ULCERATION OF THE ILEUM AND FATAL PERITONITIS FROM ENCYSTED GALL-STONES.*

By HORACE JEAFFRESON, M.D. Lond.

THE following case is one, in which large gall-stones, at an uncertain period (probably several years) prior to the death of the patient, passed by ulceration from the gall-bladder into the duodenum, and thence onwards to the lower end of the ileum, where, being too large to pass the ileo-cæcal valve, they became shelved in slightly pouched portions of the ileum just above the valve, and eventually set up irritation and ulceration of the bowel, which resulted in perforation and fatal peritonitis; one of the gall-stones, after death, being found to have escaped into the cavity of the peritoneum.

Such is, I believe, the nature of the case, of which I am about to give a somewhat more detailed account. The main interest of the case arises from its rarity; and I bring it to your notice more as a pathological curiosity which should be recorded, than as a subject likely to give rise to any very profitable discussion.

Emma B., aged 53, a married woman, had been for four years the subject of progressive paralysis agitans, attended with great emaciation, especially during the last two months of life. During the latter six weeks, she had from time to time complained of griping pains in the belly, varying in position, and not referred more to the right than the left side. On one occasion, when the abdomen was examined, a hard body—giving the idea of an enlarged gland—about the size of a walnut, was felt situated midway between the umbilicus and the right iliac fossa. On subsequent examinations, this body was not felt, and little further thought was given to it. Hot fomentations and slight opiates usually gave relief when pain came on. The bowels, which were habitually confined, were as regularly kept open by an aloetic dinner-pill. The motions were healthy, and of a full bile-colour. From time to time, there was sickness, but the vomit had no special characters. She was never known to have suffered from any such attack as usually attends the passage of gall-stones. She had never been jaundiced; and the presence of gall-stones had never been suspected. These facts I gathered from her former medical attendant, Dr. Grove, and from the husband, whose information extended backwards for upwards of fourteen years.

At noon, on Saturday, Dec. 28, 1867, pain in the abdomen, of a very severe character, set in. Shortly afterwards, I saw her. She then had an altered pinched look, great restlessness, and thoracic breathing. The belly generally was very tender, hard, and flat. There was vomiting of dark green grumous fluid. Hot fomentations, with turpentine, were applied to the abdomen, and opium given in frequent doses. The patient steadily sank, and died in thirty-six hours from the onset of acute symptoms.

That she died of peritonitis was quite clear, and that it was caused by perforation of some portion of the alimentary canal was the most probable suggestion that came to my mind. Before making the *post mortem* examination, I had pretty well settled in my mind that the emaciation and failing nutrition of the past two months had resulted in a perforating ulcer of the stomach, which I expected to find.

In making the examination, I was only permitted to open the abdomen. Peritonitis was general, but most marked in the right iliac fossa. The intestines were intensely injected, fleshy, and matted together with recent lymph and bathed in sero-pus. The stomach was small, but healthy, and shewed no sign of ulceration. To the duodenum, at about its middle, the fundus of the gall-bladder was adherent. An attempt to carefully separate them led to the making of a hole in the duodenum at the point of adhesion. The gall-bladder itself was shrunken, and its coats thickened. It contained no bile; the whole cavity being filled with gall-stones. Four of them, found nearest the fundus, were about the size of Spanish nuts, of light fawn colour, and flattened on two or more sides. The remaining fragments were darker, striated, and very irregular in shape, not at all corresponding to the facets of the other four stones. These darker and less regularly formed gall-stones were situated at the upper part of the gall-bladder, nearest to the cystic duct. On further examination of the intestines, a large slough, about the size of a shilling, was found to have separated from a pouched portion of the ileum just above the ileo-cæcal valve. From the hole thus formed, a hard body had escaped, and was found lying loose in the cavity of the pelvis. This proved to be a portion of a large biliary calculus, which, together with a second part found inside the bowel above the valve, formed three-fourths of a cast of the gall-bladder. These two pieces fitted together by smoothly polished circular facets. The other portions

required to make up the complete cast of the gall-bladder, as it would have been in health, could nowhere be found in the bowel. They must either have been smaller and able to pass by the ileo-cæcal valve, or they never came from the gall-bladder when the other two portions ulcerated through, but were represented by the irregularly shaped and darker portions of calculus, which I mentioned above as having been found at the upper part of the contracted gall-bladder. All the gall-stones were composed of nearly pure cholesterine; and the composition of those taken from the bowel only differed from the more recent ones found in the gall-bladder, in being stained of a dark colour by the faecal fluids.

