Perforating ulcers of the ileum from obstruction after ovariotomy / by Alban Doran.

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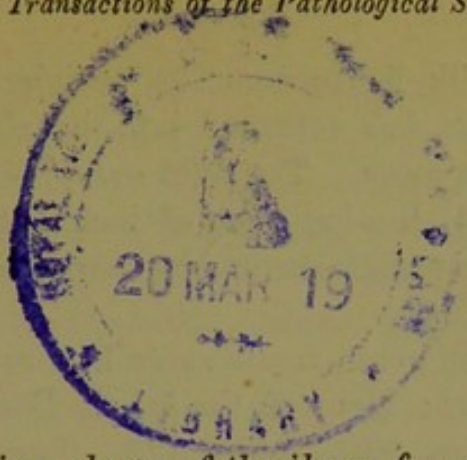

19.

Perforating ulcers of the ileum from obstruction after ovariotomy.

By Alban Doran.

A. M—, æt. 26, a lady's maid, was admitted into the Samaritan Free Hospital, under the care of Dr. Granville Bantock, on November 29th, 1878.

Five weeks previous to admission she had been seized with rigors and severe abdominal pain. A practitioner who was called in to attend her, informed her mistress that the patient was suffering from typhoid fever. A fortnight later she was seen by Mr. Manser, of Tunbridge Wells, who could detect no symptoms of any specific fever, but as her temperature varied for several days between 100° and 102°, and as he found that a large fluctuating tumour filled the lower and middle parts of the abdomen, he believed that there had been an attack of peritonitis consequent on ovarian disease. In three weeks the patient was free from all pain and feverishness, and was able to walk about. She then came to London, where she was examined by Mr. Spencer Wells and Dr. Bantock, who were both of opinion that an ovarian tumour existed.

During the few days that the patient spent in the hospital before operation her temperature was generally a degree or a degree and a half above normal in the evening. On the night of the 3rd of December it reached 100·6°. The operation was performed by Dr. Bantock on December 4th, and as I assisted that gentleman I had the advantage of seeing the condition of the intestine during life-time. A suppurating multilocular tumour of the left ovary was discovered, containing seven pints of turbid fluid. It was very closely adherent behind to eight or ten inches of the lower part of the ileum. The adhesions were broken down by sponges, and as the raw surface of the intestines bled freely, six small open vessels

were secured by fine silk ligatures. The pedicle, transfixed, and ligatured by silk threads, was returned into the abdominal cavity after the tumour was cut away. The right ovary, being enlarged to the size of a walnut, and showing signs of incipient cystic disease, was also removed and the pedicle secured by complete intraperitoneal ligature.

The patient brought up green vomit several times on the evening after operation, but on the night of the 5th of December she was quite comfortable. Temp. 99·8°, pulse 122. Two days later the temperature rose as high as 101·4°, and there was fetid discharge from the vagina, which canal was washed out with a weak solution of sulphurous acid. There was no distension of the abdomen. For a few days the temperature continued above normal, rising as high as 102° on December 10, when the rectum was washed out for the removal of a small quantity of fæcal matter which came away with much flatus. The patient frequently vomited. On the 11th, as the vomiting continued, with high-coloured urine and slight icterus, her food was discontinued and she was fed by beef-tea enemata. The abdominal wound had healed very well.

At nine o'clock on the next evening, the eighth day after operation, the patient complained of feeling of tightness across the abdomen; her temperature was then 99·8°. At 10.30 p.m. she was in a state of collapse, the pulse scarcely perceptible and temp. 100·6°. At 12 a.m. she still complained of abdominal pain, and her temperature had risen to 101·4°. She expired at 12.45 a.m.

I made a *post-mortem* examination of the patient's body fifteen hours after her death. Rigor mortis was very slightly marked. The thoracic viscera were healthy.

On opening the abdominal cavity, over a pint of perfectly liquid fæces was found diffused over the coils of the small intestines, the coats of which were much softened, tearing readily when pinched by the forceps. A coil of ileum, partly adherent to the abdominal wall by recent lymph, was gently raised, and a jet of fluid fæces immediately gushed out of a perforation in its coats posteriorly. The small intestine above the aperture was filled with flatus and liquid fæces, and the remainder of the ileum below the perforated coil, as far as to within three inches of the ileo-cæcal valve, was matted together by recent lymph on the serous coat, the site of the former adhesion to the back of the cyst. This obstructed mass, much narrowed and quite empty, hung down over the promontory of the sacrum. The end of the

ulcerated coil, being full of flatus, had risen so that its free border almost touched the mesentery above. Hence the intestine was sharply twisted at the point where this coil joined the dependent, obstructed mass. This complication, evidently secondary, made the obstruction complete. The perforating ulcer was nearly a foot above the twist in the ileum. The ascending colon, sigmoid flexure and rectum, were full of solid fæces.

The remaining abdominal viscera were normal, and the pedicles of the tumours were undergoing those changes which should naturally occur after the ligature. There was no pus to be found in the pelvic cavity.

The mucous membrane of the alimentary canal from the stomach to the seat of obstruction was, in most parts, deeply injected. In the ileum, towards the seat of obstruction, there were signs of inflammation along the course of the larger blood-vessels and on the edges of the valvulæ conniventes. In the middle of these inflamed streaks small elongated ulcers could be detected. The perforating ulcer was nearly circular, its edges were clean-cut without any thickening. The muscular coat was exposed and also perforated, and in the serous coat was found a hole one eighth of an inch in diameter. Perforation was commencing in several neighbouring ulcers and accidentally completed (as the specimen shows) after death, when the diseased portion of intestine was washed to free it from mucus and fæces. There was no trace of ulceration of Peyer's patches. In the ileum, below the twisted point, the mucous membrane was pale, thrown into folds, and presented no trace of disease.

The perforated portion of intestine will henceforward be found in the pathological series of the museum of the Royal College of Surgeons (No. ~~1201 p~~ 2470).

This case recalls a somewhat similar instance where perforating ulcers were found some distance above a strangulated portion of intestine, death occurring about thirty hours after an operation for the relief of femoral hernia. The case is recorded by Mr. Morrant Baker in the twenty-seventh volume of the Society's 'Transactions.' In both cases there is a distinct history of intestinal disturbance for some time previous to operation. But in Mr. Baker's case there was sloughing; in the specimen I bring forward no slough can be found. Mr. Wells in his work 'On Diseases of the Ovaries' refers to one case under the care of Dr. Lyon, of Glasgow, where symptoms of obstruction followed the removal of an ovarian tumour. Minute

perforations were found in a portion of intestine adherent to the bottom of the abdominal wound. The severe intestinal disturbance, previous to the removal of the tumour, in the patient from whom this specimen was taken, became aggravated by the complication after operation. The impaired health of the patient contributed probably in no small degree to cause the inflammatory changes in the ileum to assume an ulcerative character.

February 18th, 1879.

F. E. Taylor, see reference, entered in error at end of the next reprint ("[illegible]" &c)

Gans "Typhusvereiterung des Ovarialtumors" Monatsschr. f. Geb. u. Gyn. Bd 28 (1908) 2. H. pp 163– & summary in Rev. de Gyn. et de Chir. abd. Vol 13 p 738 (July & Aug 1908)