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Rare Cases of Abdominal Disease occurring in Country Practice.

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MB and ChB (Edin, Univ) 1871.

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29th April 1884.
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Rare Cases of Abdominal Disease

Occurring in Country Practice

Introduction

Cases of Abdominal Disease involving difficulty of diagnosis have always had a special attraction for me, the difficulty constituting the attraction. It is so aggravating to have such a large area to work in: to be able for example to get one's fingers almost round a swelling of some sort or other, and move it about at will: to be able to per- cure and auscultate with the greatest ease; and yet after all, in many cases, not to be able to say what it is that one can almost see: a worse state, to have one's confidence in diagnosis upset by the post mortem exam- ination that one was so positive would con- firm it.

When the latter contingency arrives the physician wonders why he did not credit with their proper value certain signs or symptoms which he had thought...
thought little of, or had even ignored, and
be vows that a similar case shall never again
perplex him. But it is a curious fact
in connection with difficult abdominal cases
that one does encounter a peculiar similar
case. No two are ever alike. Each
has to be judged on its own merit.
Let down half-a-dozen experienced physicians
a surgeons at the bedside of a patient, the
subject of an obscure abdominal swelling.
How many different opinions will you get as to its
nature etc.? Most probably, yes! And how
many will be the opinions of these experts?
Practicing as I do in a small country village,
out off as I am from hospitals and dispensaries,
my opportunities for seeing curiosities of medicine
and surgery are limited, yet I venture to hope
that the few cases following, which I make the
object of my thesis, are not altogether unworthy
of being recorded.

George John Malestune Smith.

Anstruther.

April 1854.
William Jones, married, was aged 64 when he came under my notice in 1878: born at Jefferson, Sussex; had formerly been a whipper-in of hounds and grooms.

History.

Enjoyed good health until he was 42 when he sustained a severe accident, a wooden beam falling on his head and rendering him insensible. From that time until a few years ago he was subject to fits of melancholia. He attempted to commit suicide several times, and continually ill-used his wife and children. He was therefore sent to a Lunatic asylum in 1858 and detained there for six months. He never after wards had any regular employment, but spent his time drinking, fighting and wandering about, doing odd jobs when he thought fit. His wife a decent quiet woman had to keep him.

She says that he never was a hearty eater, but this she attributed to his excessive drinking. For some time before he became my patient he was subject
subject to occasional twinges of pain in the stomach and to pyrosis. These twinges be-
coming as length wore before he consulted me six years ago. He was a thin, short, active, looking man with a somewhat anxious expression of countenance. He then complained of great pain in the pit of the stomach. The tongue was furred; there was com-
plete loss of appetite; there was no tenderness over the abdomen; the bowels were evacuate. Dimes of stimulants, a purge, and administration of bismuth and morphia relieved him, and in a few days he was able to work in his garden, and soon after he resumed his drinking habits. For two years afterwards he was from time to time subject to gastralgia. The pain was so severe that he would kneel down in front of a chair and press his abdomen against its edge in order to obtain relief. Solid food made him worse, but liquids were well borne, and indeed often lessened the pain. Pyrosis was frequent, but he never vomited. I gave him at different times bismuth, alkalies, oxalate of cerium, hydrocyanic acid and preparations of opium hypodermically and by the mouth. Drugs however seemed to do him little good. The attack would last for a few hours, or for two or three days. During the interval he enjoyed fair health, though as time went on he became weaker. He gave himself indulging
indulging in liquor to excess, and lived a quiet
inoffensive life.

In 1880 his complaint assumed a new phase: not
only did he suffer from excruciating, lancinating
pain in the epigastrium, darting through to the
back, but during his attacks, which now con-
secrated him to bed, he had coffee-ground vomiting
in large quantities, in which were abundances of
mucus. Several times it seemed as if he would never get about again; however
when things were at their worst he would walk,
and soon would be down-stairs and out again.

The pain was dulled by large doses of opium.
Liquid nourishment was taken very well and gen-
erally retained. Cod-liver oil was given during
the intervals.

