

Correspondence.

"Audi alteram partem."

THE DRAWBACKS OF CÆCOSTOMY WITHOUT GENERAL EXPLORATION.

To the Editor of THE LANCET.

SIR,—In an article on the treatment of acute obstruction due to carcinoma of the colon, in THE LANCET of Nov. 25th, Mr. J. P. Lockhart-Mummery recommends the surgeon to make a cæcostomy without general exploration of the abdomen, a method which was also advocated by Sir Berkeley Moynihan about 18 months ago at a meeting of the Medical Society of London. These two surgeons are such great authorities, that any attitude short of complete agreement with them must require considerable justification before it can be adopted. Yet I think a little reflection would convince most surgeons that to make this procedure a routine would land us often in rather an unfortunate predicament. I do not say that the method should never be employed, but rather that it should be reserved for desperate cases.

Mr. Lockhart-Mummery in advocating this blind cæcostomy has mentioned some of its advantages but gives scant consideration to its drawbacks, which are indeed very real. Putting aside the question of the possibility of a wrong pre-operative diagnosis, there is the difficulty of planning the subsequent steps to be taken. If we do not know where the growth is situated, owing to the absence of a primary exploration, we must either perform an exploratory laparotomy or give a barium enema for X ray examination. Suppose, as he suggests, we open the abdomen on the left side, how are we going to remove a growth in the hepatic flexure without unnecessary mutilation? I have done this through a mid-line incision, but one is unnecessarily hampered by difficulty of access to the ascending colon, and I feel it would be much more difficult from the left side of the abdomen. It might be thought that skiagraphy would remove the objections to the blind cæcostomy. But this is not so. I once relied upon a barium enema to show me the site of obstruction after performing a simple cæcostomy. The plate showed a definite stricture at the splenic flexure, I planned the incision to remove a growth here, only to find that it was in the pelvic colon. Twice have I seen this spasm at the splenic flexure associated with a pelvic growth, and only this very morning I operated upon a man who got acutely obstructed whilst actually in hospital owing to a ring growth in the pelvic colon. A barium enema a few days before had run freely into the colon; no stricture was visible. The truth is that a stricture can be concealed in the pelvic colon if one loop lies in front of another in the skiagram.

To deal with Mr. Lockhart-Mummery's objections to a primary exploration—the expulsion of dilated coils, the rupture of the cæcum, the increase of shock. The best way to deal with the cæcum is to have a moderately large hollow needle ready, so that as soon as the abdomen is opened and this viscus presents it can be punctured. Nearly always through this needle sufficient gas will escape to remove all danger of spontaneous rupture. The cæcum will then be amenable to manipulation and the small puncture can be sutured. It is truly remarkable how patients extremely ill, in whom the cæcum actually begins to rupture on the table, will recover with simple cæcostomy and will require further treatment. As to the question of the increase of shock. This is bound up with the permission afforded the distended coils to protrude. It is a general rule in abdominal surgery that the best place for a viscus is inside the peritoneal cavity. There is very seldom need to allow distended intestines to come on to the surface, except one coil at a time. The deliberate gentle insertion of the hand to determine the site of the growth can be done with very little insult to the viscera and the knowledge gained is

almost inestimable in value. Suture of the abdominal wall will present but few difficulties if the forceps described by me a few years ago in "Surgery, Gynaecology and Obstetrics" (1920, xxx., 408) be used.

I am, Sir, yours faithfully,

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Professor of Surgery, St. Mary's Hospital
Medical School.

St. John's Wood, Nov. 24th, 1922.

THE RETURN OF VIRULENT PNEUMONIA.

To the Editor of THE LANCET.

SIR,—I consider that I should write to you on the above subject, for the fatal pneumonia, so difficult to diagnose, met with a few years ago, is with us again.

A youth of 21 years was quite well on the morning of Thursday, Oct. 19th; towards the end of the evening of the same day he felt unwell and retired to bed early. During the night he had four attacks of diarrhoea, and after the last one, when returning to his bedroom, fainted. I was asked to see him on Friday morning early (Oct. 20th) and found his temperature raised and his pulse quickened; he had been delirious; the pulse-respiration ratio was not suggestive. The only chest sign he presented was an almost complete absence of the breath sounds over both lungs; there was no dullness to percussion, no adventitious sounds, and tubularity in the small fraction of breath sounds which was heard, but only occasionally, towards the upper part of the lungs. While I was writing a prescription and discussing the illness with the parents in a room downstairs he got up, dressed and sat by the fire. His parents persuaded him to return to bed, but when the nurse arrived shortly after he had become so ill that she telephoned to me to come and see him again. I went at once and found that he was obviously dying. Death took place at 12.45 P.M. There had been no cough and the signs were as above described at my first visit.

