SOME RECENT ABDOMINAL CASES TREATED IN THE ROYAL HERBERT HOSPITAL, WOOLWICH; WITH REMarks.

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The following five consecutive cases of abdominal disease presenting themselves for treatment at this Hospital make an interesting series. It is often urged as a great objection to military service, that the Medical Officers of the Army have not sufficient opportunities of studying the ordinary diseases of every-day life, or of performing the usual operations of surgery. While we cannot claim that they see the enormous amount of practice to be met in one of the large metropolitan hospitals, I think the following cases, which occurred within the space of a few weeks in the ordinary routine of this Hospital, demonstrate that there are opportunities for differential diagnosis, and also for surgical practice, in our military hospitals.

That surgical interference is now held to be indicated in an increasingly large number of abdominal cases is I think generally conceded, and the question when to open the abdomen, and when to refrain from doing so, is by no means an easy one to answer in every case. Certainly with our present knowledge and surgical methods, the operation for opening and exploring the abdomen in doubtful cases is not such a serious undertaking as it was formerly looked upon. For good to result, however, this operation must not be too long delayed. My experience leads me to believe that many more cases are lost either from not operating, or delaying too long, than from an over anxiety to operate.

Case 1.—Acute obstruction occurring in a case of malignant disease of the colon: laparotomy—death.

Sergeant W., aged 36, was admitted on March 31, 1902, complaining of vomiting which had lasted some days, and severe pain and colic. He stated that for the last eighteen months his bowels had not acted regularly, and he had suffered from dyspepsia and colic. At times he had constipation, at other times diarrhœa. No blood had been observed by him in his motions. He stated that he had suffered from three somewhat similar attacks previously. His appearance was very earthy and cachectic, and he looked like a man suffering from malignant disease. This Non-Commissioned Officer had been employed latterly as a clerk and was therefore
able to remain out of Hospital longer than he would otherwise have been able to. The acute symptoms had been present for some days before his admission. On admission the abdomen was a good deal distended and tympanic all over. There was no great localised tenderness on pressure but the whole abdomen was painful to the touch. Colicky pains were referred to the umbilical region. He was vomiting at intervals, the vomit being sour and offensive, but not stercoraceous. Enemata were administered, with the result that a small quantity of faecal matter came away, but the distension and vomiting were not relieved. He was unable to pass any flatus. It was evident that some acute intestinal obstruction, superadded to a chronic condition, had become established. The symptoms of obstruction becoming more marked, and no relief being obtained by other means, it was decided after consultation to open the abdomen and explore it. Malignant disease of some part of the greater bowel was diagnosed. The operation was performed by Lieut.-Col. Hickson, in charge of the surgical division. The abdomen was opened in the median line in the usual way. The intestines were found much inflamed and distended. On reaching the descending colon a tumour was found to occupy the lumen of the gut. The growth was adherent to the abdominal walls. In manipulating the gut a rent took place, which was at once closed by Lembert sutures. The intestine above the tumour was brought into the median wound and opened and stitched to the abdominal parietes. After the abdomen had been freely washed out, the external wound was closed. The patient, whose condition at the time of the operation was very bad, did not rally. The tumour was found to be an epitheliomatous growth, involving the entire circumference of the gut, and obstructing the lumen of the descending colon. Colloid degeneration of part of the tumour had taken place.

Remarks.—This case was not seen till an acute obstruction had become established on a chronic condition. The Sergeant being a clerk did not report sick till his condition was far advanced. Laparotomy was undertaken with a view of establishing the diagnosis, and if malignant disease was found, to afford relief by colotomy, if complete removal, or short circuiting, could not be carried out.

Case 2.—Malignant disease of the rectum: inguinal colotomy—temporary relief.

Private W. P., aged 20, was invalided home from Bermuda on March 19, 1903, with the following history. For the last nine
months he had suffered from diarrhoea and uneasiness in the abdomen. He had pain in the left iliac fossa, where a hard mass could be felt. Examination by the rectum revealed a well-marked stricture about 3½ inches from the anus, which admitted the tip of the index-finger with difficulty. There was no history of syphilis or of dysentery. The stricture was annular in shape, hard and resisting. He had an evening rise of temperature of about one degree.

