THREE CASES OF ACUTE PERFORATION OF DUODENAL ULCER: LAPAROTOMY: RECOVERY.

BY

E. HUNTLEY, B.S.LOND., CAPTAIN R.A.M.C.(T.C.),
SURGICAL SPECIALIST, MILITARY HOSPITAL, TIDWORTH,
SALISBURY PLAIN.

THE notes of these cases illustrate the importance of early operation to secure a successful issue.

CASE I.

B. M., aged 32, a private A.I.F., was brought into hospital in the early hours of the morning of October 13th, 1919, cold and collapsed; he vomited some coffee-grounds fluid as he was being put to bed. He gave a history of being first taken ill with pains in the upper part of the abdomen on October 6th, and being sick once or twice. The pains came on worse two to three hours after taking food. He reported sick on October 7th, and was given a "dose of medicine." On October 8th he felt better, but vomited several times during the day, the vomiting relieving the pain in the epigastric region. He seems to have dragged about until the evening of October 12th, when he had a sudden acute pain just above the umbilicus, to the right of the middle line, and was very sick. On admission the whole abdomen was very hard and rigid, and abdominal respiratory movements were absent. There was acute tenderness above the umbilicus, distinctly greater towards the right of the middle line. There was no distension of the abdomen. Liver dullness was absent.

He was prepared for operation, and as soon as possible laparotomy was performed through the right rectus muscle. Immediately on opening the peritoneum gas escaped, as well as a certain amount of bile-stained fluid. The perforation was soon found in the first part of the duodenum, on its anterior aspect, through which gas and fluid were escaping. As much fluid as possible was mopped out of the right kidney pouch of the peritoneum and the perforation closed, a small tag of omentum being sutured immediately over the opening to strengthen the closure. A wick drainage tube was placed in the right kidney pouch and the incision closed. A second opening was made in the middle line, below the umbilicus, and a considerable quantity of thick bile-stained fluid was mopped out of the pelvis, into which a second wick drain was passed and the incision closed. This ulcer was found to be of quite recent origin, there being no marked hardness of its edges and very little recent lymph about.

This patient made an uninterrupted recovery; he did not vomit once after the operation down to his departure to a convalescent home on November 21st, 1919.

CASE II.

C. T. W., aged 22, a bombardier in R.F.A., was admitted to hospital on the evening of November 27th, 1919, in a mildly collapsed condition with pain in the upper part of the abdomen. He gave a history of having had "indigestion pains" of a gripping nature for a week, but with no vomiting. He had taken aperient medicine which had acted. The pains were worse about four hours after food. On the morning of November 27th, 1919, they became suddenly more severe, and he reported sick. Marked rigidity of the whole abdominal wall was found with tenderness above and to the right of the middle line. During the examination he vomited some thin greenish fluid. There was no distension of the abdomen, but the liver dullness was absent.

Laparotomy was performed the same evening, but only after some delay, owing to patient refusing operation, as he said he did not feel ill enough and would give permission, if necessary, in the morning after he had had a good sleep. An incision was made through the right rectus muscle; on opening the peritoneum, gas escaped and a large quantity of fluid had to be mopped out of the right kidney pouch and elsewhere before any perforation could be found. It was seen to be situated at the junction of the first and second portions of the duodenum. There was much recent lymph about and the ulcer was hard edged and difficult to get at, partly owing to its position and partly to bile-stained fluid constantly welling up through the perforation. After closing this and soaking up as much fluid as possible in the right pouch and pelvis, both these regions were drained with wick drainage tubes and the incisions closed. A very large quantity of fluid had gravitated into the pelvis in this case.

The patient was very troubled for several days following the operation with vomiting and distension. Once the bowels had acted, however, he progressed quite happily, and was discharged from hospital on December 31st, 1919, to convalesce.

CASE III.

J. B., aged 34, a gunner, R.G.A., was brought into hospital at about 6 p.m. on January 17th, 1920. He stated that he had abdominal discomfort for three weeks, with pain, a feeling of nausea, distension above the level of the umbilicus, and occasional attacks of vomiting. The pain was worse several hours after food. He was able to carry on his duties until the morning of January 17th, 1920, when he was seized with violent pain about the epigastric region whilst he was sweeping out his hut. He vomited and went to lie down. The pains got worse, and he began to feel ill and reported sick. On examina-

tion the abdominal wall was very rigid all over, with considerable tenderness in the epigastrium almost directly in the middle line. There was decided distension of the abdomen, with dullness marked towards the right loin. The liver dullness was completely absent. He vomited some greenish fluid.

