DIVERTICULITIS WITH UNUSUAL COMPLICATIONS

REPORT OF TWO CASES

BY

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In most textbooks the subject of diverticulitis is dismissed in a few lines, but practitioners have had experience of difficult cases which have turned out to be diverticulitis, with some complication or another. These two cases illustrate such difficulties.

Case Record No. 1

The first case was that of a man of 54 who gave the following history. His health usually was good, but some years ago he had a duodenal ulcer for which a short-circuit operation had been performed. This operation had been a complete success, and the only symptom which reminded him of his former trouble was occasional "acidity." When this condition arose he had been advised by a consulting physician to take at any such time 60 grains of sodium bicarbonate. He stated that this always gave him immediate relief. It had been his custom for some years to keep a supply of 5-grain tablets, and when he required a dose he would take twelve of these, as he found this the easiest way of measuring 60 grains. These tablets he purchased himself. Although he had a tendency to constipation he never allowed this to get the upper hand, as he was in the habit of taking purges; this point is rather important from the subsequent history.

On the morning of February 26th I was called in to see him owing to his being extremely sleepy, from which condition he could be roused with great difficulty for a few minutes only, during which time he remained drowsy and was never fully awake. The preceding day had been very cold, with a heavy fall of snow, and he had had a good deal of indigestion. He had noticed on former occasions that snow always made him "livery." As he was going out to dinner that evening he took his usual dose of sodium bicarbonate just before leaving home. He then drove himself and his wife about a mile to the dinner party. Before dinner he took a cocktail, but only drank half; normally he was an abstemious man. The house was very hot and the dinner started with some hot soup. After he finished it he pushed his plate away, folded his arms on the table, laid his head on them, and went fast asleep. He was roused with great difficulty, and he walked into another room, where he said he felt very funny. He then managed to make himself vomit, after which he felt better, but very sleepy. He was left in this room, where he slept soundly for about three hours. After having been woken up he was able to drive his car home without much difficulty, but could not drive into his garage. Before going to bed he took another twelve tablets of sodium bicarbonate.

Next morning when I saw him he was, as already stated, in an exceptionally sleepy condition. His pulse rate was 56 and of rather poor character. On the left side of the abdomen, about the middle of the descending colon, there was a lump as large as a big fist which gave the impression of being possibly a faecal mass. Rectal examination was negative; urine normal.

I gave him hypodermically 1 c.cm. of pituitrin and 0.5 c.cm. of 1 in 1,000 adrenaline, and after a short time he seemed to become a little less drowsy. The relatives expected, and demanded, a diagnosis. I therefore told them that I had found a condition of partial intestinal obstruction which must have been going on for a long time, and this allowed a slow absorption of waste products to take place, so producing a condition of poisoning by auto-intoxication. In other words he was suffering from sapraemia.

Later in the day a simple enema was given following an injection of 6 oz. of olive oil, with the result that an

enormous stool was produced, in spite of the regularity of the taking of purges. During the rest of the day he gradually got better and by the evening was almost normal, except for a slightly drowsy state.

On February 27th—that is, two days after the onset of the sleepiness—he had a return of "acidity" and took another 60 grains of sodium bicarbonate about 6 p.m. At 7 p.m. he was extremely drowsy and had to be helped to bed. He slept soundly for about fourteen hours, when he was roused and was able to keep awake. He was given another enema, with a very large result, but still felt sleepy during the day.

On the fourth day he felt quite well again, and was so definite that he felt much better than on the sixth day he went back to his office and spent the usual day. An x-ray examination was carried out following the administration of a barium enema, and this revealed a condition of diverticulitis affecting mainly the descending colon, which also showed a very marked spasm. Thus the diagnosis of diverticulitis was confirmed. On the strength of this he was advised a daily bowel irrigation, and this was carried out.

We were now all congratulating ourselves on a satisfactory diagnosis and felt we were dealing with a more or less straightforward case, but on the same evening—that is, the sixth day—he came home from his office owing to a return of indigestion and took yet another 60 grains of sodium bicarbonate. The following day I was called in to see him and found him just as drowsy as he had been before, and I called in a consulting physician, who could throw very little light on the case. A lumbar puncture was performed. The intraspinal pressure was normal and the fluid itself was found to be normal to every test. We were then not very much further on, except that once again the patient recovered.

