A CLINICAL DEMONSTRATION ON A CASE OF RHEUMATIC PERITYPHLITIS.

Given in King's College Hospital.

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GENTLEMEN,—The case before you I am justified in calling, as you will see when I have related to you its history, a case of rheumatic perityphlitis. Rheumatic affections of the peritoneum are believed to be exceedingly rare, but we shall discuss that point with more interest after I have given you an account of the history and course of this case.

I will outline on the patient's abdomen the region to which our attention is now to be especially directed—namely, the right iliac region and the adjacent part of the right lumbar region. In this region, as you know, we have the cæcum and the commencement of the ascending colon and the termination of the small intestine at the ileo-cæcal valve; and there is also here another very important structure, and one claiming great consideration in connection with the occurrence of evidences of disease in this locality, and that is the vermiform appendix, which usually lies closely applied to the cæcum. Let me also remind you that the cæcum is almost invariably entirely surrounded by peritoneum.

Since in inflammatory affections in this region, and particularly in the grave and fatal forms, the appendix is usually found *post mortem* to have been the structure especially involved, and in which the malady originated, those who are prone to read the history of disease backwards—and there is much to be said on behalf of this mode of reading—are disposed to regard nearly all inflammations arising in the right iliac region as primarily dependent on appendicitis; and you must always be on the alert, when you have to deal with such attacks, and bear in mind that local suppurative inflammation in, or connected with, the appendix is a very common cause of the troubles that arise in this locality. But the case I am now showing you proves as clearly as possible that clinically we may have a true perityphlitis without any necessary involvement of the appendix.

Our patient is a young girl 18 years of age, who was admitted into the Todd Ward on April 16th. Her previous history may be related in a very few words. She had been attending for about a fortnight as an out-patient, complaining of anæmia and menstrual irregularity, and of pain in the head and in the elbows and knees. She had had an attack of acute rheumatism last November.

The present attack began four days before her admission, with stabbing pains in the right iliac region spreading into the adjacent part of the right lumbar region. She vomited several times and, indeed, whenever she took solid food, and her bowels were constipated. Two days before her admission she felt giddy and was obliged to leave her work (wig making). She was still inclined to vomit after taking solids, but she could retain liquid food. She also felt pains in the arms and knees.

On admission she was still complaining of pains in the right iliac and lumbar regions. There was entire loss of appetite. She was constipated, and her tongue was large and flabby and thickly furred with a moist dirty covering, and her breath was offensive. Examination of her abdomen revealed no general distension or tenderness, but over the right iliac region and just above in the lumbar region there was much tenderness on pressure; there was also great rigidity of the abdominal walls over the situation of the cæcum and the first part of the ascending colon. This part of the abdomen was hard, tense and resisting, and felt pun- gently hot to the touch. We could not, however, distinguish any distinct local tumour or bulging, nor any notable dul- ness on percussion.

There was no evidence at this time of any pain or swelling of any of her joints, but there was a loud systolic murmur

audible over the pulmonary area, which was referred to the previous anæmia, and there was a softer systolic murmur heard over the cardiac apex. The pulse was 84 and rather full. The urine was of normal aspect, its density 1022, free from albumen and with no deposit of lithates.

Her temperature the evening of her admission was 102.8° (a dose of castor oil had been given her, and she had passed a fluid motion). The next day it fell a degree or more, but on the following day (18th) it rose in the evening to 105°, and the pulse to 124. She was then suffering from much local tenderness in the right iliac region, and especially when pressure was made over the first part of the ascending colon behind, in the lumbar region.

On the 19th the temperature was still high (104° to 105°), and the enemata (she was given a large enema of warm water, containing a little bicarbonate of soda in solution twice a-day) brought away a number of small, dark, hard faecal masses mixed with the fluid of the injection.

