was examined, and gonococci were found to be present. No Klebs-Loeffler bacilli were detected.

The condition was treated at first with mild antiseptic drops and subsequently with argyrol. At the end of a month the discharge had quite ceased.

COMMENT

This case presents many interesting features of clinical and sociological importance.

1. Gonococcal rhinitis may easily be overlooked as the true cause of a coryza. The bacteriological diagnosis is made difficult by the similarity of the *Micrococcus catarrhalis*, which is also Gram-negative and sometimes occurs in pairs, but is never intracellular.

2. The prophylactic instillation of drops into the baby's eyes at birth undoubtedly averted an attack of ophthalmia.

3. Inquiry into the history of the labour revealed a prolonged third stage, predisposing probably to the inoculation of the infant's nasal mucous membrane with infective vaginal secretion.

4. The diagnosis of gonococcal infection in married women presents many difficulties, but its possibility as the cause of a vaginal discharge should always be considered. When the infection is transmitted by a male with chronic gonorrhoea the urethra is seldom affected, and symptoms of mild endocervitis may alone develop. These may be attributed to a cervical laceration.

5. A thorough examination of the male genital tract before marriage is of paramount importance to exclude the possibility of latent disease.

6. The gonococcus retains its virulence for years in the glands of the prostate, seminal vesicles, and Littre's follicles, and a negative blood serum reaction does not exclude the possibility of a gonococcal focus. The best single routine test of cure is examination of the prostatic fluid for pus cells.*

The foregoing presents ample opportunity for criticism and discussion, and comment from our colleagues would be welcomed.

RUPTURE OF THE PANCREAS

BY

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The rarity of this lesion encourages us to publish the following case.

The patient, a man aged 20, while playing football, was charged by another player and fell to the ground with his opponent on top of him. The latter's knee hit him on the abdomen. He attempted to carry on but failed.

He was seen by one of us within fifteen minutes of the accident, and presented the following typical picture of shock. He was pale and anxious, with beads of sweat on his brow, but he was quite conscious and intelligent. The lips and ears were pallid; the skin was cold and clammy, and of greyish hue. Pulse rate was 108 per minute and feeble; temperature was 97° F. Respirations were thoracic, sighing and irregular. He complained of severe abdominal pain, chiefly in the area under the umbilicus. The whole abdomen showed an absolute board-like rigidity, and his knees were drawn up to a marked degree.

He was treated by heat, and sent in to Ashford Hospital for operation with a provisional diagnosis of ruptured viscus. When seen in hospital by both of us an hour later his condition had considerably improved. Muscular rigidity was almost negligible; pulse rate 92 per minute and quite strong; temperature 97.6°; and respirations 20 per minute and regular. We decided to leave him under observation. Two hours later, however, his condition had changed. Pulse rate was still 92 per minute and strong, but he again looked haggard and anxious, and his abdomen showed muscular rigidity, most marked in the right hypochondrium. It was decided to operate at once.

* The technique of this test is described in Storer's *Youth and Disease*, third edition, p. 122.

A right paramedian incision was made, and the first thing evident was extensive fat necrosis, chiefly in the mesentery and omentum. Greenish-yellow areas were seen, varying in size from a pin-point to areas half an inch in diameter, these latter having an appearance not unlike gas gangrene. In addition, there was a large extravasation of blood under the peritoneal coat of the whole ascending colon and caecum. It was found impossible to stitch the pancreas, so drainage tubes were inserted and the abdomen closed. No wound was found in any other viscus.

The following morning the patient seemed somewhat better. His pulse rate was 96 per minute, temperature 98°, respirations variable. There was a copious greenish serous discharge from the drainage tubes. In the afternoon incessant vomiting of dark foul-smelling material set in, and he complained of tenesmus of the bladder. Twenty-four hours after the operation his heart began to fail, and he died forty hours after the accident.

Even during the operation his pulse was slow, and at no time till cardiac failure set in did it exceed 96 per minute.

Post-mortem examination revealed: (1) A tear of the pancreas anterior to the vertebral column; there the pancreas was changed into a dark haemorrhagic slough. (2) Extensive fat necrosis, especially in the omentum and mesentery. (3) A haematoma under the peritoneal coat of the ascending colon and caecum, but this was not so marked as during life. (4) Multiple adhesions of a fairly firm nature. (5) No free blood in the peritoneal cavity. (6) No tear of any other organ or of the gastro-hepatic omentum, and no bruise of the anterior abdominal wall.

REMARKS

The following points in this case seem noteworthy.

The Form of Violence.—This cannot be compared with that of most published cases—for example, a crush between the buffers of a train or a heavy fall of earth. The opponent's knee must have been applied directly over the vertebral column, when the muscles were quite lax, and the pancreas crushed across the backbone. It is strange that rupture of no other organ was found.

Muscular Rigidity.—Rigidity was present a quarter of an hour after the lesion and passed off only to recur. The textbook pancreatic lesion gives muscular rigidity as slight or absent. Is it possible that very early in the picture of a pancreatic lesion muscular rigidity does occur, and has already passed off when the patient comes under observation?

Pulse and Temperature.—The pulse was slow, and the temperature subnormal in this case. This is the rule in pancreatic lesions.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

AN UNUSUAL ABDOMINAL INJURY

Mr. C. H. Fagge, in his paper entitled "A plea for the earlier diagnosis of abdominal emergencies" (January 10th, p. 50), laid emphasis on the importance of the pulse rate in diagnosis. The following history of a case of abdominal injury may be of interest.

A man, aged 56, was admitted into the Stockport Infirmary in April, 1930, suffering from a penetrating wound of the abdomen. He had been transfixed by an iron bar about 4 feet in length and 1 inch in diameter. The bar entered the anterior abdominal wall 2 inches below the right costal margin and 2 inches from the middle line. It emerged behind, just above the crest of the right ilium at the outer border of the erector spinae muscle. The patient himself extracted the bar. On admission to the hospital he complained of pain at the site of the anterior wound. The pulse rate was 76, and the temperature 98° F., and there did not appear to be much shock. The tenderness was superficial, and the rigidity diminished with gentle local pressure, unlike the rigidity due to peritoneal irritation. There was no loss of