Clinical and other Notes

in three cases, but Ehrlich [9] ascertained that 132 capsules of the same supply of “606” sent out to five different clinicians caused no similar effects. Hence it may be concluded that “606” in a dose of 0.6 gramme is harmless.

Schreiber [10] has recommended intravenous injection. But Ehrlich thinks that it is desirable that the compound should be fixed in the muscle or subcutaneous tissue. He [14] states that “606” should not be given in advanced degenerations of the nervous system.

Neisser advocates the use of “606” in every case of syphilis where no contra-indication exists. A review of the evidence before us would lead us to believe that we have entered on a new era in the treatment of syphilis.

REFERENCES.

A CASE OF ENTERIC FEVER WITH COMPLICATIONS; OPERATION; RECOVERY.

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PRIVATE E. was admitted to the Station Hospital, Lahore Cantonment, on January 18th, 1910, with symptoms of enteric fever. On the 20th some blood was taken for a bile test, and on the 23rd the test was reported “positive.” On the 24th a few spots were noticed, and the abdomen, previously retracted, showed some distension. From this date to the 30th the disease ran a normal course, the temperature gradually falling, till on the latter date it remained 98.4° F. all day. Towards evening on the 31st the patient complained of pain and passed a motion containing a little blood. The pain was colicky in character and came on gradually, but there was no local tenderness or rigidity in the abdomen and no
tympanites. The temperature ran up from 98° F., till at 8 p.m. it was 103° F., but by midnight it was again normal, the pulse being 94 and strong. The possibility of perforation was considered, but the patient's general condition and the absence of tenderness and rigidity seemed against it. Twenty drops of tinct. opii were given and the patient passed a quiet night.

The next day, February 1st, the patient's condition was quite good, there being no pain, but the evening temperature was 102° F., pulse 108. The bowels did not act all day.

On February 2nd and 3rd the improvement was apparently maintained, the temperature again falling to and remaining normal. The pulse was 90, and no pain was complained of, the patient sleeping well. The bowels did not act.

On the morning of February 4th there was marked distension all over the abdomen, with tympanites, but no rigidity or local tenderness anywhere. The liver dulness was lost for about the last three ribs in the axillary line, but rose to a corresponding degree above. Two glycerine enemata were ordered and resulted in the passage of some hard masses of faces. A rectal tube was also passed and some flatus drawn off. Next day the distension was still marked, although there was less pain. As the quantity of urine passed was very small (8 ounces in twenty-four hours) a catheter was passed, but only 4 ounces of urine resulted. The glycerine enemata were repeated and turpentine was given by the mouth and used also as stupes. The temperature was 99° F.; pulse 84.

On February 6th and 7th the improvement was maintained, the distension gradually becoming less and the bowels moving freely without enemata. On the 7th and again on the 8th the temperature rose to 101° F., but the pulse remained quiet.

On the 10th the temperature was normal, but there was some return of the colicky pains and the patient had not slept well. The bowels acted four times.

During the 12th he complained of great pain. The distension was very marked and the liver was further displaced upwards, but there was no rigidity or tenderness anywhere. The pulse was somewhat more rapid, but strong. Some peristaltic movements could be seen outlined on the surface of the abdomen. The bowels did not act naturally, but were twice moved by enemata. Urine was passed freely. His temperature remained normal. On the 13th the patient's condition was much the same as the day before, but the pain was less. His temperature still remained normal; pulse 84. The bowels did not act. Morphia was given hypodermically and in the evening the patient reported himself much better. At no time was there any vomiting.