On the 20th some fulness as well as great hardness and resistance was noted in the right iliac region, and the superficial veins were unduly prominent. The enemata continued to bring away small hard masses as before. The tongue remained thickly coated and the mouth was foul, although an antiseptic mixture was being taken regularly. She now complained of some pain and tenderness over the right patella. For the next two days she was freer from pain, and the temperature oscillated between 100° and 103°, but on the 22nd she suddenly developed an acute arthritis of the joints of the right arm (shoulder, elbow, and wrist), and the temperature in the evening rose to 103.6°. At the same time, the systolic apex murmur became louder and more marked. When I saw her the next day, I ordered her 20 grains of sodium salicylate every three or four hours. She had hardly taken more than five or six doses before the arthritis entirely disappeared; but the salicylate had caused so much cardiac depression with an intermittent pulse, that Mr. Turner, our excellent and zealous house-physician, most properly at once stopped its administration, more especially as the joint affection was completely relieved. The temperature had fallen for two days below 102°. On the 26th, however, we noted that there was an increased feeling of fulness in the right iliac region, with much resistance and rigidity of the abdominal wall over this locality, and we were able to make out distinctly, on gently pressing the abdominal wall with the hand horizontally over the subjacent parts, a palpable creaking friction.

On the night of the 27th the temperature again rose rapidly, and on the 28th had reached 104.4°. When I visited the hospital on that day, Mr. Turner, who had watched the case most attentively with his usual zeal and interest, remarked to me on this return of high temperature and its possible significance, although the arthritis had completely disappeared; and, bearing in mind the predominating tendency to regard all inflammatory attacks in this region as probably connected with some suppurative affection of the appendix, we discussed the advisability of calling a surgical colleague into consultation, with the view of some possible operative exploration. I had, however, expressed my belief early in the case that this was an instance of perityphlitis independent of any affection of the appendix, the sudden occurrence of acute arthritis of the joints of the right arm, and its rapid disappearance under the influence of sodium salicylate and the history of a former attack of acute rheumatism suggested to me the possibility that this local peritonitis might be of rheumatic origin, so I again prescribed the sodium salicylate in 20-grain doses every three hours.

A glance at the temperature chart will show you the remarkably rapid effect, on the local peritonitis and the temperature, of this second administration of the salicylate. Within little more than twenty-four hours the temperature had fallen from 104.4° to below normal, and it has not risen since, although we had again to discontinue the salicylate after five or six doses, on account of the great cardiac depression and intermission of the pulse it produced. As the temperature fell the tongue began to clean rapidly, and the tenderness, hardness, and resistance in the right iliac region, as well as the palpable creaking, gradually disappeared, and the patient is now quite convalescent. She has had a few doses of sodium sulphate as an aperient, and her bowels now

act quite naturally. The cardiac apex murmur is only just distinguishable, but the murmur over the pulmonary area remains much the same.

Extremely rare though the occurrence is, there can be no doubt that this was a case of rheumatic perityphlitis. The intercurrent of rheumatic arthritis of the joints of the right arm, the previous history of acute rheumatism, the endocarditic murmur, the complete and rapid disappearance of the local symptoms, and the sudden fall of temperature on the administration of sodium salicylate, are facts which leave no room for doubting the rheumatic nature of this attack of local peritonitis.

All authorities agree in regarding rheumatic peritonitis as a rare affection. Fagge asserts that "rheumatism seldom or never affects the peritoneum." Bauer, in Zeimsen's *Cyclopædia of the Practice of Medicine*, says rheumatic peritonitis "is undoubtedly an exceedingly rare complication of acute articular rheumatism," but he adds that when it occurs it tends to run a very favourable course, as in this present instance. Professor R. Palmer Howard, in Pepper's *System of Practical Medicine*, observes: "I have but once met with acute peritonitis as a complication of acute rheumatism." He adds: "The immunity of this serous membrane from rheumatic inflammation is an inexplicable anomaly in view of the proclivity of the pericardium and pleura to that process."

