A CASE OF CHRONIC INTUSSUSCEPTION.

BY

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THE case recorded below is of interest not only on account of the long duration of the intussusception, but also because of the condition found at the first (palliative) operation, and the discovery at the second operation of a tumour which proved on examination to be a carcinoma.

A man, aged 68, had for a year been greatly troubled by constipation. Three days prior to admission to hospital he had taken a large dose of purgative, and the bowels had acted once; there had been no action since, but pain in the rectum and copious discharge of blood-stained mucus. Vomiting had not occurred.

The abdomen was considerably distended, and peristalsis was obvious. On examining the rectum the anal sphincters were found to be very lax, and a tense smooth mass was discovered reaching to within half an inch of the external orifice.

The patient on overhearing a remark that "there was something to be felt" volunteered the fact that he himself had made that discovery over a year previously, and had noticed something inside the rectum constantly, this discovery coinciding in point of time with the onset of his constipation.

Immediate operation was advised; this the patient refused, but changed his mind on the following day, when the symptoms of intestinal obstruction had become more distressing.

The patient was anaesthetized and placed in the lithotomy position, to facilitate a more thorough examination. On passing a speculum it was found that the rectal mass was trunk-shaped, and digital examination failed to reach any attachment to the rectal wall. The only possible diagnosis seemed to be chronic intussusception causing obstruction, through engorgement brought about by purgation.

The patient was placed flat on the operating table and the abdomen opened by retracting the left lower rectus outwards. An intussusception of the sigmoid into the rectum was found, the ensheathing joining the entering layer, at a point about one inch above the recto-sigmoid junction. All the intestines were greatly distended, the large intestine, as far back as the caecum, being a solid mass of faecal material; this seemed to bear out the patient's statement of the duration of the trouble. All attempts to reduce the intussusception proved of no avail, even though one hand was placed in the rectum to manipulate its apex. In these circumstances some palliative measure had to be decided on, the choice lying between caecostomy and colostomy. Eventually colostomy was performed through the outer left rectus with the idea that it would give more efficient drainage to the overloaded intestine, and in the event of the patient refusing further operative measures allow him to get about. The colostomy was opened at the end of twenty-four hours by simply cutting across one of the longitudinal bands. The patient got on well, but the discharge of blood-stained mucus from the rectum continued.

Six weeks after operation rectal examination showed that the intussusceptum had considerably decreased in bulk, but still reached to within three-quarters of an inch of the anus. It was decided to open the abdomen again to see if the intussusception could be dealt with in any way. The patient was put in the Trendelenburg position, and the abdomen opened by displacing the left rectus outwards. Contrary to expectation, it was found that the intussusception was now easily reducible, and that a hard mass was present in the sigmoid about seven inches from the recto-sigmoid junction. Nothing suggestive of this mass had been felt at the first operation, presumably because of the large amount of oedema present. No glands were discovered in the sigmoid mesentery. After careful packing off of surrounding structures the suspicious portion of the sigmoid was excised, together with its mesentery, and an end-to-end anastomosis performed with Duxlo catgut. The abdomen was closed without drainage.

The patient got on well, and three weeks later, having changed his mind as regards surgery, expressed a wish that his colostomy should be closed. This was done by Greig Smith's method, without opening the peritoneal cavity. Fluvine solution was used at the operation to prevent infection of the tissues. The wound kept clean, but at the end of eight days a small faecal fistula made its appearance, which has since closed. Since the closure of the colostomy the bowels have been regularly opened without any gripping pain, and for some time past without any purgatives.

Examination by my colleague Dr. Donaldson of a portion of the mass in the sigmoid shows a typical columnar-celled carcinoma.

The chief points of interest in this case are:

1. The very long duration of the intussusception—over a year. This, of course, depends on the patient's story, but there seems no reason to doubt this, as he is a most intelligent man.
2. The slow growth of the sigmoid carcinoma, if we grant the fact that the growth was the primary cause of the intussusception.
3. The marked effect that drainage of the intestine above the intussusception had in decreasing the size of the intussusceptum, making its reduction possible.
4. The advisability of suspecting the presence of some

growth in all cases of large-gut intussusceptions in adults. It is often quite impossible to palpate a neoplasm in the intestine at operation because of oedema of the parts.

In my opinion all such cases should be re-explored when the patient has recovered from the acute symptoms.

QUININE IDIOSYNCRASY AND CINCHONINE.

BY

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IDIOSYNCRASY to quinine is much less common than one would gather from the textbooks. One of us has been in the Malay States for twenty years, and the other for more than thirty-five; but, though it is a very malarious country, the only case of pronounced idiosyncrasy to quinine which we have encountered is the patient who forms the subject of this note. Even in this instance there is some doubt whether her illness, which resembled exfoliative dermatitis, was due to quinine or to some other cause. During the war we treated large numbers of soldiers who had contracted malaria in all quarters of the world, but saw no similar cases.

