Acute intestinal obstruction caused by the ileum becoming adherent to a lithopedion / by J.H. Bryant.

5.

REPRINTED FROM

GUY'S HOSPITAL REPORTS.

VOL. LV.

5.

ACUTE INTESTINAL OBSTRUCTION CAUSED BY THE ILEUM BECOMING ADHERENT TO A LITHOPEDION.

By J. H. BRYANT, M.D.

I have thought this case worthy of publication for two reasons, firstly on account of the extreme rarity of the occurrence of a lithopedion, and secondly because, as far as I know, acute intestinal obstruction from this cause is unique.

A very full account of lithopedions is given in the Bulletin of the Johns Hopkins Hospital, vol. viii., No. 80, p. 221, by Dr. J. G. Clark. He reports an interesting example of this condition, and gives a review of the cases hitherto published. He refers to Kuchenmeister's table of forty-seven cases reported between the years 1582 and 1880, and mentions eighteen others published subsequently, in addition to his own case, in all, a list of sixty-seven. No mention is made of any of these cases terminating fatally as a result of acute intestinal obstruction from the intestine becoming adherent to the lithopedion.

In the case recorded below the cause of the intestinal obstruction was, partly kinking and partly strangulation. A small loop of

ileum was found to be adherent to the body of the lithopedion in two places; through the small aperture thus formed an adjacent coil of ileum had passed and become strangulated. There was also considerable kinking of the ileum at the two points where it was adherent to the body of the lithopedion, and there was another piece of ileum higher up which was also kinked, on account of its being adherent to the head of the lithopedion. The kinking alone was not sufficient to account for the acute symptoms, which must have been caused by the loop of the ileum becoming strangulated between the adherent loop and the body of the lithopedion.

The presence of the lithopedion was not suspected during life. The only possible indication of it was the history of five months' amenorrhœa, which had occurred two and a half years before. There was no previous evidence to suggest or indicate in any way a ruptured tubal pregnancy. The hard mass which was felt before and at the time of the operation was considered to be a malignant growth. It was unfortunate that the patient's condition precluded the possibility of investigating the tumour at the time of the operation, as from the post-mortem examination, I should say, it would have been quite possible to have dissected out the lithopedion and to have completely removed the obstruction. I am indebted to Dr. Perry for permission to publish the clinical notes and to Dr. Stevens for his excellent drawing.

Hannah H., 37, was admitted under the care of Dr. Perry, on November 28th, 1899, for intestinal obstruction (clinical clerk, E. Cohen). About two and a half years ago she had an attack of intestinal obstruction which lasted about five days. The bowels were eventually relieved by enemata. Since then she had never had any trouble with her bowels and had been quite well. On Thursday, November 16th, she partook of a big supper, and after going to bed complained of a pain in her abdomen. On the next day she was able to get up and do her work. The bowels were opened on the 17th, but the pain soon afterwards came on again, and as it continued, a doctor was called in.

Numerous efforts were made to relieve the bowels by means of purgatives and enemata, but without effect. Mr. Dunn was asked to see the patient on the 27th, and he advised her removal to the hospital with a view to laparotomy in order to find the cause of the obstruction and if possible to remove it. On November 23rd, she had a bad attack of vomiting which lasted about twenty-four hours. The vomit had a very foul odour and she stated that it smelt like a motion. She did not vomit on the 26th. Two and a half years ago she gave a history of five months' amenorrhœa; before and after the menstrual disturbance she had always been regular. There was no history of pain or anæmia, and, as far as she knew, she had never been pregnant. There was no history of any previous pelvic trouble.

Condition on admission.—Temperature 99·2°, respiration 24, pulse 104. She was rather collapsed. Her tongue was dry and furred. Her eyes were sunken and she had an anxious expression. She did not appear to be in pain, and was not wasted or cachectic looking. There was no darkening of the areolæ, and there were no lineæ striæ on the mammæ. She complained of a constant desire to pass her urine. The abdomen was distended. On palpation, a hard mass could be felt in the lower part of the abdomen but extending almost as high as the umbilicus in the median line. On the right side it appeared to extend a little higher than the umbilicus, and it was fairly well defined and was movable. On percussion, a tympanitic note could be obtained all over the abdomen except in the right iliac fossa, where there was dulness. The outline of a distended coil of intestine could be seen crossing the abdomen just above the umbilicus. No peristalsis was visible. The heart and lungs appeared to be normal. The urine was 1020; there was no albumen, sugar or blood present.