He was admitted to the Royal Herbert Hospital on April 27, 1903, on his arrival as an invalid from Bermuda. He gave a long history of uneasiness in the abdomen and diarrhoea. No blood had been noticed in the stools, but slime had occasionally been present. He had arrived at Bermuda in January, 1903; two days after he landed he had a severe attack of colic and was admitted to the hospital, where the stricture of the rectum was discovered. On his admission to the Royal Herbert Hospital he was emaciated and weak. The abdomen was distended and dull on percussion in the left iliac fossa. A hard mass could be distinctly felt in this position. On May 5 he was examined while under the influence of an anaesthetic. A hard tumour was found completely encircling the gut about 3 inches from the anus. The tip of the index-finger was only just admitted, and it was impossible to pass the finger through the stricture, and thus to find out its extent. He experienced great difficulty in passing his motions, and several sub-acute attacks of obstruction had occurred; it was therefore decided to perform inguinal colotomy. This was done by Lieut.-Col. Hickson on May 29, the gut was fixed to the abdominal walls, and opened some days later. He obtained a good deal of temporary relief, but the growth increased rapidly and he died on July 21.

Post-mortem examination showed that the growth involved the whole of the circumference of the rectum, starting 3½ inches above the anus. Capt. Lawson, R.A.M.C., the pathologist, reported that the growth was a columnar epithelioma, which had in places undergone marked colloid changes, and also mucoid degeneration.

Remarks.—The patient was rather young for this form of disease. The advisability of performing a Kraske's operation for complete removal of the rectum was discussed; but the advanced nature of the disease did not hold out any prospect of success, and inguinal colotomy was simply performed as a palliative measure. Lumbar colotomy would probably have been a better operation, as the growth was very close to the artificial anus in the inguinal operation.

Case 3.—Intestinal obstruction, probably functional and resulting from paralysis of the small intestine: recovery.
H. R. Whitehead

Lieut. K., R.H.A., aged 22, was admitted to Hospital May 29, 1903. He gave the following history of his attack: On Sunday, May 24, he went up the river with some friends, and had lunch and dinner at riverside Hotels. The next morning he was seized with severe colic, he took a dose of castor oil and opium. That evening and the next morning his bowels were freely opened. He was staying in London, but as his leave was up he returned to Woolwich on Tuesday, May 26. Early the next morning he was again attacked by very severe colic, and took another dose of castor oil and opium, after which his bowels were opened very freely, but the pain remained constant. The pain was general over the abdomen, and he vomited at intervals. The abdomen became considerably distended, and was painful on pressure; he also had some rise of temperature. I saw him on May 29, he seemed very ill and I ordered his removal to the Hospital. For the next few days his condition was serious, he had considerable abdominal pain and distension, and vomited every two or three hours. The distension of the abdomen was uniform, and there was a good deal of abdominal pain, chiefly referred to the umbilical region. No action of the bowels took place after May 27 and he was unable to pass flatus. On May 30 hiccough occurred. The temperature was now normal, but the patient was very weak and feeble with a quick pulse, and his condition very serious. On June 3 the vomit was distinctly stercoraceous. He was being fed nearly entirely by nutritive enemata. On June 6 he passed a considerable amount of flatus by the rectum. After this the vomiting ceased, and the abdomen became more flaccid, and on June 3 the bowels were opened naturally, and the vomiting and other symptoms disappeared. From this date he slowly but steadily recovered.

Remarks.—This was an exceedingly interesting case. The question arose as to the cause of these symptoms, and whether the case was one of acute obstruction requiring operation. The presence of stercoraceous vomiting at one time seemed to favour this view, but the onset of the case, with diarrhoea and purging, appeared rather to negative it. Probably some acute enteritis, either from purgatives or ptomaine poisoning, was present, and paralysis of some portion of the small intestine took place. I had the advantage of the opinions of Dr. Allchin and Dr. Tunnicliffe in this case.

Case 4.—Acute inflammation of the liver and spleen, with general peritonitis, due to malaria: death.

Pte. A. R., R.G.A., was admitted on June 4, 1903, as an invalid
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from Hong Kong, suffering from ague. While in Hong Kong he was admitted to Hospital thirteen times with this disease. His last attack of ague there was a very severe one, evidently a form of "pernicious malaria." It was noticed that he had malignant parasites in his blood. The spleen and liver were enlarged, and he had suffered from hematemesis. On his admission to the Royal Herbert Hospital, he was suffering from marked malarial cachexia and was very feeble and weak, but stated that he had considerably improved on the voyage home. On examination, both liver and spleen were found much enlarged and tender to the touch. On June 20 he had a sudden and sharp rise of temperature in the evening, he complained of abdominal pain, which was general, but rather more marked in the right iliac fossa, and hepatic and splenic areas. The abdomen was distended and tympanitic. The next day, June 21, the pain was less, but he commenced vomiting; his bowels were opened and his urine, on examination, showed a trace of albumen. On June 24 the abdominal pain was much less and the vomiting had ceased, the abdomen was still distended, however, and tympanitic. His temperature was lower, and the patient seemed better. The tongue was clean and the bowels open. On June 27 the vomiting commenced again, and his temperature rose. The abdominal pain was not so marked, and was more localised over the hepatic region, but the abdomen was considerably distended. On examining his blood Capt. Lawson found malignant quotidian parasites and crescents. There was no leucocytosis. On July 1 the vomiting was incessant, the patient became very exhausted and died the next day.