Many French authorities, however, from Andral downwards, have recorded cases of rheumatic peritonitis and a valuable summary of these is to be found in the article on "Péritonites" in the *Dictionnaire Encyclopédique des Sciences Médicales*.¹ The authors of this article point out that the observations they have collected show that all degrees of rheumatic inflammation of the peritoneum may occur "from simple hyperæmia with very little exudation, to fibrinous, sero-fibrinous, purulent and hæmorrhagic exudations," and they insist that "in order that we should admit without reserve

the diagnosis of rheumatic peritonitis, it is necessary that there should be at the same time other manifestations, visceral or articular, of rheumatism," as we had in the case before us.

I will only add a few words with regard to the treatment that was pursued in this case. In the first place I will mention three courses which we avoided.

1. We did not purge this patient; it is true a single dose of castor oil was given her on her admission, but no other aperient was given until she was convalescent. In avoiding aperients we acted on the principle of keeping an inflamed part at rest. It is possible we may push this principle a little too far in certain cases, analogous to the one before us, and that an unirritating saline aperient might often be of service, but we can rarely be quite sure of this. What we did was to wash out the large intestine twice a day with copious warm water enemata, and we added a little bicarbonate of soda to this water to lessen its hardness and to increase its solvent and cleansing properties. At the same time we gave an intestinal antiseptic in the form of the eucharine mixture which you see me so often prescribe. Had we suspected at the onset of the attack that it was of rheumatic nature, salol would certainly have been the appropriate intestinal antiseptic to employ.

2. We avoided the internal use of opium. We applied opium locally, but we did not give any opium internally. There was no need to do so, although I find many practitioners, whenever they have a case of peritoneal inflammation to deal with, give opium as a matter of routine. I advise you not to do so. It may be necessary, in cases where there is very acute suffering, to give opium to allay it; but my experience is that the routine use of opium in these cases often retards recovery. It checks excretion and elimination at a time when the blood is often charged with pyrogenic toxins, and it aggravates the parietic condition of the intestinal walls. The local application of opium on linseed poultices or hot fomentations will often be found as effectual in relieving pain. I have discussed this question more fully in my *Manual of Medical Treatment*.

3. We did not apply an icebag—a very popular expedient now in treating inflammation of serous membranes. I am glad we did not, as we should probably have provoked some very undesirable metastasis.

Finally, let me call your attention to the remarkable action of the sodium salicylate in this case. We gave it first because of the appearance of acute arthritis of the joints of the right arm; a very few doses caused its complete subsidence. The extreme sensitiveness of the patient to this drug was shown by its depressing effect on the heart, so that we had to discontinue this remedy as soon as the arthritic symptoms were relieved. When we administered it a second time for the perityphlitis, when the temperature had again risen to over 104°, its action was even more striking, as will be apparent to you all on glancing at the temperature chart. The temperature came down with great rapidity as the other symptoms disappeared. Again, its use had soon to be suspended owing to the amount of cardiac depression it induced.

BEQUESTS AND DONATIONS.—At the monthly meeting of the Swansea General Hospital Committee, on June 7th, it was announced that someone who wished to be known as "a friend" has given, through Mrs. Ebenezer Davies, £1,300 for the endowment of a bed to be placed in the institution.

DR. CORNELIUS HERZ, the sick untried extradition prisoner, whose miserable ill-health has kept him at Bournemouth since December, 1892, has further changed in appearance, and has been distressed by almost hourly sickness since January last. Medicines afford him no appreciable relief; he never leaves his bed, and suffers from dangerous syncope if he rises from the recumbent position. Long deferred legal proceedings in France, which may, it is to be hoped, elucidate the situation, are at last promised, and may be in progress while the patient still lives, for with his inflexible determination he avows, even during his worst paroxysms, that he will never die while the stain is unremoved from his name. He rigidly follows the régime dictated by his diabetic condition, and cherishes the hope that summer weather will bring an amelioration of his condition.

¹ I am indebted to Mr. Treves for this reference.