On February 14th I saw him at 7 a.m.; the pulse was 112, small; temperature normal. The case was now one of intestinal obstruction, the colicky pains being very severe and the peristaltic movements of the
bowel could be distinctly seen. The patient's condition appeared to call for immediate operation, so Lieutenant Wells, R.A.M.C., saw the case with me and decided to operate at once. He describes the operation as follows:—

Operation.—I saw the patient with Captain Boyce, R.A.M.C., on the morning of the 14th, and from his condition we decided to operate at once. The patient was taken to the theatre and anaesthetised with chloroform. The skin was prepared in the ordinary manner and afterwards painted with tinct. iodi. The abdomen was opened by an incision 5 inches long in the middle line below the umbilicus. On incising the peritoneum no gas escaped and no fluid was seen. The small intestine was greatly distended and in a condition similar to that found in a case of strangulation: there was no peristalsis noticed in the distended portion. On attempting to examine the intestine towards the right iliac fossa, I found the coils of gut in the hypogastric and iliac regions firmly bound to one another and to the parietal peritoneum by adhesions and covered by a plastic exudation. Owing to this condition and to the fact that the patient was extremely collapsed, I did not attempt to search further for any constriction or possible perforation.

I then packed off a distended loop of gut with aseptic gauze wrung out in warm sterile salt solution, and made a small opening into it. A considerable quantity of foul-smelling gas and some brownish fluid escaped and the loop of gut collapsed. I then closed the opening with Lembert sutures and the distension being only slightly diminished I brought up another loop of gut, as near as I could judge, close to the end of the ileum, and anchored it to the parietal peritoneum by four sero-muscular stitches. I then closed the external wound above and below the piece of gut, suturing layer by layer, leaving some pint or pint and a half of warm sterile salt solution in the peritoneal cavity.

As it appeared imperative from the patient's condition that the distension must be relieved at once, and no Paul's tube being available, I opened the gut and inserted a rubber tube, fixing it in position by two sutures into the skin. A large quantity of gas and brownish fecal matter escaped at once. The end of the tube was then closed with a stopcock, and the wound having been painted with tinct. iodi., was dressed with aseptic gauze and a firm bandage applied, the rubber tube being left outside the dressings. This was afterwards connected up with another long rubber tube reaching into a vessel under the patient's bed.

During the operation the patient showed signs of collapsing and injections of strychnine and ether were given, and also a pint or pint and a half of saline solution was injected intravenously.

In the evening, after the operation, the patient's condition was very good and he said the pain was much less, the temperature was normal, pulse 112 and good. He was kept on plain milk, with a little brandy, in small quantities at frequent intervals and, as it was impossible to be
certain as to the exact position of the coil of bowel opened, rectal feeding was adopted as well. It was found that there was a considerable amount of leakage where the tube joined the bowel, necessitating frequent dressing, and to prevent ulceration of the skin round the wound the skin was thickly smeared with lanoline, with the object of protecting it as much as possible. This was done at every dressing, and the result was very satisfactory, as never at any time did the skin give the slightest trouble.

The patient passed a quiet night, sleeping fairly well, and there was little or no pain. Several pints of fluid passed through the tube during the twenty-four hours. There was a rise of temperature to 99.2° F. in the evening, which was the last rise above normal during the course of the case.

On the 16th, all pain and distension had quite disappeared and the food was increased, three eggs beaten up, and sanatogen, 2 teaspoonfuls being given thrice daily. The tube was working well, but apart from this the bowels were acting freely.

From the 18th onwards the matter passing through the tube became curd-like and, as the lower section of the tube frequently became blocked, it was removed and a short length allowed to empty into a bottle in the bed. The passage of greenish curds through the tube seemed to indicate that the bowel had been opened rather higher up than was at first thought; but against this is the fact that the patient’s nutrition was in no way interfered with.

On the 20th the rectal feeding was stopped and essence of chicken given by the mouth. On the 22nd the tube was removed and a pad applied and the next day the skin sutures were removed.

From this time onwards the patient’s recovery was quite uneventful; food was gradually increased until six weeks after the operation the patient was on ordinary diet with extras, and was quite as well nourished, if not better, than on admission to the hospital.

The wound gradually healed, and now, at the time of writing, nothing remains but a small faecal fistula which is rapidly becoming smaller. An operation to close this fistula was considered but thought to be unnecessary.

The case appears to have been one in which deep ulceration caused infection to spread through the bowel to the peritoneal cavity leading to chronic plastic peritonitis, which in its turn, owing to the formation of adhesions, caused paralysis, and consequent obstruction of the bowel.