FOUR BILIARY ANOMALIES: A PLEA FOR CHOLECYST-GASTROSTOMY

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The following four cases of biliary disorder seem not unworthy of record as curiosities, while each presents one or more features of clinical, therapeutic, pathological, or surgical interest. The first two, contemporaneous in the same nursing home, demonstrate extremes in gall-bladder dimensions.

A Diminutive Gall-Bladder

A farmer, formerly robust, was never well after phlegmonous tonsillitis in 1924. In August, 1929, he came into our care, gravely ill from pernicious anaemia, with advanced subacute combined degeneration of the cord. Vigorous treatment with liver, combined with arsenite of iron and hydrochloric acid, soon rendered feasible and successful an operation under novocain infiltration for a large left incarcerated scrotal hernia, and for a right hydrocele of generous proportions. The former was a menace, and both militated against his re-education in walking. A series of attacks of biliary colic began in May, 1930, of increasing frequency and severity, until the situation became intolerable; and his importunity overcame our reluctance to accept the operative risk. On operating through a Kocher incision, under ether-assisted infiltration anaesthesia, we found the liver, reduced to half its bulk, tucked high under the dome of the diaphragm, to which it was intimately bound by perihepatic adhesions defying mobilization. The gall-bladder, which was extricated with difficulty from its fibro-fatty shroud, was about three centimetres long, and of the width of a rather meagre appendix. Its lumen was charged with black grit, and contained one friable black pigment stone. The viscus was enucleated, and the cystic duct drained through a separate stab puncture. A complete and fairly rapid convalescence ensued, at first seriously interrupted by paralytic ileus, which fortunately proved tractable to anti-gas-gangrene serum.

This case not only exemplifies the modest size to which a gall-bladder may shrink, and the pathological association of the pure black pigment stone with haemolytic disorders, but it affords an instance of the value of liver therapy, even in the nerve manifestations of Addison's anaemia, and of the encouraging results, which, on the whole, outweigh the disappointments associated with the giving of anti-*B. welchii* serum in paralytic ileus.

A Large and "Pelvic" Gall-Bladder

A female, aged 38, married, was suddenly prostrated with lower abdominal pain, and frequent urgent micturition, following two days of mechanical difficulty with her corset. She had a history of two years' indigestion, so vague as to amount to little more than stomach consciousness. (After the operation she admitted that she had had one or two attacks mildly reminiscent of angina pectoris.) Her temperature was 100° F., and her pulse rate of 110 was full and bounding. The whole abdomen was too tender to attempt an accurate diagnosis. A large tense cystic swelling occupied the hypogastrium and right iliac fossa; there alone rigidity was present. Pelvic investigation revealed a tender, elastic, fluctuating tumour distending the recto-vaginal pouch. The elevated bladder yielded about eight ounces of residual urine. She collapsed on her way to the nursing home. On exploration through a small tentative gynaecological wound, a cystic mass reticulated with engorged veins was discovered in the pelvis, but with a taut and twisted attachment to the under surface of the low-lying liver. For the safer negotiation of a pedicle of such potentialities a Kocher incision was employed. The cyst, which was of the size and shape of a Rugby football, was attenuated, and proved to be a gangrenous gall-bladder, suspended by a twisted, elongated,

and occluded cystic duct. The cystic duct had implicated the hepatic and common ducts, so that they occupied the upper reaches of the stem. The whole tumour was clothed in front by a flattened dependent prolongation of liver substance, comparable to a Riedel's lobe. The thin fluid content, bile-free, but iridescent with cholesterin, was evacuated. The detached mucous membrane was heavily cholesterosed, though no free calculi occupied either the ducts or gall-bladder. The gall-bladder and Riedel-like process were excised. Bleeding from the denuded bed was so profuse that deep sutures through the liver substance were needed to control it. Recovery was rapid, complete, and free from untoward incident.

Apart from its gigantic proportions, the clinical interest of this gall-bladder rests in its close resemblance to an ovarian cyst with torsion of the pedicle.