As far as I know, the case I have just detailed is an unique one: That gall-stones too large to pass by the ducts occasionally escape by ulceration into the intestine—usually the duodenum—has been long well known. Frerichs drew attention to this fact; and one singular case has come to my own notice. It occurred in the practice of my brother, Mr. G. Jeaffreson, of Framlingham, in Suffolk. His patient vomited a large gall-stone; and, on examination after death, which occurred some time subsequently, the gall-bladder was found adherent to the stomach. Frerichs also speaks of fatal obstruction sometimes occurring from a gall-stone becoming coated with faecal matter and so blocking up the canal. But the case I now give is, I believe, the only one on record where large gall-stones have ulcerated into the bowel quite safely, and then, after a long interval, caused death by ulcerating out again, and passing into the cavity of the peritoneum.

Of course, I only speak of this case as unique in reference to my own experience and reading. It may be that some gentlemen present, or some of the readers of our JOURNAL, may be able to give or refer me to cases of a similar description.

CASE OF ANTIPHLOGISTIC TREATMENT.*

By AUGUSTIN PRICHARD, Esq.,

Senior Surgeon to the Bristol Royal Infirmary.

IN these days of universal tonics and stimulants, before the shape of a lancet and the taste of purgative physic quite fade away from our memories, I should like to take the opportunity afforded by this meeting to record a well-marked instance of antiphlogistic treatment of the olden time.

It is difficult to perceive the causes of the rapid and thorough change in our practice which has occurred in so short a time. That the so-called change of type in the nature of disease is a fact, the memories of many of us will amply testify; and the changes in the relative frequency of various diseases, the occasional appearance of a new disease, and the reappearance of an old one, help to confirm the idea. But this is not sufficient to account for the complete change which we have seen; and, although we may flatter ourselves that our modern ideas are the result of conviction, I fear that we must plead guilty of being in some degree the willing victims to fashion.

In my earlier days, three cathartic pills every night, and a good strong black dose every morning or even three times a day, was an ordinary prescription, instead of the iron and quinine and liquor cinchonæ of the present day; and the operation of venesection has become so rare, that many of our pupils have but little opportunity of practising it; whilst, as surgical pupil at the Bristol Infirmary, I have bled forty patients in the day with my own hand. I believe that bleeding was sometimes carried too far, whilst now it is far too much neglected; but I cannot recall the case where a patient was the worse for a good purgation; and I am certain that many acute and chronic diseases, not only of the digestive, but of other organs, and especially many classed under the fashionable, convenient, and comprehensive title, "neuralgia," may be cured by purgatives alone. If my younger hearers would give their patients more opening medicine than they usually get now, I believe it would be better for them: for the patients, I mean. I have notes of cases taken in bygone years in our medical wards, where patients were bled for many very different diseases; and there was no lack of success. I am sure that it was of service in cases of obstinate chronic skin diseases. A list of the diseases for which, as a pupil, I performed venesection, under the direction or by the orders of the physicians of the infirmary at that time, is as follows:—Amenorrhœa; suppressio mensium; arthritis; ascites; amaurosis; bronchitis; chorea; cephalalgia; cyananche tonsillaris, acute and chronic; cerebral congestion; epilepsy; enteritis; gastro-enteritis, acute and chronic; fever; hysteria; hemiplegia; hæmoptysis; hæmatemesis; paralysis; poisoning by lauda-

* Read before the East Surrey District Society of the South Eastern Bra

* Read before the Bath and Bristol Branch.