For six months previous to his death in November 1883
he was confined to the house, and for the most
part to his bed. The pain was relieved only by
opium. Coffee-ground vomiting occurred every few
days. Only liquids could be taken. There was
no cachexia; bright blood was never brought up.

Physical examination revealed absolutely
nothing. It was frequent, and carefully made, and
so the patient was naturally a thin man, and
was in addition much emaciated. The abdomen
could be thoroughly manipulated. The abdominal
artery could be clearly traced to its bifurcation.
It seemed to beat more freely than natural. The
hepatie
Jaundice dulness was normal, and the feeling of the liver edge natural. The urine was free from albumen, acid. The quantity passed in the twenty-four hours was rather small.

Patient would not consent to rectal alimentation being practised, and died from insufficiency on November 29, 1853, aged 69.

Sectio Cadaveris 22 hours after death.

Body, much emaciated.

Thoracic viscera healthy.

Lungs, spleen, and kidneys healthy.

Heart, absence of fat. Annular fibres hypertrophied towards pyloric end.

Stomach of normal size. Glands much thickened.

A ligature was placed round the caecal, and of the organ, and another below the duodenum, both removed for examination. A incision being made along the lesser curvature the cavity of the stomach was exposed. It contained a few drachms of semis solid fluid. Beside the usual post mortem changes, there was considerable injection of the mucus membrane. The pylorus was a thick, hard ring, as thick as a pen, and fully half an inch thick, leaving a canal which admitted of the passage of a large probe only by force. There was no ulceration in either the stomach or the duodenum.

All the other organs of the body were healthy. The case in my opinion was one of pyloric stenosis, caused.
caused by simple hypertrophy of the walls through
out their entire thickness.

Comments.—This case illustrates very clearly
the difficulty that may occur in diagnosing
pyloric obstruction. It was a puzzle to me for many
years. I confess that I was of opinion that an
ulcer would be found on the posterior wall of
either the stomach or the duodenum, but my
diagnosis was arrived at only by the last resource
doctor: exclusion.
Carcinoma disease it could not be, for it had
lasted fully five years: there was no cachexia,
and no tumour to be felt.
There were no symptoms or signs of pyloric stenosis
except the vomiting. There was no gastric en-
glargement. There was nothing specially diagnostic
about the vomiting. It sometimes took place
directly after food had been taken; sometimes
some hours afterward. In days it would
be absent.
How are we to account for the severe pain
which was all along the most prominent
symptom? How are we to account for
the intervals of ease, and of freedom from
pain vomiting which the patient enjoyed;—in-
tervals lasting for weeks?
The lesson to be learned is that pyloric obstruction
can only be guessed at unless there be un-
doubted gastric dilatation.

F.J.M.S.
Abscess in Abdominal Wall
Perforation - Death.

On July 30th, 1881, I was called to see F.K., 12 years old, the son of an innkeeper and found him feverish, and complaining of great pain in his belly.

**History:**

His mother informed me that a few days before, visibly he had been in a neighboring brook and had shivered and felt cold for some hours afterwards. Since then he had not been himself but had managed to go to school and get about as usual until last evening when the shivering accompanied by the pain came.

Patient was a stout, healthy-looking boy, who had always had good health. He was a bright child with a terrible temper for he seemed to make the most of his illness, and moaned and whined his mother about in a most miserable manner.

There was tenderness on pressure all over the abdomen, most marked about the umbilicus and down from there.
there to the right subic fossa. There was no
distension. There was no bulging anywhere. There
was no empyema. There had been no vomiting
or feeling of sickness. The tongue was slightly
coated. The bowels were confined. Pulse was 120.
No rigor. Temperature 102°.
A very mild purgative was ordered, and a saline
mixture.
On the following day the symptoms were much the
same. The bowels had acted slightly. The pain was
perhaps greater. Temperature 102° 4. Evening temperature
Light poultices were
ordered to be applied to the abdomen with local.
Ointment spread on them. A few drops of oil
were added to each dose of the mixture.
There was nothing special to note on the 1st, 2nd,
3rd, or 4th August. The abdominal pain continued
but did not increase. Palpation revealed
nothing. The bowels were twice relieved by enema.
Soaking applications were continued, and an
aromatic mixture given. Only liquid refreshments
were allowed. Patient's irritability continued.
Temperature varied from 102° 5 to 103° 5. There
was little difference between the morning and
the evening body heat. Pulse ranged from 120 to
130.
On the 5th and 6th August the patient seemed to be
better. Temperature fell to 100°. Pulse 106.
Liquids were not taken; fair motions were passed.
pain was complained of less; bowels acted naturally.

