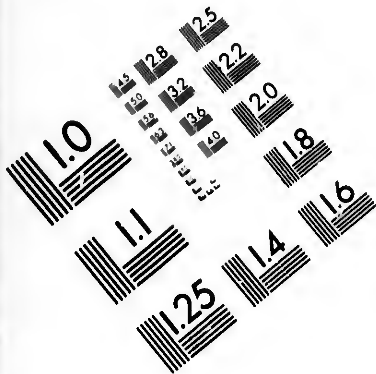

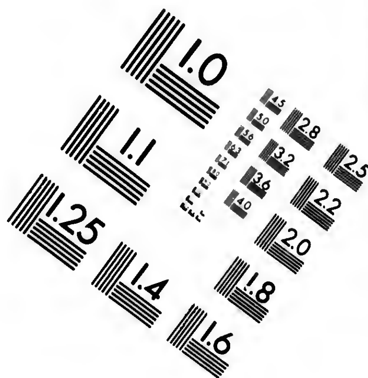

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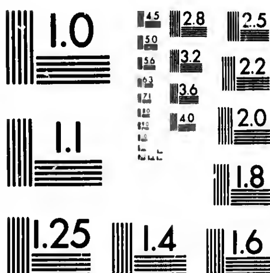

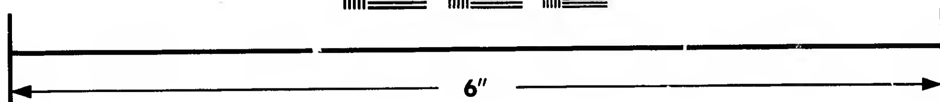

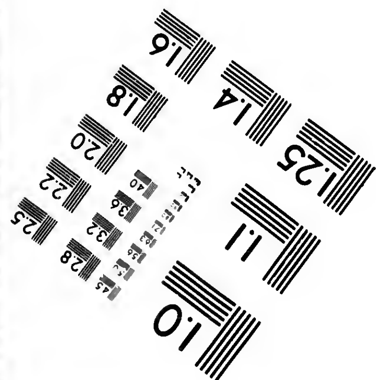

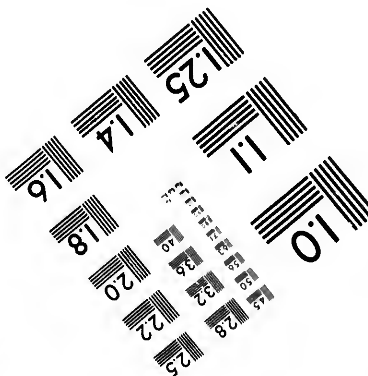

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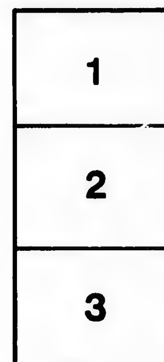
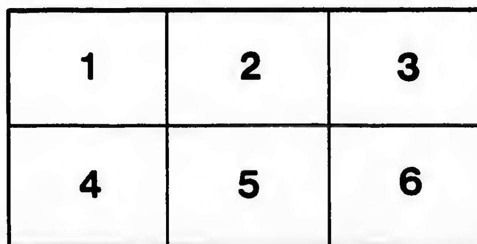




