intermittent type. Collargol August 14th, following fever spike. Second injection on 17th with no reaction. Observed to 31st; no return of fever or pain.

No. 6.—Private E. Admitted C.C.S. August 19th, 1918, to hospital on 22nd. Collargol on 24th. Return of fever and pain six days later; second injection collargol. Discharged Sept. 24th.

No. 7.—Bugler J. Admitted August 12th, 1918, with usual symptoms and extreme tenderness of shins. Said he had similar attack in July, 1916, was three months in hospital and convalescent camp. In July, 1917, second attack, spent 31 weeks in hospital, convalescent and training camps. Says present attack is more severe than either previous attacks. On August 15th collargol. Six days later fever and pain recur; second collargol on 25th. 28th out of bed, no aches or pains. Discharged Sept. 17th, with no aches or pains and gaining weight.

ADHESIONS OF THE SIGMOID

ASSOCIATED WITH CONGENITAL ABNORMALITY OF THE MESENTERY CAUSING CONSTIPATION.

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AND

DRURY PENNINGTON, M.B., B.C. CANTAB.

In a paper read before the Royal Society of Medicine¹ one of us (J. P. L.-M.) described a number of cases somewhat similar to the following. Cases have also been described by numerous other surgeons, and particularly by the late Dr. Tuttle, of New York, who recorded an almost identical case. We feel convinced that many cases of severe constipation or auto-intoxication are due to abnormalities of the sigmoid associated with membranous adhesions of congenital origin. These membranous adhesions are found in different parts of the colon but most frequently in the sigmoid and cæcal angles. A similar condition of the ascending colon is sometimes described as Jackson's membrane. These adhesions are quite common and must not always be regarded as pathological, for it is only in a few cases that any symptoms arise as the result of their presence. A significant fact, however, is that they are frequently present in cases of malignant disease of the rectum and pelvic colon. Whether they are a predisposing cause of malignant disease in this part of the intestine we cannot say.

Cases associated with a definite congenital abnormality of the mesentery are of particular interest in view of the fact that Professor Keith has put forward the theory, which we believe to be the correct one, that these so-called adhesions, or membranes, which are often associated with the large intestine, are congenital in origin. We do not think it is correct to attribute them to previous inflammatory conditions, since, as a rule, no history of any previous mischief in the abdomen can be discovered. They are not true fibrous adhesions, but folds or adventitious membranes forming part of the normal peritoneum, and formed at the time when the large bowel was being differentiated from the small intestine.

Notes of Case.

The patient was a domestic servant, aged 32, who consulted one of us (Dr. Drury Pennington). She complained that for the last three years she had been suffering from severe constipation associated with pain over the left iliac region. She was unable to get any action of the bowels except at quite irregular intervals, even with the use of drastic purgatives. She had lost health during the last year and found it very difficult to carry out her duties. Two years before she had had all her teeth removed. One wonders on what possible reasoning doctors can advise such mutilation; it would be as reasonable to cut off a patient's ears for sciatica!

On examination nothing could be felt in the abdomen, which appeared to be normal. There was some slight tenderness in the left side. Examination per rectum revealed nothing abnormal, but an examination with the sigmoidoscope showed very definite adhesions fixing the lower part of the sigmoid towards the left iliac fossa. Vaginal examination showed tenderness in the left fornix which suggested ovarian mischief. Examination of the urine was negative. We came to the conclusion that the proper course was to open the abdomen and investigate the condition. The patient was therefore admitted to St. Mark's Hospital, where she was operated upon by Mr. Lockhart-Mummery.

On opening the abdomen a very curious condition was found. The sigmoid, which was very long, was curved on itself so as to form a long loop which passed down towards the back of the pelvis on the right side, where it was firmly fixed by dense adhesions to the posterior abdominal wall and to the extremity of the small gut. There were no adhesions to the appendix. The two sides of this loop were also firmly adherent together. There was a curious abnormality of the mesentery, as the mesentery of the small intestine came across the descending colon so that this part of the colon appeared to emerge through a tunnel in the mesentery. The appearances are shown in the illustration.

A, Loop of sigmoid. B, Tunnel under mesentery into which descending colon disappeared. C, Membrane binding together the two limbs of the sigmoid loop and tying it to the termination of the ileum. D, Bands tying end of loop to posterior pelvic peritoneum.

The loop was first detached from its attachment to the pelvic wall by carefully dissecting off the adhesions, and then the two limbs were separated by dissecting

away the membrane which attached them. It was now found that the loop was free to move about in the abdomen, and the sigmoid assumed more or less its normal appearance. It was not considered necessary to perform an anastomosis, but all raw areas left uncovered by peritoneum were very carefully sutured with fine thread.

The patient made an uninterrupted recovery from the operation, with the exception that she had a small hæmatoma under the skin. Since the operation the patient's bowels have acted in a normal manner, and she has had no further trouble from constipation. A year after the operation she was in good health and her bowels acted regularly without the aid of aperients.

A PROBLEM IN THE TREATMENT OF WHOOPING-COUGH CASES.

By N. MACLEOD, M.D. EDIN.

THE problem may be formulated in the query, Can these cases be treated satisfactorily without drugs? The results of over 40 years' experience in such cases, the writer thinks, go far to justify a reply in the affirmative.

Treatment by Brushing Throat with Resorcin Solution.

In THE LANCET in 1886¹ Dr. W. H. Barlow reported the successful treatment of 50 cases of whooping-cough by brushing the throat with a resorcin solution. Shortly after the above date a lady with her four children, one of whom had whooping-cough, was about to leave Shanghai for home and the writer's aid was enlisted. The lady was told that the above method seemed worthy of trial. The mother's report was that the paroxysms of coughing had been quickly lessened in frequency and severity, that two of her other children had developed a paroxysmal cough without whoop and, as directed, had had their throats brushed from the time that the cough began. Meantime a trial of the resorcin throat-brushing in the writer's practice met with marked success in certain cases. Failure was early attributed to the directions not being thoroughly carried out, and steps were taken to secure proper execution. The test of success was a reduction of severity and frequency in the night paroxysms within a week. This reduction was usually noticeable when toleration of the brush was markedly set up in the pharynx.

With whooping-cough cases success became so marked that no other mode of treatment or drug was used by the writer from the late "nineties" to his retirement from general practice in 1913. No further opportunity occurred for testing a later suspicion, confirmed by perusal of notes consigned to an indexed portfolio when observations were

¹ Trans. of the Surgical Section, vol. v., p. 191.