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.