INTESTINAL OBSTRUCTION DUE TO A COIL OF WORMS.

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HAVING read with much interest Mr. Edward Deanesly's interesting paper on intestinal obstruction, in the JOURNAL of November 29th, I should like to record a case which occurred in my practice some twelve months ago.

I was called one morning to see a young married woman who had been taken ill the previous day. The local nurse told me that the patient was taken ill suddenly with severe abdominal pain and vomiting. I was at once struck by the distressed aspect she presented, an aspect commonly seen in abdominal cases. The pulse was quiet and the temperature normal. On exposing the abdomen I found she was in the sixth month of pregnancy and abnormally distended. I made a vaginal examination, but found no sign that labour had set in. I then examined the abdomen carefully, and was satisfied that there was abnormal distension. The vomit was bile-stained, and later became very unpleasant, bordering on faecal. I decided to give an enema, partly for diagnostic purposes. It was very carefully given, the patient lying with the head low; some three and a half pints were injected slowly, but with no result.

When I called again in the evening I found no change. I gave another enema containing turpentine, but there was again no result—not even flatus being passed. The vomiting was still continuous. I gave orders to allow the patient tepid water; this acted as a natural lavage, for next morning the vomiting was not so frequent. The nurse now showed me a large round worm which had been vomited just previous to my coming. It occurred to me that possibly I had to do with some obstruction caused by worms. So I gave *santonin* gr. 5 in castor oil. Much to my surprise this was well retained. Later, during a severe bout of vomiting, a large mass was ejected from the stomach, which on examination proved to be a coil of some twelve large worms. The vomiting ceased, and the patient's aspect altered very markedly. In the course of a few hours she complained of severe pains, which were reflected to the back. This led me to make another vaginal examination, and this time I found the os partly dilated and labour progressing. In due time she was delivered of a six months fetus, dead (breech presentation). The bowels soon after moved naturally, and she made a good recovery.

In this case the abdominal signs were masked by the pregnant uterus, which made diagnosis difficult, but taking the usual signs and symptoms in order we can see to what extent they helped. The pain was due no doubt to the colic of peristalsis, intermittent and general over the abdomen. Distension was difficult to determine, but the patient complained of it, and it was certainly noticeable in the upper abdomen. Muscular rigidity was not noticed, owing to the pregnant uterus. The pulse-rate, normal at first, later rose to 100. The temperature was normal. Vomiting was very persistent, any food taken being rejected at once. Constipation was absolute.

The diagnosis seemed to lie between constipation and intestinal obstruction. The three signs—pain, vomiting, and absolute constipation—seemed to point to the latter. Distension, a valuable sign, was in this case of little aid.

The interesting points in this case were: The difficulty of making an accurate diagnosis, the unusual cause, and the unusual termination.

The *Ascaris lumbricoides* is credited with extraordinary migrations. Gould and Pyle, in their *Anomalies and Curiosities of Medicine*, quote instances of round worms piercing the intestine, being found in the bladder and urine, as escaping through the umbilicus, as present in the biliary passages and in the middle ear. Morland mentions exit through the mouth. Holt, in his *Diseases of Childhood*, says, "When very numerous they coil up and form large masses, which may cause intestinal obstruction," but such cases must be very rare.

Another point of interest is the action of *santonin*. It is said, as well as acting on the worms, to cause convulsive movements in the intestine. As there was in this case some severe peristalsis, we can see how the drug helped. Whitla, in his *Materia Medica*, says Chéron lauded the drug in dysmenorrhoea; whether it acted as an emmenagogue one would not care to say, but labour set in in this case. I cannot quite agree that intestinal obstruction is of necessity always a case for the surgeon. In my particular case an operation would have been badly borne, owing to the pregnancy. Recently I had the pleasure of hearing Mr. Crisp English speak at the Devon and Exeter Hospital on abdominal pain, and I was greatly struck by his appreciation of the physician in abdominal diagnosis and treatment. Though not in the smallest degree minimizing the importance of the surgeon or physician in consultative

work, I feel sure many will agree with me when I say the ideal consultant at first would be an experienced general practitioner, and that it should be left to him to determine whether the case was for one specialist or another. The surgeon's advice often is to operate early. The physician says, "Wait and see." What is required is a mean between the two. In conclusion, I may say I have seen two cases of intestinal obstruction in connexion with pregnancy, but the case here described must be rare, hence my apology for entering into so many details.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

NYSTAGMUS.

DR. WILSON's statement in the JOURNAL of November 22nd, that the movements of the eyes in his two cases of miner's nystagmus were concomitant, induced me to verify his observations.

Last week I examined 26 cases of miner's nystagmus in various stages, and found that nystagmus was present, or easily produced, in 13. In all of these 13 the movements were concomitant. I found Dr. Wilson's suggestion for the use of prisms most useful.

It is interesting to note further that one man was unaware of the movements of his eyes; he had no other signs or symptoms of the affection, but was doing full work at the coal face. At some future date he will probably be told by a junior house-surgeon that he has miner's nystagmus, and will claim compensation, obtaining a list of typical symptoms from his friends.

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THE INDUCTION OF ARTIFICIAL PNEUMOTHORAX.

THE OPERATION FOR INDUCING ARTIFICIAL PNEUMOTHORAX.

WE read with great interest Dr. H. de C. Woodcock's paper on this subject in your issue of October 25th, on pages 1055 and 1056, and beg to offer the following comments on his paper:

1. The list of great Continental authorities on artificial pneumothorax is hardly adequate; it should include, amongst others, Kornmann, von Müralt, and Egbert Morland, all of whom advocate the puncture method, and have devised their own modifications of apparatus for that purpose.

2. It is important to emphasize the value of taking an x-ray negative and examining the chest on the fluorescent screen before proceeding to the actual filling.

3. As regards the preparation of the skin, we consider it sufficient to paint it with iodine, and we omit shaving, scrubbing with an antiseptic, and washing with saline, and so far we have had no evidence of sepsis to induce us to adopt a more complicated and, we think, unnecessary procedure.

4. The site of operation is all-important; it is essential, in order to avoid multiple punctures or failure to convert the potential pleural space into an actual one, that the needle should be entered at a spot where the clinical indications and x-ray findings suggest freedom from pleural adhesions. Hence it is best to puncture over supposedly healthy lung if possible. The actual site varies in each patient.

5. We consider that a local anaesthetic is unnecessary, as any shock that occurs probably originates from the nerves in the parietal or possibly also in the visceral pleura, and Dr. Woodcock apparently does not attempt to anaesthetize these. If it should be necessary to make multiple punctures on account of pleural adhesions preventing the needle from entering the pleural cavity, the additional time spent in securing local anaesthesia adds considerably to the length of the procedure for a very hypothetical benefit.

6. We recommend the needles originated by Professor Saugman, which are only 5 cm. long, and can be guarded to within any desired distance from their point by a movable stop. We usually fix the stop at a distance of 2½ cm. from the point, and increase that distance if