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SOME ASPECTS OF THE DIAGNOSIS AND TREATMENT OF DIVERTICULITIS.

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DIVERTICULITIS is a disease that is not often diagnosed unless its presence has given rise to a surgical complication. Even when a tumour exists, one's thoughts are inevitably led in the direction of carcinoma, more especially as the sigmoid flexure is a favourite site for both conditions. It is only by keeping the disease in mind, especially when a patient complains of pain in the left iliac fossa, that a correct diagnosis will be arrived at.

In a large number of cases the disease causes few, if any, symptoms, and is only discovered on a routine post-mortem examination, when death has been due to some other cause. Two of the best specimens of this condition which I possess were discovered post mortem quite accidentally. In other cases, vague abdominal pain, often of a cramping and colicky nature, together with constipation, which may possibly alternate with diarrhoea, may give rise to the suspicion of carcinoma. Examination may prove negative, and yet the symptoms continue, when suddenly there may be an escape of gas per urethram, or perhaps faeces, which will make the diagnosis clear; or an abscess may form usually in the left iliac fossa. When a lump suddenly appears in this situation, which is tender, with the edges irregular, accompanied by fever and general signs of malaise, diverticulitis is

probable. Unfortunately, it may be very difficult to feel this tumour, as these patients are usually very fat, and may be obese. It might be thought that this should be a point of differentiation between diverticulitis and carcinoma, but this is by no means the case. Many patients with carcinoma of the sigmoid flexure, and perhaps more commonly of the rectum, are very well covered, especially if the growth is not very toxic in nature. Moreover, the two conditions may co-exist.

Some time ago I operated on a patient with such a lump in the left iliac fossa. She was fat; a swelling could be definitely felt; there had been a history of constipation over four months, and the diagnosis of diverticulitis seemed certain. A laparotomy was performed, and a large abscess was found, bounded by the sigmoid flexure on the left, and on the right a mass consisting of bladder, uterus, and both tubes and ovaries. The adhesions were separated with great care, and three small diverticula were observed in the bowel. The abscess was drained. Unfortunately it did not clear up, and further drainage was provided on three occasions. Eventually a transverse colostomy was performed. Still the sinus did not clear up. The patient then discharged herself, but asked to be re-admitted two months later. The sinus was now filled with a mass of tissue which was heaped up on the skin edges, and was undoubtedly a carcinoma. This was proved by the microscope. The patient died, but unfortunately no post-mortem examination was allowed. That diverticulitis was present when the original operation was performed is certain. Whether carcinoma was also present, and was missed (which is probable), or whether carcinoma occurred subsequently, can only be a question of speculation.

How difficult the question can be to decide is illustrated by another case, in which the reverse sequence occurred.

Four years ago I resected a carcinoma of the sigmoid from a man aged 40. Recovery from the operation was uneventful, and he

remained quite well until eight months ago. He then complained of passing blood per rectum, and intermittent pain, of a gripping nature, at times of great severity. He was admitted to hospital for observation, and examination by the X-rays, after a barium enemata, revealed well-marked diverticulitis in an early stage.

Sufficient has been said to indicate how very difficult the differentiation between diverticulitis and carcinoma may be. Mistakes must inevitably occur, in the present state of our knowledge, and if a real doubt exists it is better to explore than to miss a carcinoma in the early stage.

Perforation of a diverticulum is another sudden abdominal catastrophe which may occur and be the first herald of the disease. The prognosis is grave, far graver than the rupture of a gastric ulcer, owing to the septic nature of the contents of the sigmoid. Sometimes a clue may be obtained by the patient complaining of a feeling of something in his rectum which he desires to pass, but cannot. It is almost, if not quite, impossible to make a diagnosis beforehand, and the condition is usually found at laparotomy. It is, however, important to bear the possibility in mind, as it may be necessary to do a colostomy, and it is always well to warn a patient or relatives beforehand that this may be necessary. Little gratitude or thanks are to be obtained when a patient finds he has a colostomy opening. To the average patient this is a calamity and a horror, and a feeling of grievance is often held that no previous warning had been issued.

