

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

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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 caecal 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.

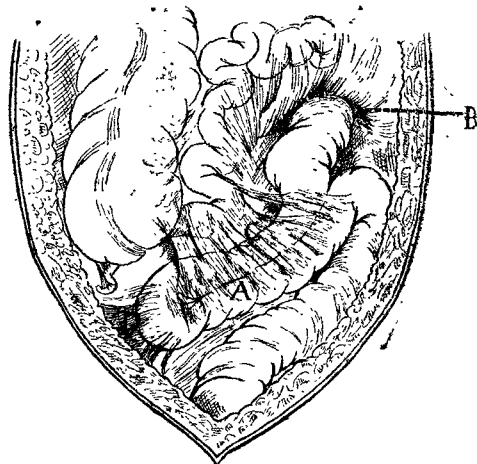
Cases associated with a definite congenital abnormality of the mesentery are of particular interest in view of the fact that Professor Keith has put forward the theory, which we believe to be the correct one, that these so-called adhesions, or membranes, which are often associated with the large intestine, 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.

made, but overlooked until a case with severe paroxysms seen last year in consultation recalled both notes and suspicion. The latter—viz., that the drug resorcin had probably little, if anything, to do with the success of the mode of treatment, was further strengthened recently by reference to Whittle's "Dictionary of Treatment," where resorcin and some seventy odd drugs and modes of their use are said to be employed in the treatment of whooping-cough. From this it may safely be inferred that no one of them is generally regarded as pre-eminently successful.

Without the sedative and antiseptic effects claimed for resorcin, how could success be accounted for? Though the following considerations presented themselves while treatment was going on, until they were arrayed together lately their force did not appear manifest. The throat-brushing procedure is accompanied by physical and physiological results independent of the drug. Are they in themselves sufficient to account for success? They are:

1. Physical. It was very early noted that after most applications examination of the brush disclosed more or less mucus. When it is realised that the brush is used hourly during the waking period, and also that the cough frequency and violence are in all probability not so much due to the quantity of mucus, usually not large, but to its particularly tough and sticky character, it is manifest that its removal by brush lessens the need for removal by cough.

2. Physiological. The frequency and violence of the cough paroxysms and laryngeal spasm indicate increased irritability of the reflex nervous mechanism concerned. There is also inadequate inhibitory control manifested by the difficulty in getting patients to restrain or repress the cough. In the course of the disease the reflex is exercised more than the inhibitory mechanism. Inhibitory power is materially reinforced by hourly obedience to the order to open the mouth widely and stick out the tongue during forced respiratory effort, and continuing all three efforts while a brush is being even only once turned round in the pharynx, and, as not infrequently happens, in the larynx itself. Pharyngeal and laryngeal tolerance of the brush demonstrates lessened irritability of the sensory and motor halves of reflex cough and spasm mechanisms in the presence of a foreign body, and contributes to better exercise of inhibitory action in such circumstances.

Psychological effects accruing from the discipline are also involved in the hourly performance, and, even on the part of the youngest patients, satisfaction and pride in successful coöperative effort.

Description of Method.

The writer is greatly mistaken indeed if those handling whooping-cough cases may not be confidently assured of attainment of the results here set forth when the procedure recommended is carried out thoroughly—viz., such amelioration within a week or ten days of starting brushing in cases where paroxysms and spasms are violent and frequent that the disease ceases to cause distress to the patient and anxiety to the parent, and, when applied early in suspicious cases, prevention of development of distressing cough and spasm.

Material.—For each case a wire-handled throat brush, bent at first suitably for pharyngeal use; when tolerance there is established it should be further bent to form almost a right angle about $1\frac{1}{2}$ inches from its point, proximal and distal parts being straight, for laryngeal brushing—quite practicable without artificial light and mirrors; a 2 per cent. solution of resorcin in glycerine and water, 1 and 12 parts respectively.

It may be noted that when tracheal injections came into vogue for tubercular lung trouble the writer soon discarded the use of artificial light and mirrors on finding that he could introduce the syringe point into the larynx and inject the menthol solution whilst the same precautions were carried out by the patient as when the brush was used. This new mode of procedure was preferred, success and failure in entering the larynx being also distinguished, by the patient.

