Six months later, she stated that her general condition had improved strikingly, and that she was having no abdominal pain and only occasional headaches.

DISCUSSION

In cases 1 and 4, the patient's symptoms were, in all probability, the result of the diverticula but in the other two cases, it is unlikely that the diverticula represented more than an incidental finding. Certainly, the active peptic ulcers present in cases 2 and 3 were sufficient to explain all symptoms.

The association of severe headaches with the abdominal distress in the two cases in which the abdominal symptoms were definitely caused by the diverticula is interesting, although the series is of course too small to make these observations of any value. Diminution of intensity and frequency of the headaches occurred in both cases after the removal of the diverticula.

Unfortunately, there is nothing specific in the histories of patients with diverticula of the small bowel that can aid in making the clinical diagnosis. If however, a patient has gastro-intestinal symptoms consisting of pain and eructations following meals, if there is no roentgen evidence of peptic ulcer or of biliary disease, and if disorders of the colon can be excluded, it is well to bear in mind the possibility of a diverticulum of the small bowel and refer the patient to the roentgenologist with a request that especial attention be given to this question so that appropriate examinations can be made.

Medical management, emphasizing a bland diet and barium sulphate or olive oil given before meals, is often sufficient to control the symptoms referable to diverticula of the small bowel, but when the diverticula are in the jejunum, the symptoms are not infrequently quite intractable and surgical intervention becomes necessary.

SUMMARY

1. Four cases of diverticula of the jejunum are reported.
2. In one case, roentgen examination showed that the diverticulum appeared to arise from the first part of the duodenum, but at operation, it was found to come from the jejunum just below the duodenojejunal junction.
3. The two patients who did not respond to medical management were completely relieved of symptoms by excision of the diverticula.
4. There is no characteristic syndrome which makes possible a clinical diagnosis of diverticulum of the small bowel.
5. Persistent pain and eructation after meals in the absence of peptic ulcer, biliary disease, or disorders of the colon should suggest the possibility of a diverticulum of the small bowel, particularly if the symptoms are accompanied by severe headaches.

REFERENCES

1. Rankin, F. W., and Martin, W. J., Jr.: Diverticula of small bowel. *Ann. Surg.*, 100:1123-1135, Dec., 1934.
2. Gisbertz, H.: Multiple Dunndarmdivertikel. *Arch. f. klin. Chir.*, 165:314-321, 1931.
3. Helvestun, F., Jr.: False diverticula of jejunum. *S. G. O.*, 37:1-5, July, 1923.
4. Beigler, S. K., Bloom, A. R., and Wruble, J.: Diverticulum of jejunum, with case report. *Am. J. Surg.*, 17:109-110, July, 1932.
5. Schmidt, E. A., and Guttman, P. H.: Multiple diverticula of jejunum and duodenum simulating gastric diverticula and complicated by cholelithiasis. *Am. J. Roentgenol.*, 31:200-203, Feb., 1934.

SECTION VII—*Surgery of the Lower Colon and Rectum*

Ischio-Rectal Abscess: A Stage in the Development of "Horseshoe" Fistula*

A Case Report

By

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THE patient, a male, twenty-eight years old, came to the dispensary on November 9th, 1935.

He gave a history of sudden onset of malaise, fever and inability to sleep for two nights on account of throbbing pain and swelling to the right of the anus.

Examination revealed a circumscribed swelling involving the right ischio-rectal fossa. The overlying skin was reddened, felt hot and indurated, and was tender upon pressure. There was, in the central portion, a small area the size of a quarter, which was paler in color and fluctuation was noted upon careful palpation. At examination the pain was so severe that neither digital nor instrumental examination was deemed necessary.

An *emergency diagnosis* of acute ischio-rectal abscess seemed logical.

Operation: Under local anesthesia, a paramedian incision was made into the abscess cavity. About four ounces of foul-smelling pus were evacuated, the fluid being under considerable tension. The patient was told to take hot sitz baths twice daily and to apply hot moist boric acid dressings locally, and was admitted to the hospital on the following day for further operative procedure.

The patient stated he had suffered from piles, (his own diagnosis) for many years and had sought relief by self medication with various ointments and suppositories.

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Submitted February 28, 1936.

Upon admission at the hospital his temperature was 99.6° F. and pulse rate 70. The blood pressure and urinary findings were within normal limits. Discharge from the incised abscess was scant and there was slight redness and induration of the overlying skin.

