on a splint and left for two or three weeks. I do not doubt this, but even if the method I have explained to you does not accelerate their ultimate recovery or the perfection of this recovery, I do maintain that the time of recovery is more pleasantly spent than if bandaged in a more or less heavy retaining splint.

I think, however, the evidence I have been able to bring before you justifies me in making the following claims for this method—namely, that by the use of the anodal galvanic current for injuries or fractures more rapid relief of pain and swelling is secured, more complete muscular relaxation is obtained, and earlier return to useful function is possible, than by the more usually accepted methods.

[A number of skiagrams and photographs of cases were shown. These illustrated various points, such as the process of reduction without anaesthetic or counter-extension; the early solidity of the bone regeneration with this method despite the formation of a very small quantity of provisional callus; and the safety with which passive movement could be carried out, especially when the injury was in the neighbourhood of a joint.]

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THE VALUE OF FEEDING DURING OPERATIONS UPON THE STOMACH.

BY

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It is well known that patients who are profoundly anaemic from gastric or duodenal haemorrhage stand operations, such as gastro-jejunostomy, very badly. In a recent discussion of the subject at the Royal Society of Medicine, Mr. H. J. Paterson gave the mortality rate for operations for acute haematemesis at 36.8 per cent. He and most of the speakers who followed considered that surgical treatment for acute haematemesis was unjustifiable. It is also recognized that patients in a condition of extreme emaciation from chronic starvation owing to stricture of the pylorus are bad subjects for operation, and the more so when the stricture is due to malignant growth which may have completely occluded the pylorus, causing absolute starvation, and still further reduced the patient's resisting power by the accompanying anaemia and toxin absorption. In cases such as these gastro-jejunostomy, without partial gastrectomy, may lead to rapid and fatal collapse from shock, due, I believe, to inanition of nerve cells, especially of the vasomotor centres.

It has been my practice for many years to feed all such cases during the operation by introducing a pint of peptonized milk with a beaten-up egg and one ounce of brandy into the jejunum; since adopting the practice I cannot remember to have lost a single patient from post-operative shock. An improvement in the patient's condition is immediately manifest, and the pulse gains in volume and tension. It is usual for the patient to leave the table in better condition than he was in before the operation was commenced.

The method is very simple. Before the inner row of catgut sutures surrounding the gastro-jejunostomy opening is quite completed the suturing is stopped, leaving an opening of about a quarter of an inch or less. The jejunal clamp is removed, and stomach and jejunum compressed between the finger and thumb of the left hand to prevent escape of fluid; a No. 10 soft rubber catheter, connected by a short length of tubing to a funnel, is introduced through the opening and passed along the jejunum (the finger and thumb keeping up compression around it), until about eight inches or more have passed along the gut into a coil which is within the abdominal cavity. The food is then poured slowly into the funnel through a gauze strainer.

The funnel should be held about ten inches above the abdominal wall to avoid too rapid entrance of fluid and distension of the intestine. The whole process takes rather less than ten minutes. The catheter is then withdrawn and the operation completed.

Quite recently I operated upon a woman of 37, suffering from cancer of the pylorus. She was very wasted; though her height was 5 feet 5 inches she weighed only 77 lb. She had been vomiting most of her food almost daily for several weeks. She was very anaemic (35 per cent. haemoglobin). There was complete absence of free HCl in a test meal, and after six and a half hours more than a third of a barium meal remained in the stomach. The palpable growth extended for about 2½ inches from the pylorus along the stomach, and there was very considerable glandular infection.

The operation consisted of resection of nearly half the stomach with the first part of the duodenum; posterior gastro-enterostomy was performed, and during it a pint of food was introduced. She stood the operation remarkably well, had little or no signs of shock, and within a week was taking solid food. Feeding by the mouth with peptonized milk was started within eighteen hours of the operation. There was no vomiting, and her condition never gave cause for a moment's anxiety.

I feel sure that if feeding had not been adopted in this case her chance of recovery would have been very small. The case is typical of a good many others, and I feel confident that anyone who adopts this method of feeding cannot help becoming convinced of its great value.

HYDROCELE AMONGST THE LANGO OF UGANDA.

BY

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THE natives of Lango (Uganda) do not appear to be possessed of any surgical skill whatever, and so pathological conditions amongst them tend to become very gross indeed. Hydroceles and, as a consequence, haematoceles are very common; some of these tumours grow to enormous proportions, often reaching nearly to the knee, causing great disability. The scrotal tissues are, as a rule, greatly thickened; and the disappearance of the penis from view is a cause of much grief.

