during the war. On May 24th, 1889, I read a paper on the subject before the Clinical Society of London and at the same time showed a successful case. In a leaderette in the *BRITISH MEDICAL JOURNAL* for June 1st, 1889, occurs the following statement:

Among the papers read last Friday at the Clinical Society was one which chronicles another advance in conservative surgery, showing that another tissue of the body (tendon) can be successfully grafted as skin, bone, and nerve have been.

The following is a history of the case referred to:

I was asked in November, 1883, to see J. L., a weaver, aged 32, with a view to amputating his right arm for an injury caused by machinery.

The whole of the inner side of the forearm up to the elbow was hopelessly crushed and lacerated, exposing the ulna from one end to the other, but not opening the elbow-joint. The muscles were torn and the bone was rasped bare of periosteum. The wrist-joint was opened and the inner row of carpal bones was crushed. The three inner fingers were hopelessly smashed and the whole dorsum of the hand was swept clean of skin and tendons except the extensors of the thumb, which were bared but not otherwise damaged.

The index finger, excepting that its metacarpo-carpal joint was opened and that its extensor tendons had been completely torn away, was not further injured. After a little consideration, I decided to try to save the radius, the radial half of the carpus, and the thumb and index finger, and, in order to give the possibility of a useful index, to make an extensor indicis from the flexor tendon of the smashed middle finger.

The whole limb was scrubbed with soap and carbolized water, well rubbed with benzol and then thoroughly washed with 1 in 1,000 perchloride of mercury solution.

As the skin of the inner side of the forearm was destroyed and the bone injured, the ulna was excised to within a short distance of the elbow. The inner side of the carpus was removed, together with the three inner fingers, the skin of their palmar aspects being saved to lap over and cover the dorsum of the hand. The flexor tendon of the middle finger was taken out of the sheath, and four and a half inches of it detached and placed over the site of the extensor indicis. The proximal end of the tendon being stitched to the fleshy belly of the extensor communis digitorum, the distal end being fixed to the small portion of tendon left near its insertion into the phalanx. The skin was brought over to cover as nearly as possible. No drainage was employed. The wounds pursued an aseptic course, and there was no sloughing of tendon or skin. The patient returned home within a month, and was advised to try to use his finger and thumb.

He returned to his work in February, and when shown to the members of the Clinical Society he said he could perform his work as a weaver as well as ever. The movements of the fingers were very good, both in flexion and extension; the wrist-joint was movable, and both pronation and supination could be effected. During extension of the index finger the new tendon could be felt to move freely under the integument of the dorsum of the hand.

The man expressed himself as perfectly satisfied with his hand, which enabled him to earn his living as well as ever he could.

My apology for bringing to light this work after thirty years is that I venture to think an unsightly hand with a thumb and a finger is much better than any artificial limb, however perfect it may be.

ACUTE INTESTINAL OBSTRUCTION DUE TO JACKSON'S MEMBRANE.

BY

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It has been doubted by some whether the membrane covering the proximal portion of the ascending colon causes obstruction to the passage of the intestinal contents. It has been my belief that such was the case, and that to this might be ascribed the symptoms associated with this condition. In cases where the pericolicitis (so called) manifests itself as a filmy membrane little or no obstruction can be demonstrated on examination of the colon. Where, however, the Jacksonian membrane is associated with fibrous bands crossing the colon, varying degrees of constriction may be noted. It is possible that this partial obstruction may also account for the dilatation and elongation of the caecum associated with such cases. The clinical symptoms would also suggest this, for the colicky pain, occasional vomiting, gurgling over the caecum, and tenderness on pressure, point to a temporary obstruction. This syndrome forms a common type of dyspepsia

which can be recognized, but which too frequently, even now, is regarded as appendicitis and for which simple appendectomy is performed. That such a band can cause greatly exaggerated symptoms and result in acute intestinal obstruction the details of the following case show. I believe it an uncommon type of acute obstruction and so venture to place the case on record.

Mrs. S., aged 41, was admitted to the Royal Victoria Infirmary on January 18th, 1916, with symptoms of acute intestinal obstruction.

History.

For some years she had had attacks of abdominal pain and also marked constipation, the bowels only moving after an aperient. Three weeks before admission the pains had become worse, she vomited occasionally and had increased difficulty in getting the bowels open. For a week the pain had been severe, vomiting incessant and there had been no action of the bowels, while flatus had not been passed for three days. She had passed blood and slime by the rectum during the last three weeks.

On admission the temperature was 99.8°. The patient looked ill, and although fairly well nourished had a sallow complexion and had few teeth left. The abdomen was moderately distended, a distinct tumour being visible in the left iliac fossa. This tumour was composed of distended intestine; peristalsis could be seen and felt, while borborygmi could be heard during the contraction of the intestine, which caused the patient evident pain. Rectal examination was negative. A diagnosis was made of chronic intestinal obstruction become acute due probably to carcinoma of the pelvic colon.

First Operation.

On January 18th, 1916, the abdomen was opened in the left iliac fossa. Free fluid escaped on opening the peritoneum. A tense cyst was found occupying the left iliac fossa and extending to the bottom of the pelvis. The swelling had the appearance of a thin-walled ovarian cyst, but was tympanitic, and the taenia coli at once distinguished it as the caecum. No part of it could be drawn out of the wound, so it was punctured and a Paul's tube tied in. After evacuating part of its contents the caecum was sutured to the margin of the incision.

The patient improved greatly after the operation. The distension subsided and the bowels were moved normally on several occasions.

Second Operation.

On February 2nd, 1916, the abdomen was opened in the middle line below the umbilicus. The collapsed caecum was found crossing the abdomen from the right side to the caecostomy opening in the left iliac fossa. The lower part of the ascending colon was mobile and was covered by a thin membrane, at the upper border of which was a tight band passing from the parietal peritoneum to the inner border of the colon. The band was the thickness of a match stalk, it tightly puckered the ascending colon, and it was with difficulty that two fingers could be inserted beneath it. The band was removed and part of the membrane stripped away. The caecostomy opening was dissected free from the skin and closed, the caecum being returned to the abdomen, which was then closed. The appendix was normal and no trace of inflammatory adhesions were present.

After-History.

The patient was discharged from the hospital, well, on February 17th, 1916.

In November, 1916, the patient remained in good health, though she still had to take opening medicine.

On two occasions, in August and October, 1916, she had attacks of abdominal pain and vomiting, which necessitated her staying in bed for a few days. Should these attacks persist, further treatment of caecostomy or short-circuiting may become necessary.

REDUCTION EN MASSE OF A STRANGULATED DIRECT INGUINAL HERNIA.

BY

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This case impressed me as a remarkable one in several respects, and I venture to think that it should not be allowed to drift into one's personal experience without a record.

Early in September, 1917, I was asked by Dr. Taggart, of Heaton Moor, Stockport, to see a lady who three days previously had begun suddenly to have pain in the abdomen and right groin; a few minutes afterwards she vomited several times, and noticed a lump in the right groin; she had never previously suffered from hernia.

Dr. Taggart saw her some two hours after the onset and found a tense rounded swelling in the right inguinal canal, about the size of a Tangerine orange, which did not yield an impulse on coughing; the swelling was clearly a strangulated hernia, and