August 9th. Patient lively and chatty; talk of soon getting up. Temperature 99°5. Pulse 100.

At 8.30 p.m. I was summoned to see him as he was said to be very much worse. On arriving his mother told me that at 7.30 p.m. while he was lying asleep, he suddenly shouted out in extreme pain, saying "something has given way in my inside" and on putting his hand to his belly, she heard a "splashing noise." I found the poor boy in a state of collapse. It was evident that perforation had occurred. Half a grain of opium was administered, to be repeated in four hours.

Patient died next morning; room having rallied.

Sección Cadaveris about 24 hours after death.

Body well nourished.

Abdomen slightly tympanitic. It was carefully opened in the usual manner. Some blood and pus escaped during the operation. The cavity being exposed it was found to contain quite a pint of blood and pus mixed.

The source of the discharge and of the hemmorhage was soon apparent. They proceeded from a rupture abscess the size of a small orange, situated
situated deep in the muscular tissue of the abdominal cavity, immediately over the right lobe of the liver, to which organ it was adherent by connections of recent lymph. The peri-hepatitis extended over the whole of the upper surface of the liver. The liver itself was healthy, as were all the other abdominal viscera.

On explaining the cause of death to the mother and asking whether the deceased might not have received a blow on the side, it transpired that three weeks before I saw the patient he had fallen from the rafter of an old barn upon side on the hard floor, and had lain there for some minutes unable to rise. His companion said nothing about this accident until after the boy's death, and he had concealed it from his parents, as he was afraid of being punished. Why? I cannot say.

There appears to be little doubt that the abdomen had its origin in the injury then received; but we have the fact that for three weeks, subsequently, the boy went to school two and a half miles off, and indulged in play with his comrades. It is extremely likely therefore that all was going on well until he caught the chill through bathing. Acute inflammation was then lighted up, resulting as we have seen.
seen in the formation of pus. Nature by peri-
-otic adhesions endeavored to avert a fatal
issue, which nevertheless took place by per-
foration.
The questions which intimately concern myself
are these 1st Ought I to have diagnosed the
abscess? 2nd Did the fact of my failing to
diagnose it influence the fatal result?
In reply to the first of these two questions I
would urge (1) the misleading history—the most
important factor having been deliberately con-
cealed; (2) the indefiniteness of the symptoms
which points to enteritis rather than to any
other sore. Acute diffuse peritonitis I judged
it could not be. There was not sufficient
tenderness on pressure; there was no hypogastric,
the pulse was not characteristic: the patient
tossed about too much: in a word the
symptoms were not sufficiently grave. (3) That the
pain was now localized in the hepatic region,
but was diffuse over the abdomen, though
certainly most marked as I have said, about
the umbilicus, and downwards to the right
iliac fossa; (4) that there was no external
evidence of the presence of abscess.
In regard to the second question—seeing that the
patient was treated by complete rest in bed, sou-
thing applications, and opium internally an answer
may safely be given in the negative.
Putting
Putting aside altogether the question of the advisability of operating on a deep-seated abscess not cut off by adhesions from the peritoneal cavity, and not pointing externally, it having been impossible to arrive at a correct diagnosis, it is unnecessary to consider what might have been the result had operative measures been brought to bear upon the case.

E. J. M. S.
Addison's Disease

Alfred Gardner, aged 33, farm labourer, married, born and resident in Horsham, Sussex, consulted me in the autumn of 1876 complaining of great debility, and remained under treatment until February 1880 when he died, aged 37.

