NOTES OF TWO CASES OF ABDOMINAL SECTION ILLUSTRATING POINTS OF INTEREST.¹

By J. CRAWFORD RENTON, M.D.,

Assistant to the Professor of Clinical Surgery in the University of Glasgow; Assistant Surgeon to the Western Infirmary, Glasgow; formerly additional Examiner in Clinical Surgery in the University of Edinburgh.

I.—ABDOMINAL SECTION FOR LARGE TUMOUR IN THE STOMACH: DISAPPEARANCE OF THE TUMOUR: COMPLETE RECOVERY.

On November 14th, 1893, I was asked by Dr. Sinclair to see Mrs. F., aged 55. He informed me that she had suffered from recurrent attacks of vomiting for a year; five months ago a tumour was detected in the epigastric region. This had gradually increased, the vomiting had become more frequent, and when I saw her she was entirely confined to bed; she had a wasted anxious look without elevation of temperature, and I found a large tumour in the epigastric region passing down below and to the right side of the umbilicus. As Dr. Sinclair had tried all the ordinary forms of treatment I recommended that the abdomen should be opened, the tumour examined, and, if possible, gastro-enterostomy performed.

The patient was admitted to the Blythswood Home, and on November 27th, assisted by Drs. Sinclair, Bryce, Pace, Dewar, and Burnside Buchanan, I opened the abdomen, and found a large, hard, irregular tumour extending from the pylorus over the anterior wall of the stomach upwards to the cardiac end. The tumour was fixed in every direction, and had all the appearance of malignancy, and this was the feeling of those present at the operation. No operation could be performed, so the abdomen was closed. The patient recovered without a bad symptom, and has never vomited once since the operation.

The tumour has entirely disappeared, the patient has gained a stone and a-half in weight, and has returned to her work as a sick nurse. As it is now eighteen months since the exploratory incision, I think we are justified in recording the case; at the same time it must not be forgotten that malignant tumours, after exploratory incision, sometimes diminish for a time.

A good deal of attention has been directed from time to time to the spontaneous disappearance of tumours, and also to the effect which exploratory incisions produce on the internal vital activity of processes going on in the abdomen.

In a very interesting paper by Professor George Buchanan² he refers to several cases, and recently, before the Royal Medical and Chirurgical Society, Mr. Greig Smith,³ of Bristol, read a most instructive paper on the Spontaneous Disappearance of Solid Abdominal Tumours.

The case which I have recorded serves to confirm the opinion of those who have written on the subject, that where a solid abdominal tumour disappears after exploratory incision and exposure to the light—that tumour was inflammatory in its nature. Considering the effect of exploratory incisions and their almost absolute safety, it seems right that in cases of abdominal tumour giving rise to any urgent symptoms which do not yield to ordinary treatment an exploratory incision is justifiable and proper.

II.—ABDOMINAL SECTION IN A CHILD OF 9 MONTHS FOR OBSTRUCTION OF THE BOWELS: RECOVERY.

At midnight on June 14th, 1894, I was asked by Dr. Suttie to see a child, aged 9 months, suffering from obstruction of the bowels. Dr. Suttie had seen the child five hours previously, and then the mother stated that the bowels had not moved for twenty-four hours, and the child had vomited. Dr. Suttie found a tumour in the right iliac region, which he diagnosed as an intussusception. Having washed out the lower bowel, he inflated and succeeded in reducing the tumour one-half, but the other half remained, in spite of manipulations, shakings, and inversion.

On examination I found a well-marked tumour in the right iliac region, with very little tenderness, and, as the inflation and other means had been thoroughly tried, I advised abdo-

minal section. Assisted by Dr. Suttie, I opened the abdomen, and with some difficulty I drew out the invaginated piece of bowel at the ileo-cæcal region; on gently pulling out the bowel it was evident that slight adhesion had formed. The child made a perfectly good recovery.

There is no doubt that in cases in which intussusception takes place and is not reduced by ordinary means, the sooner an operation is done the better it is for the patient; on the other hand, there are many difficulties in arriving at a certain diagnosis.

We should always bear in mind that any abdominal derangement quickly lowers the vitality of the patient, and the more rapidly we can give relief the better.

A CASE OF IMPACTED GALL STONE: JAUNDICE OF SIX YEARS' DURATION.