A younger brother, aged 18 years, attended the elder brother's funeral on Tuesday, Oct. 24th. This younger brother had had a sore throat on Oct. 22nd, 23rd, and 24th. On the evening of the 24th the soreness of the throat had abated, but his voice had become hoarse. I was called to see him on Wednesday, Oct. 25th, when I found him dressed and sitting by the fire. His temperature was normal, and his pulse-rate 72. I could find no physical signs other than congestion of the fauces. On Thursday morning, the 26th, I was summoned by telephone and found he had become worse; his temperature was 103.5° F., his respirations 42, and his pulse 140, and he had a somewhat "brassy" cough such as is met with in cases of laryngitis. The physical signs of the lungs were like those of his brother—viz., *universal and almost complete obliteration of the breath sounds*. The percussion note was resonant everywhere, and there were again absence of tubularity in the vestige of breath sounds which could be brought out in forced breathing; there were no adventitious sounds; both knee-jerks were absent. The patient was quite conscious, answered questions intelligently and said that his only complaints were loss of voice and discomfort beneath the breast-bone.

With the fate of his elder brother in my mind, I asked for a consultation. This took place at 6.30 P.M. on Thursday, Oct. 26th, but no further signs were elicited. It was obvious that the patient was suffering from a severe infection of the larynx, trachea, bronchi, and bronchioles, possibly by the organism of diphtheria, or by some streptococcus, which by blocking the bronchial tubes, led to the weakness of the breath-sounds, reminding me of the co-called epidemic influenzal pneumonia of a few years ago, which so often occurred, as shown by post-mortem examination, without revealing signs of consolidation. Anti-streptococcal and anti-diphtheritic sera were injected. I visited him in the morning of Friday, Oct. 27th, finding no improvement in symptoms and no alteration of the physical signs. I was summoned again in the afternoon at 5 o'clock, as the patient had suddenly become very collapsed. I found his face cyanosed and in a few moments he died.

A post-mortem examination was made at 11 A.M. on Oct. 28th. Practically the whole of the left lung presented soft consolidation, revealing the appearance and consistence of liver undergoing autolysis, the surface of the lung was purple-red in colour and the cut surface readily broke down on pressure; the right lung was affected in the same way, with the exception of the middle lobe, which in its anterior part was markedly emphysematous. No diphtheria

organisms could be demonstrated anywhere; the *Streptococcus hæmolyticus* was found in the heart blood.

Both of these brothers about a fortnight previously to the death of the second one had visited an exhibition of the application of electricity to domestic purposes, and they had found the atmosphere very hot and oppressive and the hall crowded with people. I think it is very probable that the elder brother died of the same sort of infection as the younger one, and that he also reacted to the infection in the same way, by developing pneumonia which, as in the case of the younger brother, gave minimal signs.

I am, Sir, yours faithfully,

London, Nov. 22nd, 1922.

C. G. MACK.

PERMANGANATE OF POTASH IN SMALL-POX.

To the Editor of THE LANCET.

SIR,—In view of the fact that small-pox is spreading, and that some of the cases are of a virulent type, it seems advisable to re-direct attention to the method of treatment introduced by Dreyer of Cairo in 1910, but which apparently has been forgotten save by the Germans, who have used it on several occasions with marked success. Accordingly, I append part of a short paper on the subject which I contributed to the *Journal of Tropical Medicine and Hygiene*, and which was published on Feb. 15th, 1921.

Anyone familiar with variola amongst natives in the tropics, and more especially in the outlying districts, must have been impressed by the urgent necessity of some means of treatment likely to mitigate the sufferings of confluent cases and to prevent complications.

Small-pox in the unvaccinated and amongst primitive surroundings is a very terrible disease. I have seen outbreaks in Persia, East Africa, Uganda, Egypt and the Anglo-Egyptian Sudan, sometimes in places where proper hospital facilities were lacking, and where the condition of many of the patients was pitiful to behold. The doctor, with no ally in the shape of a trained nurse, is often at his wits' end to know what to do in such cases, and a simple method like that of Dreyer should be hailed as a boon and a blessing, especially as its value appears to have been definitely established. Indeed, Bender, of Breslau, states that he regards it as superior to every other therapeutic measure in small-pox. His technique is as follows:—

When the patient is admitted to hospital his whole body is painted over with a freshly-prepared saturated solution (5 per cent.) of potassium permanganate. On each successive day the same solution is applied, unless the skin is found too sensitive, in which case a weaker solution is employed, one of 1.5 per cent. being often suitable.