About midnight of the ninth day I received an urgent summons and I found the patient definitely cyanosed with Cheyne-Stokes breathing and a feeble pulse of only 48. An injection of pituitrin and adrenaline seemed to improve his condition somewhat. The following morning he was again seen by the consulting physician, who was still baffled by the condition. Ophthalmoscopic examination showed some anaemia of the retinal vessels suggesting cerebral anaemia.

Yet another attack occurred on the fourteenth day; and, talking over the case with his wife, who was naturally terribly anxious, it suddenly struck me that there was a definite connexion between the attacks of drowsiness and the taking of the sodium bicarbonate. I therefore asked her to let me have the bottle of tablets, and on tasting one, it was at once obvious that it was not sodium bicarbonate, but on throwing the remains of the tablet in the fire there was a yellow sodium-flame produced. I immediately took the tablets to be analysed, and the result was reported to me as medinal. This is also known as sodium bibarbiturate.

The remarkable part of this case is that in a space of a fortnight this man had taken six doses of 60 grains of medinal.

Case Record No. 2

The second case was that of a man of 65 who was normally in robust health, a stocky type but inclined to be fat. He was a great worker, being the head of a very large concern in which he took a personal interest. He always suffered from a moderate degree of constipation, but kept his bowels working with a daily dose of salts first thing in the morning. It was also his habit to take Vichy water almost daily. He was inclined to be irregular with his meals, as he felt they were a waste of time and interfered with his work.

I was first called in to see him for this present illness on August 11th because he was not feeling well and had had "difficulty with his bowels and pain in his stomach." Examination of the abdomen revealed a large mass on the left side, reaching downwards for about 6 in. from the lower border of the ribs. The consistency of this mass suggested a collection of faeces. It was fairly tender on light pressure, but quite painful when pressed hard. A consulting physician saw him on this day.

The treatment employed was liquid paraffin by the mouth, non-residue diet, mainly fluid, and enemata. This latter produced soft and watery results, with several hard, stale, dark lumps, very few being any larger than walnuts. His progress appeared to be quite satisfactory, and although the lump was still palpable, it was considerably smaller.

As in the first case, everybody concerned was quite pleased with his condition, and we thought we were out of the wood. On the sixth day, however, I received an urgent call about 10 p.m. owing to a sudden attack of very severe pain, on the left side. He was then partially collapsed, cyanosed, and sweating; his pulse was poor. He stated that he had never endured such "terrible" pain before in his life. The tenderness over the lump was very marked, and he could hardly stand the lightest pressure.

A consulting surgeon was called in the same evening, and he considered that there was a possibility of a bowel perforation. He expressed a wish to have the opinion of another surgeon, and when the latter arrived later in the evening, they both considered that, at any rate, that evening the patient was in too bad a state to have his abdomen opened. Here it should be stated that he was a difficult subject to examine, owing to his build and to the extreme tenderness of the lump. Morphine was given hypodermically, and after a short time the condition became much better. Next morning—that is, the seventh day—he was fit enough to be removed to a nursing home, to be kept under observation.

Owing to the improved general condition it was considered possible to perform a laparotomy, should this be deemed necessary. One surgeon was inclined to take the risk, but the other thought the risk was too great, and, strange as it may seem, the consulting physician was rather in favour of the operation. A third surgeon was consulted, and it was decided to give the patient a barium enema and to take an x-ray by means of a portable apparatus. The x-ray revealed the presence, as in the former case, of several small diverticula, with a marked spasm of the descending colon.

A super-consultation was then held, at which were present three consulting surgeons, a consulting physician, the radiologist, and the G.P.! The result of this was that everybody agreed that if there was a real obstruction, then the only operation possible was one to relieve the obstruction by an opening into the bowel above this area. This would mean a colostomy of the transverse colon, and we came to the unanimous conclusion that this would be exposing the patient to too great a risk. Furthermore, the patient's condition was better, and there was now very little pain or tenderness, though the bowels were failing to function.

