which may be associated with extreme collapse.^{2,3} Barber in 1887 described a case in which the uterus was replaced without an anaesthetic; as regards the after condition he wrote, "The general condition of the patient was most serious; she was insensible, pulseless, and the extremities cold."¹² In the three successful cases reported by Miles Phillips in 1911, anaesthesia was employed during the process of reduction. Blair Bell in a recent case employed anaesthesia, even though shock was not marked.¹³ In my case, which was one of moderate shock, the patient was fairly comfortable after recovering from the anaesthetic. Manipulations affecting the inner surface of the uterus are very painful and liable to be accompanied by shock, and it is now considered orthodox treatment to perform manual removal of an adherent placenta under anaesthesia. D. J. Malan in 1925, while teaching students at the London Hospital, reported a case within his knowledge where the manual removal of an adherent placenta without an anaesthetic had brought about rapid death from shock. It may also be recalled how frequently death from shock occurs at the hands of amateur and professional abortionists, as compared with the comparative absence of risk when therapeutic abortion is conducted under an anaesthetic.¹⁴

In the cases where inversion has occurred with an adherent placenta, it has been found expedient to peel off the placenta before replacing the uterus. In Barber's case reduction was found to be impossible until the placenta had been removed.

In 1923, E. Evans had an intra-abdominal view of the process of replacement through a laparotomy wound. With the patient under anaesthesia, the uterus was replaced by an assistant with a hand in the vagina. He observed that restitution began from the posterior wall of the cervix.¹⁵

The possibility of recurrence of the inversion must not be forgotten; it was in order to prevent this that we

tightly plugged the vaginal vault in our case. In the cases reported by Couvelaire¹⁶ and Schockart¹⁷ replacement was followed by return of the inversion a few hours later. Schockart, after describing his case, remarks upon the necessity of plugging the uterus itself to prevent recurrence.

Lastly, it would seem impossible to make a diagnostic error, but two cases are recorded of mistakes made by midwives. In 1897 a midwife pulled on the inverted uterus for three-quarters of an hour thinking it to be the placenta, till the uterus, one tube, and an ovary came away; the other tube and ovary were congenitally absent.¹⁸ In 1915 a midwife mistook the inverted uterus for a second child; in accordance with the rules she sent for a doctor. When the doctor arrived he was shown two basins, the placenta in one and the contracted uterus in the other.¹⁹ In the former case the patient recovered after closure of the peritoneal cavity; the latter patient succumbed.

REFERENCES.

- 1 Maxwell, Drummond: *Brit. Journ. Obstet. and Gynaecol.*, 1915.
- 2 Fox, T. S.: *British Medical Journal*, May 31st, 1924.
- 3 Phillips, Miles: *Brit. Journ. Obstet. and Gynaecol.*, 1911, 1912.
- 4 Oag, James: *British Medical Journal*, April, 1915.
- 5 Hellier: *Brit. Journ. Obstet. and Gynaecol.*, March, 1912.
- 6 Bell, Blair: *British Medical Journal*, May 31st, 1930.
- 7 Elliott, C. C.: *Ibid.*, October 1st, 1927.
- 8 Barrow, C. C.: *Amer. Journ. Obstet.*, March, 1910.
- 9 Tweedy and Wrench: *Practical Obstetrics*.
- 10 Herman: *Difficult Labour*.
- 11 Berkeley and Bonney: *Difficulties and Emergencies of Obstetrical Practice*.
- 12 Barber, F. S.: *Lancet*, October 1st, 1887.
- 13 Bell, Blair: *British Medical Journal*, May 31st, 1930.
- 14 Spillsbury, Sir Bernard: Criminal Abortion. *Transactions of the Medico-Legal Society*, 1918-19.
- 15 Evans, E.: *Surg., Gynecol. and Obstet.*, October, 1923, xxxvii, No. 4.
- 16 Couvelaire: *Ann. de gynéc. et d'obstét.*, June, 1911.
- 17 Schockart, P.: *Brit. Journ. Obstet. and Gynaecol.*, 1909.
- 18 Smith, E. H.: *British Medical Journal*, 1897.
- 19 Williams, N. G.: *Ibid.*, 1915.

