suffered great abdominal pain, relieved by vomiting, soon after even liquid food.

No diagnosis had as yet been made, but as there was obvious trouble in the abdomen it was decided on the thirteenth day after admission to undertake an exploratory laparotomy. It was at once found that there were five marked cicatricial constrictions of the jejunum about 4 in. apart, the highest constriction being nearly 3 ft. from the upper end of the bowel. The constrictions, which were very hard, were about $\frac{1}{2}$ in. in diameter. The short segments of bowel between the constrictions were remarkably ballooned to over 3 in. in diameter. It was very surprising that the obstruction was not complete. A few only of the mesenteric glands were slightly enlarged. The whole length of the bowel was passed through the fingers, but no other constrictions were found. A lateral anastomosis short-circuiting the bowel above and below the lesions was performed. The patient bore the operation well.

After the operation the vomiting entirely ceased, and the pain was very much relieved. A month after the operation the general condition of the patient was considerably improved, but he had two or three prolonged attacks of distressing hiccough, together with two periods of twelve days each of intermittent fever of the hectic type, the first period beginning thirteen days after the operation. It was not suspected that the patient might be suffering from phthisis until the pathological condition of the bowel was seen. It was thought that the hiccough might be due to irritation by the fermentation of stagnant food, secretions, etc., in the ballooned segments of bowel, and that perhaps the fever was mostly accounted for by toxic absorption from the fermenting material.

Accordingly, six weeks after the first operation, it was decided to resect the 20 in. short-circuited loop of bowel. On opening the abdomen the lateral anastomosis was found to be quite satisfactory, and there were no adhesions to the diseased loop. There was no apparent change in the loop since the first operation. No difficulty was found in performing the resection, and the opened ends of the bowel were closed 1½ in. from the anastomosis. The patient stood the operation extremely well, suffering but slightly from shock, the pulse reaching only 96.

The patient's general condition at once improved rapidly, and he was soon able to eat a large quantity of food without the least discomfort. The hiccough never returned. The temperature remained normal for six days after the operation, when again for two consecutive evenings only the temperature reached 100.5° and 103.5°. During the next four weeks there were daily variations of 0.5° on either side the normal line, the temperature reaching 100° on three occasions only, the pulse varying from 80 to 112. Obviously, in spite of the great general improvement and the complete disappearance of the abdominal symptoms, there was still some active disease

present. Seven weeks after the operation the temperature again became hectic, the evening temperature being about 101°. This fever lasted six days, and then the temperature was normal again for five days, after which the hectic fever again returned, this time with acute pneumonic symptoms, the right upper lobe being consolidated. Cough and copious foul-smelling sputum developed. After thirteen days in this condition the patient died suddenly of a profuse haemoptysis. Previously to this attack of fever he refused to rest sufficiently and insisted on wandering about the neighbouring village.

This was obviously a case of pulmonary tuberculosis with secondary tuberculous ulceration of the jejunum. Tuberculosis was not suspected till after the first operation, when slight dullness and some bronchial breath sounds were noticed near the right apex. There was very little cough or sputum until the last attack of fever.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

STEREOSCOPIC RADIOGRAPHY OF GUNSHOT WOUNDS ON ACTIVE SERVICE.

It may interest those who are acting as radiographers in the field, and, as is often the case, under difficulties, to read of a very simple, quick, and accurate method which I am employing in France for stereoscopically examining gunshot wounds for foreign bodies and fractures, the only apparatus used being the x-ray outfit supplied to the R.A.M.C. on mobilization.

The cumbersome x-ray couch I early discarded, as, owing to the overhead tube holder, it was found impossible to get a stretcher thereon, and I now use a table, the top of which measures 5 ft. 2 in. by 1 ft. 6 in., which fits inside the poles and traverses of any ordinary stretcher, so that the patient, having been comfortably settled in the ward, has not to be disturbed until his return to the ward to be put back to bed, thus saving him pain and myself time.

The method of procedure is as follows:

The patient having been carried to the department by two orderlies, is lifted, stretcher and all, on to the table, which blocks out the canvas, allowing the poles and traverses to fall out of the way. A 15 by 12 black envelope is now placed in position under the part to be examined, and into this is slipped the wrapped plate to be exposed. The exposure made, the plate is easily withdrawn, and No. 2 introduced without any alteration in the position of the patient, the table being moved laterally two inches between the exposures.

The plates are examined by placing them side by side against a window, about 6 inches apart, with a piece of cardboard between, the film side of the left hand radiogram and the glass side of the right hand one being towards the observer, who holds a dark negative (glass side to right) against the right side of his nose, thus blocking out the view of the left hand plate from the right eye. Then, if the observer looks towards the left hand radiogram with both eyes, he will, his right eye accommodating to the reflected image on the surface of the plate thus held, become his own stereoscope and get a perfect vision of the relations of the part under observation.

This is a simplification of the method which I described before the Royal Society of Medicine some years ago, but having now boiled it down to the requirements of field service, where every ounce of apparatus counts in transit, I take the liberty of again describing it with its latest modifications, particularly as I think that there may be some who will be glad to know of a method of examining cases stereoscopically without stereoscopic appliances.

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"FATIGUE DYSPEPSIA."

We have received from a correspondent, who prefers that his name should not be published, the following note illustrating the subject dealt with by Dr. Guthrie Rankin in the BRITISH MEDICAL JOURNAL of June 19th, 1915:

Dr. Guthrie Rankin describes a set of conditions which exactly fit a case that has been for many years under my