Jackson's pericolic membrane, on the other hand, may give rise to symptoms simulating chronic appendicitis. This occasional membrane is a congenital abnormality, and takes origin from the primitive right lateral process of the great omentum. When only a limited band persists as a relic of the membrane, constriction of the ascending colon may result, though often the symptoms resembling chronic appendicitis are due to an associated abnormal mobility of the proximal colon.

In the condition of mobile proximal colon, which is a reversion to the primitive pronograde arrangement, the patient is predisposed from birth to constipation and the various ills resulting from it. Symptoms resembling chronic appendicitis may result, or actual inflammation of the appendix, but in either case the right surgical procedure is not a simple appendicectomy, but fixation of the colon back into the right loin.

The commonest cause of an erroneous diagnosis of chronic appendicitis is right tubo-ovarian disease, often of gonorrhoeal or septic origin. In such cases a spasmodic contraction of the right psoas muscle sometimes occurs on palpation, which may be mistaken for an abscess or a neoplasm.

Many cases of chronic pain in the right iliac fossa cannot, with our present knowledge, be diagnosed with precision before operation. All that can be said is that they need exploration. In exploring, the incision should be adequate for an inspection of all the possible sources of the mischief, and such source when found should be dealt with by appropriate measures. The practice of a blind appendicectomy in such cases through a 2 in. gridiron incision is unscientific, and often disastrous to the patient's prospects of a cure.

AN UNUSUAL CASE OF APPENDICITIS.

BY

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A COLLIER was suddenly seized with abdominal pain of such severity as to necessitate the administration of chloroform by his medical attendant, Dr. Cooper of Kenfig Hill, Glamorgan. On the following day I was sent for in consultation and advised removal to Miss Talbot's Hospital at Port Talbot. The patient complained of sharp continuous pain situated under the heart and in the upper part of the abdomen, of obstinate constipation, and of vomiting of clear green fluid. In 1887 he had a similar pain which lasted five days; it came on after a fall from a tree. On five occasions since then he had suffered from the same pain, of greater or less severity, the attacks lasting five or six days.

His face was pale and typically Hippocratic and covered with beads of perspiration. The tongue was clean, the pulse was 78, and the temperature 96.8° F. The abdomen was not distended. The respiratory movements were good, but better on the right side than on the left. Superficial and deep epigastric tenderness were present, and there was a zone of hyperaesthesia in the left hypochondrium. There was deep tenderness on pressure over the left kidney region posteriorly. The whole of the left side was tympanitic. The liver dullness was normal. The apex of the left lung showed some apical retraction, Krönig's sign being present, and there was some impairment of breath sounds. There was a slight systolic murmur at the apex of the heart, conducted out to the axilla. The urine was normal. There was slight leucocytosis. Loewi's adrenalin mydriasis test was applied with a view to determine the possible presence of pancreatitis. The result was negative. There was nothing definitely indicative of perforation of a peptic ulcer. Repeated enemata were unavailing.

The patient was seen by my partner, Dr. J. H. Davies, and it was decided to wait twelve hours before proceeding to laparotomy in view of the patient's history. The patient appeared to improve slightly, but in about eight hours he suddenly became much worse; the temperature fell to 96°; the pulse went up to 102, and became very thin. He was now evidently moribund. Operation was out of the question, and in a few hours the patient died, evidently of shock.

Post-mortem Examination.

The caecum and ascending colon were enormously distended and hyperaemic. This part of the gut was freely movable, and had a large mesentery. It lay looped between the hepatic and splenic flexures, below the transverse colon and great omentum, and suspended on the left to the cardiac end of a dilated stomach, by the tip, middle, and mesentery of a long recurved appendix.

The appendix, when unravelled, was 9½ in. long, was full of hard concretions, and was gangrenous at its tip. The tip was densely adherent to the greater curvature of the stomach on the left side, and by fine adhesions to the spleen. The right iliac fossa was occupied by coils of small intestine.

There was a small calcareous old focus of phthisis at the apex of the left lung. There was some thickening of the mitral valve.

A CASE OF RUPTURE OF THE KIDNEY FROM SLIGHT TRAUMA.

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RUPTURE of the kidney is a comparatively rare result of trauma, and more particularly so when the actual kidney tissue itself is lacerated. Keen quotes Küster's statistics of injuries under his observation in the clinics of Berlin and Basle, and these show only 10 cases in 7,741 injuries, or a little over 1 in 1,000.¹ Israels, with a large experience of renal surgery, had only 1 operative case.²

But in practically all cases met with either in actual practice or in the records, the condition has always been caused by a severe accident, such as falling from a height, crushing between buffers of a train, or by the wheel of a heavy cart passing over the abdomen. In view of these facts the following case is of interest, as the injury was caused by an accident of the most trivial nature, and the subsequent history also contains points of interest.

