

home through the help of the relieving officer, into the local public asylum. As is well-known, the relieving officer, when informed of the presence of an insane person within his district, is bound by Act of Parliament to take immediate steps, and must within three days bring the alleged lunatic before a justice, whose duty it is to order the person to be medically examined, and he may summon any registered medical man to do so. The request to examine such a person is an official and a legal one, and although B could refuse to do this, yet he would be unwise not to comply, as were serious consequences to ensue through delay he would probably be severely censured by a jury, who might consider that he sacrificed the public welfare to personal feeling or professional etiquette. Of course, if B knew the patient to be A's, it would have been correct and considerate for him to have informed A that he had acted in regard to his patient upon the magistrate's order and under the Lunacy Act.

In such a case as your questioner puts forward only one medical certificate is required, and the justice is perfectly within his power in asking his own medical attendant, in whom presumably he has confidence, to come to his assistance to fill up and sign the certificate. The point is further raised whether an *ex officio* justice has power to sign the order for the patient's detention. In the case of pauper patients all that is required is that the justice should have jurisdiction in the district where the patient is at the time, and although the chairman of the board of guardians is *ex officio* a justice of the peace (and the same applies to the chairman of an urban district council), the Lunacy Act, 1891, 54 & 55 Vict., Sec. 25, enacts that such an authority has this power only when the Lord Chancellor empowers (in writing) the chairman to sign an order of reception for pauper lunatics, and it would seem that this power can only be used in the case of paupers (in workhouses or in Poor-law infirmaries) who ought to be removed to an asylum under Section 24, Subsection 6, of the Lunacy Act, 1890, 53 & 54 Vict., c. 5, and in all probability this is what occurred in this instance. Of course, for private patients such a person as the chairman of the urban district council could not sign an order for detention. The Lunacy Acts, 1890 and 1891, make special provision for justices to be appointed at their Michaelmas sessions for this purpose, and lists of such justices for each county and borough are issued to different authorities, and certainly there seems to be no dearth of "special justices" for signing Lunacy Orders. In London there is a perfect mob of these justices, numbering altogether about 400; yet occasionally applicants with orders will go for signatures to justices not "specially appointed," but who generally are obliging enough to sign the order; still unless the order is further countersigned by a justice "specially appointed" it will be invalid. Formerly, under the Lunacy Act, 1890, only justices having jurisdiction where the patient was at the time could sign this order, but the Lunacy Act, 1891, abolished this limitation, and a justice "specially appointed" for London can now sign an order for a patient, even in Northumberland, and *vice versa*. Your questioner has raised some very interesting points to many medical men, hence my somewhat lengthy letter.

I am, Sir, yours faithfully,

Claybury, March 10th, 1913. ROBERT JONES, M.D. Lond.

* * Our readers will appreciate as we do Dr. Jones's lucid exposition of some difficult points.—ED. L.

THE ABDOMINO-PERINEAL OPERATION FOR RECTAL CANCER.

To the Editor of THE LANCET.

SIR,—I have read with interest Mr. C. Gordon Watson's and Mr. P. Lockhart Mummery's letters. Both these gentlemen lay some stress on the disadvantage of the presence of an artificial anus at the second operation. It is, of course, a disadvantage, but one that can be easily overcome, and has frequently to be faced under other circumstances. For instance, if a growth of the colon is present causing obstruction, the first step is to perform a cæcostomy; later the growth is excised with end-to-end union or lateral anastomosis if possible; and thirdly, some operation is performed for doing away with the artificial anus. Here two operations have to be performed in the presence of an artificial anus, and the situation is much less satisfactory than in the case

of an inguinal colostomy, in that the fæces are fluid and more irritating. Yet these operations are very rarely followed by peritonitis. As a matter of fact, in this operation under discussion the danger is surely of pelvic sepsis more than of peritonitis.

My suggested modification of the existing operation would, in my opinion, greatly diminish the risk of pelvic sepsis, while perhaps slightly adding to the risk of peritonitis, though this added risk would be largely compensated by having an empty bowel to divide and not having to pass the upper end through a stab wound in the flank. Mr. Mummery in his letter intimates that I have put the mortality too high. No doubt he is right, but I only intended my figures to be approximate, and they were derived from a consensus of opinion of writers on this subject.

Again, Mr. Mummery admits to a mortality of something under 20 per cent., but has only lost one case from sepsis during the last three years. Are all these deaths to be attributed to shock with the exception of the cases of embolism? Also, if they are due to shock one would like to know how soon they died after the operation, and if in any cases that lingered and died of "delayed shock" or exhaustion the absence of sepsis was proved by a post-mortem examination? In my limited experience I have known death occur in afebrile conditions, and yet it has been due to rapidly spreading sepsis, and it is especially after these big exhausting operations that it is apt to do so.

Finally, though embolism is usually looked upon by operating surgeons as a "visitation," are these distressing cases really free from the slur of sepsis? I can only say that of the four cases I have seen three occurred in cases of suppurating appendicitis and the fourth was a suppurating prostatectomy. It is rather tempting to believe that the thrombosis was started by the infection of veins, and that later the clot was softened and loosened by the action of microbes. Whether this is so or not could easily be proved by examining the clot, when it can be found post mortem, for micro-organisms.—I am, Sir, yours faithfully,

R. LEONARD LEY, M.B., B.C. Cantab.

Great Yarmouth, March 10th, 1913.

PERITONEAL ADHESIONS.

To the Editor of THE LANCET.

SIR,—In the very interesting Hunterian lecture of Mr. J. E. Adams, published in your issue of March 8th, reference is made to the results of certain experiments which I carried out relative to the use of sterile vaseline oil as a lubricant to prevent peritoneal adhesions, and it is stated that, after employing this oil, I had found "cream-cheese-like masses in the abdomen and advised against its use." Now in the paper referred to ("The Use of Oil in Abdominal Surgery"¹) I came to no such conclusion, but to the very reverse—namely, that vaseline oil is a bland, inert, readily sterilisable and altogether safe lubricant to introduce into the peritoneal cavity, and that it will delay and thus to some extent prevent the re-formation of adhesions. The "cream-cheese-like masses" referred to were found in another series of experiments, where sterile olive oil had been introduced in cases of peritonitis with the object of delaying the absorption of bacteria from the peritoneal cavity. This erroneous interpretation of my results was initiated by Crump,² and my purpose in writing now is to prevent, if possible, its being perpetuated.

Whilst the introduction of foreign bodies into the peritoneal cavity is, as a general rule, to be avoided, I believe that, in cases where extensive raw surfaces have been exposed as the result of breaking down peritoneal adhesions, the best method to prevent the latter re-forming is to introduce several ounces of sterile vaseline oil before closing the abdomen, and then at the earliest possible moment to encourage peristalsis, firstly by hypodermic injections of pituitrin and then by enemata and by purgatives. The absorption of vaseline oil from the peritoneal cavity is not complete for at least ten days, and if during this period the bowels be kept moving a minimum of fresh adhesion will be secured.

I am, Sir, yours faithfully,

Edinburgh, March 10th, 1913.

D. P. D. WILKIE.

¹ Surgery, Gynaecology, and Obstetrics, February, 1910.

² Ibid., November, 1910.