PERFORATION OF A GASTRO-JEJUNAL ULCER: OPERATION: RECOVERY.

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THE following case is an addition to the increasing number of instances of perforation of an ulcer which has followed the operation of anterior gastro-jejunostomy. The perforation was into the general peritoneal cavity, and but for the promptitude with which the gravity of the case was recognized by Dr. Currie and subjected to operation, would, like similar cases when overlooked, have ended rapidly in death from suppurative peritonitis. In the proceedings of the Royal Society of Medicine there is a paper by Mr. H. J. Paterson (June, 1909) on the subject of jejunal and gastro-jejunal ulcer following gastro-jejunostomy. Among the cases recorded in it there are 19 in which this perforation into the peritoneum occurred. To these must be added a case published in the *Lancet*¹ recently, and this case, making 21 in all, but inasmuch as in two of these perforation occurred on two separate occasions at considerable intervals, this accident has been known to happen twenty-three times, and operation has been successful in saving life on nine occasions (Goepel 2, Hybrinette 1, Maylard 2, Battle 4). In all anterior gastro-enterostomy had been performed, in one "En-Y," and in this case with lateral anastomosis. A successful result depends more on the time that has elapsed between the giving way of the ulcer and the performance of the operation than on anything else; therefore the life of the patient depends on the ability of the medical man who first sees the patient.

A man, aged 39, had undergone an operation in 1907 by a surgeon in Glasgow for a perforated gastric ulcer, and two months later another operation for the relief of obstruction to the passage of food from the stomach.

He had afterwards enjoyed good health until the morning of August 26th, 1909. That morning, about 8.30, when taking his breakfast, he had been seized with a sudden pain in the upper part of the abdomen on the left side, and had felt sick. He had not, however, vomited. Feeling himself that his symptoms were something like those which he had experienced at the time of perforation of the gastric ulcer, he immediately sent for Dr. A. S. Currie, who, recognizing the serious nature of the man's symptoms, requested an immediate consultation with a surgeon. When first seen by Dr. Currie there was comparatively little dullness in the region of the stomach towards the left, where most of the pain was, but by 11.30, three hours after the commencement of symptoms, a dull area was evidently spreading from this spot, and from the great tenderness which existed down the left side of the abdomen and the rigidity of the left rectus it was considered that fluid was gradually escaping and diffusing itself along this side of the abdomen towards the pelvis. It was diagnosed at this consultation that the patient had a perforated jejunal ulcer, because there was a definite history of stomach operations which could only be accounted for on the supposition that the man had undergone a gastro-jejunostomy on the second occasion. He was removed to a surgical home as soon as possible, and operation performed at 1 o'clock. Dr. Currie administered chloroform, and incision was made through the left rectus muscle. There was some free fluid, thin and without odour, in the left side of the abdomen, running down to the pelvis. A perforation was found at the junction of a coil of intestine with the anterior wall of the stomach, being on the jejunal portion of the junction. There was induration round the perforation, and the coil of intestine which came up to the stomach and formed the loop was a good deal distended and much congested. The opening itself was comparatively small, and was only defined on pressure of the intestine so as to force gas bubbles through it. It was closed with silk Lembert sutures, the left side of the abdomen thoroughly cleansed, some fluid mopped from the pelvis, and the wound in the abdominal wall closed without drainage. The patient made a good recovery, only complicated by a moderate amount of bronchitis.

The amount of fluid free in the peritoneal cavity was comparatively small and of a greenish colour without odour, but gave definite evidence of its presence and diffusion, first by the area which was dull on percussion and the rapid increase of this area as the fluid gravitated towards the pelvis, and secondly by the sharp superficial tenderness which accompanied its spread and indicated its irritating character. The jejunum had been sutured to the lower border of the stomach—and the loop of gut had been joined laterally by some method of entero-anastomosis.

The stomach towards the pylorus was lost in somewhat dense adhesions of long standing. No lymph was found on the stomach or intestine, but the operation was performed under five hours after the onset of the acute symptoms and the perforation was a small one.

The anaesthetic was well borne; during the operation the condition of the patient caused no anxiety, whilst I had the additional advantage of the assistance of Dr. C. Wheen.