R. A., a girl of 14, above the average height and well made in proportion, had never had a previous illness of any consequence. At 9 p.m. on August 28th, 1913, she ran along the verandah of the house after a dog. Between the two corner posts of the verandah some light wire netting had been fixed to a height of 2 ft. and fastened on each side to the post by a light staple. The floor of the verandah was 11 in. from the ground, and immediately beneath it at that point was a large flower bed which the day previously had been dug over, and in consequence was in a soft condition. The end of the verandah was only 15 ft. from the door, and so she could not have gained much momentum in the short distance. She ran into the netting, having forgotten it was there, and it caught her in the middle, gave way, and she fell on to the flower bed. She immediately complained of intense abdominal pain with nausea, and was carried into the house. A quarter of an hour later she wanted to micturate, and passed a quantity of bright arterial blood. Dr. Parker of Kingston was sent for and he telephoned for me.

I saw the girl at 1 a.m., and she was lying in bed in a condition of profound shock. The abdomen was rigid, and she complained of great pain, not confined to any particular region. Another marked feature was thirst. The temperature was 97° F.; the pulse 124, thin and thready. The face was pallid and the facies Hippocratica well marked. The right flank was dull on percussion, but the liver dullness was hard to make out; it was diminished in area. She had passed blood by the urethra three times since the accident—about a pint in all. Owing to the fact that the parents were away from home, operation was delayed until their return at 10 a.m. on the following day.

Operation.

A median subumbilical exploratory incision was first made, and immediately the peritoneum was opened about a pint of blood-stained serum gushed out, together with a large quantity of faecal-smelling gas. With sponges the abdominal cavity was dried as far as possible and the bladder examined. There was no sign of any injury to that organ, but it was of bluish colour, due to the blood it contained.

The ascending colon was pushed towards the middle line and was congested and dilated at the caecal end. About midway between the caecum and the splenic flexure there was a kink, formed by the lower end having a long mesocolon allowing a partial volvulus. Just above this kink, and about on the level of the junction of the lower and middle third of the kidney, was a transverse tear, about an inch long, into the lumen of the gut. On replacing the lower end of the colon in its normal position and fixing it there by shortening stitches in the mesentery, a quantity of flatus escaped from the rent in the bowel wall and the whole of the ascending colon collapsed.

The tear in the wall was repaired with Lembert sutures, which were themselves oversewn again. There was no trace of faeces on the peritoneum or of any material whatever from the colon.

The left kidney was normal, but the whole of the right kidney pouch was occupied by a large fluctuating tumour.

Then the abdominal incision was closed, and in view of an after-event it is worth while noting that the layers were all sewn up separately, the inner ones with Van Horn's gut No. 1, and the skin with medium silkworm gut.

The patient was turned on to her left side and a pillow placed under her side. After a hurried cleansing of the skin and painting it with iodine the kidney was exposed through the loin. As soon as the deep fascia was opened a lot of dark blood and clot escaped. The kidney was felt to be lacerated, with the laceration extending right through the kidney substance; but as the upper pole was much more badly injured than the lower, it was decided to remove that portion and put deep sutures in the remaining portion in the hope of saving half the kidney. This was done, and having cleaned out as much blood and clot as possible, the wound was closed, leaving a large cigarette drain reaching down to, but not touching, the remains of the kidney.

The patient was then returned to bed, but as she was in a very low condition continuous rectal salines containing adrenalin were administered. She rallied well and was feeling comparatively comfortable by evening. She only vomited once.

Next day (August 30th) she felt comfortable. The temperature varied from 99° to 101.4°, pulse from 116 to 134, respirations 24 to 32. There was a good deal of blood-stained discharge from the tube; this had diminished on August 31st, but the temperature rose to 103°. The bowels were opened three times.

On September 1st the patient complained of slight headache and nausea; the temperature rose to 105°, the respirations to 42, and the pulse to 140. A vaccine of *Bacillus coli* was administered in a dose of five million. She began to cough towards evening. The bowels were opened twice during the day. During the night she was delirious at times, but at 6 a.m. on September 2nd she had a profuse sweat and the delirium ceased. By mid-day the temperature was down to 101.6°. The cough grew more troublesome, and it was found that the right base was dull with diminished voice sounds. From the way in which this condition afterwards cleared up it seems probable that the lung was also crushed at the base, although the sputum never contained any blood. No rib was broken at the time of the accident.

On September 4th the condition was much the same, but the temperature dropped still further to 99.8° at 6 p.m. The abdomen was supple, and there was no abdominal pain. The bowels acted once daily. She slept fairly well at night. There was very little discharge on the dressing that day.

On September 7th at 6 a.m. the temperature had dropped to 99°, but when the dressing was changed there was a decided smell of ammonia. Otherwise the condition was much improved and the cough almost gone. She was on a light diet and ate food well. When the wound was dressed on September 8th there was a fair quantity of urine on the dressing although the tube had been shortened on the previous day, and on September 9th a renal fistula was well established. The temperature during the day reached 103°; the bowels were opened once; the diet was reduced.

