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

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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

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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.

A longitudinal incision about 4 in. long was made over the tumour. On cutting through the integument and deep fascia, dark clots and about a pint of dark fluid blood were turned out. On exposing the femoral vein, it was seen that a sharp spicule of bone broken away from the pubic crest had penetrated the vessel just as it came under Poupart's ligament. The tear in the vein was longitudinal and about $\frac{1}{2}$ in. in length. Further haemorrhage was controlled by digital pressure below the laceration. The vein was repaired by lateral phleborrhaphy, a Lembert suture of fine thread being inserted with a domestic needle. The spicule of bone was removed and a tube with gauze packed tightly round inserted into the cavity. Towards the end of the operation the patient's condition became critical, and about 4 pints of normal saline were infused into the median basilic vein.

After-History.

The tube and gauze were removed on the third day after operation, and the patient lay between sandbags with a tight binder over the pelvis for a month. He was then discharged, and was able to walk from the ward. There was never throughout the convalescence any swelling or oedema of the limb, which remained quite painless. It is therefore most probable that at no time was there any venous thrombosis of any extent.

An x-ray photograph taken a week after operation showed a flake of bone torn away from the pubic crest to about $\frac{1}{2}$ in. from the pubic spine. The diagram shows the condition.

Arrow denotes point of fracture and spicule of bone. (Drawn from actual skiagram.)

Although laceration of the femoral vessels is a well recognized complication of fractured pelvis there are few, if any, cases on record; certainly none treated in this manner with success. The interesting physical signs in this case making it possible to differentiate the venous haemorrhage from arterial were very striking, as also the complete absence of venous complications after vein suture.

Lejars states that there have been several successful cases of suture of vein trunks reported. Out of six of the inferior vena cava there were four successes and two deaths. Jacobsthal has collected 53 cases of suture of large veins; in two only of these did lateral suture fail.

It is thus evident that a large vein such as the femoral should always be given a chance by suture rather than resorting at once to ligation, as the results of femoral vein thrombosis are so often unfortunate, to say the least. In cases in which lateral ligation (partial) can be carried out suturing can in nearly all cases replace it, and the chances of secondary haemorrhage are said to be less than in lateral ligation. In infected wounds or veins injured by sepsis suture is useless.

Lejars recommends round needles as used in the above case, and sutures of sterilized thread soaked in aseptic vaseline. He is against a Lembert suture being inserted, and always does a through-and-through suture. It is quite evident that if a Lembert suture is possible it is preferable.

My thanks are due to Mr. A. H. Burgess, F.R.C.S., and Mr. H. Buck, F.R.C.S., for permission to report these notes.

THE seventh Congress of Austrian Balneologists will be held at Meran in October (11th to 13th). Numerous papers have been promised not only from Austria, but from Hungary, Germany, and Switzerland. A special feature will be a formal tribute of acknowledgement of the work of Professor Winternitz, who has for many years been President of the Austrian Balneology Society. Communications relative to the Congress should be addressed to Dr. von Aufschneider, Baden bei Wien.

REFLECTIONS AFTER TWENTY-ONE YEARS OF GENERAL PRACTICE.*

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DANTE says that "all men are delighted to look back," and it is as well that it is so, for only by that means are we able to think over our experiences—successes and failures—and see how they can help us to steer a course in the future which shall not only increase the unity and concord among ourselves but also our power to lessen the sorrows and the average sum of human suffering. Never was the general practitioner better fitted by his training to undertake the treatment of disease, and never has he shown more than in the past few years, by his readiness to help on the work of preventive medicine, by his whole-hearted support of public health measures, that he is not here to get all he can out of life for himself, but to try and make the lives of others happier. And, although he is better qualified in every way to treat disease than he was, say, twenty years ago—owing chiefly to his greater knowledge of the cause of it—yet his responsibilities and anxieties have multiplied considerably without any corresponding acknowledgement by the public that his increased efficiency is worthy of better recognition. During the last twelve months the general practitioner has been passing through the most momentous times of this or any other age, and one has only to read the letters that have been published in the daily papers to see that our prospects are gloomy unless we fight shoulder to shoulder. We were all told at that very dull entertainment called the opening of the winter session that we were entering a noble profession, and ever since that blessed word "noble" has so rung in our ears that we seem as a body to have been quite mesmerized by it. Noble to suffering humanity we have been, and always shall be in the future, but have we shown by our loyal co-operation with each other the same nobleness of character? Have we not rather by our want of unity allowed ourselves to be at first cajoled and then threatened with ruin and disaster by self-seeking politicians, until at last we have realized that we must fight for principle and justice, cling to our ideal, and take hope in the remembrance that sometimes "from our desolation only does the better life begin." If we only reflect for a moment that medicine is the only world-wide profession following everywhere the same methods, actuated by the same ambition and pursuing the same end, it must seem to us all that it is only the want of unity, peace, and concord amongst ourselves that is responsible for the treatment meted out to us by certain sections of the community. During the last few months many men who for years stood aloof from the British Medical Association have come into the fold, having at last realized that the old maxim, "United we stand, divided we fall," is as true of the medical profession in its dealings with the public as it is of any other walk in life.

The protest made by some members of the profession, that we are forming ourselves into a trades union, seems, to say the least of it, illogical, for, while believing that each member taken individually is prompted by the highest ideal, they believe that when banded into a compact mass they are actuated by baser motives. Unless the majority of medical men are tradesmen, it is impossible to create a medical trades union. A union of professional men will be a professional union, and the more perfect the union the more possible it will be to maintain in each of its units the highest traditions of our calling. We object to being treated as tradesmen, as if our only duty is to supply all others with a bottle of medicine or liniment, very much as goods are supplied across the counter at a co-operative store, all the finer and scientific work which has been built up during the last fifty years being totally ignored or sacrificed to the cry for the "cheap doctor." It is to be hoped that all who have lately joined the Association will attend the meetings of our Branches and Divisions as frequently as possible, for by so doing they will not only increase their educational value, but help to promote that unity and friendship amongst the

*Being the Presidential address delivered before the Southern Branch of the British Medical Association.