A Bifid Gall-Bladder, associated with Acute Pancreatitis

A colliery carpenter, aged 48, had recovered reasonably, but not well enough for work, from an operation for acute pancreatitis, which appeared to comprise drainage of the gall-bladder and pancreas. After an interval of nine months he suffered from distressing prurigo for a few weeks. Intense icterus then set in and he became bronzed, and wasted rapidly. While in this condition he was suddenly seized with severe epigastric pain, tenderness, and slight rigidity. There was marked tenderness in the left costo-vertebral angle, and, as there was suggestion of recurrent acute pancreatitis, he underwent immediate laparotomy, which was performed through a right paramedian incision. The abdominal cavity contained free, rather dark fluid. Fat necrosis was present, but not conspicuous. A rather small gall-bladder readily obtruded, but a much larger one lay buried in a forbidding mass of adhesions. The two communicated through a common ampulla opening into a single cystic duct. Ducts and gall-bladders contained floating agglomerations of cholesterin, but no formed calculi. The pancreas was bulky and unduly palpable, and its head was indurated. Neither diffuse nor focal necrosis had taken place, possibly because the interval between the onset of the acute pain and the operation was short. Cholecyst-gastrostomy was the chosen procedure, the larger and now mobilized gall-bladder being impressed for the anastomosis. A noteworthy feature in the convalescence was the absence of any but very slight vomiting. Recovery has been such that the patient boasts of a degree of vigour unknown to him for many years, and is regularly engaged upon exacting work. The smaller gall-bladder was too definite to be called merely a Hartmann's pouch.

A Double-Chambered Gall-Bladder

A female, aged 56, married, was admitted to hospital for a recrudescence of attacks of biliary colic occurring at short intervals. Two years previously she had had a similar series. A thickened, fleshy, and lustreless gall-bladder, average in size and shape, was delivered through a Kocher incision. Its contents consisted of bile, mucus in excess, and viscid fluid, together with two pigment-veneered, faceted cholesterin stones. Its cavity was partitioned by a thickened sphincter-like ring of elastic, but dilatable, muscular tissue into two compartments, the hiatus between them being lined by loosely attached mucous membrane, puckered radially. There was no apparent cholesterosis. The head of the pancreas was nodular, and a little indurated. The common duct felt like an atheromatous artery. Convalescence was as uneventful as in the case of an interim appendicectomy; while there was only slight post-anaesthetic vomiting after the operation of cholecyst-gastrostomy.

COMMENTARY

From our fortunate, though very limited, experience of the application of the general principle of which cholecyst-gastrostomy is the type, this operation seems one of decided and, we venture to believe, increasing appeal, the more so since physiology has dispelled the apprehension previously associated with bile in the stomach by establishing its habitual regurgitation through the pylorus. The persistent vomiting, of pessimistic prediction, does not appear to occur. Admittedly, technical difficulty may often be prohibitive; still, there remain occasions when

intravisceral drainage is a manœuvre almost as rapid of execution as external drainage. The anastomosis commends itself, therefore, in selected cases, as a valuable alternative to cholecystostomy, with its manifest disadvantages. In this connexion, it would seem especially worthy of trial in pancreatitis of varying grades, in view of the theory of its pathogenesis, which is founded on the work of Opie and of Archibald, and on the convincing researches of Bruce Dick.

Suitably modified to the occasion, the principle might well be applied in the case of biliary disorder with peptic ulcer in "an indifferent surgical risk." In such a case the inspiration to apply it came to one of us just too late to obviate the trauma of cholecystectomy followed by gastro-jejunostomy in a patient none too well equipped. The ulcer could easily have been excised and the gall-bladder joined to the margins of the stomach wound.

The operation is more readily performed through a Kocher approach, and is further facilitated by the use of Wilkie's duodeno-jejunostomy clamps.

