Spence: *Edinb. Med. and Surg. Journal*, 1813, ix, p. 315.
 Trümper: *Gaz. des hôpitaux*, 1829, ii, p. 15.
 Wanderbach: *Journ. univ. d. sc. méd.*, Paris, 1828, p. 72.
 Waters: *Med. Record*, N. Y., 1886, xxix, p. 93.
 Weiss: *Wien. med. Blat.*, 1882, S. 1076.
 Wiebers, v.: *Mag. f. d. ges. Heilk.*, 1839, liv, p. 377.
 Wright: *Dubl. Med. Press*, 1864, xli, p. 407.
 Wood: *Insects at Home and Abroad*, vol. i.

A CASE OF INTUSSUSCEPTION OF THE TRANSVERSE COLON IN AN ADULT.

BY

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THE patient in the following case, a coloured man aged 45, came under my care on the evening of September 26th, 1909. He had had severe pain in the epigastrium, vomiting and diarrhoea for some thirty hours. Some twenty-four hours earlier still he had lifted a weight of 50 lb. with the right hand alone, but he was accustomed to lift much heavier weights, and remained in his ordinary health until the next morning. He was then on board a small sailing boat, and at 9 a.m. felt a sudden sharp pain in the right side, and an inclination to go to stool. The motion was easy and normal, but he had to lean in a strained position during the act of defaecation, the boat being under full sail and rocking a great deal. After the motion the pain in the right side became very much worse and doubled him up, and at this juncture he vomited the sugar-cane and pupa seeds which had been part of his last meal. He vomited again twice in the next two hours—green material. On getting ashore, about 11.30 a.m., the pain was less severe, and he walked half a mile to his home, though with difficulty. He drank a little sugar and water, and this was immediately rejected. Vomiting continued at intervals during the night, but no bad-smelling material. The following morning—that of the day on which I saw him—he was carried on board a boat to be brought to me. At 9 a.m. he passed about a pint of dark red clotted blood, and at the same time vomited material which smelt like bad eggs. This was repeated ten or twelve times, and he passed more blood by the bowel on four or five occasions.

Previous History.

For about twelve years he suffered from constipation on sea voyages, lasting often for eight days. The bowels never moved when at sea. Since 1902 the bowels had moved daily.

State on Examination.

He was a tall, spare man, but well developed. He was twisting about in bed, and complained of severe pain in the right hypochondrium. His face was pinched and drawn, breathing entirely thoracic; pulse 90, was full and regular; his temperature was not raised. He complained of great thirst, very severe pain in the abdomen, a feeling of sickness, and was quite worn out by the excessive vomiting. The mouth was parched, tongue coated with a thick brown fur, lips pale and drawn, and the breath was most offensive. The abdomen was retracted with scarcely any movement—with a slight fullness in the region of the pylorus; no peristalsis was detected; there was general tenderness over the abdomen, but this was especially marked over the swollen area. The abdominal muscles were contracted but not quite rigid; no tumour could be palpated. The abdomen yielded a tympanitic note all over, including the tender area. There was no enlargement of liver or spleen, and nothing was made out per rectum.

Diagnosis.

In view of these symptoms and the definite history of faecal vomiting, a diagnosis of obstruction in some part of the bowel was made.

Treatment.

He was given soap and water enema, two pints in fifteen minutes. This was returned, along with a little thin, dark-coloured blood; no clots. Sips of water were ordered, and the patient given liq. morph. 43 minims every two hours till the pain was relieved; this was after four doses.

September 27th. The next day another soap and water enema was administered, two and a half pints; it was returned with a little dark blood.

September 28th. Turpentine and starch enema, two pints, brought away a few small hard masses of faeces and a little flatus, which relieved the patient considerably.

September 29th. Patient was given calomel, $\frac{1}{2}$ grain, in the morning, and again $\frac{1}{2}$ grain in the evening.

