with the introduction of a sheet-rubber drain of the abdominal wall. The diverticulum was about 3 inches in length, and had a clear opening of about 1/2 inch diameter into the intestinal lumen. It presented itself as a blackish oval cyst on the upper leaf of the mesentery. Its contents consisted of blood-stained fluid.

There was considerable vomiting for the first few days. Continuous rectal saline injections and two doses of anti-gas gangrene serum were given. The patient improved, and on June 16th was very comfortable; but two days later the wound broke down, with discharge of intestinal contents. Acute right parotitis developed on June 20th, and the patient went rapidly downhill, but lingered on till June 30th, when he died.

CASE II

A man, aged 30, was admitted at 11.30 p.m. on June 14th with severe pain in the pit of the stomach, which had come on suddenly at 8 a.m. just as he got out of bed; it was very severe and doubled him up, but it was intermittent. There was no vomiting, but some nausea, and no definite history of indigestion; there had been vague pains for a few weeks, which had been relieved by walking about.

His temperature was 100°, and the pulse 92. The tongue was slightly furred, and the abdomen rigid, tenderness being most marked in the epigastrium and the right and left hypochondrium.

An operation was performed on June 15th on the suspicion of perforated duodenal ulcer, the right rectus slide incision being employed. Clear fluid was present, and distended coils of small intestine presented in the wound. A Meckel's diverticulum 2½ inches in length and 1/2 inch in diameter was found, arising just below the antemesenteric border. The distal end was conical, and from the tip arose a fibrous cord about 3 inches long, the other end of which was attached near the root of the mesentery on the lower leaf. Over this cord a loop of bowel was kinked, the proximal part being slightly congested. The cord was divided between forceps, and the diverticulum was excised, the stump being invaginated by a purse-string suture since there was no tendency to stricture of the intestine. Appendectomy was performed, and the wound was sutured in layers. Convalescence was uneventful, and he was discharged on June 29th.

CASE III

A man, aged 60, was admitted on August 14th at 12.15 a.m. There had been a sudden onset of severe abdominal pain the previous evening; it was situated at first low down on the left side, but spread over the abdomen. No vomiting had occurred, and the bowels had been opened the previous morning; there was no history of the passage of blood or mucus, nor of indigestion.

The patient was collapsed and sweating; the temperature was 98°, and the pulse 80. The tongue was clean. The abdomen was very rigid, especially in the upper half. There was no loss of the liver dullness.

The abdomen was opened, and a perforated gastric ulcer was discovered in the pyloric region of the stomach. There was some extravasation of stomach contents. The ulcer was sutured, and covered with a flap of omentum. Before closing the abdomen, a coil of intestine was noticed, bearing a Meckel's diverticulum, which was of almost the same diameter as the bowel, and about 1½ inches long. Its lumen was uniform and the end was not pointed or conical.

CASE IV

A married woman, aged 25, was admitted at midnight on August 15th. Pain had commenced about the middle of the previous day in the sides and the lower abdomen, and was colicky in nature. She had vomited twice on the morning of admission, and this temporarily relieved the pain. The bowels had not opened for two or three days. Micturition was normal, and menstruation regular; there had been some pain, but no intermenstrual discharge. The last period had ended one week before admission. There had been an attack of similar pain eleven years previously; the patient was ill for about six weeks, being relieved by enemata.

On admission, general tenderness and rigidity of the lower abdomen was present, especially in the right iliac fossa.

The temperature was 100°, and the pulse 120; the tongue was moist and clean. Rectal examination revealed some faecal masses, and tenderness especially on the right side.

At operation, at 1 a.m. on August 16th, no causal lesion was found, but the caecum was large and ptosed, and the colon contained faecal masses. While examining the small intestine a relic of Meckel's diverticulum was found in its usual situation, about 2 feet proximal to the ileo-caecal valve. This showed as a bulbous dilatation of the intestine just distal to a slight constriction. There was, however, no distension above the constriction, and it was not thought that the lesion was causing any symptoms. Appendectomy, therefore, was performed, but no operative treatment of the rudimentary diverticulum was undertaken. The patient made a satisfactory recovery.

I am indebted to Mr. J. T. Bailey, under whom the cases were admitted, for admission to publish details of Cases II, III, and IV, and to Mr. A. W. Berry for permission to publish Case I.

GONOCOCCAL RHINITIS IN AN INFANT

BY

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We are reporting this case, first, because a perusal of the literature on gonococcal infections and diseases of the nose revealed practically no mention of the condition, and, secondly, on account of the interesting parental history, which resulted in its diagnosis.

A man, aged 42, consulted Dr. T. Spiers Kirkland in February, 1929, about deafness. A toxic focus was considered as the cause, and in view of a history of gonorrhoea the patient was referred to one of us (R. V. S.) for investigation. Examination revealed two hard sensitive nodules in the prostate. The prostatic fluid contained numerous pus cells. No gonococci were detected. Urethrosopic examination showed numerous infected Littre's follicles. The Neisserian infection reaction of the blood serum was negative. The urine was clear and contained no albumin, sugar, pus, or threads. A diagnosis was made of chronic prostatitis and Littritis, and appropriate treatment was instituted.

The patient had had gonorrhoea two years before marriage, but believed himself cured. He had been married eleven years, and had three healthy children, aged 10½, 9, and 6½ years respectively. There had been extramarital intercourse on one occasion only, four years ago, and on the following day a drop of yellow discharge had appeared. This disappeared without treatment. On no other occasion since marriage had there been any indication of uncured disease. His wife had an intermittent vaginal discharge which attracted notice after her first confinement.

While the husband was undergoing treatment for his prostatic condition his wife was confined, and soon after birth the infant developed a "cold," which did not react to the usual domestic treatment. As a matter of interest the husband was given two glass slides and asked to bring in smears of the nasal discharge for examination. Stained by the pyronin method, one smear showed numerous pus cells, staphylococci, and typical gonococci. The other smear was submitted to a pathologist, who reported as follows: "Numerous pus cells, Gram-positive cocci, and groups of Gram-negative diplococci, often intracellular and morphologically indistinguishable from gonococci, were present."

The baby, then aged 1 month, was seen (H. K.) on April 24th, 1929, with a history of unilateral (right) nasal discharge since birth. According to the mother this was most profuse in the early morning, and was yellowish in colour and sometimes blood-stained. The baby experienced difficulty in breathing while feeding, and was seized with fits of coughing at intervals. No discharge or foreign body was visible in the anterior nares. Conjunctivae were normal. The nasal mucous membrane was only slightly inflamed. On the next day a swab was obtained covered with thick yellow pus. A smear

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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M.D.GLAS. M.D.ED.

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