A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Procemium.

ST. PANCRAS INFIRMARY.

A CASE OF THROMBOSIS OF THE SUPERIOR MESENTERIC VEINS.

(Under the care of Dr. W. M. DUNLOP, medical superintendent.)

AMONG the many conditions simulating true intestinal obstruction there is none more interesting than thrombosis of the mesenteric vessels. Either the arteries or the veins may be affected; in thrombosis of the arteries the symptoms are very acute, but when the veins only are involved the more chronic forms of obstruction are simulated. Barth,[1] Bradford,[2] and Koster[3] have published cases of thrombosis of the mesenteric veins and 14 cases have been collected by Elliot. In most cases a diagnosis of intestinal obstruction is made and a laparotomy is performed. In one case in which the arteries were thrombosed the portion of bowel concerned was excised with success. For the notes of the case we are indebted to Miss Mabel Stevenson, M.B Lond., junior assistant medical officer.

A man, aged 51 years, was admitted into the St. Pancras Infirmary in a state of extreme collapse. The patient could give very little account of himself, but stated that for some time he had been suffering privations and had had vague abdominal pain. Two days before admission he was suddenly seized with acute pain in the hypogastrium accompanied by vomiting. In this condition he was found by the police and taken to the infirmary. On admission he was evidently moribund, with subnormal temperature and pale and shrunken features. He complained of intense thirst, but the ingestion of the smallest quantity of food provoked copious vomiting of greenish-black fluid which was entirely free from fæcal odour. There was acute pain in the abdomen which was paroxysmal in character. The abdominal walls were flaccid, there was no abdominal distension or tenderness, and the respiratory movements were normal. A few hours later a quantity of bright red fluid blood was passed per rectum. The pain lessened considerably after this, but the patient quickly sank from exhaustion, death taking place within seven hours of admission.

Necropsy.—On post-mortem examination the body was found to be spare and thin, but not emaciated. The abdominal viscera were normal in position. Two feet of the middle part of the ileum were intensely congested, almost black in colour, but not distended. There was a sharp line of demarcation between the diseased and the healthy portions of the bowel, extending into the mesentery along the line of vessels supplying the affected part. There were no signs of peritonitis. On section the intestinal wall was thick and œdematous; the mucous surface was intact. The intestine contained some bloody fluid, similar to that passed before death, but no fæcal matter. The veins in the congested portion of the mesentery were uniformly plugged with firm, dark clotted blood; the corresponding arteries were pervious and healthy. The venous thrombosis did not extend beyond the affected part of the mesentery and no evidence of thrombosis was found in the rest of the venous system, neither could any cause for thrombosis be detected. The rest of the viscera were pale and shrunken, but showed no evidence of disease. The case was apparently one of primary thrombosis of the superior mesenteric veins.

[1] Semaine Médicale, 1897, p. 395.
[2] Transactions of the Clinical Society of London, 1898, vol. xxi., p. 203.
[3] Deutsche Medicinische Wochenschrift, May 26th, 1898.

MONSALL FEVER HOSPITAL, MANCHESTER.

TWO CASES OF PERFORATION OF THE INTESTINE DURING AN ATTACK OF TYPHOID FEVER TREATED BY LAPAROTOMY; ONE RECOVERY.

(Under the care of Dr. R. W. MARSDEN, medical superintendent.)

THERE is no more dangerous complication in typhoid fever than perforation of an ulcer. It is difficult to state with accuracy the mortality from these cases when treated medically, for in most of those in which the patients have recovered after apparent perforation a great doubt must always remain that perforation has not taken place, but we shall not be over-estimating the death-rate in such cases, when not treated surgically, if we put it as at least 90 per cent. Monod and Vauverts[1] have shown conclusively that the mortality in cases treated surgically is certainly less than this. Finney[2] collected 52 cases in which laparotomy was performed, and of these 17 patients recovered. In 1898 there had been recorded 83 cases and 16 recoveries, a mortality of a little over 80 per cent. This is still a high death-rate, but when we consider the low general condition of the patients we are justified in thinking the result good.

CASE 1.—On Nov. 23rd, 1899, a youth, aged 16 years, was admitted into the Monsall Fever Hospital suffering from typhoid fever. He had been ailing for a fortnight and on Nov. 22nd an examination of the blood had shown that it gave the Widal reaction. Clinically the symptoms were distinctive of a moderately severe attack of typhoid fever—i.e., rose spots, enlarged spleen, general bronchitis, a temperature of 104° F., &c.—but the abdomen was soft and free from tumidity, and there was only slight diarrhœa. On Dec. 10th he began to convalesce and the temperature remained normal until the 25th, when a relapse occurred. The relapse was only of moderate severity and was not accompanied by abdominal fulness or diarrhœa, and after 10 days—i.e., on Jan. 4th, 1900—it seemed to be terminating. The general condition of the patient at this time was extremely satisfactory. At 4.30 P.M. on that day, however, he complained of acute cutting pain in the abdomen, which caused the legs to be drawn up and was accompanied by an ineffectual desire to micturate. At 5.30 P.M. the pain was worse, the abdominal muscles were in a state of tonic contraction, and on percussion there was an absence of liver dulness at the ends of the eighth, ninth, and tenth ribs on the right side. The pulse was 88, the temperature was 99·2°, and there was no evidence of "primary shock." At 10.30 P.M. the condition of the abdomen was as described, there being a little fulness, but marked tenderness midway between the umbilicus and the right anterior superior iliac spine. In the interval a greenish fluid had been vomited on three occasions. As the patient was now looking much worse, the eyes being sunken, the pulse 120 and small, the temperature 102·8°, and the respiration of a purely thoracic type, Dr. Marsden decided to perform laparotomy.

The operation was done at 1 A.M. on Jan. 5th, 1900, apparently eight and a half hours after the onset of peritonitis. On opening the peritoneum through a median incision three and a half inches long, a considerable quantity of yellow serous fluid exuded, having a milky appearance from the presence of minute particles of lymph. The intestines were not at all distended—in fact, their walls were quite flaccid and soft. The first loop withdrawn contained a Meckel's diverticulum about one inch in length, and with this excellent landmark there was very little difficulty in finding the perforation, which was situated six inches to the cæcal side of it. It was small, round, about three millimetres in diameter, and, as usual, there was the increased quantity of lymph on the bowel in its immediate neighbourhood. The patches of lymph had a very "curdy" appearance and were readily wiped off. The perforation had occurred in the centre of a greatly thickened patch and had apparently arisen from a progressive ulceration, as there were no signs of sloughing at the edges. There were no peritoneal adhesions—in fact, there was a remarkable absence even of "stickiness" between opposed peritoneal surfaces, and though two and

[1] Revue de Chirurgie, March, 1897.
[2] Annals of Surgery, March, 1897.