The results of operation by textbook methods are disappointing. The operation herein described endeavours to avoid the worst consequences of more orthodox methods by (a) excision of redundant scrotum, (b) complete deep haemostasis. Oozing from the cut edge of the tunica vaginalis ordinarily takes place along the whole length of the cut, and only the actual cautery can seal the capillaries. When they ooze no longer and the larger vessels are secured by ligature there is no need for drainage. The procedure has been carried out many times at Lija; it has always given good results, and often the patient has left hospital within a fortnight of the operation.

Operation for Large Hydrocele.

The initial incision should be made without previous tapping. Its exact direction varies according to the thickness of scrotal tissue, age of patient, size of tumour, and the presence of ulceration, which is common. In general it should begin at the visible root of the penis, travel downwards and outwards, over the enlargement, and then upwards and inwards to the middle line; any ulcerated patches should if possible be included in the part to be removed. At the perineal side of the scrotum about 1½ inches should be left between the end of the incision and the perineum, otherwise infection is very likely. A second incision begins and ends as above, but passes straight in the middle line. In double hydrocele, where both sides are large, an incision similar to the first described encircles each side of the tumour. The incisions are deepened to the infundibuliform fascia, and the portion of scrotum between them dissected away. A great deal of contraction takes place in the stump, greater in younger than in older subjects, in larger than in smaller tumours, and in thinner than in thicker scrotal tissues. From one-fourth to one-third of the surface of the tumours should be included in the excised portion.

If, in double hydrocele, the swelling on one side is small, this can be dealt with from the other or larger side, by an incision through the septum, carefully avoiding the veins, which are here very numerous and bleed freely if injured. Having exposed the tunica it is divided longitudinally. Then, clamping each successive length with forceps, the parietal portion, including infundibuliform fascia, is cut away and the cut edge sealed with the actual cautery. A few points will require ligature. If, as in double hydrocele, the septum must be cut, it should be similarly dealt with. If the cautery is not used very free bleeding ensues.

The cut scrotum is united by a deep suture, which should include the septum, if cut, and the whole thickness of the scrotum except the skin. I always use a removable silk thread which has been boiled in 1 in 1,000 corrosive sublimate. A continuous buried fishing-gut suture is used for the skin edges, such as can be removed by pulling one end. If this type of suture is not used the gut, having buried itself in scrotal folds, is very difficult to remove. Practically all vessels in the cut edges of the scrotum either retract or are controlled by the deep suture.

A four-tailed bandage, of which two narrow tails pass out behind and are secured as usual, is used; the anterior tails, 3 or 4 inches broad, are secured so that the edges in contact with the perineum are drawn tight. If this is done the bandage never slips, even with the restless and naked savage, and considerable pressure can be exerted over suitably disposed pads by pinning its other edges together.

I have found this operation useful, even in small ordinary hydroceles, but of course part of the scrotum need not always be excised. An incision in the scrotum running at right angles to the septum avoids the scrotal veins. A deep silk thread is unnecessary.

I have to acknowledge my indebtedness to Dr. J. Hope Reford, Principal Medical Officer, Uganda, for his kind permission to publish this communication.

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

INTESTINAL OBSTRUCTION DUE TO ADHESIONS.

THE case recorded under this heading by Dr. E. J. Bradley (April 5th, p. 625) induces me to place on record the following case, at present under my care, of a similar condition, although not producing an acute obstruction.

An unmarried woman, aged 31, was referred to me by Dr. Moir (Congleton) with recurrent attacks of discomfort and tenderness in the right iliac fossa and severe constipation. At the age of 13 she had an acute abdominal attack, said to have been "gastritis," since which she had suffered from gradually increasing constipation, for which she has lately been taking from forty-five to fifty senna pods daily.

On April 2nd, 1924, I performed exploratory laparotomy through a right paramedian incision, and found numerous adhesions between the caecum, ascending colon, omentum, gall bladder, and duodenum. On separating these the gall bladder and duodenum were otherwise normal. The appendix was buried in adhesions to the posterior aspect of the caecum and to the posterior leaf of the mesentery of the terminal ileum, its wall was greatly thickened, and it was strictured one inch from the tip; I removed it. A general examination of the abdominal and pelvic viscera was made, but nothing else abnormal noted except in the ileum, where a condition of localized matting of the bowel, practically identical with that described and figured by Dr. Bradley, was met with in two situations: (1) the lower and larger, forming a mass about 10 inches long, and ending 6 inches above the ileo-caecal valve; (2) the upper, about 5 inches long, more highly placed, so that some 3 feet of normal ileum intervened between the two masses. Each mass consisted of closely packed and convoluted coils of ileum, with the corresponding area of mesentery, within a firm fibrous investing membrane having a smooth glistening external surface which was quite free from adhesions. After incision of this membrane I found the contained coils to be but very loosely attached to its inner surface and to each other, and to be still clad with peritoneum—just as Dr. Bradley found in his case on dissecting the mass after he had excised it.

