TWO UNUSUAL CASES

1. INTERNAL FISTULA

2. FOREIGN BODY IN DESCENDING COLON

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Internal fistulae associated with trauma, chronic infection, Cröhns disease and neoplasms are relatively common, but as far as I can find out, from the literature at my disposal, those associated with old-standing appendix abscess are not described.

The following case in which the appendix abscess was of 12 years' standing, demonstrates such condition Mr. A. S. consulted me complaining that he had had diarrhoea for the past 12 years. The symptoms commenced in 1942, whilst he was an internee, with a severe attack of abdominal pain, with vomiting, which was followed a day or so later by the passing of many foul-smelling stools accompanied by blood and mucus. For this condition he was given some medicine. The pain subsided, but the diarrhoea has continued, unabated, up to the present time. The number of stools passed on a good day was 5, and during acute exacerbations, as many as 20—30 a day. During this period he had steadily lost weight. He found that if he ate root vegetables and stale bread he was more comfortable, whereas meat and eggs worsened conditions considerably.

When he presented himself to me for examination he looked older than his years and was thin and wasted.

Physical examination revealed very little abnormality, except some tenderness of the lower abdomen and slight distention. Rectal examination was quite impossible, on account of intense pain. His blood pressure was 128/60 mm. Hg., and the blood count was within limits of normal, with relative leucocytosis.

Under general anaesthesia sigmoidoscopy was undertaken. The rectal mucosa was congested and a large polyp was seen 9 inches from the anus. Biopsy of this

was performed and the pathologist was extremely surprised when section of the polyp showed it to be a portion of the appendix with chronic inflammatory changes. As a result of this finding and because of his general deterioration following this biopsy, laparotomy was advised.

The patient was prepared by giving him intravenous infusions, daily bowel wash-outs for 5 days, and a course of sterothal. For 2 days before operation he was given streptomycin, ½ g. b.i.d.

The abdomen was opened under general anaesthesia through a right para-median incision, when it was found that there was a large appendix abscess, with the appendix perforating through the rectum, which in turn connected with a fairly large hole in the ileum. The abscess cavity communicated with the hole in the ileum. The appendix was removed, a piece of the ileum was resected and side-to-side anastomosis performed. A portion of the rectum was removed and this showed a small knuckle of the appendix still protruding into the cavity of the rectum.

CONCLUSION

It would seem that this man must have developed an appendicitis 12 years ago with adhesion of the tip of the appendix to the rectum. On the medial wall of the abscess was a loop of ileum into which this abscess must have drained. That such a state of affairs could carry on for 12 years seems hardly believable.

Lodgement of Foreign Body in Descending Colon

Mr. N., aged 36 years, complained of pain in the left side of his abdomen, colicky in type, with nausea but no vomiting, which had commenced 16 hours before his consulting me. His bowels had not acted for 36 hours and he said that he felt sweaty and ill.

On examination, his temperature was 100°F, pulse rate 120 per minute. Marked voluntary guarding of the left side of his abdomen was apparent with finger-tip tenderness over the 'left McBurney's point'. Dextrocardia and/or transposition of viscera was excluded. Expectant treatment was instituted, when 3 hours later there was a sharp deterioration in his condition and it was evident that a frank peritonitis had ensued. The pulse rate had jumped to 140 and the temperature dropped to 99°F. Laparotomy was advised and a provisional diagnosis of Meckel's diverticulitis was made.

The abdomen was opened under general anaesthesia through a right para-median incision and exploration commenced. The appendix itself was normal. A Meckel's diverticulum was found, but was quite blameless. However, a large abscess was found in the neighbourhood of the left para-colic gutter about 3 inches below the splenic flexure, and at this point a large thorn was found to have perforated the colon with resultant abscess formation and peritonitis. As there was thrombosis in the vessels in this neighbourhood, and as portion of the colon was gangrenous, excision of a segment of the bowel was undertaken.

CONCLUSION

Although lodgement of foreign bodies in the oesophagus, at the pylorus, at the ileocaecal valve, and at the anus, are comparatively common occurences, foreign bodies lodging in the descending colon must be rare.