MacGilchrist has shown that the several alkaloids of cinchona differ in their toxic properties, and Acton claims that the members of the laevo-rotatory group, which includes quinine, have different therapeutic properties from those belonging to the dextro-rotatory group, which comprises cinchonine and quinidine. As our patient was quite unable to take quinine and was becoming dangerously ill from malaria, we determined to try an alkaloid belonging to the latter group, and we gave her cinchonine base, with the happiest results.

One can hardly suppose that, in every case of quinine idiosyncrasy, the sensitiveness is limited to one or other of the cinchona alkaloids, and does not extend to them all; but in this instance, no sooner was cinchonine substituted for quinine than the swelling of the face and limbs subsided, the vomiting ceased, and the patient recovered.

A lady, aged 30, weighing between 7 and 8 st., became infected with benign tertian malaria and was taken ill on June 10th, 1922. On June 15th she was admitted to a nursing home, where she was treated by the medical officer with large doses of quinine. She received 30 grains of the bihydrochloride by intramuscular injection every day for three days; subsequently she was given 45 grains of quinine daily, in a mixture containing 15 grains of quinine sulphate and 3 minims of liquor arsenici hydrochlorici in each dose. On July 1st she left the nursing home, but continued to take the mixture for several days.

On July 5th, three weeks after she had commenced quinine treatment, a blotchy rash appeared, especially on the exposed parts of the body—the face, neck, arms, and hands. This rash persisted with varying intensity, until the writers met in consultation on August 31st, eight weeks after its first appearance. In the meantime malaria parasites, which were now of the subtertian variety, had been found in her blood on several occasions, and, with the exception of an interval of seven days, she had been taking quinine.

The condition at the time of our consultation was as follows: The skin over the whole body was swollen, red, dry, and peeling. The face was bloated, the eyelids were so swollen that they could hardly be opened. The lips were protruding, reddened, blistered, and cracked. There were small bullae and vesicles about the mouth. The tongue and buccal mucosa were red, peeling, and sore. The throat was inflamed and painful. The general appearance at once suggested exfoliative dermatitis due to arsenical poisoning. The patient's temperature was 102° F., and there were subtertian parasites in her blood. She was taking 10 grains of quinine bihydrochloride, in solution, three times a day, but she vomited after almost every dose.

From August 31st she was given 16 grains of cinchonine base (Messrs. Howard and Son) every day, in doses of 4 grains dispensed in gelatin capsules, and its absorption was checked by daily examination of the urine. The vomiting ceased at once, the temperature came down, the malaria parasites disappeared from the blood, the rash and swelling subsided, and within a few days the patient was up and walking about. The disappearance of the rash was followed by very definite pigmentation of the skin—it looked like dirty skin—not on the abdomen, as in arsenical poisoning, but more particularly over those exposed areas where the inflammation had been most acute.

The cinchonine was continued for several weeks, and then the dose was reduced to 8 grains daily. On one occasion, in October, the patient had a slight attack of fever with swelling of the eyelids, but it quickly subsided on resuming the original dose of 16 grains daily. The dose of cinchonine was once more dropped

to 8 grains a day in November, and on two or three days none at all was taken; a relapse of subtertian malaria occurred on November 26th, which was quickly controlled by increasing the dose.

The patient left for England on December 1st, and was in good health when we last heard of her.

THE PULSE PRESSURE IN EXOPHTHALMIC GOITRE.

BY

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THE height of the pulse pressure (the difference between systolic and diastolic pressure) is usually influenced under normal conditions by two factors—the height of the systolic pressure and the pulse rate. The higher the systolic pressure the more pronounced is the pulse pressure; the more frequent the pulse rate, the smaller the pulse pressure.

The systolic arterial pressure is usually increased in exophthalmic goitre, although in cases where symptoms of heart failure manifest themselves it may become lower than normal; but the most striking feature in exophthalmic goitre is the relation of pulse rate to pulse pressure. As is well known, the pulse rate is increased in exophthalmic goitre. A frequent pulse in any other condition is usually accompanied by a small pulse pressure. In tachycardia due to bacterial toxins acting on the heart muscle and other forms of myocardial trouble, and in cardiac neurasthenia and heart failure, etc., the pulse pressure is small, usually less than 40 mm. Hg. In rapid heart action due to amyl nitrite and atropine the pulse pressure is likewise diminished.

The following table records the various pressures in cases of exophthalmic goitre:

Initial.	Blood Pressure.			Pulse Rate.		Initial.	Blood Pressure.			Pulse Rate.
	S.	D.	P.				S.	D.	P.	
M.	125	80	45	130		S.	120	80	40	120*
E.	140	70	70	140		W.	138	67	71	160
C.	140	80	60	120		S.	165	95	70	†
J.	125	75	50	100		G.	170	85	80	120
C.	115	50	65	60		R.	170	95	75	90
D.	137	80	57	90		S.	140	80	60	120

S. = Systolic pressure; D. = Diastolic pressure; P. = Pulse pressure.

* Pronounced cardiac dilatation.