By CHARLES M. CHADWICK, M.A., M.D. Oxon.,
M.R.C.P. Lond.,

Honorary Physician, General Infirmary, Leeds; Lecturer on Forensic Medicine in the Victoria University.

THE following case of jaundice consequent on impacted gall stone appears worthy of record for various reasons, principally, perhaps, on account of its unexampled duration:

In January, 1889, J. A. A., aged 36, a respectable married woman, with no history of alcoholism or miscarriage, was seized during the night with excruciating abdominal pain, accompanied by vomiting, but without any history of rigor. Ordinary domestic remedies were resorted to and the pain was relieved. The following morning the patient was found to be jaundiced, and remained so until her death in December, 1894—a period of five years and eleven months.

No history of any subsequent or previous attack of similar pain was obtainable, and the patient remained in fairly good health until January, 1892, when she was admitted into the Leeds General Infirmary under Dr. Eddison. The notes report that she was considerably jaundiced, with enlarged liver, much ascites, and considerable tenderness over the site of the gall bladder. Xanthelasma was present; oedema of legs appeared; albumen was present in the urine; the ascitic fluid somewhat diminished; "hard nodules" were felt in the right lumbar region. When the patient left the hospital the opinion was that she was suffering from malignant disease of the liver.

In October, 1894, five years and nine months after the primary onset of the disease, the patient was admitted again under my care. She was markedly jaundiced, spare, aged-looking, with no ascites, great enlargement of spleen, irregular outline of abdomen, visible peristalsis, dilatation of the stomach, and ballooning of the rectum. She was seen by Mr. Mayo Robson, who reported no enlargement of the liver, and no distension of gall bladder. An exploratory operation was suggested, but owing to the condition of the patient's general health could not be undertaken. She was put upon chloride of calcium; the hæmorrhagic staining diminished, her blood showed no increase in white blood cells. Violent hæmatemesis with melæna ensued, and copious vomiting of yeasty material, from which sarcinae were obtained. On November 30th the patient vomited upwards of 2 quarts of blood, without any very decided shock to her system; the splenic enlargement showed considerable diminution, and three days later death occurred, five years and eleven months after the primary onset of the jaundice.

Aided by the old notes, by the fact that Dr. Roberts, resident medical officer, who remembered the patient when in the infirmary nearly three years previously, and was able to state that there was practically little difference in her appearance, the diagnosis was rendered a simple matter, and on December 4th a *post-mortem* examination by Mr. F. Walker showed general matting together of all the abdominal contents by old peritonitis, obstruction to the passage of bile by a stone which had in all probability remained where it was found for a period of nearly six years. The following report on the liver is kindly provided by Mr. W. A. Stott, Pathological Curator: "The gall stone is egg-shaped, and weighs 4

¹ The cases were shown at a meeting of the Glasgow Pathological Society.
² *Lancet*, November 7th, 1885.

³ *BRITISH MEDICAL JOURNAL*, 1894, 1, p. 190.

grammes when dry; it is so soft that it can be indented by the finger nail; one side of the stone is black with dark-brown patches, the other side is yellowish-grey. There is a shallow depression in the duodenum half an inch from the pylorus in which the stone was found; at the bottom of the depression is a circular aperture one-eighth of an inch in diameter, leading into a passage of similar diameter, and nearly 2 inches in length; from the end of the passage a distended hepatic duct leads into the left lobe of the liver for a distance of 7 inches. The gall bladder measures three-quarters of an inch in length, one-third of an inch in breadth. No trace of cystic duct can be found. The bile papilla opens into the duodenum 3 inches from the pylorus; the common duct appears normal; the liver is of normal weight; it is covered by adhesions on both the upper and under surface of the right lobe."

The facts of the whole case appear clear. In January, 1889, the stone left the gall bladder, and was lodged at the junction of the common and cystic ducts. In January, 1892, adhesion to the duodenum and ulceration occurred, setting up a general peritonitis with accumulation of fluid. This gradually subsided, and by degrees the peritoneal sac was obliterated by adhesions. Interstitial changes progressed in the liver, enormous congestion of the spleen occurred, which was relieved by several small hæmorrhages, and on November 30th by an enormous hæmatemesis (upwards of two quarts). As all this blood had been stored up in the spleen, outside the circulation as it were, no great immediate collapse occurred; but the patient's death ensued in a few days, in consequence, no doubt, of further blood being withdrawn from the "general circulation" by the obstruction in the liver.