As excision of these two separate masses would have involved the loss of a considerable portion of the ileum, I decided to try the effect of free separation of the bowel from its membranous sheath. This was divided over the whole length of the lower mass, along the antimesenteric border, when the tortuous coils were very readily freed from its inner surface and from each

other; it was then noted that about 3 feet of ileum had been involved. The divided edge of the investing membrane was carefully sutured to the corresponding leaf of the mesentery, care being taken to pass the sutures sufficiently close together to leave no pouches in which strangulation might occur; this was done in preference to excision of the membrane as being less likely to lead to subsequent adhesions. The upper mass was then similarly treated, and was found to involve about 18 inches of ileum.

The course since operation (twelve days ago) has been uneventful and the bowels have acted well; one hopes, therefore, that operative measures less drastic than enterectomy may suffice in the treatment of this rare pathological condition. In my case the condition of the appendix, the adhesions extending upwards from it along the right side of the abdomen, and the history of an acute abdominal attack at 13 years of age, all suggest appendicitis as the cause of the peritonitis which resulted in the formation of these fibrous membranes.

Manchester.

A. H. BURGESS.

INTRACARDIAC INJECTION OF PITUITRIN IN ASPHYXIA NEONATORUM.

I RECORD this case because it is the first time I have used pituitary extract in this manner, and I do not happen to have read of its being so used in such cases.

On March 28th, 1924, I delivered a primigravida, with a pelvis just under normal measurements, of a male child weighing 7 lb. The head presented in the R.O.A. position. The first stage took from fifteen to eighteen hours to complete; the membranes had ruptured at the onset of labour. At the commencement of the second stage the head was well down in the pelvic cavity; progress was slow, and, as after five hours with fair pains the caput had not quite reached the perineum and the foetal heart sounds had begun to weaken, I applied axis-traction forceps. No force was needed to bring the head into the outlet, where the forceps were removed. The child was born some ten minutes later in a condition of white asphyxia, with the cord only feebly pulsating. The child made no attempt at respiration, and by the time he had been separated and his throat cleared of mucus the pulse ceased. In spite of pulling on the tongue, hot bath, cardiac massage, and artificial respiration by inflation, the heart was not audible. I had no adrenaline with me, but, having some pituitrin, I injected 0.25 c.cm. directly into the heart, and continued inflation respiration. Within half a minute the heart began to beat and so continued with increasing force. After five minutes' further forced respiration he began to make three or four active attempts at respiration a minute. By the end of an hour he was breathing satisfactorily, and his condition gave no further trouble.

In the JOURNAL of March 29th (p. 570) there is a note of pituitrin being injected intramuscularly in a case of asphyxia pallida neonatorum; but it would appear obvious that if the circulation has actually failed nothing short of intracardiac administration can be of any avail.

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"SLIPPING RIB."

I HAVE read with much interest the letter of Dr. E. N. Russell (April 12th, p. 664) on "slipping rib." This condition, first described by me in the *Practitioner* for June, 1919 (pp. 314-322), and later on apparently independently by Mr. Davies-Colley, seems to have led to operative measures being employed for its relief. I must, however, point out that in many cases a much simpler method will suffice to induce a permanent and instantaneous cure—at least that is my experience in a large proportion of the cases that have come under my care. The procedure is: The patient must be placed flat on his face with his arms resting against his sides. The position of the head of the affected rib having been accurately located, the position of the vertebral facet corresponding to it must be defined by comparison with the rib on the opposite side. If the head of the slipped rib is not lying over this facet, then positions of the arms or the trunk (such as lateral flexion) must be varied in order to get it there. When this has been accomplished a sudden downward pressure is applied in order to bring the head of the rib against its proper facet. The muscular contraction that follows immediately upon this manoeuvre keeps the rib in its correct position and lasts long enough to ensure this being permanent. No further treatment is necessary.

London, W.

EDGAR F. CYRIAX, M.D.