November 28th. She was ordered a milk diet and appeared very comfortable in bed. At 1 a.m. she became restless and was given an injection of Morphia gr. $\frac{1}{6}$, and Atropine Sulphate gr. $\frac{1}{100}$. After this she slept for a time and was comfortable.

On November 29th she looked worse, and her eyes were sunken. Pulse 108, respiration 25, temperature 96·2°. A vaginal examination was made and the cervix was found to be anteverted. On bimanual examination, a large, undefined, hard mass could be made out in the hypogastric and lower umbilical region, which appeared to be fixed to the uterus. Dr. Perry and Mr. Dunn saw her and an exploratory operation was decided on in order to determine, and if possible to remove, the cause of the obstruction. Mr. Dunn made an incision in the median-line of the abdomen about five inches in length and commencing three inches above the umbilicus. On opening the peritoneal cavity the transverse colon was found to be collapsed. He explored the abdomen with the hand and found a very hard stony-like mass just above the pubes. It was considered to be a growth binding down and kinking some coils of small intestine. Owing to the extremely serious condition of the patient it was thought inadvisable to attempt to remove the hard mass, and so a portion of the small intestine, which was found to be very distended, was pulled out, and a Paul's tube was inserted as near to the obstruction as possible. The abdomen was then closed, a small portion of the intestine containing the Paul's tube being brought out of the lower part of the wound.

She took the anæsthetic badly, and was very collapsed afterwards. She did not rally after the operation, and gradually sank and died at 4 a.m.

I performed the necropsy ten hours after death. There were no signs of decomposition. Rigor mortis was well marked. There was an incision about five inches in length in the median line of the abdomen commencing three inches above the umbilicus, the upper portion of which had been united by gut sutures. A piece of small intestine in which was situated a Paul's tube occupied the lower part of the incision. The lungs and pleuræ were normal. The heart weighed 234 grammes, and was normal in appearance. The mouth, pharynx, œsophagus and stomach were normal. On opening the peritoneal cavity the hard mass felt during the operation proved to be a lithopedion; it was situated in the median