His skin was so dark that I at first took him to be a native of India. He had exactly the appearance of an Erevaman. He informed me that skin had been getting dark only of late.

Family History.

Father and mother alive and in good health. Several brothers and sisters are known to me. They are all of strong and fair complexioned

History.

He always enjoyed good health until four or five years previously when he was laid up for three weeks with diarrhoea, and what he called "inflammation of the bowels." He recovered perfectly, and continued at work as before until a few months before I saw him when his present symptoms began. His debility gradually made it necessary for him to give up work. The dark colour of the skin
Skin was little heated at first. In some time he thought that he stood in need of washing, but soap and water he found made no impression on his colour. Afterwards, he ascribed his hue to "laborious and painful". He was languid and listless in the extreme, lethargic on the least exertion. He suffered frequently from gastric pain and vomiting, also from pain in the back. The appetite was deficient and capricious. The bowels were regular. The pulse was small and weak; the heart sounded normal. The Respiratory System was normal. The color of the skin was uniformly tanned. He had quite the appearance of a native of a tropical climate. The face, neck, back of the hands, and feet, the axilla and the genital organs were darker than the rest of the body. These parts, which were darker shaded gradually into the general colours. The palms of the hands and the skin on the lateral aspects of the fingers were the fondest parts of the surface. There were no cicatrizes. The conjunctiva were pearly white. There were no black patches, on the mucous membrane of the mouth.

The patient never became emaciated; the skin never became wrinkled as in cachectic disease. The urine was normal in quantity and free from albumen and sugar. As time went on difficult
was experienced in performing the act of coitus, though his wife was confined a year before his death, and I am not aware that there was doubt as to the paternity of the child.

Ascension of "fries and needles" was often complained of in the fingers and feet. Sleep was disturbed. He had occasional somnambulism.

He remained under my care for three and a half years, during which time there was nothing special to note except that he became slightly darker and gradually weaker. Every now and then he suffered from violent sickness and gastric pain. At times he seemed to gain a little strength, and once or twice he attempted light work but soon had to give it up.

Three days before his death after a longer walk than usual, unmitigated sickness set in, and he died semi-conscious on February 18th, 1880.

The medical treatment consisted in giving iron, quinine, arsenic, cod-liver oil etc. Complications were treated as they arose. The patient was exhibited before the members of the Brighton Medical Therapeutical Society in 1878.

Sectio Cadaveris. 30 hours after death.

Body not examined.

Craniial cavity not permitted to be opened.

Heart
Heart and lungs normal: no tubercle in the latter.

Abdomen.
The suprarenal capsules were absent. Their places were occupied by small masses of fat, through which ran some strips of fibrous tissue. The kidneys and other abdominal viscera were healthy.

Comments. During seventeen years experience first as a student and afterward as a graduate it has fallen to my lot to see but one case of the disease first described by the late Dr. Addison in 1855 under the name of "Amyloid Disease," and afterward known to the profession as "Addison's Disease" out of compliment to the celebrated physician of Guy's Hospital.

Dr. Addison had been struck by the dark or clouded appearance of the skin in certain cases of anaemia the cause of which he could not ascertain, these having been too important for blood, too minuscule for poisoning, too long or apparent wasting disease. Still there was in all the cases the most marked debility, ending invariably in death.

Addison on the Constitutional and Local Effects of Disease of the Suprarenal Capsules - London - 1855
Careful post-mortem examination reveals the fact that in every case there was some pathological condition of the suprarenal capsules. Dr. Addison believed he was justified in ascribing the peculiar discoloration and the emaciation of asthenia to suprarenal disease.

Addison's treatise naturally directed the attention of physiologists and physicians at home and abroad to this newly discovered disease.

M. Brown Légeraud* made experiments on animals to ascertain the effect of excision of the capsules, and found in 60 cases that death invariably followed — 1½ hours being the average length of life after the operation. — Death was not the result of hemorrhages, peritonitis, injury to the kidneys or liver or any other important organ in the neighborhood of the capsules.

