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 Duxol 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. Flamine 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.

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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