September 30th. Calomel, $\frac{1}{2}$ grain, was given at 6 a.m. At 11 a.m. the patient had a good motion, which was quite natural and formed. He was then allowed a little milk and water and albumen water; up till this he had taken nothing but water. He had another natural motion in the evening, and continued the calomel, $\frac{1}{2}$ grain morning and evening during the following day the bowels being moved twice, morning and evening.

Result.

In the afternoon of October 2nd, at 3 o'clock, the patient felt something move at the painful spot, accompanied by a shooting pain and a "feeling of hollowness." He had a motion between 4 and 5 o'clock, which he passed with great difficulty. His friends noticed that he had passed a piece of bowel, and sent me a most urgent message to come at once. I found the patient much alarmed but considerably better, and was able to reassure him that everything was all right. This prognosis proved justified, for after this day the patient's recovery was steady. I ceased attendance on October 26th, but have since heard that there has been no recurrence of any symptom.

The piece of bowel passed proved to be the transverse colon. The intussusceptum was about 1 ft. in length, and consisted of the two tubes of gut—the middle and internal tubes, so that about 24 in. of gut were involved. There was evidence of a tight constriction at the neck of the intussusceptum, but in the specimen the little finger could be introduced into the inner tube. This would explain the passage of natural formed motions previous to the passage of the intussusceptum itself. The whole bowel was gangrenous and very offensive; but the two tubes were not adherent, and the inner tube could be reduced a little way. Attached to the middle tube was a mesentery, which contained fat, and which was believed to be omentum. The mesentery attached to the inner tube was in shreds and gangrenous. The three longitudinal muscular layers were clearly made out, so that the part involved would be mostly the right half of the transverse colon, with possibly a part of the ascending colon.

I have felt justified in reporting this case because of:

1. The rarity of acute intussusception in the adult.
2. The absence of any definite exciting cause.
3. The very rare occurrence of spontaneous cure.

Muscular strain and indigestible food are the causes commonly ascribed in textbooks, but this man was accustomed to lift heavy weights up to 300 lb, and when he happened to lift 50 lb. with the right hand alone on the morning previous to the attack he felt no immediate bad effect.

His food was that to which he was accustomed. The strained position which he occupied during defaecation on board the sailing boat may have increased the extent of the intussusception, but the pain had then already commenced.

As regards the treatment adopted, my first thought was operation, which I offered to perform, but as the patient was unwilling I did not press the point, in the absence of hospital accommodation and other medical assistance. Remembering the dictum of an experienced physician of my acquaintance that "nearly all cases of acute appendicitis could be cured by morphine and hot water," I tried this treatment, adding daily enemata in an attempt to reduce the obstruction. As the patient passed a little flatus with the third enema, I felt justified in prescribing small doses of calomel to overcome the effect of the morphine on the upper part of the bowel. This, as the case showed, proved successful, as I believe, by causing a movement of the bowels, it prevented the stercoraemia which might have caused the death of the patient from exhaustion; and, although unforeseen, it probably hastened the separation of the gangrenous gut, thus preventing a certain amount of toxæmia.

In conclusion, I attribute the result of the case to be due in a large degree to the physique of the patient, who was one of those thin, spare individuals who seem best able to survive a serious illness.

AMONG the new Senators of the Kingdom of Italy are two representatives of the medical profession. These are Dr. Camillo Bozzolo, Professor of Clinical Medicine in the University of Turin; Dr. Tommaso de Amicis, Professor of Dermatology and Syphillography in the University of Naples. The same distinction has been conferred upon Professor Cimician, who, though not a doctor, has taught chemistry to so many generations of medical students, first at Rome and afterwards at Bologna, that he may be claimed as of the household of medicine.

UNDER the will of the late Mr. Henry Minson, of Green Lanes, Newington, the following institutions each receive one-seventeenth share of the residue of his estate: The Royal Sea Bathing, Great Northern Central, London, Metropolitan, and London Fever Hospitals, Earlswood Asylum, and the Royal Asylum for Incurables, Putney. The residue is of such amount as to secure to each of the beneficiaries between £400 and £500.