AN INAUGURAL DISSERTATION
ON
Chronic Peritonitis

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On Chronic Peritonitis

There are two kinds of chronic peritonitis, differing entirely in their origin, and much in their degree of mortality, which are nevertheless so similar in their symptoms, that it is not always easy to distinguish them. In one the inflammation is of the ordinary character, and originates in the ordinary causes, in the other, it depends upon tubercles disseminated in the membranes and serving as a constant source of irritation. I shall first describe the former and then point out those additional symptoms which may be supposed to indicate the existence of the latter.

Symptoms—The disease is sometimes original, but, when the inflammation is of the ordinary character, it is more frequently a mere sequel of an ill-conceived acute attack. In the former case, its commencement is often very obscure, a little pain being sometimes felt in the abdomen, with derangement of digestion.
and alternations of Constipation and looseness of
bowels, which exist for a considerable time without
attracting much attention. At length the general
health is affected, a little febrile excitement is experi-
enced towards evening, the patient loses flesh
and strength, and the disease becomes fully
developed. Then the result of a preceding acute
attack it exhibits the characteristic phenomena
immediately after the subsidence of the pri-
mary symptoms. In some instances, it would
be difficult to decide whether the disease began
in its acute or Chronic form; for, even in
cases which might be considered as belonging
to the latter the pain is severe at first and
afterwards diminished and the truth
appears to be, that there is no distinct line
of division between the two varieties.
When the complaint is fully formed there
is usually slight pain in the abdomen,
which in many instances is scarcely felt
unless direct pressure, or on the occasion of some shock or jar such as that produced by a false step, or the motion of the carriage, or some effort on the part of the patient, such as coughing, straining, or which causes a sudden compression or compression of the abdominal viscera, sometimes the pain and tenderness are confined to one spot, sometimes are diffused or variable. There is occasionally a sense of heat in the epigastrium. The abdomen is sometimes swollen in consequence of effusion into the cavity, but when this is not the case, it may be even flatter than in health, in consequence of the tension of the muscles. In the former case there is dulness on percussion, often more or less fluctuation, and sometimes an edema of the feet and legs. In the latter the abdomen is firm.
and elastic to touch, and often more or less
inequal from the irregular formation of
adhesion and the development of tumors
or of sand within the folds of the peritoneum.
Occasionally the abdominal
effusion is so great as closely to imitate
ascites if not to constitute a variety of
that disease.
The appetite is felt or irregular, and the dig-
station impaired. In most cases there is
nausea with occasional vomiting, and the
stools are irregular, being either Constipated
or affected with diarrhoea.
Food produces a feeling of weight in the stom-
ach, and, in some instances, causes pain
in particular portion of the abdomen occuri-
ing at a certain interval after eating.
The state of the tongue is variable, but
generally it is either slightly furry, or
smooth, red, and moist or less opaque.
The pulse is frequent, the urine scant, the skin usually dry, unless in the latter stages when hectic has been developed, and the face pale and expressive of anxiety. The progress of the disease is usually very slow. Strength gradually fails, and the patient worn out by the constant irritation, as well as by the failure of digestion and nutrition, sinks in a state of debility and emaciation, which terminates at length in death. The fatal issue is sometimes accelerated by the superintervention of an acute attack of inflammation. The disease is sometimes complicated in its course by functional disorders of various organs, the action of which is interfered with adhesions, or tumours formed in the peritoneal cavity. Thus, jaundice may result from pressure upon the gall-ducts, and obstinate constipation from pressure on the bowels.
Sometimes the disease is quite latent until near its close. It is not always easy to determine, during life, whether the disease is or is not connected with tubercles of the peritoneum. Whenever it is protracted and very obstinate, resisting the Curative measures employed, and when its origin cannot be traced to a preceding acute attack to local injury of the abdomen, or to Chronic affection of the abdominal viscera, there is strong reason for believing it to be tuberculous.

In this form of the disease a close examination of the abdomen will often detect small tumours. Consequent upon enlargement of the mesenteric glands, and the iliacal lymphatic glands especially in the groin, are also occasionally enlarged. The simultaneous existence of tubercles in the lungs, or an obstinate diarrhoea, indicating tuberculous ulceration of the bowels would be further
evidence of the nature of the affection. Some aid in the diagnosis may also be drawn from the general habit of the patient and his hereditary tendencies.

The disease is always one of danger, but, in the tuberculous form, may be considered as quite incurable. When partial, or dependent on a curable disease of neighboring organs, or consequent upon an acute attack, and especially when not connected with tubercles, there is reason to hope that it may yield to remedies.

Anatomical Characters. This uncommonly there is almost universally adhesion of the peritoneal membrane, in consequence of the effusion and organization of coagulable lymph. Occasionally, small spots of lymph are observed, thickly strewed over the surface of the peritoneum, which at first sight might be mistaken for tubercles,
but are distinguishable by their less regular form, and by being easily detached from the membrane while tubercles being situated in the subserous tissue, are not thus removable.

In those cases in which the false membrane covers the peritoneum, it is usually very thick of a grayish, reddish, or dark color, often rough and of an ascorbic appearance upon the surface, and sometimes of an almost cartilaginous hardness. Sometimes the intestines are so agglutinated as to form tumourous sensible externally and now and then, in consequence of partial adhesion of the peritoneum, sacs are formed, which are filled with liquid, and give an irregularity to the outline of the abdomen. The liquid effusion is variable in quantity, position, and appearance, being in some cases very scanty, in others more or less abundant, sometimes anterior to the bowels, which are compressed into the
back part of the abdomen and sometimes, partially or almost in both, occasionally nearly opaque, and limpid, with fibrinous flakes. Occasionally, more or less opaque, and of a yellowish, brownish, blackish, or reddish colour, from admixture of pus or blood. In some instances, it consists exclusively of pus. In cases complicated with tuberculous deposits, this is found either in small distinct granulations, or in masses formed by their aggregation, more or less extensively diffused over the peritoneum, and generally adhered with false membrane, and adhesions. The tubercles exist in all stages of development. They are usually solid, but are sometimes met with in the softened state, and even opening into the peritoneal cavity. Instances have occurred in which tuberculous matter
deposited in the adhering Coats of the intestinal Convolutions has produced ulceration in both, and thus formed a communication between them.

Treatment. The remedies to be chiefly relied on are rest, occasionally lancing, fomentation or emollient Cataplasms, warm bathing, blisters, and the Constitutional inunction of mercury and of iodine. Rectangular applications to the abdomen, protrusion by tatar emetic, and Belles or fuses on the insides of the thighs, have also been recommended.

Mercury may be used both internally, and externally, the ointment being applied by friction over the abdomen, or as a dressing to the blistered surface. Iodine may be used in the same way.

Attention should be paid to the state of the bowels, Constipation being avoided by
lapatives, and diarrhea by opiates combined with astrineous preparations.Irrons powdering or the extract of hyoscamus may often be usefully given at night, especially in connection with the mercurial preparations.

Injuries may be employed to promote the absorption of the effused fluid.

The diet should be regulated by the circumstances of the case. In the more active stages, it should consist exclusively of vegetable matters. When the strength fails under this rigid course, milk may be added, and circumstances of debility and exhaustion may occur, requiring the use of animal food.

In the tuberculous cases, the diet as a general rule, should be made nutritious than in those of uncomplicated inflammation. In these cases moreover a preference should be given to iodine.
over mercury, and the necessity of counteracting the tendency of general debility to produce tuberculous deposition, may render a resort to bitters, chalybeates, cod-liver oil, and moderates of a passive character, desirable. Should abscesses form with an apparent external direction, their tendency to the surface should be favored by inflamed poultices.