DIAGNOSIS AND TREATMENT OF TUBERCULAR PERITONITIS.

Dr. Samuel Fenwick, in the course of his lectures on cases of difficult diagnosis, writes as follows upon the diagnosis of tubercular peritonitis in the adult (*Lancet*, March 9, 1889): The diseases with which we are most apt to confound acute tubercular peritonitis are typhoid fever and acute non-tubercular peritonitis, and in some instances the resemblance is so close that it is only by great care and watchfulness that we can avoid falling into error.

As a general rule, tubercular peritonitis of this kind begins suddenly, whilst typhoid is usually preceded by a period in which the patient has been weak, feeble, and feverish. In the former, pain in the abdomen is more marked, and there is tenderness over different parts whilst pain in the latter is rarely severe, and any tenderness that may be present is confined to the iliac region. In tubercular peritonitis the temperature rises at once, and not regularly, as in enteric fever, and the pulse is usually more rapid. As the case proceeds the temperature varies more in peritonitis, spots are rarely observed, and the stools have not generally the typical appearance of those passed in typhoid; whilst at a latter period the persistence or frequent returns of abdominal pain and tenderness and of vomiting, the variations of the temperature, the alternations of constipation with diarrhœa, and the increasing prostration, will in most instances enable you to distinguish between these diseases. In addition to these differences, you will in many cases be able to render your diagnosis more certain by the discovery of fluid in the peritoneum, or by the detection of a tumor in the abdomen; or you may find the signs of effusion in the pleura or of a consolidation in the apex of one or both lungs.

Still more difficult is it to distinguish between acute tubercular peritonitis and ordinary peritonitis when the former does not assume from the first the typhoid form. In many cases I believe it is impossible to arrive at a certain conclusion in the early stage, for both may attack persons previously healthy, both may be ushered in by similar abdominal symptoms, and it is only by watching the progress of the disease that you can form an accurate opinion. As a general rule, the pain, tenderness, and vomiting are less distressing in the tubercular form, the temperature is lower, and there is more usually diarrhœa than constipation. As the disease progresses, the abdominal symptoms recur from time to time instead of slowly subsiding, the temperature remains high, emaciation becomes more marked, the effusion into the peritoneum is very slowly absorbed, and you may discover signs indicating effusion into the pleuræ or pulmonary consolidation.

As regards the treatment of acute tubercular peritonitis in the adult, he says: In the typhoid form I have usually treated the case as if it were one of enteric fever; that is, the patient has been kept at rest, the food has been restricted to liquids, and cold sponging has been employed whenever the temperature has been unduly high. Quinine in moderate doses in combination with opium has been prescribed to relieve pain and to check diarrhœa. In the cases in which the symptoms were chiefly abdominal the treatment has been directed as in ordinary peritonitis; poultices and hot fomentations have been applied to the abdomen, and small doses of opium have been given to relieve pain and diarrhœa. You must, however, be careful not to induce constipation, for it is usually followed by attacks of vomiting that quickly reduce the strength of the patient.

You may ask whether the washing out of the peritoneum, which is so successful in some cases of suppurative peritonitis, is likely to prove beneficial in this kind of case. I have never seen it tried, chiefly because the real nature of the disease has more frequently been suspected than actually diagnosticated during life; but I do not think it would be of much value, as I have found the fluid serous, not purulent, and the patients have seemed to me to sink from the general acute tuberculosis, and not from the effects of the inflammation of the peritoneum.

COUNTER IRRITATION IN WHOOPING COUGH.

Dr. Inglott, district officer of the Island of Malta, writes to the *Brit. Med. Jour.* of the success which he has had in the treatment of pertussis by the application of strong counter irritation of the pneumogastric nerve between the mastoid process and the jaw. One case is quoted of the many which he has had under treatment:

G. C., a boy, æt. 12 years, of weak constitution, was suffering from frequent and intense attacks of whooping cough. At a time the fits were so vehement that blood came out of his eyes and mouth. The case was a severe one and I thought that it would very likely end fatally. I prescribed several medicines, and even subcutaneous injections of morphine, but without any avail. I then tried for the first time the counter irritation on both sides of the neck, and this means acted like magic. In four or five days the patient recovered, and was able to go to school. Since that time I have been applying the same treatment, either on th eright side only or on both, with the greatest benefit.