It was remarked that when both capsules were extirpated the following series of phenomena almost certainly followed: "an excessive perspiration, respiration at first more active, soon slower, dyspnoeic, irregular; the heart action quickened; temperature below normal — and as death approached various phenomena such as vertigo, convulsions, coma." (Clinique Médicale - Trouseau, tome III, p. 585)

When one capsule only had been removed, the same symptoms were produced, but more

*Brown Légeraud. Journal de Physiologie 1858.
more slowly, and after the animal had seemed to rally. The convulsions were restricted to the side on which the caustic had been applied, and the animal turned round and round exactly as happens when one of the nerves of the cerebellum is divided.

Mr. Brown-Legend Fortune believed that he had discovered the cause of a certain epigastriæ disease in rabbits, characterized by a remarkable increase in the colour-mixture of the blood, to be an inflammation of the suprarenal caustics. The conclusion he arrived at is that "one of their functions exist in modifying a certain substance destined to be transformed into pigment, modifying it in such a way that the transformation does not take place."

On the other hand Mr. Harley demonstrated that if the operation of expelling were carefully performed & alteration was caused in the health and optimum appearance of the animal.

Schiff, Schmidt, Lancansky and Rosbach "see


Giemsen's Cyclopedia. Vol VIII. p. 637
'said no special evil resulting from the removal of the spleen and the nerves supplying the capsules; and Eulenburg and Guthmuller assert "we have no actual decisive proof that disease of the aërenchymal sympathetic nerves rise to the symptoms of Addison's Disease." The theories of other physiologists who look upon the capsules as essentially blood-glands are equally conflicting, and the important fact must be borne in mind that it has never been shown that the blood in these excretories (in Addison's disease) presents any constant departure from the healthy state."

After consulting all the best authorities, English, French, and German, it appears to me that our knowledge of the physiology of the suprarenal capsules so far as morbid disease is concerned, is to be found in the words of Dr. Addison himself, written recently thirty years ago:—"We know that these organs are situated in the immediate vicinity and in contact with the solar plexus, and the semi-lunar ganglia, and receive from them a large supply of nerves, and who could tile what

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** Brinton. Practice of Medicine.

what influence the constant of these diseases
organs might have on those great-nervous centries, and what share their secondary
effect might have on the general health,
and in the production of the symptoms
presented."

Whatever may be the divergence of opinion as
regards the physiology of the supra-nerved eaf.
nerve, and the part they play when diseased,
there can be none as to the following facts: viz.
that Addison's Disease is characterized by a
peculiar condition of anemia, and deepening
of the color of the pigment in the cells of
the late-necromous accompanied, if not caused
by a pathological condition of the supra-nerved
fibers. What the pathological condition
consists in, is a question on another question.
As regards the Anemia, a as some call it
anemia, little need be said. In the case
which I have just recorded it struck me
very forcibly. I have never seen anything
like it except in cases of melancholia.
The pigmentation of the skin in a well-marked
case is of itself diagnostic of the disease.
In my case the man had all the appearance
of a Eunuchian, and as I lived for a
while in India I ought not to make any
mistake on this head.

In some
In some cases, I believe it is not so characteristic, and authors warn their readers against confusing with it the dirty colour seen in filthy people, the result of filth, venereal exposure, (Vergänzung forbeny of Vogt) and the change which sometimes occur in the skin of subjects of malaria, syphilis and wasting diseases. No case of Addison's disease is at all likely to be taken for anything else, but other disorders may be supposed to be indicative of Addison's disease, by those who have never been a genuine case.

I do not know whether special attention has ever been directed to the infra-sexual castrates in the dark races; but if so, it would be interesting to ascertain whether they differed in health from those of European, and were more liable to disease.

It is when we proceed to inquire what the pathological appearances are in the disease under consideration that we again enter on the field of controversy.

