above. With a normal arrangement of the mesenteries of the small and large intestines such an accident would appear to be impossible, and, as Leichtenstern observes, it seems as if that variation in the development of the mesentery in which the ileum, cæcum, and ascending colon possess a common mesentery is especially disposed to it.

Manchester.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF INTESTINAL OBSTRUCTION FROM REDUCTION EN MASSE.

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THE patient, a man, aged 62 years, was admitted into the Llandrindod Wells Hospital and Convalescent Home on the evening of July 22nd, 1902, suffering from intestinal obstruction. He suffered from an old-standing left inguinal hernia for which he wore a truss. On July 17th the rupture came down and he had considerable difficulty in returning it, but managed to do so by himself in ten minutes. The rupture seemed to go back in the same manner as usual. He began to suffer pain, however, and was very sick on the next day. This had continued ever since. He saw a medical man on July 21st who suspected reduction *en masse* and sent him into the hospital. On admission the patient was extremely exhausted, having been driven ten miles in a rough country cart. On examination nothing abnormal could be detected in the left inguinal region. The patient, who had been given some opium, did not complain of any pain. Copious enemata were tried without success and laparotomy was performed next morning as giving the only possible chance. On opening the abdomen a small knuckle of bowel (small intestine) was found to be strangulated by the neck of the sac which had been reduced apparently entire. This was divided and the bowel was easily released. It was deeply congested but not gangrenous. As the patient was in an extremely bad condition the operation had to be conducted quickly. He improved somewhat after the operation and the sickness, which had been practically continuous, ceased. The pulse, however, continued almost imperceptible and the patient died early on the morning of July 24th. Only a partial post-mortem examination could be performed. There was no peritonitis and the strangulated loop of bowel was deeply congested but not gangrenous.

The case is an instructive one as showing how a reduction *en masse* may occur without giving any external signs even in a thin patient; the vomit while he was in the hospital though brown was never faecal. The ease with which the strangulated bowel was found was remarkable. The patient passed flatus freely after the operation.

Llandrindod Wells.

A CASE OF LUPUS VULGARIS: TREATMENT BY EXCISION AND REPLANTING.

By B. H. NICHOLSON, M.B., C.M. EDIN.,

SURGEON TO THE ESSEX AND COLCHESTER HOSPITAL.

I RECENTLY had a boy under my care in the Essex and Colchester Hospital with a large patch of lupus vulgaris covering the whole side of his foot and extending into the sole. He was of marked tuberculous constitution with angular curvature of the spine. The patch presented the usual appearance of clusters of semi-translucent nodules imbedded in the corium, which Hutchinson has so aptly likened to the appearance of "apple jelly." Many of the nodules had run together, broken down, and formed ulcers. The usual internal and external remedies were employed for a considerable time without benefit. On account of the large extent of skin involved I determined to try the following treatment. The foot was

thoroughly disinfected by turpentine, perchloride of mercury, and carbolic lotion (as for an aseptic operation), an anæsthetic was administered, and the whole patch was excised, the incision being made through healthy skin. The subcutaneous fat was completely removed with scissors and the lupoid patch was placed in a 1 in 40 hot carbolic lotion. The hæmorrhage was stopped by placing over the wound green protective and using hot carbolic lotion (120° F.). The lupoid patch of skin was removed from the water, dried, re-planted, and dusted with sterilised iodoform. The wound was dressed with protective blue gauze, &c., and a splint was applied. The graft quickly joined, the ulcerated points healed, and the result was perfect except that the skin was blue and livid.

I cannot remember having seen this method of treatment of lupus described before. I should be much interested if other members of the profession would give it a trial. I refrain from discussing any ideas regarding the means of cure in tuberculosis. Why Bier's method in tuberculous joints? Why laparotomy in tuberculosis of the peritoneum? It seems to be owing to a change in the blood-supply repugnant to the tubercle bacillus.

Colchester.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

KINGSTON VICTORIA HOSPITAL.

A CASE OF PERFORATING GASTRIC ULCER; LAPAROTOMY; RECOVERY.

(Under the care of Mr. J. E. S. BARNETT and Mr. C. E. TURNER.)

ONE great point in the prognosis of cases of perforated gastric ulcer treated by laparotomy is the length of time which elapses between the perforation and the operation. When the operation is performed within 12 hours of the perforation over 70 per cent. recover¹ according to the statistics of recorded cases. When 12 hours have elapsed, but less than 24 hours, only 36 per cent. recover; and the number of recoveries steadily diminishes till if 48 hours have elapsed in cases of acute perforation the chance of recovery is very small indeed. In the following case about 12 hours had elapsed between the perforation and the operation and this made the prognosis somewhat favourable. There are, of course, many other factors influencing the prognosis, but the next most important point is the condition of the stomach, whether full or empty, for it is obvious that if the stomach be void of contents the risk of general peritonitis is much lessened. The influence on the prognosis of the variety of microbic infection of the peritoneum in perforated gastric ulcer has not hitherto received the attention which it deserves.

Mr. C. E. Turner was called to see the patient, a married woman, aged 34 years, at 10.30 P.M. on Oct. 21st by Dr. J. E. C. Bradley of Raynes Park, the patient's usual medical attendant, with a view to admit her into the Victoria Hospital. The patient was found to be much collapsed, with a drawn expression of countenance, suffering from violent pain in the abdomen in the region of the right iliac fossa, and with a constant desire to vomit. The history was as follows. The patient had been suffering from periodical attacks of indigestion for some time past but had otherwise been in fairly good health. About 1.30 P.M. on Oct. 21st she stepped on to a tub to look over her garden wall when she was suddenly seized with violent pain in the lower part of the abdomen, coupled with uncontrollable vomiting. Mr. J. E. S. Barnett was called in and ordered her to bed; hearing, however, that her usual medical attendant, Dr. Bradley, had been sent for he left the case in his hands. Dr. Bradley injected half a grain of morphia hypodermically and she

¹ Robson and Moynihan: *Diseases of the Stomach*, p. 161.