The anastomosis operation has the merit of revocability, and might well become that of election when there is doubt of the viability of the common duct, or certainty of its occlusion, when measures for the relief of the obstruction are impracticable, or fraught with grave hazard.

UNUSUAL DISTRIBUTION AND MORPHOLOGICAL MODIFICATION OF COMEDO

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Topographical and morphological variation in quite common skin diseases occasionally introduces an element of confusion in diagnoses which otherwise would present no difficulty. Until quite recently I little suspected that a condition so common and obvious as comedo might roughly simulate in distribution and colour the lesion of xanthoma palpebrarum.

A retired journeyman engineer, aged 72, sought relief, in October, 1930, at the skin department of the Western Infirmary, for an affection of the eyelids. He appeared to be well preserved for his years, exhibited a mild degree of acne rosacea, and was bald save for a fringe of hair, approximately three inches deep, laterally and posteriorly. He had been in the habit of occasionally taking a little alcohol, of smoking three ounces of tobacco a week, and of eating a fair amount of sugar. On taking his seat he gave the impression of being the subject of xanthoma palpebrarum, more particularly of the left upper eyelid. This impression, however, on closer inspection, was soon dispelled, the lesions proving to be comedones of atypical distribution and, in my experience, of unique shape.

He said that he had been accustomed to work in a very hot atmosphere—subject, however, to some temperature variation—and with a great deal of oil. He had perspired very freely, and blackheads had developed, especially round the lower eyelids. The blackheads had been removed from time to time. Later, about ten to twelve years ago, blackheads had appeared on the upper lids some of which had slowly increased in size, gradually become flattened and pale yellow in colour, but had caused no difficulty in the closing or opening of the eyes, and had never been treated.

On inspection the left upper eyelid, mainly anteriorly, showed flat, approximately circular plaques, raised slightly above the skin level, pale yellow in colour, with

a more or less central black spot, and resistant to the touch. They were distributed mainly anteriorly, and some tended to project beyond the palpebral margin. The largest was about a quarter of an inch in diameter. The right upper eyelid was affected, but did not exhibit

Left upper eyelid shows modified flattened disc-like comedones, in one of which, near inner canthus, a central dark point is visible. Some project beyond the palpebral margin.

the same degree of modification. Comedones were present on both lower lids.

While I have seen comedo on the lower eyelid in more than one patient, I have never noticed it, save in this particular case, on the upper one, nor has one of my colleagues, an ophthalmologist of careful observation and long experience.

The morphological modification is of particular interest. Although working a good deal with oil, he had habitually washed his face with cold water. This ablution is practised by many in a careless, half-hearted manner, as may be demonstrated in the case of some town dwellers in large smoky industrial centres during foggy weather, where a "high-water mark" may sometimes be left in the orbital region. Assuming that the patient had washed in this perfunctory manner, and especially so with cold water, the follicles would tend to remain plugged with oil and particulate matter. Two factors would probably largely account for the peripheral increase and resulting disc-like shape of the lesions—namely, the underlying dense fibrous tissue of the tarsal plates, and the diurnal palpebral movements.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

SARCOMA OF THE LUNG

In view of the difficulties of diagnosis involved, the following case may be of interest.

G. B. A., of fair physical development and with a chest expansion of three inches, enlisted in the Army in 1916, at the age of 32. In 1917 he was accidentally burnt on the face and hands while on service. Three months later, while still in hospital, he had a "haemoptysis—right apex crepitations"; two months later, "bronchitis—feeling faint on exertion"; no other symptoms or signs. In 1919 he was pensioned on account of bronchitis—"coughing up blood-streaked phlegm; V.F. and V.R. plus at right apex." These conditions remained much the same until September 29th, 1925, when pulmonary tuberculosis was diagnosed, and there was "active infiltration of the upper lobes of both lungs." His expansion had become "poor," and "a few crepitations were heard at the apex." On March 11th, 1926, pulmonary tuberculosis was admitted by the Ministry. He continued to show very