caused no staining of the dressings on the chest wound. At this time the patient had an attack of influenza, which was prevalent. He had severe headache, which was relieved in less than an hour by aspirin gr. x. given in milk by the jejunostomy tube. A fortnight later a little liquid food by the mouth was given and gradually increased, at the same time the feeds by the jejunostomy tube were decreased.

At the end of another fortnight the patient was getting a fair diet of milk and malted milk by the mouth, so the jejunostomy tube was removed, a dry dressing being applied. There was no excoriation of the skin around the wound, and in less than a month after removing the jejunostomy tube the abdominal and thoracic wounds were both soundly healed. As the jejunum was brought up to, but not through, the parietal peritoneum, on removing the tube the wound closed up and healed rapidly.

The patient made a complete recovery, took his ordinary diet without any pain or discomfort, and said he felt exceedingly well. The lung expanded and the cardiac apex beat returned to about the normal position.

I am indebted to Lieutenant-Colonel R. F. Standage, I.M.S., Surgical Consultant, East African Field Force, for his advice and assistance in this case.

CASE OF SUDDEN COMPLETE PROCIDENTIA RECTI IN A YOUNG ADULT MALE.

BY W. R. M. TURTLE, M.B., B.S. LOND., D.P.H.,
SENIOR ASSISTANT MEDICAL OFFICER, WHIPPS CROSS INFIRMARY,
LONDON, N.E.

THIS case appears to be of sufficient interest to record, as I believe the sudden formation of a complete prolapse of the rectum to be very unusual in a young adult.

S. H., a male, aged 26 years, was admitted to the Whipps Cross Infirmary on August 26th, 1919, suffering from complete procidentia recti. The prolapse formed a firm, oedematous, egg-shaped mass, the long axis of which was 5 inches and the short 4 inches. Hæmorrhoids were present in addition.

The history of the case was that once, when a very small child, the rectum came down and had to be replaced by a doctor, but the patient himself had no recollection of ever having had any trouble of this nature, until suddenly, on the day previous to admission, during the act of defæcation, the bowel came down.

On August 27th the mucous membrane of the prolapse was commencing to ulcerate in places. On that day I excised the prolapse by the method, so clearly described in Cheyne and Burghard's "Manual of Surgical Treatment," for "excision of the entire prolapse, when the prolapse involves the whole thickness of the bowel." Hæmorrhage during reflection of the mucous membrane was free, and troublesome to control, owing to congestion of the mass from partial strangulation and the presence of hæmorrhoids. Apart from this the operation presented no difficulty. The peritoneum covering the bowel was stitched to the parietal peritoneum and the cut edge of the bowel to the skin at the anal margin. The external sphincter was, of course, not touched at the operation, and quite half of the internal sphincter was left.

The patient made a good recovery; the wound healed without suppuration. There was incontinence of fæces for a month, and then control over the sphincter gradually returned. Two months after the operation control was fully established. He was discharged from the infirmary on Nov. 19th.

I have to thank Dr. J. C. Muir, medical superintendent, for permission to send the above notes on this case for publication.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

THE APPLICATION OF WAR METHODS TO CIVIL PRACTICE.

A MEETING of this section of the Royal Society of Medicine was held on Jan. 9th, Sir ANTHONY BOWLBY, the President, being in the chair.

The PRESIDENT gave an address on the Application of War Methods to Civil Practice, which will be found in full in the present issue of THE LANCET.

Discussion on the Address.

Mr. REGINALD VICK said that he had had an opportunity in Salonika of practising primary suture on compound fractures for a period of 18 months while at a general hospital on the Seres Road, to which large numbers of transport accidents were admitted. The invariable practice was to do primary suture on these cases, and the results were so uniformly satisfactory as to convince him that this method of treatment was as ideal as anything human could be and certainly as successful. The essentials for success were present—facilities for immediate operative treatment, a good theatre, and no reason for moving the patient until the wound and bones were healed. Since his return to England he had had the opportunity while working under Mr. G. E. Gask in the surgical unit, of treating all compound fractures admitted during their tour of duty. Primary suture had been performed in these cases, and where complete closure of the wound was possible the results were satisfactory. Where, owing to hæmorrhage, complete closure was impossible, secondary suture had usually been required at a later stage. In cases of compound fracture of the skull with the dura unopened, the end-results were excellent. It was important that operation should be performed at once, with complete removal of all damaged tissue and perfect splinting with subsequent immobility until healing was complete in cases of fractures of long bones. He had usually used ether in the final stages before closing the wound.

Sir CUTHBERT WALLACE remarked upon the difficulty in applying the Thomas splint in the case of women on account of their clothing. In fractures in civil life there was much more extensive injury to surrounding tissues than occurred in fractures under war conditions.

Mr. W. GIRLING BALL said that much had been done during the war in the bacteriological examination of wounds. In a series of 100 cases at the front treated by delayed primary suture 80 per cent. healed by first intention. Since his return he had endeavoured to carry out the same method of treatment. In the home hospitals cases were too often left to the inexperienced for treatment. This was difficult to avoid unless the house surgeon had been taught by someone who had actually carried out the method. He thought that large wounds such as were so often met with in civil practice were very amenable to treatment by primary suture.

Sir CHARTERS SYMONDS said that he had begun his war work in London, where men were arriving from the Aisne in a highly infected condition. In the case of severe fractures he kept the part in complete rest by putting it up in plaster-of-Paris. When the general inflammation had subsided in from four to seven days he removed the plaster. The wounds were generally found full of pus, but this seemed to act as an effective dressing. In the summer of 1916 he had employed first continuous and later intermittent irrigation. On his return to England he saw the cases from France, and noted the excellent results which followed primary suture. If the wounds were dry and free from pus it was possible to suture at once. He agreed that failure in the Carrel-Dakin method was due to defective technique. Asepsis should be perfect, and the wound should never be touched by the hands.

Mr. A. W. SHEEN said that in India they had received cases from Mesopotamia ten days after wounding. The wounds did not seem to be so infected as those in