Intussusception in Children and Adults.

In studying cases of intussusception occurring after the first year of life we are at once struck by three features in which they contrast forcibly with cases in infants. In 70 per cent. of the cases a definite cause can be discovered; they tend to be chronic; the symptoms are irregular.

Causation.

In an extensive series of cases (Eliot and Corscaden) the following were found to be direct causes:—

1. *Tumours* were found in 40 per cent. Of these, 24 per cent. were innocent and included mucous polyps, fibromata, lipomata, submucous hæmorrhages; 16 per cent. were malignant, carcinomata, and sarcomata.

2. *Ulcers* were found in 14 per cent., and were due to typhoid, dysentery, and tuberculosis.

3. *Meckel's Diverticulum* (inverted) was the cause in 12 per cent., a very remarkable number considering the comparative rarity of this abnormality.

4. *Trauma*, such as a blow or a violent strain, was a definite cause in a few cases.

We have already discussed the manner in which these causes act.

Chronicity.

More or less acute attacks occur, with intervals during which the patient is free from any acute symptom and only complains of general poor health. The attacks become more frequent and severe as time goes on, but they may go on over a period of from a month to a year.

Symptoms and Signs.

Pain is always a prominent feature. At first the attacks of pain are sudden and severe, and may cease as suddenly as they began. As, however, adhesions form and tend to check the progress of the intussusception, the pain takes on a different character, and its onset and cessation are both more gradual.

Vomiting occurs in two forms which should be carefully differentiated. With the pain we have the bilious vomit due to dragging on the mesentery. Apart from pain, and in the later stages, we have the dark vomit of intestinal obstruction, with all the grave characteristics of that condition.

Wasting and Anæmia are always marked and frequently lead to a false diagnosis, such as tubercular peritonitis or carcinoma.

Either *Constipation* or *Diarrhœa* may be present. The former is more usual in enteric intussusceptions; the latter occurs in colic cases, and is accompanied by the passage of blood and mucus.

A *Tumour* is to be felt in the abdomen in most, if not all, of the cases. It presents the characteristics we have already described. In form it resembles a concave sausage. With each attack of pain it becomes firm, increases in size and advances in position, following always the path of the colon. In 30 per cent. of all cases its apex can be felt by rectum. It is tender, and manipulation brings on an attack of pain.

The *Abdomen* is not distended till obstruction has become a marked feature. Emptiness on the right side and fulness on the left are frequently noticed and are very characteristic.

Such are the symptoms of a typical case, but they may occur in such masked form that diagnosis is practically impossible.

The *Treatment* of these cases only differs from that of the acute infantile form in a few details. Laparotomy is as essential in the one as in the other, but here we are dealing with an older patient, and extensive operations can be successfully carried out. And we have the further incentive to resection that we can thus remove the *cause* which so often is of a definite nature in these cases. Once the condition is suspected, operation should not be delayed, for many cases terminate with startling abruptness in a few hours. And, in any event, operation during an acute exacerbation is a very grave proceeding. Spontaneous recovery is rare, for although cases where the intussusceptum has passed by rectum are not very uncommon, the great majority of these have died.

The Central Midwives Board.

Examination Paper, August 2nd, 1911.

1. Give the measurements of the normal pelvis at the brim. What signs would lead you to suppose that the pelvis was contracted, and how would you determine its size?

2. What instructions should be given to a pregnant woman?

3. How would you recognise that labour is obstructed, and what may this condition lead to?

What is tonic contraction of the uterus?

What is the duty of the midwife in a case of this kind?

4. Describe in detail the management of twin labour after the birth of the first child, and give reasons for all you do.

5. What abnormal conditions may occur in the passage of urine (*a*) In pregnancy? (*b*) During labour? (*c*) In the puerperium? How would you treat them?

6. What are the rules of the Central Midwives' Board regarding the child's eyes?

What is the common cause of inflammation of the eyes, and in what ways may they become infected?

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