PERFORATION OF A SILENT DUODENAL ULCER COINCIDENT WITH PERFORATED APPENDIX.

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THOUGH lesions of the appendix, coincident with chronic ulceration of the duodenum, are a recognized and almost a common occurrence, yet a simultaneous perforation of both is of sufficient rarity to deserve record.

A mechanic, aged 44, was admitted to hospital at 6 p.m. on May 4th, as a case of "acute abdomen." The pain had started at 10 p.m. on May 3rd; it was not rapid in onset, but came on gradually, starting in the umbilical region and spreading to the bottom of the abdomen. He had vomited six or seven times, the last time being 10 a.m. on May 4th. Vomiting relieved the pain for a time. At about 12 noon there was an exacerbation of the pain. Bowels open May 3rd. His last meal was at supper, at 9 p.m. on May 3rd, which consisted of chipped potatoes with a pint of beer.

The previous history was that he had had an attack of "colic" a year ago; no history of indigestion.

Condition on Admission.—Well nourished and healthy. Expression characteristic of general peritonitis. Tongue moist and furred. Temperature 100.8° F., pulse 112. The abdomen moved very imperfectly on respiration. It was completely rigid, and acute tenderness was present in both the iliac fossae, especially the left, and also under the left costal margin; marked hyperaesthesia. Abdominal reflex lost; marked diminution of liver dullness. Rectal examination negative. Chest: chronic bronchitis, some rhonchi present. A diagnosis of perforated duodenal ulcer was made.

Operation.—At 8 p.m. Dr. F. L. Buttar operated. A right paramedial incision was made, and on entering the peritoneal cavity some gas escaped, and purulent fluid was found. A short search revealed a small perforation in the anterior aspect of the duodenum, about an inch from the pylorus, round which some thickening was present. The perforation was sutured, and the fluid present was evacuated. As this did not seem sufficient to account for all the symptoms present, the right iliac fossa was explored, when a perforated gangrenous appendix was found, with

free pus in the abdominal cavity. Appendicectomy was performed, and the wound closed with drainage. The operation being completed, the appendix was slit up and found to contain pus; it was gangrenous for about an inch from the tip, and half an inch from the tip a small perforation was present. The patient suffered considerably from shock, which was successfully combated, but unfortunately broncho-pneumonia supervened, of which he died on May 7th.

Comment.

Both from the history of the case and the operative findings one is inclined to conclude that the appendix was the primary lesion. I would suggest that the appendix perforated between 10 p.m. and 12 midnight on May 3rd, shortly after the pain began, and that the duodenal ulcer perforated at about 12 noon on May 4th, when the exacerbation of the existing pain occurred.

In the literature on the subject I can find no record of a similar case, the nearest being a case, reported by Moore, of "Simultaneous suppurative appendicitis and perforated gastric ulcer" (*Lancet*, 1910). There is also one by André, "Appendicitis; perforated ulcer of the duodenum; subphrenic abscess" (*Clinique*, 1911). A case reported by Matheson (*British Medical Journal*, 1901) also bears a resemblance to it; but in this case the girl—who was recovering from appendicitis and was seized with violent haematemesis, with symptoms of gastric perforation—was not operated on, and after death, which occurred a few hours later, no autopsy was performed, so that one can only speculate as to what condition was actually present. The case reported on by Moore was that of a girl, aged 19, who had been treated medically for gastric ulceration, and who also had had previous attacks of pain in the right iliac fossa. The appendix in this case, although containing pus, was not perforated.

In the present case there was no history of gastric or duodenal disturbance, and no history of appendicitis. It may be remarked that some oral sepsis was present, three teeth being decayed.

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