The authors also emphasize the dictum: "Where gastro-enterostomy function is defective, early radiography is needed." They claim that this investigation is likely to show a higher incidence of chronic intussusception than is usually imagined among cases of recurrent vomiting after gastro-enterostomy.

Summary

1. Jejuno-gastric intussusception is a well-established late complication of gastro-enterostomy for ulcer. It occurs in acute and chronic forms. The former is fatal if not operated upon.

2. Diagnosis is possible, depending on the rule: "Where haematemesis or obstructive symptoms appear after gastro-enterostomy, think of intussusception."

3. If, in sudden acute intestinal obstruction, the following triad is present, then acute retrograde intussusception should be diagnosed:

- (a) Epigastric scar.
- (b) Visible peristalsis from left to right.
- (c) A palpable mobile swelling about the mid-abdomen.

4. The chronic form is to be remembered as one of the causes of recurrent vomiting after gastro-enterostomy. Early radiography is demanded in such cases and will reveal the intussusception, if present, and pave the way for a curative operation.

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RETROGRADE INTUSSUSCEPTION OF THE JEJUNUM FOLLOWING GASTRO-JEJUNOSTOMY

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Retrograde intussusception of the jejunum as a late complication of gastro-jejunosomy is a rare, but nevertheless important, condition. Only thirty-five cases (including the following case) have so far been reported.^{1,2} It is surprising that, although gastro-jejunosomy was first performed in 1881, this complication was not reported until 1917.

Nineteen of the reported cases were females and only thirteen were males; the average age was 43, the youngest patient being 21 and the oldest 75. Intussusception occurred at variable times after the original operation: six days was the shortest period and sixteen years the longest. The type and size of stoma apparently makes no difference. The length of intestine which was involved varied from only four or five centimetres to two metres.

The symptoms are rather characteristic: abdominal pain is marked—it usually comes on suddenly, is moderately severe, and may be agonizing. Vomiting almost always occurs, and is usually persistent; in eighteen cases it was bloody. Shock is an almost constant accompaniment. A tumour was palpable in twelve cases. Most patients were operated upon with a diagnosis of high intestinal obstruction; two were at first erroneously diagnosed as bleeding peptic ulcers. In two cases the condition recurred, and the diagnosis was then accurately made by the patients themselves. Operation was performed in thirty cases, with eight deaths and twenty-one recoveries (the result in one case was not stated). The condition was discovered at necropsy in five others. Early operation was almost always successful.

Case Record

History.—The patient was an unmarried woman aged 44. Seven years previously a chronic gastric ulcer had been excised from the lesser curvature, and anterior gastro-jejunosomy had been performed. (The appendix had already been removed.) She remained fairly well, except for some abdominal pain soon after food, and occasional vomiting, until she was admitted into hospital as an emergency. Twenty hours previously she began to have severe abdominal pain around the umbilicus, following pork for dinner. The pain gradually increased, and was associated with repeated vomiting. The bowels were opened normally. Whilst in hospital she was kept under

observation for twelve hours, during which time she had no pain, but vomited three times; the last two vomits were of brownish small-intestine type.

Condition on Admission.—The patient was weak and shocked, with a temperature of 97.5° and pulse of 72. There were no other abnormal physical signs, except for a little resistance over the upper part of the left rectus muscle. Whilst under observation the temperature and pulse were normal. An ill-defined soft swelling appeared under the left upper rectus, with slight peristalsis in it, and a diagnosis of high intestinal obstruction was made. There was no rigidity or tenderness at any time.

Operation (thirty-two hours after onset).—A retrograde intussusception of the upper jejunum was found. The apex was situated about eighteen inches from the old gastro-jejunosomy stoma; about six inches of jejunum had been intussuscepted upwards towards the stomach, but had not reached the stoma. The obstruction had caused dilatation of the stomach and jejunum above the lesion. The intussusception was easily reduced. The patient made an uninterrupted recovery, and has remained well, except for vague indigestion, for the past two and a half years.

Comment

It has been stated elsewhere¹ that this condition is probably not so rare as the reported cases would lead one to suppose. The treatment is operative, and if operation is undertaken early 90 per cent. of patients recover. Therefore the condition should be remembered when symptoms and signs of high intestinal obstruction occur following gastro-jejunosomy. Another possible cause of high intestinal obstruction following an anastomosis is an internal hernia through the hole made in the mesocolon; I have seen two cases of this latter condition, both of which recovered after operation. Early diagnosis and the use of continuous intravenous saline glucose (5 per cent.) is of the utmost value in cases of obstruction.

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A. Le Tensorer (*Thèse de Paris*, 1934, No. 811), who records fifty-five cases of nephritis in secondary syphilis in patients aged from 17 to 49, states that the aetiological diagnosis of nephritis in syphilis is difficult owing to the possibility of even a minute dose of mercury, novarsenol, or bismuth giving rise to this complication. On the other hand, when the aetiological diagnosis is established with certainty the prognosis is easy. Nephritis due to intolerance of the specific drug will be aggravated by treatment, which, on the other hand, will cure the nephritis due to syphilis as well as the other manifestations of the disease.