GALL STONES ASSOCIATED WITH ANOMALY OR INJURY OF BILE DUCTS.

BY

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The first and second of these three cases are very good examples of two anomalies of the bile ducts, which I described recently in an Arris and Gale lecture (*British Journal of Surgery*, April, 1923). The third is one more instance of injury to the common duct.

CASE I.

A married woman, aged 32, spare, and of rather a delicate type, had had indigestion on and off for several years. The indigestion was of the flatulent type with a good deal of discomfort soon after food, especially after certain kinds of food, such as fats and pastry. Considerable relief was obtained by belching. She had been liable to attacks of headache and what she called biliousness with vomiting. Bowels costive. Three weeks before admission she was suddenly seized with very severe pain across the upper abdomen and going through to the right shoulder-blade, requiring morphine. She was found to have a tender, distended gall bladder about the size of a small pear. There was no jaundice, and never had been any.

Operation March 22nd, 1923.—An incision was made through the upper right rectus sheath and the muscle displaced outwards. A tightly distended gall bladder was found with a stone, as large

FIG. 1.—A, Stone in cystic duct; B, accessory bile duct from right end of portal fissure to common opening with cystic duct into common bile duct; C, hepatic duct.

as a hazel-nut, wedged into the commencement of the cystic duct. The common duct was free from stones. The appendix was removed, as it was rather a thick adherent thing. There was a very short cystic artery, and on pulling up the gall bladder the right hepatic artery came up to a level anterior to that of the cystic duct.

The cystic duct was divided and tied, and the cystic artery also. Owing to the large stone it was rather difficult to obtain a satisfactory view of the distal part of the cystic duct. After separating the gall bladder from the liver, bile was seen to come from the stump of a duct, close to the liver, the lumen of which was large enough to take an ordinary wax taper. This was ligatured after ascertaining that the main ducts were intact (Fig. 1).

The specimen showed the segment of a duct on the underside of the cystic duct, about 1/2 inch long. The distal end had been tied with the cystic duct. The wound was drained. The patient recovered satisfactorily, but at the end of two weeks several ounces of bile drained away from the wound. After discharging for a few days the sinus closed, and the patient has remained very well since; there has been no more leakage of bile.

CASE II.

A stout married woman, aged 57, who down to two years before admission had been quite well, then began with flatulent indigestion and what she called "windy spasms." She obtained relief by applying hot fomentations, and in the severe attacks by vomiting. Flatulence had been a marked feature during the two years. Bowels costive. Thirty years ago she had an attack of jaundice without pain; there has been no jaundice since. There was no tumour to be felt in the abdomen, but there was a little tenderness beneath the right costal margin.

FIG. 2.—A, Lower end of cystic duct, containing four small stones; B, ligature on cystic duct; C, duodenum; D, site of incision through posterior wall of duodenum; St, stomach.

Operation November 9th, 1923.—An incision was made through the upper right rectus sheath, the muscle being displaced outwards. The gall bladder contained several stones and was removed. The common duct was not dilated, but some small stones were felt through the duodenum; these could not be displaced upwards. The duodenum was therefore opened and four stones removed through an incision just above the opening of the ampulla. A probe was passed in order to determine whether the common duct was clear, but it could not be made to enter the common duct. After passing upwards it was arrested by the ligature on the cystic duct. The common duct was not involved in this ligature, therefore there were obviously two ducts, the cystic duct running parallel to, and opening

into, the main duct just above the ampulla (Fig. 2). The patient made a perfectly satisfactory recovery.

CASE III.

A married woman, aged 49, had had cholecystectomy and choledochotomy done by another surgeon in 1915. Many stones were said to have been found in the gall bladder and two in the common duct. The wound healed in the normal time and she was perfectly well for five years. In 1920 she began to have short attacks of severe pain in the upper abdomen, going through to the centre of the back and accompanied by shivering, rise of temperature, and jaundice. Between the attacks the jaundice entirely disappeared. The attacks gradually became more frequent and per-

sisted longer until the last attack, which has never settled. This began two months ago and she is still deeply jaundiced. There has not been any external biliary fistula since the wound healed eight years ago.

