A CASE OF MALIGNANT TUMOUR OF THE STOMACH IN A MALE WITH TRANSPOSITION OF THE VISCERA

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A male, aged 30 years, was admitted to the Main Hospital, Raipur, on 20th July, 1935. He was very emaciated and complained that for the last four months he had been suffering from vomiting and constipation. It was found that his heart was transposed and that he had a tumour in his left hypochondriac region. He was unable to retain a barium meal long enough for a satisfactory *x*-ray examination but it was evident that hardly any food was passing through the pylorus which was seen to be on the left side. He was not really fit for operation but after some hesitation in order to relieve his painful vomiting laparotomy was performed under rectal ether on 8th August. It was found that the lymphatic glands were involved to such an extent that gastrectomy would be of no avail even if he could survive such a severe operation. After verifying that he had complete transposition of his abdominal viscera an anterior retrocolic gastro-jejunostomy was performed and his abdomen was closed. During the operation and for twelve hours afterwards he was given continuous intravenous 10 per cent glucose in normal saline at 45 drops per minute. He never vomited again after the operation and his abdominal wound healed perfectly. By 15th August he was able to eat pounded fish and his bowels were moving. He continued to make satisfactory progress for five days. He then began to suffer from diarrhœa and later passed undigested food in his motions. To compensate for a reduction in his diet it was decided to give him a blood transfusion but no volunteer could be found. He began to go down hill and died on 28th August, three weeks after the operation.

A CASE OF PYO-PERITONEUM

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S., a female, aged 30 years, pot-maker, was admitted into the hospital on 26th June, 1935, complaining of distension of abdomen, slight cough and extreme weakness for the last two and a half months.

History of the present illness.—Two and a half months back the patient woke early one morning with a very severe colicky pain starting in the umbilical region and radiating all over the abdomen. The patient vomited twice. The condition subsided within about six hours and in the afternoon she felt a chill and developed fever which continued, and at the same time she developed a cough. After about three weeks, the patient noticed that her abdomen was slowly and steadily increasing in size. She then came for treatment.

Previous history.—No previous illness. She had had three children the last being born about nine months before the onset of her present illness.

Family history.—Nothing having any bearing on the present condition.

Physical examination.—The patient was weak and emaciated and could hardly walk about. She had pyorrhœa alveolaris and decayed teeth. The abdomen was distended and fairly tense but it moved fairly well with respiration. The superficial veins were distended and the caput medusæ was well marked. The skin was dry and shining. There was no tenderness in any part of the abdomen. The fluid wave was very well marked across the abdomen. The flanks were dull on percussion and the dullness moved to the dependent side on change of position. The heart, though weak and quick, was otherwise normal. The lungs showed signs of chronic bronchitis. The urine was quite normal. The temperature at the time of admission was 99°F. It ranged below 100°F.

Diagnosis and treatment.—The case was diagnosed as ascites and was treated on the usual lines for about a week but without any improvement. The abdomen slowly and steadily continued to increase in size and the patient complained of difficulty in breathing.

She was tapped on the 7th of July and thin greenish and very foul pus came out through the cannula. About five pints of the pus were drawn off, and the wound sealed with collodion. The patient did not improve after tapping. Her condition became worse and she died about 4 days afterwards.

Conclusion.—Clinically this case appeared to be one of cirrhosis of liver with ascites. There was no sign of any localized or generalized peritonitis, nor could any disease of the generative organs or spine be detected.

[The writer has not indicated the special circumstances that led him to adopt a line of expectant treatment when he found free pus in the peritoneal cavity.—Editor, *I. M. G.*]

EPHEDRINE, AND THE REDUCTION OF A STRANGULATED HERNIA*

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W. J., aged 28 years, suffered from a right-sided hernia since childhood but this gave him no trouble until a few months ago. One day, recently, the hernia was found to be irreducible.

When I saw him three hours later, he was trying to push the hernia up into the abdomen and applying ice. Taxis for half an hour failing to reduce it, I injected atropine 1/60 gr. Finding taxis and ice still ineffective, I gave atropine 1/30 gr. two hours after and also a warm soap enema at moderate pressure, the can being held at a height of about 2 or 3 feet and the bowel contents evacuated.

These measures were ineffective and the patient refused to go to the hospital, so I gave him a ½ grain tablet of ephedrine, with the idea that from its direct action on the splanchnic system it might act where atropine failed. I repeated the dose six hours later. An hour later, only a small knuckle of gut could be felt in the hernial sac, and this was fully reduced on further taxis, 15 hours after strangulation had occurred.

On a previous occasion a month earlier, the hernia was reduced in two hours after a single injection of atropine, but the patient was attended to in a little over an hour after the occurrence of strangulation. This time, however, perhaps because of the longer interval before the patient was first seen, atropine combined with an enema and ice applications seemed to fail completely, but later ephedrine proved successful.

It is possible that ephedrine succeeded and atropine failed in this case because the former has a direct action on the sympathetic splanchnic nerves and produces a stronger inhibitory action on the bowel than the latter, which only acts indirectly on the sympathetic nerves by paralysing the opposing vagal nerve endings.

* Rearranged by Editor.