Under gas-ether anesthesia, the previous incision was enlarged. All septa were broken down for better drainage. The infection involved the anterior and posterior portions of the right ischio-rectal fossa. There was a communication posteriorly with the fossa on the opposite side, forming a posterior "horseshoe" abscess and fistula.

At operation, the internal opening was found in a posterior crypt. The fistulous tract extended downward, dividing into two branches, just proximal to the external sphincter, one communicating with the abscess through a short tract between the internal and external sphincters, and the other continuing superficially under the anal skin, ending at the posterior commissure. A hook was inserted into the crypt and this superficial tract *excised*, leaving the external sphincter intact. The deep tract was not divided at this time. A stab wound was made over the posterior portion of the left ischio-rectal fossa and a rubber tube inserted to afford through and through drainage. The cavity was packed lightly with gauze.

Post-operative treatment consisted of hot moist boric acid compresses changed frequently. The gauze dressing was removed on the day after operation. The rubber drain was removed on the third day. The wound was treated daily with a mild antiseptic until the patient's dismissal from the hospital on the eighth day. Thereafter he was seen twice a week, the cavity healing by granulation in about seven weeks, except for a small short sinus at the posterior angle of the wound. He was last seen on January 10th, 1936, at which time the sinus was still present. If this sinus does not heal, further division may be necessary.

Perianal Lipoma: A Case Report*

By

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THE patient, a Negro, male, aged 51 years, registered at the Clinic October 19th, 1935, complaining of a "lump" near the anus on the left side. An operation for a "swelling" at the same site had been performed at another hospital eight years previously.

Six months before admission the patient noticed the present swelling. Local soreness was present occasionally. No discharge had been noticed.

Family history and past personal history were unimportant except as noted.

Examination revealed a swelling three inches long and two inches wide, one and one-half inches to the left of the anus. The swelling was moderately firm, showing no definite fluctuation. No local heat nor tenderness could be detected. Examination of the anus, rectum and sigmoid revealed no abnormalities. Inspection of the rest of the body showed no swellings or tumors of the same type.

A tentative diagnosis was made of a perianal lipoma or a "cold" abscess. The swelling was incised under gas-ether anesthesia. The tumor was found to consist of fatty tissue. This was enucleated down to the ischio-rectal fossa where it apparently was continuous with the fat of this fossa. A ligature was placed around the base of the tumor and the tumor was excised. The wound was closed by interrupted sutures and healed by primary union.

Although fatty tumors of lipomata of the buttock frequently are reported, perianal lipomata continuous with or contiguous to the normal fat contained in the ischio-rectal fossa are not commonly encountered.

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Submitted February 28, 1936.

Annual Abstracts of Protologic Literature

(May, 1934-May, 1935) By CLEMENT L. MARTIN, M.D., Chicago, Illinois

The complete bibliography from which these Abstracts were made will be published in full in the Transactions of the American Proctologic Society, 1935.

ANESTHESIA

Spinal anesthesia is finding its place; it has gained wide usage as the details of its administration have become better known. A number of surgeons have completely abandoned it after liberal trial, some anaesthetists still use it fearfully but surgeon and anaesthetist have another valuable addition to their armamentarium in properly used spinal block analgesia. Trans-sacral and caudal block analgesia has the commendation of some; it is more difficult to give and takes longer than a spinal but if only the 2nd sacral foramina are injected in addition to the caudal canal, as is the case usually for rectal operations, the injections are not very difficult. It is very safe as the anaesthetic solution remains extra-dural; it affords a well-relaxed, well-anaesthetized field.

Avertin as a basal or preliminary anaesthetic continues to receive some condemnation but more favorable reports. Evipal given intravenously appears to be especially indicated where a short anaesthetic, of 15 to 20 minutes duration suffices. Newer drugs have been tried in infiltration anaesthesia. The use of diothane in 100 anal cases is reported by *Rosser*. He found it gave anaesthesia enduring "several, to 24 hours," the results were not uniform, a tendency to skin tag formation following its use is noted. A few cases had abscess but the use of normal saline solution to replace the distilled water in which the diothane was dissolved, avoided this complication. 1 ounce of either the 1% or 0.5% solution was used.

Bacon used nupercaine in 91 anal operations and summarizes his results thus: it may be used without ill effects,