

would make a personal appeal to their wealthy and benevolent patients and friends the difficulties of our committee might be overcome.

We need a large sum; but it is to pay a debt which we owe to our hardly-entreated brothers. Can we forget that they are in those straits because they are citizens of a country which in 1914, with nothing to gain except the world's respect, and everything except their honour to lose, stopped the German rush and so saved this Empire and France and civilisation from a catastrophe the magnitude of which we perhaps even now do not altogether appreciate?

I am, Sir, yours faithfully,

RICKMAN J. GODLEE,

Chairman of the Belgian Doctors' and Pharmacists' Relief Fund.

June 24th, 1918.

Subscriptions may be sent to the honorary treasurer, Dr. H. A. Des Vœux, 14, Buckingham Gate, London, S.W. 1.

CÆCOPLICATION.

To the Editor of THE LANCET.

SIR,—The article by Surgeons-General Sir W. Watson Cheyne and Arthur Edmunds on cæcoplication in your issue of June 15th is one of great interest to all who have to do with abdominal surgery. The condition of cæcum mobile, or perhaps more correctly “prolapsed atonic cæcum,” is a common one in females, and in a fair proportion of cases gives rise to a symptom-complex which is definitely distinguishable from that of chronic appendicitis. The two main distinguishing features are: (1) In cæcum mobile the pain is aggravated by standing, is always worse towards the end of the day, and is promptly relieved by rest in the recumbent position; (2) on examination there is no definite localised tenderness, but a sensation of diffuse discomfort on palpation of the right iliac fossa. Such symptoms are more than suggestive, and the diagnosis may be confirmed by X ray photographs after a bismuth meal, which will show unduly prolonged retention in, and the prolapsed position of, the cæcum. Previous to the war I had performed the operation of cæcoplication in some 15 cases of prolapsed cæcum, in most of which the correct diagnosis was possible before operation, and in all of which relief of symptoms followed this operative procedure. Two cases, however, were specially noteworthy, as in both the patients (young women) were admitted to hospital with the diagnosis of “acute appendicitis and peritonitis,” giving a history of acute abdominal pain and vomiting of 24 hours' duration following on chronic discomfort on the right side of the abdomen of some months' duration. In both cases there was marked tenderness in the right iliac and suprapubic regions, but little rigidity. Immediate operation in both cases revealed a greatly distended prolapsed cæcum firmly impacted in the true pelvis. Considerable difficulty was experienced in withdrawing the cæcum, which came out of the pelvis with a dull report like that heard on the withdrawal of the plunger from a plugged syringe. The appendix was normal in both cases. Lasting relief was obtained by cæcoplication.—I am, Sir, yours faithfully,

Edinburgh, June 23rd, 1918. D. P. D. WILKIE, M.Ch., F.R.C.S.

To the Editor of THE LANCET.

SIR,—The paper by Surgeons-General Sir W. Watson Cheyne and Arthur Edmunds has brought vividly before the profession the insufficiency of routine appendicectomies for so-called cases of chronic appendicitis.

Four years ago I began to perform an operation on voluminous cæca, which I noted in the hospital records as “reefing the cæcum.” This operation I found afterwards was practically identical with that described by Blake earlier in the same year. My idea at the time was not that the operation would influence any pain in the right lower quadrant, but rather that I was obliterating literally a cesspool from which there was constant absorption, giving rise, at least in part, to the various symptoms that have been ascribed to an intestinal stasis (cæcal). It was a relief to find that post-operative discomfort was in nowise increased, as the writers remark, and, further, in most of these cases the tendency to stasis was diminished, as shown by radiographic findings and the marked relief of troublesome constipation. Since then I have had others in which the results have by no means been so successful, but better results will

be obtained doubtless by more careful investigation and interpretation of the X ray findings. It is also imperative that there must be at the operation a good exposure of the ileo-cæcal region, and the surgeon will act according to the operative findings, not according to any preconceived plan.

It may be advisable to infold the cæcum and, should the cæco-colon be mobile, to suture it to the lateral peritoneum. Further, obstructive bands should be divided, kinks straightened out, and a careful re-position of peritoneum made. An incompetent ileo-cæcal valve can be improved by the method of Kellog. The surgical problems of the right lower quadrant are by no means solved, and indiscriminate cæcoplications are to be avoided, more especially by the occasional operator.—I am, Sir, yours faithfully,

Burnley, June 24th, 1918.

JOHN H. WATSON.

“HEALTH CENTRES” FOR BOROUGH AND COUNTY.

To the Editor of THE LANCET.

SIR,—With the coming in of a Ministry of Health the following arrangements will need to be made locally in each borough and county:—

1. To-day the borough medical officer of health is located in rooms in the town hall. The rooms are often quite defective in size and are without libraries, museums, or lecture halls specialised for sanitary purposes. With the removal of the medical officer of health from the jurisdiction of the borough council that official will need a new office in the town, with laboratories, museum, library, and lecture hall. This I call for want of a better title the future “Health Centre” of the borough. The State would pay the cost and the building would be under the “Office of Works” in London and completely free from borough interference or inspection in any way whatever.

In the county town a similar “Health Centre” would be built for the officer of health of the county, who under the new arrangement would cease to be a county council official, but would be a district State official paid entirely out of national as opposed to county funds and living in the county town centre. The full onus of health recommendations to the borough or county authorities would fall on the borough or county health officer, who would address the corporation direct in the name of the Minister of Public Health.

If the borough or county council desired to have an executive medical officer of health to supervise executive work and carry out routine duties this junior officer would be supplied by the State and paid for by it, in the same way that we in the Army supply a medical officer to a battalion or a subdistrict, but the medical officer remains under the discipline of the directing county medical officer and is really a local adviser on the spot.

2. At this health centre all medical and sanitary organisations in the borough or the county would be centralised. All school medical officers, all Poor-law doctors, all panel doctors—in fact, all officially paid medical men—would find in this “Health Centre” a greatly needed educational and instructional institution.

The wonder is that up to this date no such centre exists in most counties or boroughs.

These places will take time to develop and private munificence of philanthropic men may in certain cases step in to construct a model “Health Centre.” Just as the cathedral centralises clerical interests, or the county court centralises law interests, so the “Health Centre” of the borough or county will in the near future give to the medical profession a local habitation and a name in every town and county in the land. People in a generation hence will wonder how we for so long a period existed without such institutions.—I am, Sir, yours faithfully,

GEORGE J. H. EVATT, M.D.,
Surgeon-General (retired).

Junior United Service Club, June 17th, 1918.

EVANESCENT LUNG CHANGES IN UNDIAGNOSED PYREXIAS.

To the Editor of THE LANCET.

SIR,—In THE LANCET of Jan. 19th, 1918, Colonel W. Pasteur and Major B. Hudson recorded a case of pyrexia in which definite physical signs of changes in the lungs were found that might easily have escaped a rapid examination. If such signs had not been detected, the authors point out, the case would have been diagnosed as “P.U.O.,” and they suggest that further light might be thrown on many featureless cases of P.U.O. by a more careful and detailed examination of the chest.

In the spring of 1916 15 cases were observed at a base hospital in France in which fever was accompanied by abnormal physical signs in the chest that might readily have been missed, and which in some instances varied in a remarkable manner from day to day. [Here were given notes of six cases illustrating the nature of the changes noted and the type of case in which they were observed.]