In the discussion which Addison so monograph reached there were those who denied that such a disease as he described ever exists, or at least so far as any unmistakable state of the condition has to do with it. This arose from mistakes in diagnosis: and secondly, from
the fact that Addison believed that the capsule might present various forms of disease—tubercle, cancer or amyloid, fatty, a caseous degeneration, etc. Dr. Hill* maintains that Addison's disease is associated with but one series of changes in the intra-renal capsules. He asserts that inflammatory action leads to the formation of an albuminoid material which, after a time breaks down. He describes three stages in the process.

In the first, the capsules are enlarged, their original structure is gone and its place taken by an albuminoid matter, greyish-white, homogeneous, somewhat translucent. In support of the inflammatory theory he says that the cortical part of the capsule is found tough, thickened and adherent to the neighboring parts.

In the second stage, the albuminoid material degenerates into a substance resembling soft yellow tubercle镶嵌ed in the fibrolipid matter.

In the third stage it presents the appearance of ordinary yellow tubercle; the organ shrinks, a drying up process takes place, and a caseous matter may be formed.

In many cases a still further change ensues by

Dr. Wilks. Article in Reynolds' System of Medicine. Vol I.
by a process of softening, and the solid matter becomes converted into a creamy or pus-like fluid so that when the capsule is cut through this may escape just as in opening an abscess. Herein lies the explanation of those recorded cases of supposed Addison's Disease where it is stated that no capsules were discovered, but a little purulent matter occupied their place. Is my case to be thus explained? But in it there was not even any purulent fluid. The capsules were represented by fat.

The greater number of authorities have agreed in designating as truly "tubercular" the appearances, described by Dr. Wells; some agreeing with him that they are the only appearances ever met with, while again other writers declare that haemorrhage into the medullary substance, and new formations have been found in undoubted examples of the disease.

Against the tubercular theory Dr. Wells argues with much force that it is against clinical and pathological experience to find tubercle ultimately proving fatal existing for so long a time without manifesting itself in other organs, notably the lungs: for in the majority of cases the capsules are
are the only organs found diseased after death.

In the case of cancer, it runs a rapid course, and affects neighboring parts, and visera is seems also doubtful whether it can ever be a factor in any case of Addison's disease: but may be the "inflaming" product of low vitality taken in some cases malignant action? Physiologists and pathologists must speak in more certain terms before the mystery of Addison's disease is solved.
Ascites

Undiagnosed cause. Pericarditis.
Recovery.

Charles Chatfield, aged 51, married, Carter,
of very intractable habits, born and resident in
Gwenfryn, consulted me in November
1879 complaining of debility, cough—
and shortness of breath which had come on recently.
The debility was partly due to excessive
drinking, beer being his favourite beverage. He
rarely drank spirits. He was one of those
rare cases patients who make the most of their
ailments, and frequently appear to be very
much worse than they really are.

Respiratory System:
Inspection note over both lungs was equal, and
normal. On Auscultation, a few moist
rattles were heard over both sides of the
chest. Sputum, mucous.

Circulatory System:
Pulse small, regular, 80. A脉 beat below the
6th rib, three inches, directly below the nipple.
Transverse
Transverse cardialik dulness 2½ inches. The heart sounds were normal; the action regular. There were at this time no abdominal symptoms. The temperature was normal.

The patient was suffering from slight bilious cholic, and cardiac hypertrophy.

After a few weeks rest in bed, ordinary medicinal treatment, and plenty of good nourishing food, patient's health was so much improved that he was able to come downstairs. His ankles swelling and the dulness remaining his legs he was ordered back to bed where it was found that the peritoneal cavity was filling—the ascites increasing rapidly. The vertical hepatic dulness was 5½ inches compensatory, and 4 inches positive dulness in the vertical ripple line. The lower edge of the liver corresponded with the false ribs, and was not rough to the touch. There was no jaundice. No abnormal abdominal growth was anywhere to be felt. The urine was slightly diminished in quantity, and was free from albumen. It was frequently examined. The chest symptoms had disappeared but the health again to be embarrassed by the ascites.

