

Case Reports

SOLITARY DIVERTICULITIS OF THE CÆCUM

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The following case report is presented as of interest because of the rarity of the condition, only eight similar cases having been reported in the literature. (Leonardo, *Annals of Surgery*, April, 1930).

A. L., a male, aged 54 years, was admitted to the Montreal General Hospital, on April 28, 1930, complaining of abdominal pain and tenderness.

He had been perfectly well until 2 p.m. the day before, when he was suddenly seized with severe generalized abdominal pain, cramp-like in character. He had had no nausea or vomiting. The bowels were regular and he had had no urinary disturbance. By the following morning the pain was unchanged in severity and character, but was localized to the right lower quadrant. He was seen by the ship's surgeon, who made a diagnosis of subacute appendicitis and referred him to the Montreal General Hospital.

The patient lay quietly in bed, could move freely without pain, and did not look ill. His temperature was 98.2°; pulse 80; respirations 20; leucocytes 8,200. He denied any previous attack similar to the present one.

He was a fairly well nourished, well developed middle-aged man. His colour was good; the eyes clear, pupils equal, reaction to light and accommodation, normal. The ears, nose, and throat showed no abnormality; the skin, clear and moist; tongue coated; teeth bad. No superficial lymphatic enlargement. The urine was negative. The chest and lungs were negative; the heart normal. Blood pressure was 140/90. No sensory or motor disturbance. Genitourinary system, normal. Extremities, normal. The abdomen of flat, muscular type, moved freely on respiration; there was no visible peristalsis or asymmetry. The abdominal wall was resistant throughout, with some tenderness and rigidity in the right lower quadrant over Mc-

Burney's point. The organs were not palpable and there was no palpable tumour. Rectal examination was negative. A diagnosis of subacute appendicitis was made.

Operation.—Under ether anaesthesia, palpation of the abdomen revealed a mass in the right lower quadrant, which could not be felt before the anaesthetic was administered. Because of this mass, a right rectus incision was made below the umbilicus, for exploratory purposes. Examination revealed the presence of a mass in the posterior wall of the cæcum which was hard and firm to feel, but had not the clinical characteristics of a carcinoma. It was decided that this mass was inflammatory and not malignant. The appendix was normal.

For the cure of this condition a resection was done of the cæcum, with anastomosis of about two inches of ascending colon and eight inches of the terminal ileum. The abdomen was closed in layers without drainage.

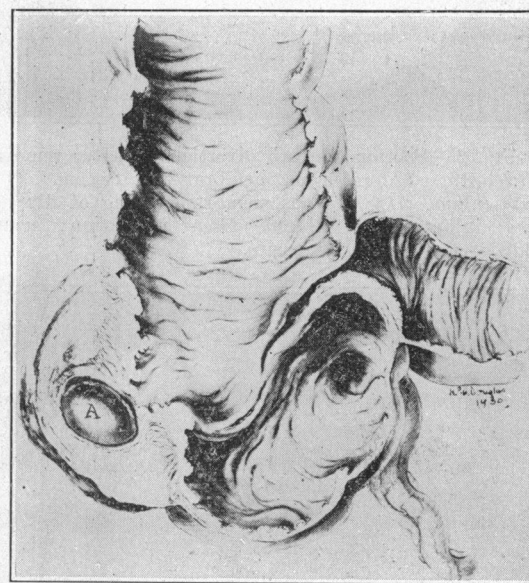


FIG. 1.—Note the fecolith A impacted in the diverticulum and the marked thickening of the adjacent portion of the cæcum.

The pathological report (by Dr. L. J. Rhea) was as follows:

“The specimen consists of the cæcum, a portion of the ascending colon, terminal ileum and the appendix. On the posterior wall of the cæcum there is a firm mass which has been

opened into. This has a thick fibrous tissue wall and between this and the wall of the cæcum there is a well circumscribed cavity measuring 1 by 0.5 cm. In this cavity there is a fæcolith. The cavity connects with the cæcum by a minute opening with regular edges. It is about 0.5 cm. in diameter. This opening is approximately 1 cm. above the orifice of the appendix. The appendix shows no gross lesion.