In the three other instances of perforation of simple ulcer of the jejunum² on which I have been called to operate the ulcers were on the efferent branch of the intestinal loop of attached bowel. In one the ulcer was not far from the junction ($\frac{3}{4}$ in.), but in all of them the perforation was clearly punched out, and well defined. In this instance the ulcer was situated at the gastro-jejunal junction, and the amount of thickening of the base suggested that the process of ulceration had been a chronic one, in spite of the absence of symptoms preceding the perforation. This perforation was not clearly defined, nor was it in any way punched out. It is interesting, therefore, to note the association of the entero-anastomosis with the anterior gastro-jejunostomy, for the bile and pancreatic secretions would thus pass down the digestive tract without going round by the junction where the ulceration developed. It resembled the more common form of gastric ulcer, whilst the others could not be distinguished from some perforations found, and successfully operated on, in other parts of the smaller gut when typhoid fever³ was present. Similar ulcers have also been met with when there was no evidence of previous operation or of intercurrent disease, as in the most interesting and highly successful cases brought before the Medical Society of London last year by Mr. H. Lett.⁴

These ulcers are so rare after the posterior operations of gastro-enterostomy, that they are likely to become extinct in surgical practice. The posterior "no loop" operation of the Mayos is accepted as the ordinary routine operation excepting when the conditions calling for gastro-enterostomy do not permit of it.

REFERENCES.

¹ Maylard, *Lancet*, 1910, vol. i, p. 497. ² *Lancet*, 1906, vol. i, p. 276. Paterson, *Trans. Roy. Soc. Med., Surgical Section*, June, 1909. ³ H. Mackenzie, *Lancet*, 1903, vol. ii, p. 863. ⁴ *Lancet*, 1909, vol. ii, p. 1143.

RECURRING JAUNDICE IN MOTHER AND INFANT.

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DR. ROLLESTON'S interesting case of jaundice recurring in mother and infants in four successive pregnancies (*JOURNAL*, April 9th, p. 864) recalled to my mind a similar case which occurred in my own practice:

Mrs. H., aged 26, after two normal pregnancies had a bad miscarriage. During the latter part of her next pregnancy she became slightly jaundiced and at the onset of labour very deeply so. The jaundice lasted for about a fortnight after confinement. The child was ill developed, and became jaundiced on the second day, and remained markedly yellow up to its death, four weeks later. The mother's milk was of a bright orange colour, so she only nursed the child for one day.

In her next (fourth) pregnancy a similar sequence of events occurred. This time, however, the child was so weakly that she felt obliged to feed it at the breast, although the milk was again of the same orange colour. The child became jaundiced, and died on the eleventh day.

In her next (fifth) pregnancy the same conditions recurred, but this time the child was much better developed, and she did not feed it by the breast at all as the milk was again of the same colour. The child became jaundiced, but lost its yellow colour at the end of a fortnight. It did not, however, thrive, and died after ten weeks. It suffered towards the end from otorrhoea with some obscure cerebral symptoms.

In her next (sixth) pregnancy she again became jaundiced about a month before her confinement, but this time the jaundice disappeared ten days before delivery. The child, however, became jaundiced on the second day. The mother's milk was again of the same orange colour, although she herself did not appear to be at all jaundiced. The child was never put to the breast, but was at first very weakly, and at 2 years suffered from otorrhoea, which I am told has persisted more or less up to the present time. The boy is now 18, and in other ways fairly healthy.

In her seventh pregnancy she became jaundiced to a slight extent about a fortnight before her confinement, but the yellow colour had disappeared before delivery. The milk, however, was as yellow as on the previous occasions. The child did not become jaundiced, was not put to the breast, but died from diarrhoea (which seems to have been of the usual summer type) at the age of 5 weeks.

In her eighth pregnancy she was not at all jaundiced, but the child was stillborn.

Her ninth pregnancy was normal and the child was healthy, but a few years later died from measles.

Her last (tenth) pregnancy was normal in every way, and the child, now aged 10, is healthy.

Here there seems to have been a definite relationship between the extent of the jaundice in the mother and the jaundice and feeble health of the child. Again, it does not seem to have made any material difference to the child's condition whether it was fed with the jaundiced milk or not. The extreme orange colour of the milk, even when the mother's skin was free from discoloration, is rather remarkable.

I came to the conclusion at the time that the condition was an infective one, and that the child was infected *in utero* and not from the milk.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TRAUMATIC ASPHYXIA.

ON April 4th, 1910, whilst H. J., aged 50, was working in a seam 24 to 28 in. in height, he ceased hewing, turned round, and reached for some timber, when a stone 6½ ft. in length, 2½ ft. in width, 1½ ft. to 2 ft. in thickness, estimated weight 1 ton, slipped from the roof and pinned him prone on the small coal on the bottom. According to his mate, working in close proximity, his only exclamation was "Oh, dear!" Liberation of the body was a task of considerable difficulty, as the stone was lying on his back, leaving head, neck, shoulders, arms, and one leg and foot free.

