PAIN IN THE RIGHT ILIAC FOSSA.

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I am writing these few notes on a condition which is seen frequently in the Service, and suggesting a line of action which I have had opportunity of observing during the last six years or so, and which has given uniformly good results in my experience.

It is the immediate care of a case which is sent into hospital as acute appendicitis, and is illustrated perhaps best by giving a hypothetical case.

A young soldier is sent into hospital labelled “acute appendicitis.” He gives a history of abdominal pain—very often vague in character—which is now situated in the right iliac fossa and has been present for anything up to thirty-six hours. He may or may not have vomited, sometimes even he has not had any nausea. Often he states that his bowels have been open daily. He has had no previous abdominal symptoms, and can give no suggestion as to the causation of his pain. His temperature is not above 100° F., and his pulse is round about 80. Very often both pulse and temperature may be normal.

On examination the tongue is slightly furred. There is no distension, the abdomen moves on respiration giving rise to little or no pain in doing so. The right rectus muscle is slightly “on guard,” but there is no definite rigidity; sometimes the rectus does not even tighten on pressure in the right iliac fossa. However, there is definite tenderness on pressure over McBurney’s Point; often the patient “catches his breath” as pressure is being made. The presence of hyperesthesia is doubtful. Usually backward pressure on the descending and transverse colon, i.e. “milking their contents backwards” gives rise to pain in the right iliac fossa. If pressure is made in the left iliac fossa and suddenly released, this sometimes gives rise to pain in the right iliac fossa.

Movements of the right leg frequently give rise to pain, particularly voluntary contraction of the psoas muscle against resistance. Rectally there is usually no tenderness. (It cannot be too often stressed that a rectal examination should be made in all cases of a suspected intrabdominal lesion. The tip of a long gangrenous appendix may be lying in the pelvis, and can only be detected per rectum.)

To sum up the situation, the tongue is furred, and there are signs and symptoms of greater or lesser severity, pointing to a lesion in the right iliac fossa; but not of sufficient severity to suggest early or established peritonitis.
Pain in the Right Iliac Fossa

SUGGESTED ROUTINE TREATMENT.

(1) The patient is put to bed in the highest Fowler position.

(2) He is given a turpentine enema, irrespective of whether he states that his bowels have been opened or not. Commonly one sees a large constipated stool follow a turpentine enema in a man who states that his bowels have been open daily. Perhaps this is due to a fear on his part that if he admits to constipation he may be given a dose of castor oil.

(3) He is given water only by the mouth.

(4) A white blood-cell count is done. If this is much above normal, a more serious view of the situation is taken.

(5) A hot-water bottle to the right iliac fossa is permitted if the patient does not settle down immediately; but this is not insisted upon.

(6) The pulse and temperature are charted half hourly—I insist upon these being charted and not just dotted down on a scrap of paper, which as often as not promptly gets lost.

(7) I give instructions that should his symptoms become worse or should his pulse rise above 100, I am to be sent for.

In my experience, these cases resolve themselves into one of four categories:

A. Those whose signs and symptoms rapidly subside so that they are quite fit in forty-eight hours.

B. Those who gradually get better, taking four or five days in the process.

C. Those who remain stationary.

D. Those—the minority—who become worse.

Now as regards further treatment. Category A, I discharge to duty with instructions to report sick immediately should similar pain recur.

I am fully aware that many surgeons are of the opinion that once a person has had an attack suggesting appendicitis, he should have his appendix removed on the ground that he may have another attack in some place far away from surgical assistance. This is a bogey which I do not think justifies a laparotomy in every case of this category; there is always a certain risk in a laparotomy, and often the possibility of adhesions and other troubles to follow.

Should an acute attack supervene in an out-station, the patient can always be sent to the surgeon or the surgeon can go to the patient. The immediate danger to life of an average attack of appendicitis is very small, and does not justify opening up every abdomen where there is pain suggestive of appendicitis. In support of my opinion, I would mention that I have recently seen two cases of appendix abscess (in Indian soldiers), which had not been treated on the lines I am suggesting here. One of these was sent 150 miles over extremely bad roads by ambulance; the other came 160 miles by train. I operated upon both these cases and they made excellent recoveries.
Here I would digress for one moment to suggest that in cases of appendicitis in which pus is present in the abdominal cavity, only the minimum possible should be done. I advise that a tube through a separate stab wound should be put to the site of the pus and a similar tube drain into the cavity of the pelvis; the laparotomy wound should be closed. I give antistreptococcal (20 cubic centimetres), and antitoxin-gangrene (10 cubic centimetres) sera. I consider that under no circumstances should protective adhesions be broken down in order to remove the appendix. However, the appendix should be removed some six weeks to two months after the wounds have healed.

In Category B, I advise appendicectomy but do not press the point if the patient demurs.

In Category C, I suggest that appendicectomy should be performed ten to fourteen days after the onset of the initial symptoms.

In Category D, immediate laparotomy is indicated as soon as one or more of the following signs or symptoms appear: (a) High or increasing white blood-cell count. (b) Increase in pain, rigidity or tenderness. (c) Pulse rate of over 100.

In conclusion, I would like to mention two more points:

(1) I have found spinal stovaine anaesthesia, usually preceded by morphia, ¼ grain, half an hour prior to operation, highly satisfactory. If necessary this anaesthetic can be combined with open ether: recently, I removed the whole of the ascending colon and part of the transverse colon in a case of carcinoma of the hepatic flexure in a young soldier, using this combination of anaesthesia with very little difficulty and no distress to the patient.

(2) Should I be called to see a case such as I have described in an out-station some distance from my own station, I always remove the appendix, because I feel it unwise to leave a case which might have an exacerbation and progress into Category D.

Probably these observations will be redundant to many medical officers, but I hope that they will be of value to some, as it is often forgotten that the "art of a surgeon is to know when not to operate."