A COMPLICATED CASE OF APPENDICITIS.

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Of all the surgical diseases there are few, if any, which present the same constant similarity of symptoms, which result in so many different pathological changes, and lead to such a variety of complications as acute appendicitis. The following is an illustration:

Miss Z., a school teacher, aged 23, had been for several months failing in health, losing flesh, anaemic, suffering from some vague abdominal pains, and from an offensive vaginal discharge. When seen with Dr. Syfret, of Mowbray, her medical attendant, she had been ill for five days, presenting all the classical symptoms of acute appendicitis. The case was urgent, and immediate surgical interference suggested, but as her physician thought that there were signs of improvement, and because she was in a very septic condition and her parents wished for delay we agreed to wait. Two days later, the symptoms getting worse, she was operated upon. Inside the peritoneal cavity coils of small intestines were seen glued together, and on dealing with these a sac was opened containing a good deal of pus, and on a higher level another cavity was entered and more offensive pus let out. As the appendix could not be felt, the caecum firmly anchored down, and the patient's condition septic, nothing further was done; the sacs were cleaned with gauze and drained with split tubes. The immediate results were satisfactory. The drainage tubes were removed on the tenth day, the discharge having stopped. The wound looked very unhealthy.

On the fifteenth day the temperature began to rise and the abdomen to swell, but there were no special pains. This condition lasted a fortnight, and she was then operated on again. The delay in operating was due to the unhealthy condition of the wound, the greater part being covered with grey sloughs. To try to asepticize this was almost an impossibility. The wound was painted with tincture of iodine and covered over with sterilized plaster, and the skin sterilized in the best way possible. The new incision was made outside the former one so as to enable one to work from without inward. The caecum was fixed and adherent to the lateral wall and not covered by peritoneum. Carefully dissecting always inward, a grooved cavity was reached, and in it a faecal concretion the size of a hazel nut found; no appendix could be seen, but low down in the pelvis the end of the appendix was felt adhering to the right tube or to the uterus; I could not tell which, for whilst attempting to solve this question the appendix gave way. From the terminal end to its origin the appendix was pocketed in a mass of adhesions. The appendix was then dissected upward, leaving in some places its peritoneal covering behind. I could not find any trace of its mesenteriole. The pocket was cleaned out and the external wound sewn up without drainage. The appendix was large and ruptured in two places—at its end and a little higher up where the adhesion had taken place and where the concretion had escaped. The wound healed by first intention, but the first wound remained very unhealthy.

A week after this last operation the temperature began to rise and the lower part of the abdomen to swell, and in addition to this there was some indefinite pain in the right renal region. The abdominal cavity was then reopened by an incision through the right rectus extending for 6 in. above the umbilicus. Every inch of the abdominal cavity was explored by touch and by sight whenever possible. Nothing could be found to explain the cause of these symptoms. The liver appeared to be normal; the right renal pouch gave no indication of mischief; bowels and stomach were healthy, and the spleen and pelvic organs were normal. The needle of an aspirator was introduced in three directions: (1) into the liver; (2) between the ninth and tenth ribs posteriorly, aiming at the subphrenic space through the diaphragm; and (3) through the fifth and sixth ribs into the pleura. The two first explorations aspirated pure blood, the last pleuritic fluid. The abdominal wound was sewn up and healed by first intention. The symptoms then became distinctly hectic, with steeple temperature and profuse perspirations. The pulse was rapid and small, and at this time she complained of slight pain and discomfort about the suprahepatic region. A careful examination gave no indication of mischief in the right chest.

Four days later a small abscess appeared at the site of the diaphragmatic puncture. The abscess was opened and a small quantity of pus let out. Two hypodermic injections of antitoxin were given with no obvious result. A much larger abscess formed at the same place as the other; this was opened under cocaine, and a large quantity of dark offensive pus escaped; a small drainage tube was introduced. The first wound still looked very unhealthy. The patient, who was very weak and hectic, was suddenly seized with a violent cough, became breathless, and brought up pus and blood; an injection of morphine relieved somewhat the severity of these symptoms, leaving her exhausted and restless. At that stage some small crepitation and dullness was heard at the right base, and from the nipple upwards drum-like resonance and other signs of pneumothorax. Twenty-four hours after the first attack she

had another but milder one. She was then without delay put under anaesthesia, laid on her left side, and the abscess opened along the drainage tube. During the operation respiration was very bad; the face and hands almost black, and mucus and pus escaped through the mouth. Part of the ninth rib was resected, the bone was denuded of periosteum. The diaphragm could be seen pushing the pleura upwards. A sinus forceps was pushed through the muscle and some pus escaped; a pair of dressing forceps was then introduced and opened, giving vent to a large quantity of dark-coloured, offensive pus. Two large rubber drainage tubes were introduced into a cavity measuring about 3 in. in depth and kept in position, one by a catgut, the other by a silkworm, stitch. From that time all bad symptoms rapidly abated and disappeared; the cough ceased, and all pulmonary trouble left her. The catgut drain was removed after four days, the silkworm at the end of ten days. It is now six months since the last operation was performed, and she is in perfect health.

This case illustrates well my point that whilst ordinarily it is easy enough to diagnose inflammation of the appendix, it is impossible to foretell what you are going to find and what complications will have to be met.

The case has many points of special interest. The adhesions of the appendix to the tube, the disappearance of the offensive vaginal discharge after the operation, together with abdominal pains and failing health, point to the probability of chronic appendicitis leading to adhesion of the appendix to the right Fallopian tube, and subsequent rupture and discharge into it. Mr. Bland-Sutton lately described this condition well in the *BRITISH MEDICAL JOURNAL*.

The second point of interest is the double rupture. It is clear that the one at the apex of the appendix occurred first, and that the second, which brought on the acute attack, was caused by the pressure of the large faecal concretion, leading to gangrene of that part and rupture. Judging from the pathological conditions found at the first operation—the adherent and uncovered caecum—the tendency of the septic tract would have been to infect the right renal pouch, as indeed was suspected at first. The infection in this case must have been conveyed by means of lymphatics.

It was very fortunate for all that pus found its way through the aperture made by the aspirating needle, which made the last operation so much easier and shorter. But above all is the wonderful power of recuperation of the patient, considering that she had been ill for a long period previously, and had to undergo four very severe operations whilst in a toxic condition, and taking further into consideration the last phase of the disease, the rupture into the lung of an abscess which contained matter most likely extremely septic, causing severe shock, pneumothorax, and pulmonary infection.

THE IMPORTANCE OF THE COLON,

AS SHOWN BY A CASE OF ULCERATIVE COLITIS TREATED BY OPERATION.

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In an address entitled *Clinical Remarks Round About Constipation*, delivered by Dr. J. F. Goodhart on October 15th, 1902, and subsequently published by him, the following words occur: "I would not mind arguing the point with any one that the colon is the most important organ in the body." On the other hand, Metchnikoff in *The Nature of Man*, quoted by Sir James Barr in the *BRITISH MEDICAL JOURNAL* of January 20th, 1906, says: "Some very large parts of our alimentary canal must be regarded as useless inheritances, bequeathed to us by our animal ancestors. It is no longer rash to say that not only the rudimentary appendage and the caecum, but the whole of the large intestine, are superfluous, and that their removal would be attended with happy results." I think it will be admitted that the history of the case now related goes to show that, of these two entirely contradictory opinions, that of the English physician is the most worthy of acceptance.

The patient will probably be remembered by those members of the Medical Society of London who were present at a clinical evening on November 11th, 1901, as he very kindly showed himself on that occasion. He was 52 years of age when he first came under my care in 1897,