CLINICAL MEMORANDA.

PARACENTESIS PERICARDII.

THE patient, a fairly-nourished though anæmic-looking girl, aged 20, I found suffering from a very severe attack of rheumatic fever, and she had been ill for some days before I saw her. I found her sitting up erect in bed. The respirations were very rapid, about sixty-five to seventy in the minute; quick, irregular pulse; and the temperature high. The joints were much swollen. She was sweating profusely and suffering great pain, and was literally gasping for breath. It was pretty clear, therefore, unless something were promptly done to relieve her, she could not live long.

On examining the cardiac region, muffled sounds could only be heard, and nothing was to be made out of the state of the heart for certain, although it was pretty evident she was suffering from endocardial or pericardial trouble. The apex of the heart appeared to be tilted up to and under the edge of the sternum, about one inch and a half above its attachment to the ensiform cartilage, and, as far as one could make out, it was close to the under surface of the bone. My partner, Mr. C. P. Hooker, saw the case with me, and we determined to perform paracentesis pericardii. This I did with an ordinary exploring trocar, passing the instrument carefully a little to the left of what seemed the apex of the heart, the trocar going through the edge of the cartilage of one of the ribs on its way to the pericardium. About one ounce of yellowish-red fluid was drawn off, and it was clear this came from the pericardium, as the cannula could be seen "bobbing" up and down with each pulsation of the heart. She bore the operation very well, and the symptoms were at once relieved, the respirations rapidly falling to about thirty-five to forty a minute.

She made a good recovery, and has been earning her livelihood as a domestic servant for some years.

Tapping the pericardium is an operation which has not been often performed, I believe; but I feel sure, unless we had done it in this case, we should have lost our patient; and, if ever called upon to perform the operation again, I should not hesitate to do it, for surely the relief given to the embarrassed heart was the means of saving the patient.

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REPORTS
ON
HOSPITAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN, IRELAND, AND THE COLONIES.

ST. MARK'S HOSPITAL FOR FISTULA, CITY ROAD, E.

THREE CASES OF INGUINAL COLOTOMY.

(Under the care of Mr. ALFRED COOPER.)

[From notes by the House-Surgeon, Mr. ARTHUR CHILCOTT.]

D. M., aged 55, a clerk, came up to the out-patient department on February 22nd, 1888, complaining of constant diarrhœa, pain on defæcation, and bloody discharge from rectum, dating from about five months previous.

On examination *per rectum* a hard mass could be felt encircling the bowel, causing stricture, through which the finger could not be passed; the mucous membrane was ulcerated to a large extent; the lowest part of the growth was about three inches from the anus.

Excision not being thought practicable, as it was not easy to say how far up the growth had extended, it was decided to open the colon in the left inguinal region The operation was performed on February 29th. The incision was made running parallel with Poupart's ligament, having its centre almost opposite the anterior superior spine of the ilium, at about two inches from it; and measuring three inches in length. The muscles having been divided and the peritoneum exposed, it (the peritoneum) was carefully opened the whole length of the incision; a flat sponge was inserted through the peritoneum to keep the intestines out of the way; the peritoneum was then stitched to the edges of the incision with silk sutures; the sponge was then removed; the colon, which was at once found, was drawn out of the wound and stitched to the sides by means of silk inserted through partial thickness of bowel; the colon was left unopened. No deep sutures were inserted to form a spur as in the following case.

In the evening the temperature reached 99.6°; on the following day it came down to 98 6°, and remained thus till he left the hospital. The bowel was opened on the fifth day after the operation; the colon was covered with lymph, to which the inner dressings were adherent. The stitches were removed at intervals, and the case progressed without a bad symptom, although no deep sutures had been inserted through the meso-colon to bring forward the back part of the bowel; the bowel was flush with the abdominal wall, no fæces passing to lower part of the colon beyond the opening.

He left the hospital on March 29th, wearing a form of truss made to cover the opening.

June 10th. He came up for examination to-day; he was extremely grateful for what had been done for him; he said the opening caused him but slight inconvenience.

W. K., aged 30, first came to the hospital on November 3rd, 1887, suffering from malignant disease of the rectum. As the growth did not extend far up, and considering his age, excision was performed, but this growth having returned he came into the hospital again on March 9th, to have colotomy done.

The operation took place on March 13th, being done exactly in the same manner as the former one, except that two sutures were put through the meso-colon, in the following manner. The colon being drawn out so that the finger and thumb could reach behind it; the suture was passed through the abdominal wall at the centre of the incision, then through the meso-colon and out through the skin on the opposite side of the incision; two were thus inserted and tied tightly together on either side.

After the operation he complained of pain in the wound, so was given opium: during the following few days he suffered some slight pain; the colon was opened four days after the operation, fæces passing through at once.

On March 19th, six days after the operation, his temperature rose to 103.4° F., and he complained of severe pain on either side of the incision, the deep sutures were dragging very much on the skin, causing some suppuration around; they were removed and the wound poulticed; in a few days the temperature became normal, and he recovered without any further bad symptoms, though he still complained of occasional pain and tenderness where the deep suture had been. No motion can pass to bowel below the incision, though the spur of bowel does not appear more prominent than in the former case, in which no deep suture had been inserted. He left the hospital for the seaside on April 28th.

June 31st. He says he can attend to the opening perfectly easily himself, and does not suffer much discomfort from it; he has gained weight, and is in every way benefited greatly by the operation.

A. T., aged 58, a clerk, whose rectum had been excised eighteen months previously, by Mr. Cooper, for malignant disease, came in on March 15th, to have colotomy performed, owing to the growth having returned accompanied with severe pain in the rectum, especially at night.

The operation was done on March 20th; the colon was found at once, and brought to the front. The operation was performed in the same manner as the first; no deep sutures being inserted, as they seemed to cause pain and the spur of bowel was sufficiently prominent without them. The temperature the same evening was 99.6° F. No pain.

The bowel was opened on the third day following. As the colon was found in the former cases to have become so adherent to the dressings, a small piece of oiled silk, thoroughly carbolised, was laid over the colon; this much facilitated the opening of the bowel, as the parts could be so much more easily made out. His old pain in the rectum having returned he has morphine at night, otherwise he is quite comfortable.

On March 29th his temperature rose to 101.4° F. No cause could be discovered, except that the bowels had not acted; it came down to normal on the following day, and remained so till he left the hospital; he complained of no pain in the wound at any time since the operation. He left on April 4th.

REMARKS.—Mr. Cooper finds in all his excisions of the rectum the after-trouble is the great contraction, which nothing seems to prevent; he has tried bougies from the beginning, but to no good result, showing that early inguinal colotomy is the best treatment for malignant disease of the rectum, and not excision.