The case appears interesting in several particulars:

1. The unexampled duration of the jaundice.
2. The very great enlargement of the spleen during the later stages, and comparatively moderate size (21 ounces) after death, a fact explained by the very copious hæmatemesis (2 quarts) which occurred a few days before death, and explaining the comparatively slight general upset resulting from such an enormous sudden loss of blood.
3. The entire absence of xanthelasma in 1894 when its presence was noted in 1892.
4. That the presence of a gall stone causing irritation and jaundice for a period of six years had not given rise to any appearance suggestive of malignancy.

TREATMENT OF GALL STONES BY LARGE DOSES OF OLIVE OIL.

By WILLIAM H. STEPHENSON, L.R.C.P., L.R.C.S. EDIN.,
Harpurhey, Manchester.

In July, 1893, Mrs. T., aged 43, came under my care suffering from biliary colic. She was suffering from acute pain, situated over the hepatic region and extending through to the right shoulder blade, accompanied by severe retching and vomiting and collapse. The pain was relieved by hypodermic injection of morphine. The attack was followed by well-marked jaundice, which, however, passed off in a few days' time. She stated that she had suffered from these attacks at various intervals for upwards of four years, and that they were invariably followed by slight jaundice. I had the fæces carefully examined for gall stones, but none could be discovered. About two months later she was again seized with a severe attack of colic, but very careful search failed to detect any trace of gall stones in the fæces. These attacks continued at intervals of about three to six weeks for nearly five months, although the patient was constantly under treatment, all the usual remedies, such as Carlsbad salts, phosphate of sodium, sulphate of sodium, salol, ether, and turpentine, being tried without avail. In no instance was a gall stone ever found in the fæces.

On examination the patient complained of pain on pressure over the region of the gall bladder and there was a somewhat resistant swelling in this region, but, as she was rather stout and the abdominal walls were very thick, it was very difficult to make out any gall stones. About the end of February 1894, she had a very severe attack of colic, which lasted for

nearly thirty-six hours, during which time she was kept continuously under the influence of morphine and free stimulation, as there was severe collapse. She managed, however, to rally, but remained jaundiced for a fortnight. Acting on my advice she decided to go into hospital and have cholecystotomy performed.

Whilst waiting to be admitted, however, I decided as a last resort to try the effect of large doses of olive oil. Pil. hydrarg. (gr. iij) was taken at bedtime, and this was followed at 6 A.M. by 3 iij of pure olive oil, the patient being ordered to lie on the right side. At 8 A.M. the blue pill acted, producing a copious biliary motion, but no gall stones were passed. The oil was continued in tablespoonful doses every three hours during the day. In the three motions that were passed between 3 and 8 P.M., six large gall stones were found; two of them measured nearly half an inch, and were faceted. No pain was experienced during the passage of the stones, nor did the oil cause much nausea. The jaundice passed off in a week or ten days, and the patient made a complete recovery. She has never had an attack of colic since, now twelve months ago.

The treatment by large doses of olive oil is, I think, well worthy of a trial in cases of recurring biliary colic, and also in cases of jaundice due to impacted gall stone. How the oil acts in these cases it is difficult to explain. Gall stones and their constituents (cholesterin) are soluble in solutions of olive oil at body heat. Is it possible that it acts by softening and reducing the stones in size, or by assisting in relaxation of the duct, or in both ways? Whatever its *modus operandi*, its administration was followed in this well-marked and persistent case by exceedingly satisfactory results.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

HYPERPYREXIA ACCOMPANYING PLEURISY AND PNEUMONIA: RECOVERY.

ON February 12th last I was called to see a lady about 30 years old, who complained of great pain in the left side and difficulty of breathing. I found the usual signs of pleurisy and pneumonia. The dulness on percussion was confined to the base of the left lung. The temperature was taken at 10 A.M., and was 102° F., as will be seen by the accompanying chart. Linseed poultices were ordered, and a mixture of

spirits of nitrous ether, aconite, and liquor ammoniæ acetatis was given. By 1 P.M. the temperature had risen to 110° F.