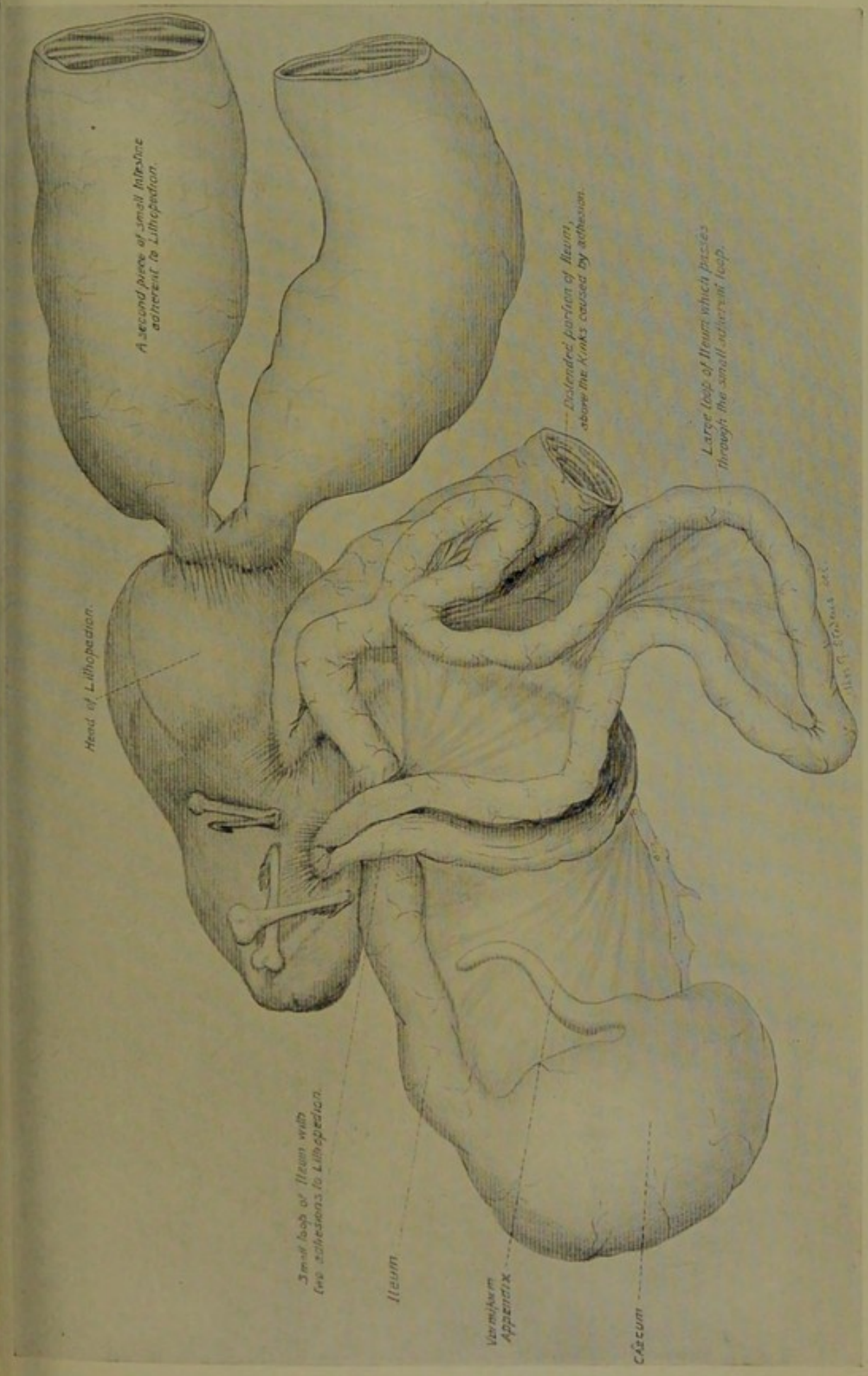
line between the pubes and umbilicus, reaching to the level of the latter. The head was pointing to the left. It was found to be attached to several coils of small intestine, and also by a few fibrous adhesions to the uterus and right broad ligament. The jejunum had been opened about one and a half metres from the duodenum. A coil of the lower end of the ileum measuring about 60 centimetres was completely collapsed, it being strangulated by having passed through a small aperture which was formed by a small portion of the ileum immediately above having become adherent to the body of the lithopedion in two places close together. At both points where the gut was adherent it was sharply kinked, so that the obstruction was partly due to kinking and partly to strangulation. A little higher up another piece of the ileum was adherent to the head of the lithopedion and this was also kinked but not so markedly as the loop below. The uterus measured 7·5 centimetres in length. The cevix was nulliparous. There were general pelvic adhesions. Both Fallopian tubes were found to be running backwards over the surface of the ovaries and were adherent in Douglas' pouch. The left ovary was normal in size and appearance. Attached to the right ovary was a spherical tumour measuring 5·5 centimetres in diameter; it was firmly fixed to adjacent parts by firm fibrous adhesions and it was with difficulty freed from these attachments. On section it was reddish brown and appeared to be made up principally of altered blood. It appeared to be the remains of the old placenta. Dr. Stevens very kindly cut some sections and found degenerated chorionic villi and said the tumour was undoubtedly made up of placental tissue with blood clot. The lithopedion was found to be lying almost free in the peritoneal cavity; there were a few adhesions attaching it to the uterus and right broad ligament. It was in a condition of general flexion as if it had been subjected to much pressure. The head was flexed on the thorax and there was marked kyphosis. The feet, legs, hands and arms were fully flexed. The left knee was tucked under the middle of the right femur, and the right leg was lying across the middle of the

left leg. The arms were placed close to the sides of the thorax. The head was flattened from side to side. The measurements were :—

Head—Biparietal diameter	... ...	5·1 cms.
Vertical ...	... ...	5·5 cms.
Antero-posterior	... ...	6·4 cms.
Circumference	... ...	19 cms.
The length of the Body was	... ...	7·5 cms.
,, Femur ,,	... ...	4·5 cms.
,, Tibia ,,	... ...	4·2 cms.
,, Radius and Ulna was	...	3·5 cms.
,, Humerus ,,	...	4 cms.

The measurements of the lithopedion very nearly corresponded to those of a five months' fœtus.

Acute Intestinal Obstruction, caused by the Ileum becoming adherent to a Lithopedion.



Acute intestinal obstruction, caused by the Ileum becoming adherent to a Lithopedion. T. G. Stevens (del.)

No available reprint of Dr. Bryan's
paper on - Bacteria in Trombi

Vide - Vol 56
(Paper read) Guys Hospital
Pathological Society
May 7th 1901