Procedure.—Immediately before each early application of the brush it is well to put the patient through a preliminary drill in breathing deeply with the mouth wide open and the tongue well protruded, to be persisted in while the brush is introduced into and passed quickly once round the walls of the pharynx. Mucus should be washed off on withdrawal and the brush kept in a tablespoonful of the resorcin solution—renewed daily—to be ready for the next performance an hour later, the procedure being repeated regularly during the waking period. In cases shy of the brushing it is helpful at the first performance or two to be satisfied with brush introduction short of the pharynx, so that the tongue, &c., contact becomes tolerated sufficiently, and the sweet taste of

the solution experienced, repeated say three or four times on each occasion. Gradually introduced further the brush soon reaches the pharynx, where a single turn round its walls will suffice. The attempt to enter the larynx should not be made until brush toleration is set up in the pharynx. An exhibition of successful performance by another patient—younger if possible—is a good preliminary to beginning operations with new ones.

Perhaps someone already using this method of treatment, or adopting it, will be good enough to test and report whether resorcin is essential to its success.

Shanghai.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF

ACUTE ERYTHEMA RESEMBLING MEASLES.

BY F. H. KELLY, M.B., B.S. LOND.

CASES of acute erythema simulating scarlet fever have been described not infrequently, and a certain diagnosis may be wellnigh impossible. Cases in which measles is the disease simulated are less common, and diagnosis usually comparatively simple. The case to be described is of interest both on account of the intensity of the eruption, and also because in the early stages the resemblance to measles was more than usually close.

The patient was a healthy boy of 13 at a large public school. He had had four attacks of urticaria for which no cause had been found, and also measles. There was no infectious disease except influenza during the term in question. In the middle of term he was found to have a rash. He had felt perfectly well previously and did not feel ill. Temperature 100° F. The rash consisted of large discrete papules with a well defined edge about $\frac{1}{4}$ inch in diameter, confined to upper part of front of chest. One small gland in posterior of neck; occipital glands not palpable. Marked, though not intense, conjunctivitis of both eyes, about as intense as seen at commencement of measles. Thin layer of whitish fur on tongue; papillae not enlarged; slight inflammation of fauces. No Koplik spots.

Next day the rash had spread rapidly and coalesced, covering whole body, except scalp, palms of hands, or soles of feet; circumoral region completely covered. The rash, brick-red on the trunk owing to underlying pigmentation, was a vivid scarlet on the face and limbs, and was especially bright on the legs. Considerable oedema of skin generally; no hæmorrhages in skin. A large bulla had formed on the neck, discharging watery fluid. Eyelids stuck together by exudate in morning. Lips cracked and sore. The tongue was as on previous day, except for an elongated blister $\frac{1}{2}$ inch long. There was now intense inflammation of the mucous membrane of the mouth and pharynx, most marked in five or six places on inside of cheeks; on these places small vesicles, up to $\frac{1}{8}$ inch across, had formed. But for the larger vesicles the smaller might easily have been mistaken for Koplik spots. The inflammation of the throat was fairly uniform. Temperature 102° .

On the third day the intensity of the rash was still greater; oedema of skin so marked as to cause great stiffness of limbs; joints and muscles unaffected. The face was quite unrecognisable, being very similar to a severe case of dermatitis venenata. Around the neck and on the limbs numerous bullae had appeared, not at all tense, and in most discharging contents freely. A few small subcutaneous hæmorrhages on the trunk. The lips were cracked, and bled profusely on the slightest touch. The vesicles in the mouth had spread, and in some cases burst.

No marked change for some days. The bullae increased in size, one over right patella 5 in. long. Any part subject to friction or pressure became sore owing to bullae which burst, but the sacral region, where the rash was not so intense, did not become sore. The formation of bullae passed imperceptibly into desquamation, and also in places where bullae had not formed, such as anterior surface of trunk; the epidermis when it separated revealed a dry surface underneath. In places it was hard to say whether the desquamation had been preceded by bullous formation or not. Approximately desquamation may be said to have commenced at least as early as the fourteenth day, occurring while the rash was still well out, although oedema of skin had lessened a good deal. The whole surface desquamated,