† Auricular fibrillation.

So far as I am aware it is only in thyroidism that there is both an increase in pulse rate and at the same time a high pulse pressure. In some cases of irritable heart with manifest signs of thyroidism pulse pressure is also increased. This fact is of value in the differential diagnosis between thyroidism and other conditions. It is also important from the point of view of treatment. I have shown elsewhere¹ that digitalis increases the pulse pressure. Obviously this drug is not indicated in a condition where the pulse pressure is already high.

The electro-cardiograph reveals still another characteristic sign of exophthalmic goitre; the P wave is usually exaggerated in this condition, suggesting hypertrophy of the auricle. A similar electro-cardiographic condition is found in mitral stenosis, and it is significant that exophthalmic goitre, too, predisposes to auricular fibrillation.

REFERENCE.

¹ *Lancet*, 19.1.1, 1072.

THE seventh Sicilian Medical Congress will be held at Palermo from April 20th to 22nd, when the following subjects will be discussed: Deficiency diseases, introduced by Dr. Giuffrè of Palermo; the present state of our knowledge on the etiology and treatment of cancer, introduced by Dr. Parla-vecchio of Palermo and Dr. Fichera of Messina; and the organization of the Italian medical profession, introduced by Dr. Salpietro of Palermo.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

SUPPRESSION OF URINE AFTER LABOUR.

SUPPRESSION of urine after labour is apparently very rare, and is not even mentioned in most obstetric textbooks. I have inquired of several medical practitioners—some of them of thirty-five years' experience—and find that none of them have ever seen a case. The following may therefore be of interest.

Mrs. G., aged 30, had the following obstetric history. She was married in 1916, had a miscarriage in May, 1917, a full-time child in May, 1918, a full-time child in August, 1919, a two-months miscarriage on January 30th, 1922, and twins on February 4th, 1923. I attended her on all occasions except the first miscarriage; in 1919 I attended her continuously for the last two months of her pregnancy, and feared acute phthisis, but, to my surprise, she improved and got apparently quite well after the birth of the child. During her last pregnancy she complained of vague symptoms, most of them nervous, but there were no physical signs, and she appeared in better health than ever before. Repeated requests for a specimen of urine, however, were made in vain (a not uncommon event in general practice), so that I cannot be sure as to the state of the renal system.

On January 20th, 1923, I examined her and diagnosed a twin pregnancy. On February 4th I was sent for by the midwife because "the placenta had not arrived after forty-five minutes," a child having been born. On examination I found that another foetus was present in the uterus; it was presenting transversely, and there was prolapse of an arm. With the help of a colleague who gave chloroform, I performed internal podalic version. Both twins lived; there was little shock after the manipulations, and the haemorrhage, though rather free from a flabby uterus, was not alarming. On the following morning I was told that the patient had had continuous bilious vomiting, and she was still retching. I hoped that this was due only to the anaesthetic, but I noticed that there was extreme oedema of the eyelids, and the patient told me that "everything was a mist before her." There was no headache—which I mistakenly took to be a good sign. The same day, at 6 p.m., I was informed that the patient had passed no urine, and on discovering that there was no distension of the bladder, the seriousness of the situation was apparent. I passed a catheter, but found, as I expected, that not a drop of urine was obtained. Later in the evening, after appropriate treatment, the patient looked and said that she felt better; the oedema of the eyelids had improved, and she did not complain of headache. The following morning, however, when I saw her at 8.45, she was unconscious, breathing stertorously, the pupils were pin-point, and she died an hour later—forty-one hours after labour was completed. There was no headache nor convulsion at any time. No urine had been passed.

The vomiting was uncontrollable by drugs, and none of the usual measures, such as hot blankets and bottles, hot steam, cupping of the kidneys, pilocarpine, etc., had the slightest effect. No post-mortem examination was obtained.

In view of the feared development of phthisis the possibility of a tuberculous focus in the renal system is suggested, though there was nothing to lead me to suppose this during her pregnancy, when, as I have remarked, she appeared in better health than ever before. However, as I did not have the opportunity of examining the urine, I cannot be definite on this point. The urine was normal on all other occasions, on which I had examined it.

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TRAUMA AND APPENDICITIS.

THE reports of cases under this heading (January 6th and 13th) induce me to record a similar case which came under my observation at the Marine Lines War Hospital, Bombay, in 1920.

A young clerk was hit by a ball over the right iliac fossa while playing hockey. He was admitted into my ward the next morning suffering from a typical attack of acute appendicitis. He refused operation at first, but submitted to it a week later, when the pain and swelling had increased. At the operation the caecum and the terminal ileum were found matted into a hard lump, with the tip of the appendix projecting about the middle. This last was removed for examination, and a drainage tube was tied in. The patient made a good recovery after some days of suppuration. Microscopic examination showed a sclerosed appendix with the lumen obliterated.

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