in the interscapular region; (3) the instinctive adoption of the prone position, with leaning forward, to relieve the epigastric pain; (4) the absence of pain around the umbilicus and below it.

A CASE IN WHICH ENTEROSPASM WAS A PRONOUNCED FEATURE, NECESSITATING ABDOMINAL SECTION FOUR TIMES WITHIN TEN MONTHS.

By C. W. DEAN, F.R.C.S.E.,

HONORARY SURGEON, THE ROYAL LANCASTER INFIRMARY.

UNTIL I read Dr. Ashe's most interesting account of his case of enterospasm, in the *BRITISH MEDICAL JOURNAL* of March 2nd, 1907, I, like him, was ignorant of this condition as a recognized pathological state. As it was, the perusal of his paper and the clear and concise description of the symptoms and of the conditions found at the subsequent operation enabled me some months later to solve, without leaving much room for doubt, what otherwise would have been a difficult problem; and although the treatment adopted in my case of necessity differed from that followed in his, still the picture disclosed in the case I am about to describe at once told me that I was looking at a piece of intestine in a state of tetanic spasm, a sight I had never before beheld.

Since reading Dr. Ashe's paper, Dr. Herbert P. Hawkins has most kindly sent me a reprint of his commentary on *The Reality of Enterospasm and its Mimicry of Appendicitis*, which appeared in the *JOURNAL* of January 13th, 1906. This most able paper tells us practically all that is known up to the present time of spasm of the intestine and enteralgia—two conditions which seem to accompany each other in all the recorded cases. In Dr. Hawkins's paper one sentence specially impressed me as being pregnant with truth—how true no one can appreciate until he has been many years in practice; that is, "there is much abdominal pain which has no name and does not kill."

How often has the abdomen been opened for acute symptoms simulating gastric ulcer or obstruction, symptoms which were perhaps not classical, which did not quite fit in as they should with the description given in the textbooks, but which were too alarming apparently to admit of delay, in which laparotomy has been performed, and yet nothing has been found subsequently to justify the operation?

I know this has happened to me, and it must have occurred over and over again in the experience of other surgeons; but cases like these are not recorded—may they not in many instances come under the category of acute enterospasm? I venture to think so.

The notes of the following case may possibly be of some interest, for these reasons: laparotomy was performed four times in less than ten months, a cyst of the ovary was removed at one operation, enterotomy performed at another, 4 in. of small intestine removed at the third, and 7 in. of small bowel were resected at the fourth. The crowning point of the whole thing is that the patient is now in excellent health and expresses herself as "feeling better than she has done for years." On reading this account casually some people may be inclined to think that the aid of surgery may have been invoked perhaps somewhat too hastily, but I can assure them that such has not been the case in this instance.

The late Dr. W. Croft Helme, a man of much experience and knowledge, under whose care the patient was, asked me to see the case with him in consultation to decide as to the advisability of operation. The symptoms on each occasion, in our opinion, presented features of extreme urgency. The final operation, of course, admitted of no delay, being due to the fact that the patient was suffering from acute obstruction. A point I think of much interest is the prominent part enterospasm played in the case, and the fact that the spastic bowel was seen and handled, and its condition deliberately noted, and so adding another instance to those already recorded.

History.

A young woman, aged 29, of a singularly placid disposition, has had three children, of whom two are living; her previous illnesses have been an attack of influenza every year for the past five years. For about four years she has had attacks of what she describes as cramp in the bowels, always attended by

vomiting and difficulty of defaecation. These attacks came on at any time without warning, while engaged in household work or while in bed. After the attacks passed off constipation always remained, sometimes for quite a long time. In addition there was constant pain in the left iliac region. In December, 1907, a lump was found in this situation, presumably in the left ovary, but its nature at the time was undetermined; in all probability, however, it accounted for the above-mentioned pain.

First Laparotomy.

