alive to the immense difficulty that there is in many cases—so great as to make a sure diagnosis in some cases impossible, especially in stout people and in pregnant women. In the majority of instances, however, it is not because a diagnosis has not been made, but rather because, having been made, it has not been acted upon, that so many cases come to the surgeon with complications.

SPONTANEOUS REDUCTION OF INTUSSUSCEPTION.

BY

T. BONHÔTE HENDERSON, M.A., M.B.,
B.CH. OXON., F.R.C.S. ENG.,

ASSISTANT SURGEON TO THE SALISBURY INFIRMARY; LATE SURGICAL REGISTRAR TO THE CANCER HOSPITAL, BROMPTON.

SPONTANEOUS reduction of an intussusception in infancy is admitted by the textbooks to be a possibility, though stated to be a very rare occurrence. There is an obvious difficulty in forming a definite opinion on this point in that the proof of such a happy ending is necessarily absent owing to the disappearance of the intussusception. Until quite recently I have never seen any real amelioration of symptoms in this disease unless relieved by operative interference, but the following case upon retrospective study would appear to be a genuine exception to the usual course of events.

J. B., male, aged 13 months, previously healthy, with no history of intestinal disturbance. He was present at a juvenile tea party on April 8th, and, in the absence of his mother, was given quantities of unsuitable food and whole strawberry jam. He passed a restless night, and next morning had some diarrhoea. On the same day I was urgently sent for at 2 p.m., and was told that the child had been seized with frequent and violent attacks of abdominal colic, several of which had been so severe that he had literally stood on his head, boring into the pillow and screaming out with pain. The diarrhoea continued, the stools being thin and offensive and accompanied by a quantity of mucus, but no blood. There had been no vomiting.

The child was white, restless, not intensely collapsed, but with a small, quick pulse, and a marked expression of abdominal distress; every few minutes he obviously had abdominal pain. The abdomen was hard and resistant, a little distended, and everywhere highly resonant. No tumour was felt and the rectum was empty. This examination being highly unsatisfactory owing to rigidity, and it being very desirable to make a diagnosis, if possible, I returned at 4 p.m. with my partner to give an anesthetic in the hope of settling the question. I found the child very much better, with lessening pain, returning colour, and an improved pulse. It was decided that an intussusception was improbable, and an anaesthetic was not given, it being determined to watch the child closely. The improvement was maintained, and in the course of a few days on a rigid diet with the cautious use of small doses of castor oil, the child recovered his usual health.

Some six weeks later, on May 21st, a similar attack took place, of corresponding severity, but on this occasion there was no diarrhoea, only a little blood and mucus being discharged from the bowel. There was no vomiting, and again no tumour could be felt in the rectum or abdomen. With the history of the former attack in one's mind and the recovery therefrom, and with the child close at hand under immediate observation, it seemed justifiable to again adopt expectant treatment. This was again attended by success. The bowels were opened with difficulty, the stools being constipated, but free from blood, and the abdominal pains disappeared, except at very rare intervals.

All went well for five days. On May 26th I received again an urgent message to see the child, whom the parents thought to be dying. This time the clinical picture of acute intussusception was to be read in the child's appearance. The collapse was of that degree of profundity which is associated with this lesion in infancy and which once seen is never forgotten. The child lay motionless, colourless, hollow-eyed, and apparently moribund, the recurring abdominal pains momentarily restoring the

appearance of life. All this was well within an hour from the first onset. Blood and mucus had again been passed, and vomiting had commenced. The child was at once taken to a nursing home. On opening the abdomen some hour and a half later a little clear serous fluid escaped. A quite recent intussusception, some seven or eight inches in length, was found in the left iliac fossa, which I had no difficulty in reducing. It was apparently of the ileo-caecal variety. The abdomen was rapidly closed with through and through sutures of one layer only, and the patient returned to bed certainly much better than before the operation. The after-history was uneventful and the recovery uninterrupted, small doses of opium (tinct. camphorae co., m v) being freely used for the first three days.

The presence of a congenital umbilical hernia did not lessen the difficulties of diagnosis in the first two attacks. This was always reducible, but the possibility that a small piece of omentum might be nipped had to be borne in mind. The hernia was not interfered with at the operation, but curiously enough it has not reappeared, the empty flaccid sac lying on the abdominal wall.

My personal conviction is that the first two attacks were undoubtedly due to the commencement of an intussusception, which in each case was spontaneously reduced—completely so in the first attack, perhaps incompletely in the second, in spite of the fact that reduction at the operation was easily effected, and that the intussusception appeared to be a recent one.

The third attack alone showed the full degree of collapse which one is accustomed to expect, but there can be no doubt that this degree depends upon (a) the length of bowel involved, and (b) the amount of tension and compression of the mesentery.

A CASE OF FRACTURED PELVIS COMPLICATED BY LACERATION OF THE FEMORAL VEIN TREATED BY LATERAL VEIN SUTURE.

BY

MANFRED MORITZ, B.A. CANTAB., M.B., CH.B. VICT.,
SENIOR HOUSE-SURGEON TO MR. A. H. BURGESS AT THE
MANCHESTER ROYAL INFIRMARY.

THE following case possessed characteristics which were deemed worthy of report:

J. C., a clerk, aged 35, was admitted to the Manchester Royal Infirmary with a history that he had been jammed between a lorry and a gate post at a railway station goods yard. The strain was apparently slightly oblique from right to left and oblique from before backwards.

The patient stated that on freeing himself he walked thirty yards or so; he was then seized with acute pain in the right groin and collapsed.

Condition on Admission.—The patient, who was admitted one hour after the accident, was a well-built man, but looked anaemic and ill. Respirations were quick and sighing, and he was very restless though fully conscious; the pulse was 120 and thin; the temperature was 97° F.

On inspecting the abdomen and groins a large swelling about the size of a melon was seen, filling up and mapping out Scarpa's triangle on the right side. The integument over this was of a mottled purple colour. The swelling was non-expansile, soft, and fluctuant. It had a feeling as if there was very little tension in the tumour, and was tender. The pulse could be felt perfectly well in the posterior tibial artery at the ankle, and was also quite palpable in the popliteal space. There was a slight impulse on coughing and straining. On jarring the crests of the ilia there was exquisite pain. Rectal examination revealed great tenderness and a bony prominence in the region of the pubic crest on the right side. The abdomen moved well on respiration, was soft, and not tender, and was resonant in the flanks. A soft Jacques catheter was passed, and 12 oz. of normal urine drawn off.

Diagnosis.

The history of the accident, the rapidity with which the swelling had appeared, and the fluctuant feel of the tumour led one to a diagnosis of haematoma. The absence of expansile impulse, the presence of the pulse at the ankle, the soft non-tense feel of the tumour made it most probable that it was of venous rather than arterial origin. The results of the rectal examination and the great pain on jarring the hips showed that the pelvis was fractured.

Operation.

The man's condition was so urgent that the resident surgical officer, Mr. Howard Buck, F.R.C.S., decided on immediate operation.