At this moment in the consultation a very dramatic interruption occurred. There was a tap at the door and the sister of the nursing home came in with a specimen glass full of a fluid that looked like blood. It actually was almost pure blood, and in fact was haematuria. The case was now more obscure, but one of the experts took a very serious view and expressed the opinion that the haematuria must be of toxic origin and that therefore the outlook was very grave; nevertheless, we still stood by our opinion that no operation was possible. The problem, however, was completely cleared up next day.

When I saw the patient next morning he seemed very much better. He had got rid of the barium and with it he had passed a good deal of faecal matter, but, more than this, he made a very important statement—namely, that when passing water that morning he had heard a little "tinkle." To cut a long story short, he had passed a small stone. Suddenly the case became clear. The severe attack of pain in the left side which occurred on the evening of the sixth day was actually an attack of renal colic due to the passing of a small stone down the ureter. The lifting about of the patient for the taking of the x-rays had been enough most probably to move the stone on over the brim of the pelvis into the bladder. This caused the haemorrhage which the patient got rid of a little later. The passing of the stone per urethram the following day completed the picture.

AURAL VERTIGO*

BY

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HARROGATE

We recognize our position in space by means of the muscle senses in the soles of the feet, by our eyes, and by our semicircular canals. Labyrinthine vertigo consists in a false sense of movement of the patient or of his surroundings. The movement may be in a linear, rotary, or vertical direction, and is accompanied by nausea, vomiting, pallor, sweating, and sometimes diarrhoea. Sensations of forward and backward movements are not seen, but if present are in favour of a neurasthenic or cerebral vascular condition. Besides this false sense of movement the patient may really fall, or may be flung out of his chair, or have a sensation of being pushed, yet he never loses consciousness. The onset of these sensations is sudden; they last only a short time, and are followed by a feeling of unsteadiness on the legs.

The function of the labyrinth may be interfered with if there is a lesion in the vestibular tracts in the cerebellum or in the vestibular nerve, or if these nerve endings are affected by a toxin, or the blood supply of the semicircular canals is suddenly increased or decreased, or the fluid in those canals is exposed to pressure or toxins.

Lesions in Vestibular Tracts and Vestibular Nerve

The commonest cause of a lesion which affects the vestibular nerve tracts in the cerebellum is thrombosis of the inferior cerebellar artery, in which there is a sudden onset of vertigo and nystagmus to the affected side associated with ocular sympathetic paralysis and paresis of the soft palate and vocal cord and disturbances of sensation. A vascular lesion in the lateral part of the pons may also, according to Brain, produce vertigo, deafness, and tinnitus associated with paralysis of the seventh and eighth nerves and disturbances of sensation.

The vestibular nerve tracts may also be affected in disseminated sclerosis, in which there is vertigo without loss of hearing. The vertigo is usually accompanied by an intention tremor, absence of abdominal reflexes, and extensor plantar responses with possibly optic atrophy. The nerve tracts may also be disorganized by a head injury. In such cases there is tinnitus and vertigo; the vertigo usually tends to become less, though in some cases it, like the tinnitus, persists for a very long time. Vertigo may be the aura of an onset of *petit mal*, but it can easily be differentiated from aural vertigo, since in the latter there is never loss of consciousness. Vertigo may also occur in neurotic individuals; it consists in a feeling of the legs giving way, and is accompanied by intense anxiety and palpitation which may, according to Russell Brain, be due to a fear of heart disease.

The commonest lesion of the vestibular nerve itself is a tumour of the eighth nerve. The patient complains of vertigo, tinnitus, and deafness, and the striking feature is that there is anaesthesia of the cheek and later fascial nerve paralysis. (Anaesthesia of the cheek may be preceded by anaesthesia of the cornea.) Examination of the labyrinth shows a complete loss of function with, according to Eagleton, a loss of function of the vertical canal on the opposite side.

The Semicircular Canals in Causation of Vertigo

In an aurist's experience the semicircular canals themselves are the commonest cause of vertigo. These canals are surrounded by a network of blood vessels, and contain

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