On September 10th the patient felt very well. The only discomfort was irritation of the wound in the loin, due to the urine. The abdominal wound having healed by first intention, and union being apparently good, the stitches were removed and the binder replaced. The temperature still varied from 100° to 102.2°. She slept well and had no pain. As the bowels did not open on September 11th the nurse gave an enema at 7 p.m. The bowels acted without effort, but an hour later she awoke from a light sleep and called the nurse, and said that "her inside had fallen out"; the nurse raised the clothes, and saw coils of intestine protruding from the lower edge of the binder. I arrived at 10 p.m., and found that the abdominal wound had given way along its whole length, and the edges appeared smooth, as if varnished. I returned the bowels to the abdominal cavity, and sewed up with through-and-through stitches. When I removed these stitches ten days later perfect union had occurred, and there was no sign of early ventral hernia nor any division of the muscles.

For the next week she steadily improved, but on September 16th developed oedema of the legs affecting the right leg more than the left. The wound in the loin looked very unhealthy, largesloughs having formed along the track of the fistula, which was discharging urine and pus freely. The temperature also became remittent in type, although the patient herself was feeling very well.

On September 17th I removed her to the hospital, and on the following day reopened the wound in the loin. I found the remnant of the kidney in a very unhealthy state and decided that the best course to pursue was to remove it. Accordingly I tied off the vessels and ureter and removed the organ. Then swabbing out the cavity I sewed up the wound and left a small drain in.

For the next few mornings the cavity was syringed out with hydrogen peroxide solution and the temperature came down, gradually reaching normal on September 25th. By that time all the discharge had ceased and the wound was looking healthy. The oedema of the legs continued, but was now confined to the right leg, was slight and did not seem to be increased by exertion.

She eventually returned home on October 14th, after an

uneventful convalescence, and when last seen she was in the best of health and had put on 9 lb. in weight in the previous month.

The points of interest in the case are the trivial accident causing such disastrous results, and the spontaneous opening of the abdominal wound thirty-six hours after removal of the stitches on the tenth day. It is curious, considering the contamination of the peritoneum on the skin and dressings and binder, to say little of the friction of its surface by the dry dressings, that no infection resulted, but I have since heard of a similar case in a Melbourne general hospital after a hysterectomy, when the wound reopened on the day following removal of the stitches, just subsequent to the administration of an enema. In that case also no ill effects occurred.

As if to prove the irony of things, on the day that this patient left the hospital I admitted a child aged 1 year and 10 months, who had been kicked at close quarters by a big Clydesdale mare. The print of the hoof covered its abdomen, but the only injury received was a fracture of the right femur.

REFERENCES.

¹ and ² *Keen's Surgery*.

THE TREATMENT OF ACUTE GONORRHOEA IN MEN.

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I FEEL convinced that, with very few exceptions, it takes on an average from two to three months to cure gonorrhoea. The general treatment consists of dieting, resting, and the taking of certain drugs. Butchers' meat, alcohol of any kind, strong tea or coffee, condiments and spices should be prohibited; milk and milk puddings, fish, chicken, eggs, vegetables, weak tea, water, and mineral waters may be permitted. Plenty of bland fluid is advisable, though in some cases of acute posterior urethritis lessening the fluid intake seems to lessen the urgency and frequency of micturition, and so gives a little more physiological rest to the inflamed membrane. If the patient can remain in bed for a week or two, well and good, but that is usually out of the question; consequently, it is advisable to instruct him to take no unnecessary exercise, to retire to bed early, and to avoid all sexual excitements.

It is best to start at once with urinary antiseptics, such as urotropin and cystopurin, for they tend to minimize the severity of the disease and shorten the acute stages; they may be continued for some weeks. When the anterior urethra only is affected, some alkaline diuretic may be given; and when the posterior urethra is involved, some of the balsams, though often their effect on the digestive system prohibits the latter, and they are by no means necessary.

In considering local treatment we may divide the urethra into (1) the anterior or movable urethra, and (2) the posterior or fixed.

The anterior urethra extends from the meatus to the bulb, is ensheathed in the corpus spongiosum, and is about 5 in. long. Its mucous lining is studded with many openings, larger (lacunae of Morgagni) and smaller (glands of Littre). Further back, opening into the bulbous portion, are the two ducts of Cowper's glands. The chief complication of anterior urethritis is stricture.

The posterior urethra, which embraces the membranous and prostatic portions, is about 2 in. long. It is usually involved about the second week of the disease, and as the ducts from the prostatic gland and the common ejaculatory ducts open into it, it is the source of the more serious local and systemic complications. Attempts to treat posterior urethritis by ordinary anterior injections are futile. Even when the anterior urethra only is diseased we are dealing with a delicate mucous membrane, and strong injections are to be deprecated.

In local treatment support of the parts is the first indication, and should be carried out by a support that will lift both scrotum and penis up against the abdominal wall. The meatus should be protected by aseptic wool, and sponged over with some antiseptic solution whenever