On January 1st, 1908, the patient aborted at three months, and as she did not progress satisfactorily she was admitted into the Royal Lancaster Infirmary on January 14th under my late friend and colleague, Dr. W. Croft Helme. After she had been for five weeks under treatment, the tumour getting no smaller (I may say there was a suspicion in Dr. Helme's mind of gonorrhoeal infection of the tube), I was invited to see her in consultation, and we came to the conclusion that we ought to open the abdomen; this we did on February 20th, and removed a rounded dark cyst of the ovary together with the tube, after having had to separate many adhesions. The tumour was examined by Dr. W. Gough, and showed the typical structure of a multilocular cystic adenoma. On the day after the operation she had pain in the abdomen of a severe cramp-like character, accompanied by vomiting and inability to pass flatus; enemata were given, but without any result. Dr. Helme feared the onset of septic peritonitis, but there was little or no distension, no rise of temperature, and the pulse was not unduly quickened; tenderness was general, but not marked, and the patient did not seem poisoned.

Second Laparotomy.

As the symptoms continued all the next day, Dr. Helme again asked me to see her, which I did on February 23rd, and advised reopening the abdomen, the general condition of the patient being so good and there being no sign of toxæmia. We operated in the evening of that day and found absolutely no trace of peritonitis; the site of the previous lesion was healthy, in fact at first sight everything seemed natural, but on examining more closely we found what looked like a piece of collapsed bowel, and on bringing it to the surface it proved to be a portion of the ileum near to its junction with the caecum, about 6 in. long, flattened, with slightly concave sides very like a piece of thin rubber tubing from which the air had been exhausted; each end joined the healthy gut by a sharp line, the spastic portion was paler than the rest of the gut, but beyond this there was no sign of disease, no distension of the upper end of the bowel and no marked congestion. Having read the account of Dr. Ashe's case, I had little difficulty in believing we had a similar condition to contend with. As the patient's state demanded relief and as, unlike Dr. Ashe's case, the bowel could not be induced to relax, I opened the gut just above the contraction. The patient was much relieved and soon recovered perfectly, with the exception of the inconvenience caused by the enterotomy wound, and had no return of the spasm.

Third Laparotomy.

On April 2nd, six weeks after the second operation, we wished to close the opening by a plastic operation, but as the wound had stretched so much this was found to be impossible, so the abdomen was again opened and some 4 in. of bowel removed and the ends joined by simple suture.

From this third operation the patient recovered without a bad symptom, a natural motion being passed on the third day. She remained in hospital until May 16th, when she went home and resumed her household duties. She had some little trouble with a stitch abscess, but beyond that she got on very well. She now tells me, however, that she was never free from a slight feeling of abdominal discomfort.

Fourth Laparotomy.

On December 7th, 1908, she sent for me late in the afternoon (my friend Dr. Helme had died during the previous September) saying she was ill again like she was before. I found her in bed with her legs drawn up, evidently suffering acute pain. She told me she was all right when she got up that morning, and had done her usual work until about 11 a.m., when while mangling some heavy clothes she felt a sudden pain in the abdomen; it had steadily got worse, coming on every now and then in spasms. She had vomited the contents of the stomach, and could not pass flatus. I of course thought of enterospasm as a probable cause of the trouble, but as the symptoms were very severe, and obstruction was evidently pretty complete, I advised her to come into hospital, telling her I might possibly have to open her abdomen again. She came in as soon as she could, and I saw her at 8 p.m. the same evening. The pain was now very severe and paroxysmal, and the whole abdomen exceedingly tender to touch and somewhat distended. She had again been sick, the vomit now being bilious in character, moreover she had not passed flatus in spite of a large enema containing turpentine. I determined to operate at once, and with the assistance of Dr. Parker I for the fourth time opened her abdomen. The cause of the mischief was at once found—a loop of small intestine was tightly strangulated by an adhesion which had formed after one of the previous operations; the loop was quite black, and had lost its lustre in places (distinct evidence of commencing gangrene can now be seen in the bottled specimen). So for the second time within ten months I resected a portion of her bowel, this time about 7 inches, and united the ends by simple suture. From this operation she has perfectly recovered, as far as one can see. She declares she is quite well, and looks so; moreover, she has lost the feeling of discomfort she previously had.