Microscopic sections through this mass show marked fibrosis of the pericæcal tissue and also

of the walls of the cæcum. All this tissue is infiltrated with an acute and chronic inflammatory exudate. The lining of the cavity is necrotic pyogenic membrane, containing fæcal material. The outer wall of the cavity is composed entirely of inflammatory and connective tissue. At one point in the cavity can be seen remnants of mucous membrane. In the outer wall there is no muscle tissue. This is an infected diverticulum."

SUMMARY

1. The condition is rare, only eight other reported cases can be found in the literature.
2. The pre-operative diagnosis is difficult. In this case, as in all others, the pre-operative diagnosis had been acute or sub-acute appendicitis, and the true nature of the condition was only revealed at operation or in the pathological laboratory.
3. The treatment is simple, being either excision of the diverticulum or resection of the colon.
4. The prognosis is good. In this case as in all other reported cases, patients have made an uninterrupted recovery.
5. This specimen is of the type of false diverticulum. The microscopic examination showed only mucosa and serosa present in the walls, no muscle fibres being demonstrated.

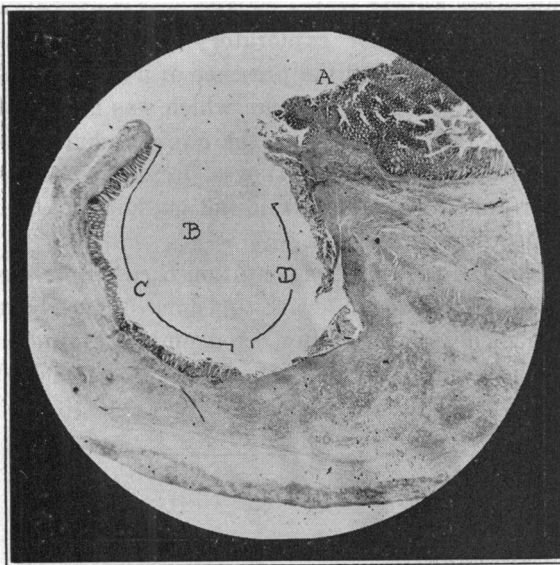


FIG. 2.—Section through diverticulum after removal of fæcolith. (A) Mucous membrane of cæcum. (B) Diverticulum. (C) Mucous membrane lining of diverticulum intact; (D) absent from ulceration; acute typhlitis most marked opposite.

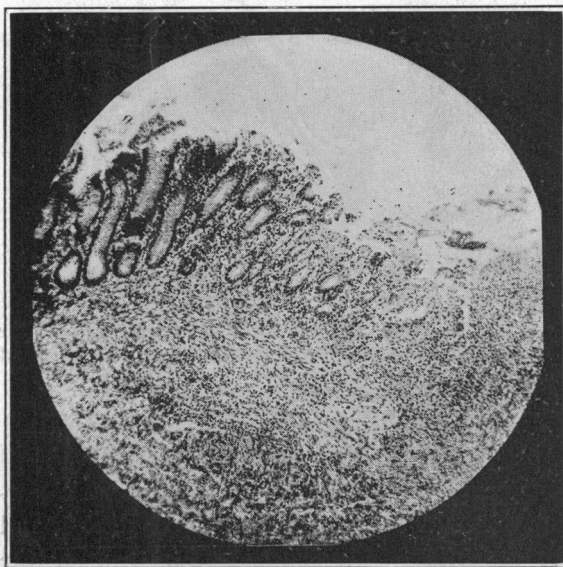


FIG. 3.—Junction of intact and ulcerated mucous membrane of the diverticulum.

A CASE OF PERSISTENCE OF THE VITELLINE DUCT IN A CHILD ONE YEAR OLD

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On September 3, 1930, a child, male, aged 12 months, was brought to me for examination. The mother explained that since the child's cord had fallen off there had been a continuous discharge from the navel. Examination proved that the child was perfectly healthy, except that in the navel a small tumour was visible, the size of the little finger nail. This consisted of bright red mucous membrane with a mucous secretion. The surrounding skin was reddened and eczematous from the continuous discharge, which showed an alkaline reaction. Probing proved that a duct led from this small tumour