CLINICAL NOTES ON SOME COMMON AILMENTS.

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ABDOMINAL PAIN.—(*Continued.*)

We have seen that the first essential is to distinguish between pain that is due to some grave organic disease within the abdomen, and that which is the accompaniment of colic, or acute digestive disturbance, and that we should examine the abdominal wall for rigidity or tenderness, and take the pulse rate, and also the temperature, in every case. It sometimes happens that the abdominal wall is apparently rigid when there is nothing serious the matter, but this is not of much importance, for no harm whatever arises from sending for a surgeon for an ordinary stomach ache, while omitting to do so for appendicitis may result in a tragedy.

We will now go rather more into detail, and see whether there are any other signs which may help us in distinguishing between the various conditions enumerated in the first part of this paper. One should, however, have the dictum of Lawson Tait in one's mind: "Accurate diagnosis in the abdomen is not possible: only the ignorant assert that it is, and only fools attempt it."

In children the difficulty lies in their inability to describe the nature and seat of the pain, but this is more than counterbalanced by their equal inability to mislead one by false statements about it. Moreover, such signs as rigidity and distension are usually more marked in children than in adults.

The first thing one does, as a rule, after having taken the temperature and pulse rate is to examine the lungs, pneumonia in young subjects being almost always accompanied by abdominal pain, and not infrequently by diarrhœa and abdominal distension also. Generally speaking, abdominal pain that is associated with diarrhœa is more often "medical" than surgical in nature, and one always feels happier if the bowels are freely open. It is sometimes almost impossible to eliminate appendicitis, and if the patient is seen within the first forty-eight hours, it is often better practice in some cases to open the abdomen, even if one is not quite certain, than to wait until the advent of general peritonitis clears up the diagnosis at the expense of the patient's life.

Another disease which should be in our minds, especially in children, is enteric fever. It is only the very inexperienced who have no difficulty in detecting an attack of enteric fever in its early stages, and, in fact, appendicitis will often simulate it very closely. There can be no doubt, incidentally, that before appendicitis was recognised as a definite disease, very many cases of that malady were thought to be enteric fever. Fortunately, the difficulty does not often present itself as an emergency at first. It may do so later on when the question of typhoid perforation of the bowel arises, but by this time there is usually no difficulty in detecting the originating illness. To suspect a perforation is practically to detect it.

The distinction, however, between the early stages of appendicitis and enteric can usually be made by the fact that in the former disease the signs and symptoms are mostly on the right side of the abdomen, and rigidity is more marked; definite resistance to the examining hand is usually present in the right iliac fossa, while a typhoid abdomen is either not tender at all, or slightly so all over. Still, the distinction is often difficult in practice.

In intussusception, which, incidentally, is more a disease of infancy than of childhood, there is collapse and vomiting; at first there may be one or two loose motions, but afterwards only blood and slime are passed per rectum, with straining. The abdomen is usually relaxed, and a sausage-shaped tumour can often be felt in the lower part of the abdomen. It is important to detect this condition, because only prompt laparotomy can save the patient's life.

In adults, the problem is more complex, because so many different conditions have to be thought of. Perhaps the first thing to eliminate is sudden obstruction of the bowel, in which case nothing, not even flatus, will have been passed per rectum, and there will be vomiting and collapse. Obviously also we must not miss a strangulated hernia, and I may say in passing that I have seen a case of this sent into hospital as typhoid fever. Then there is again appendicitis.

We next think of a perforated ulcer of the stomach or first part of the intestine, the former being most common in women, especially those who are anæmic and have previously suffered from indigestion, and the latter in middle-aged men. In either case there will be intense pain, some collapse, and rigidity in the upper part of the stomach just underneath the sternum and arch of the ribs. The pulse will almost certainly be rapid, and the patient will look ill. The great fallacy about all cases of perforation of any part of the stomach or intestines, and one which has led to more abdominal tragedies than one likes to think of, is that when, in consequence of the peritonitis which is inevitably set up by the perforation, the abdominal cavity

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