As soon as the patient could be got ready laparotomy was performed through the right rectus muscle above the level of the umbilicus. When the peritoneum was opened gas escaped, followed by a large quantity of thickish green fluid, which welled up from the right kidney pouch as well as from the lower part of the abdomen. The ulcer was soon found in the first part of the duodenum and closed. It was of recent origin, the edges being free from hardness, and hardly any lymph was about except on the liver and omentum. Both the right kidney pouch and the pelvis were drained as in the other cases.

Except for some slight suppuration at the upper end of the main incision, this patient recovered extremely well, considering the history he volunteered of a profound liking for alcohol. He is now quite convalescent.

The recovery of these three patients was, in my opinion, largely due to the great care and skill bestowed on them by the nursing staff, to whom I am greatly indebted.

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PAPILLIFEROUS CARCINOMA OF THE THYROID GLAND.

BY

BASIL HUGHES, D.S.O., M.A., M.B., B.Ch.CAMB.,
B.Sc.LOND., F.R.C.S.

ASSISTANT HONORARY SURGEON, CHILDREN'S HOSPITAL, BRADFORD;
PATHOLOGIST, ROYAL INFIRMARY, BRADFORD.

PAPILLIFEROUS CARCINOMA is uncommon at any age, and must be extremely rare in a child of 13. It presents also certain clinical features of importance in prognosis to which attention may be called.

C. S., a girl aged 13, was seen first at the out-patient department of the Bradford Children's Hospital in October, 1918. Her mother stated that three years earlier a swelling appeared in the middle line of the neck; for ten months it had been noticed that not only was the swelling getting bigger but that additional swellings had appeared on the right side of the neck, and these had grown larger. There had been no pain, cough, dyspnoea, change in the voice, or difficulty in swallowing, and no loss of weight.

Examination showed a tumour confined to the right half of the thyroid gland, moving on deglutition, but adherent to the trachea. It appeared to surround the carotid sheath rather than displace it. It was peculiarly hard and knobby to the touch, and was wholly above the sternum. In addition there were three large easily movable and discrete lymphatic glands in the right side of the neck. The pupils were equal, and the vocal cords moved normally.

The patient was admitted to hospital and the enlarged lymphatic glands were removed without difficulty, as they shelled out with the greatest ease. Sections examined microscopically were remarkable in that there was no trace of any true lymphatic tissue to be seen, the whole gland substance being replaced by metastases from the primary growth in the thyroid gland.

A month later the right lobe of the thyroid gland was removed through a transverse incision. This procedure was more difficult as the growth was firmly adherent to the trachea and carotid sheath. The superior thyroid artery was first secured and ligatured, and the tumour was then attacked from below. With difficulty it was separated from the trachea and carotid sheath; during the process some of the contents of the tumour escaped. The whole area of operation was well protected with sterile gauze so that soiling of the wound was prevented. Branches of the inferior thyroid artery were ligatured as they were divided and the recurrent laryngeal nerve was carefully preserved. The resection completed, the wound was approximated with buried catgut sutures and the skin brought together with a subcutaneous stitch of fishing gut. Drainage was not employed. The wound healed by first intention and the subcutaneous stitch was removed on the sixth day.

Microscopical examination of the tumour showed it to be identical in structure with that in the lymphatic glands—that is, it was a true papilliferous carcinoma. The tumour itself was hard to the touch and contained on its surface numerous dark-coloured irregularities resembling cysts into which haemorrhage had occurred. On opening these a sanious fluid escaped, and slight pressure caused the exudation from them of a yellowish caseous material, which proved to be intracystic papilliferous growth. This was the naked eye structure of the tumour throughout, and in it no normal thyroid tissue appeared to exist. It was evidently these tense cystic structures that gave the knobby, irregular feel to the tumour.

In places where the tumour was firmly adherent to the trachea and carotid sheath this seemed to have come about in the following way. The cyst wall had ruptured and the papilliferous growth had directly grafted itself on to these structures.