Apart from the physical signs of a tumour on the intervention of some complication as narrated above, the diagnosis rests with the interpretation of a careful history, the possibility of disease, and an X-ray examination.

X-RAY EXAMINATION.

This is usually the crucial and deciding factor, especially in the cases of diverticulosis, i.e., those cases in which inflammatory

any effect will certainly cause a dry mouth, and tend to dry up the secretions generally. The pain, if it is severe, is best allayed by small but sufficient doses of morphia, though here again caution must be exercised in case constipation is produced, with a concomitant aggravation of the symptoms.

Surgical treatment is indicated for the following :—

If resection is deemed too risky or impossible, the colostomy, usually of the transverse colon, will have to be undertaken.

TREATMENT.

(a) To provide a diet which will form as little residue as possible, cellulose in all forms should be forbidden, such as cereals, nuts, fruit skins. Anything that is likely to produce the popular "roughage" such as brown bread, &c., must be rigidly excluded.

(c) Belladonna is said to relieve the spasm. I am very doubtful if this drug has any effect on the large intestines, and its administration in any dose likely to have

the acute symptoms, and the patient will then be spared the discomfort of a permanent colostomy, or a second operation for its subsequent closure. On the other hand if subsidence of the disease does not occur a second operation to make the temporary fæcal fistula into a permanent colostomy will be necessary. Valvular cæcostomy would seem to be a way out of this difficulty, but I believe this to be a dangerous operation as leakage may occur.

(c) *Abscess formation.*—The abscess must be drained, but if it forms deep in the pelvis the operation may and usually is exceedingly difficult and trying. The adhesions must be separated in order to obtain adequate drainage but the separation must be conducted with the utmost circumspection and gentleness in order to avoid damage to adherent and surrounding structures. Colostomy may be necessary.

(d) *Fistula formation.*—Repair of fistulæ between the diseased bowel and the bladder or vagina is obviously a difficult procedure. Nevertheless it can be carried out successfully. It will probably be necessary to perform a colostomy for a few weeks previously. Space will not permit me to go into the details of the operation for closing such fistulæ.

(e) *Perforation.*—As mentioned above this is a very grave complication. It may be impossible to close the perforation by suture as each stitch cuts out, like sewing butter. The perforation may be able to be closed by suturing one of the appendices epiploicæ over the opening. It is as well if possible to make the loop of bowel extraperitoneal, by sewing both margins of the peritoneum to the meso-sigmoid, or by bringing down the omentum and placing the affected loop of bowel through an opening therein. It is always wise in this condition to drain the bowel above the perforation by a colostomy or by a cæcostomy. A Paul's tube in the cæcum is probably preferable, as although a second operation for its closure will be necessary it is easily performed and the site

is well away from the diseased bowel. The disadvantage is that the fæcal stream is not entirely cut off—this can only be obtained by a colostomy in some part of the colon above the original perforation.

PRACTICAL NOTES ON LYMPHADENOMA.

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THE disease known as lymphadenoma, or, to use the more modern and perhaps more correct term, lymphogranuloma, was described in 1832 by Hodgkin, with whose name it is commonly associated. He gave a clinical description of a series of cases in which enlargement of the lymphatic glands was associated with characteristic pathological deposits in the spleen. The ordinary features of this disease in its most typical form may, of course, be found in any textbook of general medicine; the object of the following short article is to call attention to some of the details of the condition as they appear to the practitioner, who may be introduced to the patient at different stages of the disease, and to assist him in regard to a few of the more obvious points of differential diagnosis, and still more in regard to the less satisfactory question of treatment.

The malady may occur at all ages, but it is, generally speaking, a disease of comparatively young people. According to the most reliable statistical information, half the cases occur between the ages of 20 and 40, and males are affected twice as frequently as females. It is uncommon to find it in persons over 60 years of age, but one of the most classical examples of the disease I have ever seen occurred in a man of well over 70, who was sent into a general hospital for observation and diagnosis, and who displayed the most characteristic enlargement of lymph nodes in neck, axillæ and groins.