Inspection of the body about three hours afterwards revealed: (1) Numerous indentations (pittings), interspersed with bluish-purple discolorations, of the skin of the thorax and epigastrium, due to the pressure of corners of small coals under superincumbent weight of stone on the body. (2) Suffusion (a) of the skin of the front and sides of the face, neck, and upper part of the thorax, of rose-purple tint; and (b) of the skin of the back of the neck and head, of a bluish-purple hue. The mucosa of the lips and gums also showed a rose-purple suffusion. (3) No indications of fracture or any injury in head, trunk, or limbs.

Durham.

JOHN H. R. GARSON, M.B., D.P.H.

SPONTANEOUS PASSAGE OF GALL STONE.

A PATIENT, aged 69, had been under observation from time to time with gastric symptoms without local evidence of tumour to suggest malignant disease. His last illness was

Photograph of stone, natural size: Length, 2½ in.; breadth, 1½ in.

a typical attack of gall stones, with marked tumour. He was seen by Mr. Openshaw, who advised operation. Before this could take place acute haematemesis, melæna, and collapse set in, and the operation for the time being could not be done. Large doses of morphine with atropine were administered hypodermically, with the result that the patient rallied for a day or two, and the tumour vanished. Symptoms of acute obstruction set in, again with collapse. With almost poisonous doses of atropine, followed up by enemata and castor-oil, the patient passed the stone, and after a fortnight's convalescence went to Bournemouth to recuperate.

Hornsey.

AMB. ATKINSON.

UNDER the will of the late Mr. Samuel Leeming Haldane, a partner in a firm of Hull steamer trawlers, the Hull Royal Infirmary receives a legacy of £5,000 and the Hull and Sculcoates Dispensary a sum of £1,000.

CARDIAC LESIONS RESULTING FROM ACUTE RHEUMATISM.

IN examining candidates for life insurance policies how frequently, owing to lesions discovered by auscultation, does one have to put the question, "When did you have rheumatic fever?" This fact has often caused me to ask whether we are, as a rule, treating acute rheumatism on really correct lines. Statistics, I believe, prove that the mortality in this disease is only 1 per 1,000. We have, therefore, not a fatal termination to fear, but do we in treatment recognize the very large percentage of cases (called cured) in which lesions are left which prove fatal in many cases, and in others cause endless pain, fear, misery, and shorten life? Looking these things fairly in the face, I think we cannot but look upon acute rheumatism as one of the most important and serious diseases that flesh is heir to.

I need not enumerate the various remedies in use, but I believe it has been proved that (1) the lactic acid circulating in the blood, whether from an excessive secretion of it, or from a decrease in elimination of a normal amount, due to liver inaction, "does not deposit itself in the white fibrous tissue (its special affinity) on the valves of the heart, while all the excretions of the body have an alkaline reaction"; (2) if the valves of the heart do become affected they do so during the first ten days of the disease. Acting on this I some years ago treated a number of cases on plain common sense lines. To neutralize existing acid in the blood I simply gave 3ss doses of potassium bicarbonate, freely diluted, every four hours. To eliminate the acid and keep the liver acting, I gave 3 grains of mercury subchloride two or three times a week for the first ten or twelve days. Of course, it is a great advantage to begin with a case at its commencement. A nourishing, easily-digested diet; sedatives, tonics, and local applications to relieve pain, if and when necessary.

Whether my tried cases were accidental I know not, but I saw them all afterwards at different periods, and I can say that any one of them might have applied for a life policy without being asked, "When did you have rheumatic fever?"

Farningham, Kent.

W. HENRY HARRIS.

Reports

ON

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

BRADFORD ROYAL INFIRMARY.

FURULENT MENINGITIS SECONDARY TO A LATENT APPENDIX ABSCESS.

(By SYDNEY HARTILL, B.M., B.Ch.Oxon., House-Physician).

A BOY, aged 8 years, was admitted on January 28th, 1910, in a semiconscious condition. The history (obtained from the mother) was that the child was quite well until January 21st, when, on arriving home from school, he complained of pain in the left knee. There was no redness or swelling, and the pain passed off in a few hours.

He remained apparently well until January 24th, when he complained of a severe headache, and stayed away from school. The headache became worse, and on January 26th he appeared to be drowsy, and shouted out when touched. From January 26th to 28th he gradually became more drowsy, and his general condition appeared to be worse. As far as the mother knew he never complained of pain in the abdomen. The bowels were regular and stools normal. There was nothing of note in the past or family histories.

When admitted at 4 p.m. his temperature was 103°, pulse 88, respirations 36. He was conscious, but very drowsy, cried out when touched, and strongly objected to being disturbed. The head was slightly retracted, and there was some stiffness of the muscles at the back of the neck. Tache cérébrale was marked. The pupils, moderately dilated and equal, reacted naturally. The discs were a little swollen, and the veins dilated. The mouth was covered with sordes, the lungs and heart were