

that the diarrhoea has certainly been less frequent. She has slept better and the weakness of the knees has not troubled her so much nor has the tremor. The headache, palpitation, and throbbing of the neck have, however, been much the same as before. I should certainly try the treatment again in any case where the expense was not prohibitive. I am quite aware that no definite arguments can be drawn from one trial of the drug in one case, but from other cases which have been reported I think that the drug deserves a further trial.

Westerham.

RUPTURE OF THE INFERIOR VENA CAVA.

BY WM. ST. CLAIR SYMMERS, M.B., C.M. ABERD.

I RECENTLY performed a post-mortem examination on a boy in whose thorax the following unique condition was found. A lad aged 16 years was brought to the Royal Victoria Hospital, Belfast, with the history of having been kicked in the chest by a horse. The patient survived for several hours, dying about four hours after the infliction of the injury. At the necropsy the skin over the chest was found to be normal in every respect; there was slight hæmorrhage in the right pectoralis major near its sternal attachment; the sternum was snapped through transversely just below the attachments of the third costal cartilages, the underlying mediastinal tissues being slightly ecchymotic. The pericardial sac was distended with dark blood containing a single large dark-red clot. The anterior surface of the heart was uninjured. The inferior vena cava was ruptured to the extent of exactly one inch on its anterior aspect, the rupture beginning at the auricle and running straight down the wall of the vessel. This rupture was gaping so that the orifice was oval in shape and nearly a quarter of an inch wide. Apart from some very slight hæmorrhage near the head of the pancreas the other organs were normal.

Belfast.

A CASE OF APPENDICITIS COMPLICATED WITH ACUTE OBSTRUCTION OF THE INTESTINE.

BY HENRY S. BENNETT, M.R.C.S. ENG., L.R.C.P. LOND.,
ASSISTANT MEDICAL OFFICER, NATAL GOVERNMENT HOSPITAL,
DURBAN.

THE following case is of interest inasmuch as it comprises two serious conditions occurring at one and the same time, the cause of each being unusual.

The patient, a trooper in the Zululand Field Force, was admitted to hospital with the history that four days previously he experienced sudden and severe pain in the lower part of his abdomen; he commenced to vomit from this time. His abdomen had become distended and his bowels had been unopened. The symptoms continued and nothing could be retained in the stomach. On admission he looked worn, his eyes were sunken, and he was vomiting without reference to food, the vomited matter having a faecal odour. The abdomen was tense and distended in the centre but there was no bulging in the flanks; there was tenderness on pressure all over but this was especially marked in the lower portion; no definite tumour could be made out. Percussion gave a tympanitic note in the centre but a dull one in the flanks, the area of dullness encroaching towards the umbilicus over the appendix region; the dullness in the flanks was shifting. Per rectum nothing abnormal could be felt. The pulse was 88 per minute, full and of good tension. His temperature was 96.6° F. An inquiry into his past history then elicited the fact that some five months previously the patient had experienced sudden and severe pain in the lower part of his abdomen, the symptoms lasting, however, one day only. A two-pint enema was given, but without result except that a few specks of faecal matter came away.

The abdomen was opened through a median incision made below the umbilicus; the small intestine was much distended and its surface showed signs of acute inflammation; there was no great quantity of free fluid, and what there was was serous in character. On exploring the cavity some thickening could be felt in the neighbourhood of the appendix and on inspecting this site the appendix could be seen wrapped round a coil of gut. In order to facilitate working a transverse incision was made at right angles to the first one and directed towards the right flank. It could then be seen that

the appendix was completely encircling a portion of the small bowel; the organ had formed a collar around a single piece of gut only, showing that it must have taken up that position previously to its blind end becoming adherent, rather than first forming a loop through which a coil of gut had slipped. It was impossible to free the adherent end of the appendix without risk of tearing the intestine, for that organ had formed almost a complete circle on itself, the distal end being adherent to the posterior abdominal wall close to the cæcum and beneath that portion of gut which it was constricting. The ring of appendix was therefore divided, the cut ends being immediately touched with pure carbolic acid. The gut having been freed the distal end of the appendix was detached from its bed, the proximal end being afterwards removed in the usual way. It was necessary to evacuate some of the contents of the small intestine in order to lessen tension and so allow the edges of the abdominal wound to be drawn together. The peritoneal cavity was washed out with normal saline solution and a drainage-tube inserted down to the site of the adherent appendix. On opening the appendix its wall was found to be much thickened and a pin, surrounded by a hard faecal concretion, was seen filling its lumen.

As to the immediate cause of the intestinal obstruction, the history of sudden pain, vomiting, and other signs of obstruction had suggested that a coil of gut had become kinked under a band or had slipped through a hole in the omentum or mesentery, but this was found not to be the case, for, as stated, the appendix was encircling a single portion of bowel only and from the density of the adhesions must have been so situated for some considerable time, at all events for a longer period than four days. No doubt what had actually occurred was that a fresh attack of inflammation within the appendix had supervened, causing further swelling of its wall, and this had led to such constriction of the lumen of the gut as to cause absolute obstruction. The fact that the patient was on active service with the Militia force at the time of being taken ill is sufficient evidence that there was no serious obstruction to the passage of faeces before the present illness began; certainly he volunteered no history of constipation or of colicky pains when on duty. The patient was extremely collapsed after operation and died within four hours of leaving the theatre. He rallied sufficiently, however, to be able to state that he had no recollection of ever having swallowed a pin.

I am indebted to Dr. Joseph H. Balfe, the medical superintendent, for permission to publish the case.

Durban.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

Presidential Address: Discussion on Adolescent (late) Rickets.

A MEETING of this society was held on Oct. 12th, Mr. H. H. CLUTTON, the President, being in the chair.

The PRESIDENT, after a few words of welcome at the opening of the new session, delivered an address on the subject of Adolescent (late) Rickets, illustrated by lantern slides, radiograms (prepared by Dr. A. H. Greg), and post-mortem specimens from the Royal College of Surgeons of England and the Hospital for Sick Children. It had long been believed, he said, that all the signs of rickets as seen in infancy might appear in adolescence but it was not until the advent of the x rays that conclusive evidence had been furnished. Coxa vara and genu valgum were no doubt related to adolescent rickets, though the epiphyses did not show quite the same changes. The first case brought forward was that of a man who was 21 years of age when he came under observation nearly three years ago. The ends of the long bones were enlarged and he presented considerable deformity of the legs. His history showed that at the age of 12 years he had had to wear steel supports for genu valgum; that osteotomy was done for both knees at the age of 16 years, and that the present curvature of the lower limbs began to appear at the age of 19 years. The most striking part of this deformity was a bending backwards of both knees. The skiagrams proved that the changes in the bones were of very long duration and had apparently commenced at the epiphyseal lines. In the shafts of