A CASE OF RUPTURED JEJUNUM ASSOCIATED WITH A BURST APPENDICULAR ABSCESS.

(By kind permission of Dr. W. W. W. WATT.)

This case is presented on account of its interesting and perhaps unusual history.

HISTORY.—N.B., aged 15 years, was sparring (with 8 ounce boing gloves) with his elder brother after supper on the evening of the 6th March, 1928. He states he was struck in the pit of the stomach and was merely "winded," the blow not having been a severe one; he took to his bed shortly afterwards. At about midnight he complained of pain in the region of the stomach and commenced vomiting; this continued until morning, the pain radiating all over the abdomen and finally settling down in the right iliac region.

EXAMINATION.—Patient seen the same evening.

Pulse 96. Temperature 100.4. Cold clammy sweat on forehead. Pain chiefly in the right iliac region. Hyperaesthesia on right side abdomen. Muscular rigidity especially marked in right iliac region, though not confined to this area. Respiration not entirely thoracic. No diminution of liver dullnes.. Both thighs held flexed.

Four hours later in Hospital, rigidity had extended to whole of abdomen, as also tenderness. Pulse now 112. Temperature 101. His mother had given him castor oil at home, but his bowels had not worked. The medical practitioners called to see the case differed as to the diagnosis, one view being that it was a ruptured bowel with peritonitis, the other, that it was a burst appendicular abscess with peritonitis. An emergency operation was performed.

OPERATIVE MEASURES.—ANÆSTHETIC: Chloroform induction, Ether and Oxygen.

Pararectal incision was made on right side. On opening into Peritoneal cavity, the pus came up into the field of operation; no foul odour. The Omentum was lying over the Caecum and Appendix. The latter was presented with great difficulty, an appendicular abscess being found present. Appendicectomy performed, stump being buried with purse string suture.

Before closing the abdominal wound some grape pips and mucus were found lying in the Peritoneal cavity. Small intestine was presented and a ruptured Jejunum discovered, site of rupture being 18 inches to 2 feet from Duodeno—jejunal junction. The opening was through all coats of intestine, being about the size of a shilling.

Abdominal incision was increased in length upwards, Jejunum repaired, peritoneal coat being overstitched.

Bowel returned, abdominal cavity gently swabbed with saline and two drainage tubes inserted, one into the right side of the pelvis, the other into the epigastrium. These discharged for eight days, the lower tube more so, and having the odour of B. Coli pus. Tubes were removed on tenth day.

POST OPERATIVE TREATMENT.—Immediately after operation the patient required stimulation, and was given 1 c.c. Pituitrin, 1/30 gr. Strychnin and 5 c.c.'s Thromboplastine (as a precaution against Hæmorrhage). He was then put on to Eserine 1/100 gr., six hourly, until the 4th day.

After the operation his pulse went up to 114, his respiration 32.

His general condition was quite good, however.

On the second day he returned a strong Saline enema with clear result; on the 3rd day he was given his oil, and his bowels operated successfully; on the 4th day he was started on injections of B. Coli

Vaccine, 25 million, doubling the dose every 4th day until getting 200 million; continued latter for two further injections.

His temperature rose gradually each day till it reached 100 on the 4th day and then subsided.

POST OPERATIVE DIET.—FIRST DAY: Milk only.

SECOND DAY: Robinson's Patent Groats.

THIRD DAY: Strained porridge, Nutrine.

FOURTH DAY: Jelly, junket, and custard added to the diet.

At the end of the week, fine mashed Potatoes with Butter, Beef Juice and stale Bread crumbs, and a soft Boiled Egg.

On the 10th day he was put on to Minced Chicken one ounce, increased slowly. Then given convalescent diet. Horse serum dressings to wound expedited healing.

The patient left Hospital at the end of six weeks.

CONCLUSION.—The points of interest in this case are:—

(1) The patient had been indulging in fairly severe exercise without suffering any symptoms from the appendicular abscess.

(2) A blow, with a bloxing glove, of only moderate force (the physique of the two brothers much the same) was sufficient to cause at one and the same time a rupture of the Jejunum and a bursting of the Appendicular abscess.

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A CASE OF COMBINED INTRA- AND EXTRA-UTERINE PREGNANCY GOING ALMOST TO FULL TERM.

On the 13th July, 1928, at 10.30 p.m., a native woman, aged 20, was admitted to the Non-European Hospital, Johannesburg, complaining of acute abdominal pain. Patient had given birth to an eight months child six days previously; the child had lived for three days. The pain of which she complained commenced immediately after the birth of child.

On admission her temperature was 102, her pulse 140 per minute. She appeared to be very ill. Her abdomen was distended and there was palpable a large mass rounded in contour and extending from the pelvis, whence it arose, to the level of the umbilicus. To the right of this was another mass which was identified as a foetal head. Toward the left hypochondrium could be felt the foetal limbs, movement of which was determined. On auscultation, foetal heart sounds were distinctly heard. Per vaginam it was decided that the mass to the left was the uterus. In the posterior fornix a soft boggy mass was to be felt. There was also a considerable amount of tenderness.

The diagnosis rested between a twin pregnancy with ruptured uterus, the uterus rupturing while the first child was being delivered per vias naturales, and a co-incident intra- and extra-uterine pregnancy. It was decided to operate immediately.

On the 14th July the abdomen was opened. The child was found lying across the abdomen, the head in the right hypochondrium and limbs in the left. The back of the child was towards the back of the mother. The placenta was attached to the right side of the uterus and the broad ligament. The umbilical cord was pulsating and the child was removed alive, and the cord had been ligatured and severed. The abdomen was then rapidly closed, the patient's condition not allowing time for marsupialisation of sac.

The child died half an hour after delivery, and the mother four days later from Broncho-pneumonia.