Operation February 11th, 1923.—The old scar was excised, and after separating many adhesions the common duct was found very much dilated, and a small stone felt in the ampulla. It could be moved upwards, but could not be made to present in the dilated part of the common duct. This dilated portion was opened and an attempt made to pass a probe down the duct. It would not, however, go beyond the upper border of the duodenum. After some manipulation the stone was made to appear just above the upper border of the duodenum and was removed by cutting on to it. It was then found that there was a stricture in the common duct about 1/2 cm. above the level of the duodenum, through which it was impossible to pass the finest needle. The dilated upper part of the duct was at least six times larger than the lower end, and so, after excising the stricture and tying the upper end of the lower segment, the dilated upper end was anastomosed to the duodenum.

The abdominal wound healed within ten days, the drainage tube having been removed on the third day. The patient has remained perfectly well ever since.

These three cases are interesting and are good instances of the more uncommon pitfalls in this area, full of traps for the unwary. I have called them uncommon rather than rare because since February, 1923, when I gave the lecture referred to above, I have had three cases showing an accessory bile duct, and I know of two others.

ABSCESS OF THE BRAIN THAT POINTED EXTERNALLY.

BY

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THE following case is of interest chiefly because it shows that a cerebral abscess may, like other collections of pus, point externally; also it illustrates the fact that changes in the fundus oculi may be absent even in the presence of conditions best calculated to favour their development and when they would be most valuable.

A man, aged 23, consulted his doctor in September, 1923, for pains of a neuralgic character over the left side of the head and discharge from the left ear, following an attack of earache, which was ascribed to cold caught when bathing and to a blow on the ear. In a short while the discharge ceased, but as the hearing was affected and the pain continued he was seen by an aurist, who reported mastoid tenderness with signs of external otitis involving the tympanic membrane, which was retracted but not perforated. Eventually, as the headache increased in intensity, he was admitted under my care into a private hospital. His father stated that for some weeks prior to the ear discharge it was noticed that he was irritable and did not look well, and had occasional attacks of neuralgia.

On admission he complained of trigeminal neuralgia on the left side, affecting chiefly the temporo-malar branch of the second division, together with more or less fixed pain referred to the temporal region above and in front of the external auditory meatus. He was emotional and excited at times, especially when the pains were most severe, which was usually at night. The temperature was normal or slightly below the normal line, but without marked remissions. The pulse was regular and on the slow side, but this was only occasional, though once or twice it was down to 58. The knee-jerks were active and the plantar reflex flexor. There was no nystagmus and no sign of ataxia when on his feet. There was no vomiting and the discs were normal; with the exception of a peculiar tendency to use a wrong word which failed to convey his meaning, and the habit of asking one to repeat a question, as though he did not understand (sensory aphasia), there was practically nothing to suggest a gross cerebral lesion. This defect of speech, however, was only apparent after a bad night, and then it lasted only a short time.

By the end of a fortnight the improvement in the symptoms was so marked that he was allowed to return home, but in a few days the headache and neuralgic pains returned in a severe form, and he vomited on two or three occasions; consequently he was brought back to the private hospital. It was now noticed that he looked pale and ill. The right plantar reflex was found for the first time to be extensor, and the difficulty in expressing himself was more marked, but only as a temporary defect. As there was some degree of deafness on the left side and the pains were referred chiefly to the malar bone and adjacent parts in front of the ear, he was again seen by an aurist, who could no longer detect tenderness over the mastoid, and found the external auditory apparatus practically free from disease and bone conduction normal.

A week later a swelling, with acute tenderness on pressure, was noticed over the zygomatic process of the left temporal bone, and this gradually increased. The skull was examined by x rays, but the radiograms showed nothing of importance. He now complained of slight dimness of vision of the left eye, but the disc was normal in appearance and there was no nystagmus. As the swelling increased, difficulty in opening the mouth was complained of.