Tu. Finley, F. G. 616.38

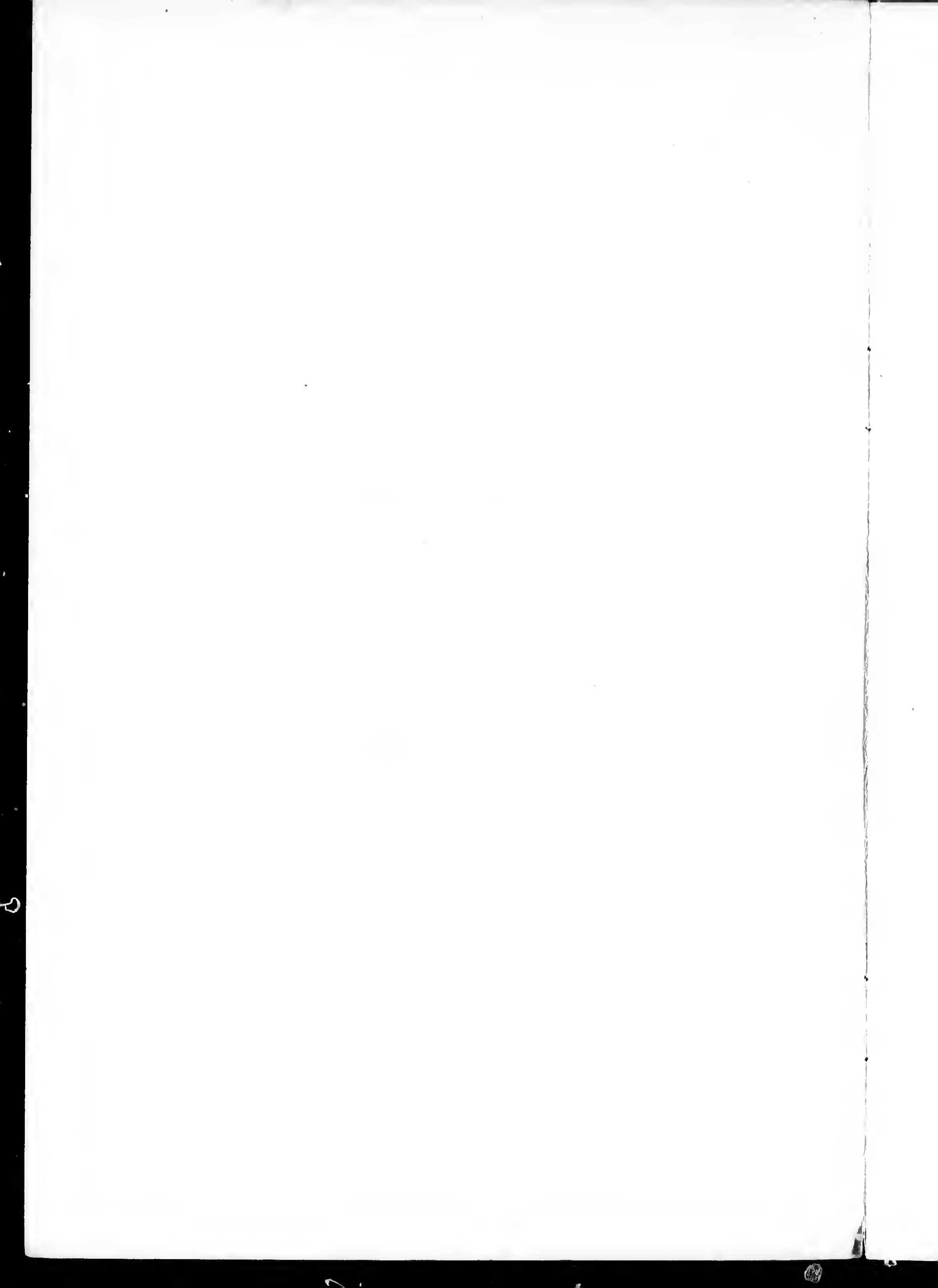
TUBERCULAR PERITONITIS.

BY

F. G. FINLEY, M.D.,

Assistant Professor of Medicine, and Associate Professor of Clinical Medicine,
McGill University ; Attending Physician, Montreal General Hospital.

(*Reprinted from the Montreal Medical Journal, April,* 1898.)



TUBERCULAR PERITONITIS,

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F. G. FINLEY, M.D.,

Assistant Professor of Medicine, and Associate Professor of Clinical Medicine McGill University; Attending Physician, Montreal General Hospital.

Tubercular Peritonitis—Abrupt onset—Latent Pulmonary Tuberculosis—Laparotomy.

The patient, a man of 42, was admitted to the hospital on February 7th, 1898, for pain and swelling in the abdomen. He stated that his health was always good up to last July, when he suffered with shortness of breath for two weeks. Toward the end of December he felt tired and unable to work. After a long drive on January 2nd, the following day he was feverish, and suffered from severe pain in the back. There was also pain in the right inguinal region, and pain and difficulty, but not undue frequency, of micturition. The abdomen became swollen on January 6th.

Pain has been present in the left side of the abdomen for about an hour whenever he takes much solid food, at times sharp and startling in character. He has lost 30 lbs. since July. Neither cough nor expectoration have ever been present.

The *family history* is negative as regards tuberculosis and cancer.

Examination.—He is a rather poorly nourished man, slightly anæmic, the temperature varying between 99° and 101°, the tongue coated, and the pulse 80. The abdomen slightly distended and the muscles rather tense. There is increased fullness on the left side below the ribs, and a gurgling sensation, but no clearly defined tumor. The note is dull in both flanks, especially the left, unaltered by change of position, and there is slight fluctuation over the tumor. At the right apex there is dullness both front and back, with fine crackling and sibilant râles; no cough or expectoration. The other organs are normal, and the urine is alkaline, contains a trace of albumen, and a heavy deposit of phosphates, but no pus.

