Clinical Notes

A CASE OF LUMBAR ABSCESS OPENING THROUGH SACRO-SCIATIC NOTCH.

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The following case came under my care in the Station Hospital, Umballa, Punjab, and presents a curious condition which, although similar cases are on record, is, I think, sufficiently interesting to publish a short account of.

Private C. J., 2nd East Lancs., attached to Telegraph Department, aged 26 years 2 months, service 7 years, was admitted into this hospital on August 13th, 1903, complaining of attacks of giddiness, fever, and pain over sacrum. The medical record showed two severe attacks of secondary syphilis, complicated with inflammation of spinal membranes and partial paresis affecting left arm. No tubercular taint. He stated "he had bruised his sacrum in June, 1903, by a fall, but this did not incapacitate him at the time, and up to the present date he had suffered no subsequent ill-effects." He complained of feeling "out of sorts" for the two days previous to admission, i.e., the 11th and 12th inst. On examination: tongue furred, constipation, and slight tympanitis present. Over right sacro-iliac articulation slight hyperemia was noted with tenderness on pressure and pain on rotatory movement of right leg being made. Purgatives and hot fomentations were ordered. From date of admission until August 27th condition remained unaltered, with varying temperature. Swelling appeared on 26th over right sacro-iliac joint, and on the 28th this was aspirated, when on pus being discovered a large free incision was made extending from half an inch below posterior superior spine for about four inches downwards. The glutæus maximus was cut through and a large quantity of fetid green pus was evacuated. The ilium between crest and superior curved line was exposed, but there was no evidence of erosion of bone. The wound was probed and a sinus was discovered leading towards hip joint about one and half inches in length. The cavity, which here was very small, was doused out with hot perchloride, 1 in 2,000, and a large india-rubber drainage tube was inserted. The wound was again dressed in the evening; there was a copious discharge. Patient felt better; temperature showed marked fall and kept low until the 31st inst., when it again rose. Free drainage was established and large quantities of pus daily drained, so much so that the dressing became soaked and necessitated dressings being changed four times in the day, perchloride 1 in 2,000 being used. Medicinally, patient was ordered iodide of potash and nux vomica.

The respirations were rapid and shallow, but no thoracic disturbance beyond very slight hypostatic congestion at base of left lung could be found. It was then noted that the patient kept his right leg semi-flexed, but could straighten it if required to do so, and did not complain of any pain while
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doing this. On September 6th patient complained of pain in left shoulder-joint with swelling and tenderness. On the 7th, similar condition of right elbow-joint appeared; under treatment these conditions completely disappeared. Condition unsatisfactory; patient appeared to be losing flesh rapidly, although taking nourishment well. On September 11th condition became suddenly worse; vomiting; abdomen distended and tympanitic; very restless.

Turpentine enema was given at once. Rectal feeding and hypodermie of morphia was ordered. Discharge had rather increased than decreased. Wound looked very unhealthy, muscles having a "pus-sodden" appearance. Towards evening patient became delirious and noisy. Abdomen after enema became less tympanic, flatus having been freely passed; but during September 12th abdomen again became tense. A soft tube was passed which gave relief. Stimulants and nourishment were taken well, rectal feeding being discontinued on September 13th. Pulse became weak and irregular and hypodermics of strychnine and digitaline were ordered. Friction sound was noted in fourth left interspace in front, very localised; no pain on pressure.

On September 14th patient became completely unconscious with very noisy delirium. Pulse feeble, rapid and compressible, and in the afternoon he became collapsed and died. Nourishment was taken well to end, but patient did not respond to stimulation. Autopsy was performed shortly after.

Autopsy Notes.

Thorax.—Slight hypostatic congestion of base of both lungs, and very small pleuritic effusion into left pleural cavity. Heart normal.

Abdomen.—Viscera normal. Intestines slightly distended. Peritoneum viscera normal. Peritoneum, parietal congestion in right iliac fossa. Right psoas muscle bulged forward, and on cutting through this muscle a large abscess cavity was exposed. Psoas muscle was not involved. Course of pus could be traced over pelvic brim and through great sacro-sciatic notch into operation wound. The periosteum covering the right sacro-iliac articulation had disappeared, as also the upper portion of iliacus muscles. The sacro-iliac joint showed slight erosion. The sac of abscess was only traceable upwards for short distance. There was no appreciable vertebral disease.

The foregoing case appears to me to be of interest from a diagnostic point. There was marked absence of abdominal symptoms. The tympanitis present during disease with exacerbations, as on September 8th and 12th, might be explained by the presence of flatus alone, and certainly the autopsy showed no peritonitis. The absence of all abdominal pain and tenderness appears unaccountable, as one would suppose that a large abscess such as this was would cause either local or referred symptoms by pressure on nerve trunks. The flexure of the right leg was a late
symptom and did not give any diagnostic assistance, for movement caused no pain and the position was explained by patient as “giving him a rest.” The pus track was perfectly marked at the commencement, but was more distributed on nearing the operation wound, and on this account pus welled into the wound on all sides, and not directly by a distinct opening through the sciatic notch. It was suggested at the time, that probing in this direction should be avoided, fearing pelvic infection might result.

In suggesting the original cause of the abscess I am inclined to put it down to syphilitic origin, although no vertebral disease was found.

The injury mentioned as having occurred in June, may have been sufficient to start an inflammatory condition at the sacro-iliac joint, and in this manner weaken this part and cause the pent-up pus to force its way downwards in this direction.

The patient’s final condition was the result of septicemia, although the drainage was free and an enormous quantity of pus was removed daily.

In writing this case it is my object more to leave it a subject for discussion than to attempt to explain the condition.

NOTES ON A CASE OF STRANGULATED CONGENITAL INGUINAL HERNIA.

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LANCE-CORPORAL J. E., 2nd King’s Shropshire Light Infantry, was admitted to the Station Hospital, Ranikhet, October 10th, 1903, with a right inguinal hernia. He stated that about four years ago, while he was at gymnasium, the hernia first appeared. He fell out and was sent to hospital, but on the way there the gut returned, and fearing he would be kept in hospital he said nothing about it to the medical officer. The hernia has occurred frequently since, but he has always been able to reduce it himself and has never worn a truss.

On the morning of October 10th, 1903, patient was in perfect health, when suddenly, for no apparent reason, the gut descended. He had not strained himself in any way, and was doing nothing out of the ordinary. He tried to reduce it as usual, but found he could not do so; he then commenced to feel faint and had to lie down. Shortly afterwards he started vomiting and had colicky pains about the abdomen. He had a constant desire to pass flatus, but could not do so, and had a feeling as if it would give him great relief if his bowels were moved. There was no actual straining.

When brought to hospital, about 4 p.m., patient was in a collapsed condition, pulse small and thready, eyes sunken, and anxious expression. He complained of slight pain in the abdomen. His skin was cold and