A CASE OF EMBOLI ORIGINATING FROM A CARDIAC CLOT PRODUCING ACUTE ABDOMINAL AND OTHER SYMPTOMS.

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PRIVATE A., aged 34, service seventeen years, married, was carried into the Military Hospital, Londonderry, at 9 a.m., on the morning of May 21st, complaining of very severe pain in the lower part of the abdomen on the left side, and he stated that he had vomited during the night.

He said that for the past six weeks he had been greatly troubled with constipation, and attributed the onset of his present acute illness to a dose of salts which he had taken forty-eight hours before admission.

From May 7th to 17th he was a patient in this hospital, the principal symptom being pains in the back. During that time his bowels acted regularly after purgatives; there was no vomiting, and on discharge there was no sign of rupture or abdominal tumour.

On admission he was very anemic, indeed almost cachetic, but stated that he had not noticed any change in his appearance of late years. He looked very ill, his face was pinched, and his pulse rapid and feeble. A large tumour could be seen and felt in the left iliac fossa and on the same side there was a small, incomplete, but irreducible, inguinal hernia; this and the tumour were dull on percussion and extremely tender on palpation. The movements of the abdominal walls were good except in the region of the tumour. Examination per rectum revealed the presence of hard scybalous masses. Frequent enemata produced no result but some flatus was passed. As his condition was becoming worse, and symptoms of collapse were beginning to appear, strychnine was injected hypodermically, and immediate operation decided upon. Operation at 3 p.m.

The hernia was cut down on, and found to consist of a strangulated appendix epiploica; the hernial sac contained blood. The abdominal ring was then opened up and the strangulated contents of the sac were drawn down as far as possible, ligatured and cut off in spite of the fact that really healthy tissue had not been reached. The inguinal canal and wound were then closed.

The abdomen was now explored through a separate incision and the tumour was found to consist of the greatly swollen left iliac meso-colon, which looked quite black; one-third of the circumference of the bowel next to the meso-colon was also very dark in colour. The abdomen was rapidly closed, and the patient put back to bed in a collapsed condition. Saline injections were administered per rectum and strychnine hypodermically. The patient improved towards evening, and took small quantities of liquid by the mouth. After the operation the patient did not suffer from any abdominal pain, there was no further vomiting, and he passed two small motions, the result of saline enemata.
May 22nd.—The patient did not sleep during the night, but is easier and stronger today; slight jaundice is noticeable and the right hypochondrium is tender, but flatulence and distension are troublesome. Albumen water only given by the mouth. Purgative enemata still fail to produce any results. Strychnine and saline injections continued.

May 23rd.—He kept well till 4 a.m., when he suddenly became collapsed, and could not retain the saline injections. The abdomen was tympanitic, and the heart was displaced upwards. Strychnine and stimulants were administered, and two pints of saline fluid were infused into the cellular tissue of the chest. These measures were followed by some improvement. A little later on an enema produced a slight action of the bowels, after which large quantities of flatus were passed. Powders containing salol and bismuth were given by the mouth.

May 24th.—The patient slept a little during the night, and is easier today. The wounds were dressed for the second time. Enemata were followed by slight results. Calomel in one-grain doses and bicarbonate of soda were given hourly for four hours.

May 25th.—Last night the patient slept for four hours, after which the bowels moved well, causing some discomfort. No blood was detected in the motions. He is taking nourishment well.

May 26th.—He had a good night. The abdominal distension has now disappeared and the tumour can be palpated up to the left hypochondrium. A mitral systolic murmur is audible today for the first time. The patient has complained of pain in the left leg for the past twenty-four hours; this has now become worse, and the femoral pulse can no longer be detected.

May 27th.—The patient is better and is taking nourishment well. He had two motions as the result of half an ounce of castor oil. At 9.30 p.m. he cried out and immediately became unconscious, the limbs were flaccid, the pupils dilated but equal, and the breathing deep. He died at 10.12 p.m. without having recovered consciousness. Blood-films made before death showed a very profound anaemia of a secondary type, the number of red corpuscles was reduced, the haemoglobin greatly reduced, a moderate leucocytosis, but only slight poikilocytosis.

Post-mortem Examination.—The abdomen contained a large quantity of blood-stained fluid and many clots. The left iliac meso-colon was greatly swollen, black, and friable, and occupied the whole left side of the abdomen; but strangely enough the bowel appeared to be quite healthy. The other abdominal viscera were all healthy. The embolism could not be identified in the left iliac or femoral arteries, as only a limited examination was permitted. The skull cap was not removed. The heart showed no signs of valvular disease or atheroma, but a large ante-mortem clot was found in the left auricle.

The case was evidently one of multiple emboli originating from the clot in the left auricle. Why this clot should have originated is not
clear, but it may have been the result of his severe anaemia, the predisposing causes of which were malaria and syphilis, from which he had suffered; the syphilis only received symptomatic treatment by the mouth. The strangulated condition of the hernia can only be accounted for on the supposition that the straining induced by the purgatives had forced the appendix epiploica into the inguinal canal, and that while in this position the left colic artery became occluded by a thrombosis, in consequence of which an extreme degree of engorgement of the colon and its appendices was set up, resulting in a condition of strangulation. The revitalization of the bowel, of which a considerable portion was black at the time of operation, is interesting and shows the very free anastomosis of the blood-vessels of this part of the lower bowel.

There is a considerable amount of literature on the subject of superior mesenteric thrombosis, but I have failed to find more than a mere mention of the possibility of thrombosis of the inferior mesenteric artery.

A CASE OF PENETRATING WOUND OF THE CHEST:
OPERATION—RECOVERY.

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This case is recorded on account of the peculiar complications, both as a result of the injury and following on operation.

Private G. S., 2nd Bedfordshire Regiment, employed in the shoemakers’ shop, was cutting the sole of a boot towards his chest, when the knife slipped, penetrated his leather apron and entered the chest. He fell down and was carried to hospital at 2.30 p.m. on April 30th, 1910. Half an hour after the accident I saw him, when his condition was as follows: Pale, very collapsed, and with a cold sweat all over him, he exhibits signs of active haemorrhage, with rapid fluttering pulse. There is no movement of the right chest, but breath sounds are to be heard faintly. Over the fourth interspace, about one inch from the right sternal margin is a linear wound, almost horizontal, which carefully probed goes into the chest 1½ inches or more. Shirt blood-stained, but not excessively so considering the wound was a cut ½ of an inch long. The wound was stitched, a full dose of ergotin injected hypodermically, and the patient placed in bed with the foot raised; the chest was firmly strapped on the injured side. He improved, but as the shock passed off and the circulation was restored, the right chest became progressively dull. At 8.30 p.m., remembering a previous experience at Edinburgh, where I found post mortem a small cut in the right auricle which might possibly have been sutured, I determined to operate with a view to stitching the wound in the lung, or tying the internal mammary artery, which I felt sure was bleeding. His condition was grave in the