Favourable results from the use of permanganate solution have also been recorded by Kulka, Jochmann and Morawetz. Indeed, the only discordant note is sounded by Rolly, who, according to Kulka, was sceptical as to the utility of the treatment. I have not been able to consult Rolly's paper, but the other authors all undoubtedly think well of the method, though they differ somewhat in the strength of the solution they employ. Kulka, for example, finds 3 per 1000 efficient, but as he speaks of this as a concentrated solution it is possible that he really means 3 per cent.

Dreyer¹ had two objects in view when introducing the treatment, the first being to colour the skin and thereby obtain an effect similar to that which the Finsen red light treatment is said to produce; the second to secure a disinfecting and deodorising action.

In the view of many the value of the red light treatment of small-pox is not considered to have been established, and hence the good results of the Dreyer method must probably be attributed solely to the germicidal and oxidising powers of the permanganate.

There seems to be no doubt that in the case of small-pox this line of treatment, especially if employed early, is of signal service in lessening the suppurative process and adding to the patient's comfort. It is also said to prevent complications, the formation of bed-sores, and the occurrence of general sepsis. Septic fever is thus avoided and the recovery rate improved. As the suppuration is mitigated the pitting of the skin is reduced.

Further, it would seem to possess hygienic advantages by lessening the risks of infection. At the present time, if employed on a large scale, this permanganate treatment would be somewhat expensive, but there appear to be good

grounds for recommending its employment, if not universally, at least in severe cases where facilities for proper nursing and attention are lacking. It is hoped that medical officers in the tropics will give it a systematic trial and report their experiences with it.

I may say that as a result of this note several reports have been received from colonial and medical officers testifying to the value of Dreyer's method in their native cases.

The late Dr. C. J. Baker, of Uganda, records a case which was not confluent, but in which the eruption was fairly extensive. The salutary effect of an application of a 3 per cent. solution of potassium permanganate all over the body in the earlier papular stage was most marked. Dr. Baker in his report says:—

The patient suffered very little discomfort, and expressed profuse gratitude for the treatment, which is rare in natives.

The attendants, who had had a great deal of experience in nursing small-pox cases, were much impressed with the result. The application was repeated daily. There was practically no scarring.

Dr. P. S. Selwyn-Clarke, in his monograph on small-pox in the negro of British West Africa, writes as follows:—

Several experiments were carried out with varying strengths of aqueous solutions of permanganate of potash, painted over the body by means of pledgelets of cotton-wool at different stages of the eruption. When applied in the macular stage of the disease these solutions did not appear to influence the severity of the eruption. On the other hand, beneficial effects were so apparent when the solution was used prior to the rupture of the pustules—possibly owing to the mildly antiseptic effect produced—that this method of treatment became very popular amongst the patients and their friends and attendants, and the available supply in the dispensary of the Native General Hospital was temporarily exhausted. Half-saturated solutions applied two or three times daily gave a good result. Permanganate solutions, in addition, applied after the rupture of the pustules undoubtedly hastened cure and desquamation.

Finally, Dr. J. S. de Sousa, acting principal medical officer, Zanzibar, speaks favourably of the use of a 5 per cent. solution in definitely discrete cases. He found it of less service in confluent cases, and therefore modified the method by placing such patients in a long bath filled with 5 per cent. permanganate solution at body temperature for ten minutes to a quarter of an hour twice daily. He states that this procedure greatly reduced smell and sloughing, rendered the patients much more comfortable, and appeared in one or two cases to save life.

Of course, small-pox in this country, properly nursed under good hospital conditions, is unlikely to assume the exceedingly serious aspect it frequently presents in the tropics. Even so, however, confluent small-pox is always a dangerous and disgusting disease, and any method of treatment likely to prevent its spread, mitigate its severity, alleviate suffering and render the work of nurses and attendants easier and more pleasant deserves careful trial.

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I am, Sir, yours faithfully,

ANDREW BALFOUR.

Wellcome Bureau of Scientific Research, Nov. 25th, 1922.

¹ According to W. Dreyer, this treatment should be used with care in cases suffering from actual heart disease, or from cardiac weakness the result of the small-pox infection.