Diuretics were given; and the bowels freely acted.
acted on by the terium. The ascites increased very fast, so much so that in less than two months time the patient measured 47 inches round the abdomen, and appeared to be slowly dying.

As it had become evident that relief could be afforded only by perecutaneous abdominis, I tapped the abdomen with a common trocar and cannula in the ordinary situation, and drew off about five and a half gallons of light straw-coloured fluid. Support being given by a broad bandage gradually tightened. The operation was done fairly well.

I naturally supposed that the means employed for the removal of the fluid would give only temporary relief, but it was not so; the patient improved from the day of the operation. No more ascitic fluid was secured, and no symptoms whatever existed. The anaemia of the patient, extirpation of the appendix, symptoms quickly disappeared. Stimulating treatment and generous diet completed the cure and in three months time patient resumed work.

The liver was carefully examined after the perecutaneous, but afforded no clue to the case.

All
All this happened four years ago. During these four years patient has been at work excepting twice when he has been under my care—once for an injury to the thigh caused by the kick of a horse, and once for a few days from nervous vitality reduced by excessive drinking.

I examined him a week ago. Perussion and auscultation revealed nothing abnormal in the lungs. The apex of the heart beats between the 6th and 7th ribs as before: the transverse diameter in the nipple line is 2½ inches. The heart was duplicated once while I auscultated. The sounds were normal.


Comments. What was the cause of the ascites? Here we have a weakly patient who has drunk beer (her drink) excessively suffering at first from the effects of slight cardiac hypertrophy. Anasarca and ascites set in. The latter to a large amount. There are no signs of hepatic or other abdominal disease. The urine does not contain
contain albumen. The patient is evidently dying when he is tapped; a large quantity of fluid is drawn off. The ascites disappears, and in a few weeks the man is well, and has continued in fairly good health for more than four years.

It is impossible to attribute the ascites to the condition of the heart; and yet that again was the primary cause of the man's illness. Are we to seek for the cause in the peritoneum itself; in an obstructed portal circulation; or lastly, in an impoverished state of the blood generally?

As regards the last named cause, ascites arising therefrom is usually small in amount, and accompanied by general anaemia; or if considerable in amount, the liver is certain to be found primarily or secondarily affected. Besides, the fact of the rapid, and what may be called permanent recovery, is against the theory that a disease affecting the general circulation gave rise to the effusion.

Undoubtedly the vast majority of cases of abdominal dropy owe their origin to obstruction of the vena portae, either directly.
directly or through the liver, and the disease most commonly is cirrhosis of that organ. That the man did not and does not suffer from cirrhosis is almost certain. In the first place he is a beer-drinker; secondly the liver was not, and is not diminished in volume; thirdly the man is alive, and the death has never returned. There is no evidence of other hepatic disease. Does the vena porta directly resemble upon outside the liver? Such cases are rare. During the man's illness I considered it possible that there might be pressure from malignant growth, but the man recovered, and this simple answer refutes every thing that can be added under the two series of causes already considered. We are driven then to the conclusion that the cause of the death was the peritoneum itself. Ordinary acute and chronic Peritonitis may be dismissed without comment, as may tubercular and cancerous disease. There remains heaving them save the theory that the minute capillaries of the peritoneal membrane became temporarily obstructed from some unknown cause; the fluid poured out by
by them by pressure posteriorly on the veins of the mesentery and omentum still further favoured expulsion. Once the pressure was removed the circulation righted itself.
The anaesthesia of the lower limb was of course due to pressure of the ascitic fluid on the inferior vena cava.
Intestinal Obstruction.
Fecal Vomiting.
Unknown Cause.
Recovery.

A case of the above which interested me much occurred in my practice in February 1877. It was the sixth attack which the patient, N. J., had had.

N. J. is a retired winemaker, a native of Surrey, aged 76 years, tall and hearty. He has not lost a single tooth, nor has he a single decayed one. With the exception of the attacks of illness which I am about to describe he has always had robust health.

He is not and has never been subject to constipation, and although formerly drinking sometimes a little more than was good for him he may be called a regular liver.