On post-mortem examination the abdominal cavity was found in a condition of acute septic peritonitis, with thick greenish flakes of pus scattered all over the intestines, which were matted together. The liver was also thickly covered with similar flakes, and its surface was intensely congested. The coils of the intestine were separated with great difficulty. The vermiform appendix was normal, but found down to the cecum. No perforation of the intestines was present. The liver and spleen were both much enlarged. On hardening and cutting section of the liver, Capt. Lawson found a condition of profuse pericellular inflammation, and made the following remarks on the case: "Pericellular cirrhosis of the liver is now becoming a recognised sequel of prolonged exposure to malarial infection, especially the pernicious type. I think the condition is due to the irritating nature of the yellow pigment, most probably manufactured in the spleen, and not, as usually supposed, to repeated attacks of congestion."
Remarks.—In this case the onset of acute septic peritonitis was considerably masked by the other symptoms. Had the condition been thoroughly recognised, drainage and irrigation might have held out some prospect of success. The condition, however, appeared one of acute inflammation of the liver and spleen, so often associated in old-standing cases of malarial poisoning.

Case 5.—Intraperitoneal abscess, peritonitis—laparotomy and drainage: recovery.

Driver J. M., R.F.A., aged 29, a local case, was admitted to the Hospital on June 19, 1903, suffering from perforation of the membrana tympani and a purulent discharge from the right ear. On June 29, while under treatment for the above condition, he began to complain of pain in the abdomen, principally referred to the left iliac region. On palpation there was a distinct feeling of hardness and resistance in this region. The bowels were open, but the motions were scanty. He had suffered from dysentery some months before, and occasionally had blood and slime in his motions. He began to have constant fever, and vomited at times. The abdomen became distended, and the hardness and tenderness remained in the left iliac region. On July 3 the symptoms were more pronounced. He had a temperature of 101° in the morning, his tongue was moist but thickly furred, and his abdomen considerably distended. The diaphragm did not move much on expiration, and the abdominal walls were hard and rigid. He now complained of considerable pain over the whole abdomen. On percussion the upper part of the abdomen was tympanitic, but marked dulness existed two inches below the umbilicus and extended right across the abdomen. On July 4 he seemed better, the bowels were opened three times, and he passed a good deal of flatus, but chiefly by the mouth. There was less tenderness and more confined to the left iliac region. His blood was examined by Capt. Lawson, R.A.M.C., and marked leucocytosis found. It was evident that the case was one of acute peritonitis. The abdomen became more distended, and the fever and vomiting continued. On examination per rectum the finger could feel high up a hard resisting mass, which was situated in front of the finger and to the left side, and was acutely painful. The abdomen was now very distended and painful, the vomiting became more frequent, and the patient’s condition was very grave. On examination of the urine, albumen and epithelial casts were found present.

On July 8 I decided to open the abdomen and explore it, and to wash it out and drain, if necessary. The usual incision in the
middle line was made between the umbilicus and the pubes. On opening the peritoneal cavity a quantity of thin purulent fluid escaped. The fluid had a very faecal odour, and contained numerous flakes of yellowish lymph. The coils of the intestine were reddened and covered with shreds of lymph and were much matted together. The cæcum and appendix were examined and found normal. The upper part of the abdomen was not affected and was shut off by adhesions. On examining the abdomen towards the descending colon a collection of very offensive thick yellow pus was discovered. In this region there was considerable matting of the intestine, and the surface of the large gut was covered with lymph. The abdomen was thoroughly washed out with warm sterilised saline solution. No perforation was discovered, and it was thought undesirable to disturb the intestines to any great extent. A drainage tube was passed well down into Douglas' pouch and the abdominal wound closed. The patient was rather collapsed during the operation, but rallied well under the usual remedies. For the first few days the discharge continued very faecal in odour and very profuse. The dressings had to be repeatedly renewed. Gradually the discharge lost its faecal smell and became less. For several days after the operation the temperature remained above the normal, but this gradually fell and the wound was completely healed by August 16.

Remarks.—The case was evidently one of localised abscess about the descending colon, with peritonitis of the lower part of the peritoneal cavity. The origin of the abscess seems doubtful. The patient had chronic kidney disease, but there was nothing to point to the abscess being connected with the kidney or ureter. The man was suffering on admission from subacute dysentery, and possibly the abscess was caused from a dysenteric ulcer as the starting point.
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