in the bowel they absorb moisture and form a gelatinous mass. They must always be taken dry and can be used in any quantity desired. Perhaps it is because they are so often prescribed for chronic constipation that they tend to be forgotten in diarrhoea. They can be given alone in mild cases, in more severe ones they form a most useful addition to other treatment.

Peristalsis can be directly decreased by opium, and this is by far the most effective way of treating diarrhoea. Morphia addicts not only harm themselves; they do great damage by inducing quite an unwarranted timidity in the use of opium and all its derivatives. Tinct. opii, pulv. cret. aromat. cum opio and pil. codeinae are the most useful preparations. Not only can they be used in acute attacks, but they can and should be given in long cases of ulcerative colitis to give the patient necessary rest from the bedpan. If vomiting is present morphia may be used by injection, but not otherwise as it is not so effective in checking diarrhoea as opium. Unfortunately morphia sometimes causes vomiting. There are occasions when this risk must be taken, but it is as well to begin with a small dose.

In the astringent group the subnitrate and the carbonate of bismuth stand alone. They are far more widely used than anything else for diarrhoea, and can be given in combination with opium, while mist. bismuthi et sodae is probably the most commonly prescribed mixture there is and for mild diarrhoea it is excellent. The only other astringent worth mentioning is tannic acid, which is sometimes given by the mouth, but more often as a 1 per cent solution for lavage.

Colic and flatulence often go arm-in-arm with diarrhoea. Colic can frequently be reduced by atrophine, belladonna or tincture of hyosciamus, but wind is the bugbear of all mankind especially when it is in the bowel. Charcoal or kaolin sometimes help; if they do, the patient is lucky.

Clinical Page

ANOTHER RARE TUMOUR OF ILEOCAECAL ORIGIN

By M. D. SHEPPARD, M.B., F.R.C.S.(Eng.)

A woman of forty-nine first fell ill with generalised abdominal pains five years ago, accompanied by vomiting. It was diagnosed as gastritis and she improved with treatment, only to suffer a relapse a fortnight later, when she vomited blood. Ever since then, she has had attacks of acute abdominal pain every four to five weeks, but she has not been sick. During these years she quite often suffered from diarrhoea, being at times completely prostrated by the frequent bowel actions.

The pain was described as a general, abdominal colicky pain. At the height of the spasms of pain a lump would appear in the right iliac fossa. This was followed by a loud gurgling noise and the disappearance of the pains.

She has a family of three, and her periods stopped quite uneventfully four years ago.

Examination showed her to be an intelligent woman, very thin, rather pallid and grey, and thoroughly resigned to her complaint. I was fortunate enough to witness the manifestation she had described. She warned me that they were due, and after a few severe colicky pains, a rounded smooth tumour appeared in the right iliac fossa, which felt quite firm. It was obviously a powerful peristaltic wave in a loop of grossly hypertrophied intestine, for it disappeared completely, leaving no more than the sensation of an ill-defined mass in the right iliac fossa. This was followed by loud borborigmi.

Vaginal and rectal examination suggested an indefinite mass high up in the right side of the pelvis, but no more.

She was having two or three loose bowel actions daily, but sigmoidoscopy revealed a normal mucous membrane and no cause for diarrhoea. A barium enema flowed uninterruptedly as far as the caecum, but could not be forced into the ileum. A barium follow-through showed some delay in the terminal ileum, and dilated small gut, but no evidence of the string sign. Blood count, pulse, temperature and urine were all normal.

In view of the long history, diarrhoea, and obstructive signs and symptoms, a diagnosis of Crohn's disease was made, and under gas, oxygen and ether anaesthesia, the abdomen was ex-

plored through a lower right paramedian incision. The most striking feature was an enormous hypertrophy of the last fifteen inches of ileum. Proximal to the ileocaecal junction was a circular tumour in the bowel wall, almost bone hard and nodular, but not more than half an inch in width. This was the site of the obstruction responsible for the hypertrophy of the ileum. The ileocaecal mesentery was grossly thickened and injected, and contained numerous large glands, extending almost up to the root of the mesentery. Examination of the hypertrophied ileum showed a hard nodule about the size of a pea in the antimesenteric border, apparently not arising in the mucous membrane but in the muscle, and eight inches from the caecum.

A correct diagnosis could not be made at the time, but tuberculosis rather than Crohn's disease was favoured, and owing to the poor physical state of the patient I was very tempted to by-pass the obstruction by an anastomosis between ileum and transverse colon. However, the presence of the enlarged mesenteric glands and the history of distressing diarrhoea decided me to resect two feet of ileum, caecum, ascending colon and right transverse colon in order to allow a complete removal of the affected mesentery. The posterior peritoneum stripped up quite well, and the ureter was easily freed. After an end to side anastomosis between transverse colon and ileum, the extraperitoneal area was covered as far as possible and the space was drained into the flank. She received a pint of blood operatively, and a few hours later was in good condition.

She appeared to be making an uninterrupted recovery without pain or distension, when, on the evening of the fifth day, she suddenly complained of severe abdominal pain worse than any she had ever endured before. General peritonitis was diagnosed, and the abdomen was explored through the original wound, which showed some slight suppuration around the catgut sutures, but the cause of the pain was found to be localised peritonitis, resulting from a small leak at the anastomosis, no doubt due to a tiny area of necrosis, unfortunately on the anterior aspect away from the posterior drain.

The pelvis was drained as was the site of the leak, and about fifteen grammes of sulphanilamide powder left in the abdominal cavity. From this catastrophe she made a good recovery, after developing a very trying faecal fistula, which fortunately healed quite suddenly three weeks later. Four weeks after her second operation she was discharged, quite well, taking full diet, and having a normal bowel action daily.

Report on Sections of Specimens Removed

(a) Nodule in ileum: Small nodule of polygonal and columnar celled trabecular and intratrabecular argentaffinoma in sub-mucosa of ileum, involving slightly the mucosa and whole thickness of muscularis.

(b) Small mass of argentaffinoma in sub-mucosa near ileocaecal valve, extending into the very hypertrophied muscularis and mesentery. This growth appeared to cause considerable stenosis, and considerable muscular hypertrophy of ileum above the growth. A mass of similar growth in the mesentery apparently continuous with the lowermost primary. The adjacent mesentery also contained a calcareous nodule of obsolete tuberculosis.

Comment

This type of neoplasm often arises in the appendix but in this case the appendix appeared normal. An interesting feature was the very long history, in spite of which the primary was represented by no more than a narrow ring of tissue, and its appearance certainly never suggested a malignant neoplasm.

Another problem of interest in this case was the precise cause of the diarrhoea. It may have been due to an intermittent but sudden escape of a large quantity of small intestine contents, possibly rendered irritant by the presence of superficial ileitis. As this symptom is a marked feature in many cases of Crohn's disease, the same cause may be suggested rather than any specific toxin formed by the disease itself.

Post operative peritonitis of this nature is often fatal, and the happy outcome in this case may be attributed partly to intraperitoneal sulphanilamide and large post-operative doses of sulphapyridine, but mainly to the remarkable tolerance of the patient to peritoneal and intestinal trauma and infection.

Reference should be made to the report in the Clinical Page of the November 1942 issue where Mortimer Woolf described three other rare ileocaecal tumours.—Ed.