The condition remained unchanged, slight fever being present, and on the 24th he was transferred to Dr. Armstrong's ward for laparotomy. The operation was performed on February 25th, when the intestinal coils were found much matted together by moderately firm adhesions. Numerous tubercles were scattered over the peritoneum, and small pockets of fluid were present on the left side. A good recovery from the operation ensued, the stitches being removed on the tenth day, and the patient was up on the 18th. The temperature continued elevated in the evening, but showed a rather lower average than before the operation, but with occasional rises to between 102 and 103. He left the hospital on March 9th, feeling in better health, free from abdominal pain, and his general condition somewhat improved.

In this case the diagnosis of tubercular peritonitis rested on an indefinite tumor in the abdomen, with fever, and on the presence of physical signs of tuberculosis at the apex of the lung.

Miliary tuberculosis of peritoneum — Laparotomy—Subsequent involvement of pleuræ and pericardium.

The patient, a woman about 21, domestic servant, was admitted to the hospital for abdominal swelling. She came to the city last fall, and had been gradually

losing flesh from the previous summer, going down from 124 to 106 lbs. between these periods. On January 23rd, 1898, she noticed slight abdominal swelling in the morning, and by evening she was unable to button her clothes. About the same time she began to suffer from night sweats, and was admitted to the hospital on Febrvary 6th. There was then some shortness of breath on exertion. There was at the time of her admission evidence of ascites and fever. A diagnosis of tubercular peritonitis was made, and Dr. Armstrong performed laparotomy and emptied the abdominal cavity of fluid on February 11th. The peritoneum was then studded thickly with tubercles. She continued, however, to have high temperatures, with evening exacerbations; the loss of flesh continued, and on February 24th she was transferred to the medical ward. The note made on this date states that the patient is much emaciated, the cheek bones are prominent, the face flushed, the muscles small, the sub-cutaneous fat scanty, and the skin normal. The abdomen is slightly distended, measuring 27½ inches, there is dullness in both flanks, changing with alteration of position, but no fluctuation. The breathing is slightly hurried, 24 to 28 per minute, no cough or expectoration. Expansion is deficient on the left side; there is dullness in the lower axilla and base behind to the fifth dorsal spine. The dullness in the axilla disappears on lying on the other side. There is distant blowing breathing over the dull area. Owing to the feeble voice, resonance and fremitus show no alteration. A loud grating pleural friction which had been heard a few days previously has disappeared.

On the right side there was dulness and a few crackling rales for a hand s breadth at the base posteriorly. The apex impulse was felt in the fourth space, somewhat feeble in spite of the thin chest wall. The cardiac dulness was triangular in form, beginning above at the third rib, its right border extending obliquely downwards and outwards to join the hepatic dulness at the fifth right rib, the lower part of the sternum and the fourth and fifth intercostal spaces to the right of the sternum being dull. The left border of the triangular area of dulness extended down from the third left rib to the apex and then blended with the dullness of the fluid in the pleural cavity. On sitting up in bed the line of cardiac dulness fell about a finger's breadth; the other organs are normal.

March 13th. The patient has gained somewhat in strength, but continues emaciated. The temperature ranged from 97 to 103, being higher at night.

The fluid in the left pleura has diminished, and a pleuro-pericardial friction is present along the left border of the heart.

March 25th. The patient is gaining flesh and strength, and is able to sit up daily in a chair. The fluid in the pleuræ has much diminished.

This case is clearly one of tuberculosis involving the serous sacs and without obvious disease of the viscera. On her admission the presence of fluid in the abdomen, high temperatures, and gradual loss of flesh preceding any local symptoms, and strong hereditary tendencies to tuberculosis, rendered the diagnosis clear. The later involvement of the three great thoracic serous membranes is undoubtedly of the same character. The physical examination indicates very clearly the signs produced by small quantities of fluid in the pericardial sac. Percussion gives us the earliest and most certain indications. Dulness of a roughly triangular form, extending obliquely down and out to the right of the sternum, and especially to the fifth right space (Rotch's sign) is the earliest sign of pericardial effusion. The presence of movable dulness can often be demonstrated as in this case, and is a further sign of much value. In this case the percussion dulness was readily made out owing to the thin chest wall. It is in stout

people that a pericardial effusion is most likely to be mistaken for cardiac enlargement. The prognosis in this case is extremely unfavorable. With such extensive disease an unfavorable prognosis must be given, and although a gain in strength has occurred, the continued fever shows the process to be still active. The improvement which is going on seems remarkable in the presence of the general involvement of the serous sacs. It seems highly inprobable that laparotomy should influence the process in the pleuræ and pericardium, and it seems more rational to attribute the improvement to the natural tendency to arrest of the pathological process seen in many cases of tuberculosis.