

only liquid diet—strong beef-tea, eggs, milk &c.—for a week or ten days before the operation. The bowels should be kept well opened for some three or four days before by castor oil or some saline aperient, and the rectum washed out as far as possible once a day with warm water enemata.

Operation.—The abdomen being opened by a straight incision in the usual position, a small flat sponge with a long string attached to it is passed into the cavity to keep the small intestines and omentum from protruding; the index finger of the left hand is then passed backwards along the brim of the pelvis until it reaches the sacro-iliac synchondrosis, when the descending colon will usually be felt dipping into the pelvis; the finger is then passed over the colon, and a portion of the sigmoid flexure hooked up into the wound, and a loop some inches long withdrawn through the opening. A band of indiarubber is now to be passed through the mesocolon and fastened tolerably firmly round the intestine as high up as possible, to prevent the passage of its contents when the intestine is divided. The wound is next packed with small sponges, to each of which a long string should be attached, and the loop of intestine is surrounded with cotton-wool pads soaked in warm and carbolised water. The intestine is now cut across with scissors about three inches from its upper end, and the contents, if any, evacuated, in some cases it will be desirable to wash the gut out with warm carbolised water. All bleeding points being secured, the divided end of the lower segment is to be invaginated into itself and the end closed by a continuous catgut suture passing through its serous and muscular coats. The mesocolon may now be torn downwards for an inch or more if necessary, and the torn edges stitched over with fine catgut suture. This portion of the flexure is then allowed to drop back into the abdominal cavity. The divided end of the upper portion of intestine is next invaginated and secured in place by means of a continuous catgut suture and the indiarubber band removed. All sponges and wool-packing can now be removed and the parts thoroughly washed, and the parietal wound closed in the usual manner, care, however, being taken that the suture just above the intestine should pass through its serous and muscular coats, and the suture below is passed through the meso-colon. Two fine silk sutures are to be passed through the muscular and serous coats of the intestine and the abdominal parietes on each side, so as to thoroughly secure it from slipping. Finally, the spur of intestine, about three inches long, which is left protruding from the wound, is packed carefully round with thymol gauze, the whole covered with a thick pad of cotton-wool and a many-tailed flannel bandage lightly applied. The dressings should not be disturbed for three or four days unless symptoms occur necessitating their removal. On the fourth or fifth day the spur may be cut away on a level with the skin, all bleeding points secured, and the wound dressed with eucalyptus or boracic ointment. One great trouble to be feared in Allingham's operation, and the one I am describing, is the tendency of retraction of the stirrup of intestine when the loop or spur is cut off. I therefore in future shall content myself with opening the spur on the fourth or fifth day, and delay its total removal until some days later. This would have the further advantage of enabling the wound to be kept quite free from contamination from the escaping faeces.

I am, Sirs, yours faithfully,

FRED. BOWREMAN JESSETT.

Upper Wimpole-street, December, 1889.

DR. RENTOUL'S SCHEME.

To the Editors of THE LANCET.

SIRS,—As chairman of the meeting at Bethlem Hospital, referred to in Mr. R. H. S. Carpenter's letter in your last issue, I shall be glad if you will allow me to make some remarks in answer. Mr. Carpenter is mistaken on one or two points. The meeting was one of the South London District of the Metropolitan Counties Branch of the British Medical Association, and was summoned at the instance of the committee of that district for the purpose of obtaining the opinion of members of the district on the proposal of Dr. Rentoul, a course which was subsequently approved by a meeting of the council of the branch. On this occasion no general invitation was issued to the practitioners of the south of London.

The members of the Association were not outnumbered by visitors. There were seventeen members present,

including the chairman and secretary, and only seven whose names are not on the list of the Branch. In reference to the proceedings, I can only say that, as chairman, I was bound by the rules of the district, one of which is to the effect that the chairman shall invite all visitors to express their opinions; but another prohibits voting by any but members of the Branch. It would clearly be against the spirit of that rule to allow any visitor to propose a resolution which he could not support by a vote. Such regulations do not seem to me peculiar to the British Medical Association. No Society or Association could allow its visitors—however free to speak—to vote, and thus control the action of that Society. But I can assure Mr. Carpenter that there was no attempt to hoax anyone, and I quite fail to see how the meeting can be so regarded.

I am, Sirs, yours faithfully,

FREDERICK TAYLOR,

Vice-President of the South London District.

St. Thomas's-street, S.E., Nov. 30th, 1889.

To the Editors of THE LANCET.

SIRS,—The meeting at Bethlem Hospital on Nov. 13th to which Mr. Carpenter refers was a meeting of the South London District and not of the whole Metropolitan Branch, as might be inferred from Mr. Carpenter's letter. As mover of the amendment in favour of Dr. Rentoul's proposals, I wish to point out that it was by no means in the interests of our party that the voting was restricted to members of this Branch of the Association. The chairman and secretary, who both opposed Dr. Rentoul's proposals, were responsible for the enforcing of this bye-law of the Branch. For my own part, I thought that it would have been in better taste if the chairman had left this rule in abeyance in case no member insisted upon it. Mr. Carpenter must remember that a bye-law of the Metropolitan Branch, while allowing visitors to join in the discussions, forbids their voting.

As a special meeting of the whole Metropolitan Branch will shortly be held, and as the same rule is liable to be enforced, I would suggest that the above bye-law should be left in abeyance. I think I can say that there will be no objection to this on behalf of Dr. Rentoul's supporters. As a matter of fact, if anyone present at these meetings chooses to vote, there are never, so far as I know, any steps taken to test the right to do so. No doubt the proposer and seconder of a resolution run the risk of being challenged; and it is certainly irregular for anyone but a member to vote.

As to Mr. Carpenter's sneer at the officials of the British Medical Association, I beg to remind him that they have no power to set aside existing rules of the Association.

I am, Sirs, yours faithfully,

Highgate, N., Nov. 30th, 1889.

HUGH WOODS, M.D.

THE PATHOLOGY OF CHOREA.

To the Editors of THE LANCET.

SIRS,—I trust that you will allow me to reply briefly to some of the criticisms of Dr. MacLagan upon the paper in which I suggested that the clinical associations of chorea point to the possibility of its origin in some temporary overgrowth of connective tissue in the nerve centres. Dr. MacLagan asks what evidence there is that rheumatism is capable of producing increased growth of connective tissue. Of its power of doing so I would quote the subcutaneous rheumatic nodules as standing examples, for they have been repeatedly shown to consist of connective tissue in a state of active growth. Dr. MacLagan adds that few pathologists are likely to endorse the view that the lesions of endocarditis are analogous with those which result in nodule formation; yet this view is supported by the results of microscopic research, and since it was first enunciated by Drs. Barlow and Warner in 1881 has gained wide acceptance. Nor can I see that it is in any way disproved by the so frequent limitation of the endocardial process to the valves, and to certain portions thereof; for although, with all respect to the opinion of Dr. MacLagan, I am not prepared to agree entirely with his views as to the influence of strain, I should be the last to deny that mechanical influences play a very important part in determining the distribution and seat of rheumatic lesions either in the joints or heart. If the clue to the association of chorea with rheumatism lies in the fact that one is a disease of the motor apparatus, the other of the motor centres, we might surely expect to