The history of all his attacks is pretty nearly the same viz.: severe pain, coming on suddenly in the abdomen without previous emesis. Constipation; Complete prostration; inability to go to stool; etc.
go to stool; sickness; diarrhoea; vomiting; coming on on the second or third day; and lasting for two or three days; and rapid recovery after having at last had a movement of the bowels. He has never been able to assign any cause for his illness, nor have the numerous medical men who have attended him been able to enlighten him.

The first attack was in 1850 when he lived at Newhaven, Sussex. He was then attended by the late Dr. Skinner and Nokes, who tried very heroic treatment, stopping short of giving solid mercury only because the patient suddenly recovered, much to their surprise. This attack came on after violent exertion at rowing. He was laid up a second time at Newhaven, a year or two subsequently. His third attack took place in Brighton, where he was attended in 1857 by the late Mr. Lawrence. He was again ill in 1871, under the care of the late Mr. Holman, and again in 1878 (Mr. Monckton) with precisely similar symptoms.

On February 28th, 1878, I was sent for to see him, and found him suffering from severe abdominal pain, which had lasted several hours, and "come on all at once" when he was in his usual
usual health. The bowels had been relieved on the previous day, but he could not now have a motion, although he strained very hard. Pulse and temperature were normal. There was no abdominal tenderness or distension. Physical examination of the abdomen revealed nothing abnormal. There was a small and easily reducible incisional hernia which he had had for five or six years only, and which had never caused him much inconvenience.

Knowing well the history of his previous attacks, I yielded to his solicitations and gave him a strong dose of castor oil. This not having the desired effect, an enema of castor oil, and acetate of iron was administered with no better result.

On the following day, March 1st, sickness had come on, and he told me he was now sure that he was in for one of his turns. The abdominal pain was at times excruciating. There was nothing to be discovered on physical examination. The patient described a sensation of "something rolling over and over in his side," but no rolling movement was communicated to the examining hand. I refused to give any more opium, and prescribed opium in pill every two hours until the pain was relieved. As the patient thought that he felt more abroad he
be consented to take them. Two enemas were thrown up in the course of the day, a long tube being employed. "Percutaneous" sticks were applied to the abdomen. Ice and champagne were given by the mouth.

March 2nd. Stomach seems vomiting began. Liquid, stringy vomiting forces were brought up by the patient. Patient, a headling man, required an inducing solution to induce one draught of liquid to facilitate their coming up, as he said.

March 3rd. Patient in much the same condition; constantly vomiting forces; he is in less pain, but is more tormented. Brandy has been substituted for champagne. Nothing is retained on the stomach.

March 4th. Patient's condition unchanged except that he is somewhat more tormented. No relief by the brandy. The case appeared to me to be hopeless. Patient's wife said that she had never seen him so ill, and he himself began to be despondent.

Towards evening he had a slight return of hardish forces which had been thrown away before I had an opportunity of examining them. There was no blood passed, nor any felt-like lump. No particular sensation was experienced in the abdomen before the brandy acted.

March 5th. Patient had a good night and is in good spirits. Vomiting has quite ceased. Bowel passed twice naturally.
In a few days the patient had completely recovered. He has not had an attack since.

Comment. It seems idle to guess what may have been the cause of the obstruction in the above case. The mode of origin and progress of the case point to intestinal strangulation of some part of the small intestine. Of what nature was this strangulation? It is only reasonable to suppose that it was the same in all three attacks. Does there exist some aperture in one of the peritoneal duplications through which a coil of intestine got caught, or are we to look to the foramen of Winslow or the vermiform appendix for an explanation? Or again does the gut get twisted upon itself? The most incomprehensible part of the whole case is how the gut frees itself from the strangulation. Perhaps a post mortem examination may some day elucidate the difficulty.

S. J. Malcolm Smith.

Add. Mr. 1871.
G. J. M. Lee-Smith, M.B. On.

1871.

"Rare Cases of Abdominal Disease occurring in Country Practice"