

be studied in the light of the case-mortality of each group. In the vaccinated this is found to be 2·8 per cent., while in the unvaccinated it is 20·4 per cent.

In the course of an inquiry into the reasons why patients had remained unvaccinated, one but seldom met with the story of ill-health in infancy. Unreasoning prejudice accounted for quite a considerable number of cases. Of interest, also, was an attempt to define reasons for neglect of revaccination. Procrastination played an important part and its victims were not a few. There are still, however, persons who go about during an epidemic without being revaccinated, not for want of belief, but because of an ingenuous trust in marks many years old. If statements could be accepted, vaccination that was merely so in name, in that it created a false sense of security, again and again proved itself a snare, and the proof came in the form of a very unpleasant surprise. That there is vaccination and vaccination is a proposition which one would suppose to be pretty widely known; but whereas there are some persons who will point with assurance to almost invisible scars, there are others who declare that, inasmuch as vaccination of this quality has failed to protect, vaccination in general is an imposition. In this regard an analysis of the case-mortality relative to the efficiency of vaccination may be quoted. Owing to stress of work the recorded measurements of scar areas were incomplete and the number of insertions is therefore taken as the standard. There were 138 cases with one mark, with 23 deaths, or 16·6 per cent.; 144 cases with two marks, with 17 deaths, or 11·1 per cent.; 214 cases with three marks, with 19 deaths, or 8·8 per cent.; 361 cases with four marks, with 25 deaths, or 6·9 per cent.; and 271 cases in which the patients were unvaccinated, with 92 deaths, or 33·9 per cent. That the groups are larger in proportion to the number of insertions will doubtless suggest to the opponents of vaccination that the latter predisposes to small-pox. A cleverness so misplaced as to be capable of basing this conclusion upon premisses so inadequate is probably equally capable of providing an argument sufficiently oblique to explain the relative death-rates. And, further, it may possibly be trusted to negotiate with more or less success the fact that whereas patients with one, two, three, and four vaccination marks were in hospital on an average for 37 days, 35 days, 33 days, and 32 days respectively, the stay of the unvaccinated extended to 58 days.

The early incidence of small-pox where protection has not been acquired is illustrated by the fact that of 198 persons under 10 years of age attacked by small-pox 47, or 23·7 per cent., were vaccinated and 151, or 76·3 per cent., were unvaccinated. It is hardly necessary to mention that the unvaccinated group in the first decade of life in the community is much smaller than the vaccinated. In the first decade the case-mortality was but 6·3 per cent. in the vaccinated as against 37 per cent. in the unvaccinated. In the subsequent decades the fatality percentages are, for the vaccinated 9·8 and for the unvaccinated 30. These figures are sufficiently relevant to the question of the modifying effect of the acquired resistance, even when it is below the immunity level. An analysis, based on the extremes of severity of cases occurring in later decades, demonstrates the gradual ebb of immunity. Thus in the second decade 44 per cent. of the vaccinated cases were returned as "mild" and 15 per cent. as "confluent." For the third decade the figures were respectively 33 per cent. and 17 per cent. and for subsequent decades 27 per cent. in both cases. The gradual loss of immunity is clearly indicated. Its retrogressive character is also clearly shown by the fatality rates in succeeding decades of ages. These work out at 6·3 per cent. for the first decade and for subsequent decades respectively 4·2 per cent., 8 per cent., 11·5 per cent., 19 per cent., 26 per cent., and 33 per cent. The percentage in the first decade represents three patients whose condition with regard to vaccination can only be described as eminently unsatisfactory and whose ages were respectively 10, 9, and 10 years.

Dagenham.

BRISTOL UNIVERSITY COLLEGE.—Sir James Crichton Browne will be the guest of the Bristol University College Colston Society at the annual dinner to be held in the lecture hall of the College on Jan. 13th. The Bishop of Bristol is the President and the Right Hon. H. Hobhouse, M.P., the President-elect.

VOLVULUS OF THE SMALL INTESTINE.

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INSTANCES of volvulus implicating the whole extent of the small intestine are sufficiently rarely met with to justify the publication of every case observed. The following example of this interesting pathological condition has recently come under my notice and I regret that since medical aid was not sought until just before death, when the patient was in a moribund state, I have only been able to obtain a very imperfect account of the clinical manifestations during life.

The case was that of a boy, aged eight years, who, with the exception of some few slight "bilious attacks," had always enjoyed perfect health and who, so far as is known, had not eaten anything unusual on the morning of the onset of the symptoms. At 11 A.M. on Nov. 4th, 1902, whilst at play, he was suddenly seized with acute and violent pain in the abdomen, causing him to cry out, and this was shortly followed by vomiting, at first of partially digested food and later of a greenish fluid. The pain and vomiting continued at intervals during the day and the boy's mother put him to bed, poulticed his abdomen, and gave him an aperient draught which, however, was speedily rejected. The bowels acted twice, but the character of the stools was not noted. Towards night the pain abated somewhat and the general condition appeared to improve, although the boy still vomited everything administered to him. At 2.30 A.M. on the following day he became very much worse. He rapidly sank and died at 2.55 A.M., only 16 hours after the onset of the first symptoms. Permission for a post-mortem examination was obtained.

On opening the abdomen, which was not at all distended, it was noted that about one pint of serous effusion, deeply blood-stained, escaped. The stomach and duodenum were filled with gas but their walls presented a normal appearance. The whole of the small intestine, the cæcum, and the lower half of the ascending colon were of a dark purple colour and were covered with ecchymoses of varying size, while the corresponding mesentery was similarly affected. The upper half of the ascending colon and the rest of the large intestine were unaltered in appearance. On incising the small bowel its contents consisted for the most part of extravasated blood, its walls were thickened and cedematous, and its mucous membrane was covered with ecchymoses. On exposing the root of the mesentery it was noted that the whole of the jejunum and ileum, together with the cæcum and commencement of the ascending colon, constituted a volvulus the pedicle of which was formed by the intertwining of the beginning of the jejunum with the middle of the ascending colon. As viewed from the front the twists had been in the direction of the fingers of a clock, the cæcum travelling at first upwards, then across the middle line towards the left, and then downwards and towards the right, the twist being almost through 360 degrees. The volvulus was easily untwined and showed no tendency to recur. The small intestine, cæcum, and lower portion of the ascending colon possessed a common mesentery which while of considerable depth as measured from its spinal to its enteric attachments was of very limited vertical extent, so that the commencement of the jejunum and the middle of the ascending colon were closely approximated. The root of this common mesentery did not reach below the third lumbar vertebra and was directed much more horizontally than normal, leaving the right iliac fossa quite free from any mesenteric attachments. With the exception of these abnormal peritoneal arrangements the body was perfectly developed nor were there any indications of disease in any of the viscera.

This condition is certainly of extreme rarity. Sir F. Treves¹ has not observed a case of volvulus implicating the whole of the small intestine, although he mentions the few alluded to by Leichtenstern, and one recorded by Dr. T. T. Whipham² in a female, aged 19 years, the anatomical features of which were closely similar to the case which I have described

¹ Intestinal Obstruction, second edition, 1899, p. 347.

² Medical Times and Gazette, 1876, vol. ii., p. 33.

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.

By S. G. FLOYD, M.D. LOND.,

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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.,

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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.