perature was never above the normal after the first day, and the pulse was generally between 80 and 90 per minute.

The paralysis of the sixth nerve in this case made the diagnosis rather uncertain, the lesion being either a basal meningitis of limited extent, or a tuberculous tumour which afterwards became quiescent. If the latter, the amenorrhœa was, perhaps, purely accidental, or, if the former, had they any relation to one another as cause and effect?

RUPTURED INTESTINE FROM ACCIDENT : LAPAROTOMY : SUTURE OF GUT : RECOVERY.

By W. THELWALL THOMAS, F.R.C.S.,

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HISTORY.

E. G., single, aged 55, was admitted into the infirmary on April 3rd complaining of abdominal pain and vomiting. Twenty-four hours previously she was returning from her garden into the house carrying a chair before her, which inadvertently struck the doorpost, bringing her abdomen into violent contact with the other side of the chair. This caused her severe pain, and she vomited immediately afterwards; the pain continued, increased, and with difficulty she managed in a doubled-up condition to reach her bed, when she again vomited.

Dr. Pitts, of West Derby, was sent for. She was unable to pass flatus, although feeling a great desire to do so. Four years previously Mr. Mitchell Banks operated on a left femoral hernia, strangulated, since which time she had worn a light truss.

Dr. Pitts examined her, and considered that a small knuckle of bowel had become constricted at the old hernial site. He did not attempt taxis, but advised immediate operation. She vomited again next morning, and the abdomen continued to distend.

Owing to the absence of Mr. Banks, she came under my care. The patient, a thin woman, walked across the casualty room, and without assistance climbed on to a couch for examination. She was in good general condition; the tongue moist, pulse about 80 and strong. The abdomen was distended, and very tender on palpation; the recti muscles were rigid, and standing prominently on the thin walls. In the left Scarpa's triangle could be felt an irregular nodule, the size of a walnut; firmly adherent to a linear cicatrix, and very tender. A recurrence of the hernia was diagnosed.

OPERATION.

Half an hour after admission the swelling in the groin was explored and found to be the old femoral sac firmly adherent to the femoral vein; in the centre was a narrow canal through which the little finger was forced; no bowel was discovered, but there rushed out a few ounces of putrid serum containing flakes of yellowish lymph. It was now clear that the intestine was ruptured. The femoral sac was ligatured, the wound thoroughly carbolicised, and a temporary dressing was applied and held in position by a dresser.

The abdominal wall was rapidly cleansed with a nail brush, using soap first, then 1 in 20 carbolic lotion. An incision $2\frac{1}{2}$ inches in length was made below the umbilicus when half a pint or so of putrid serum with large yellowish flakes of puriform lymph escaped. The intestines were all distended, no collapsed coils could be found, so the small intestine was withdrawn. After 2 feet had been examined a perforation was found situated opposite the mesentery, oval in shape, measuring $\frac{3}{4}$ inch by $\frac{1}{4}$ inch, from which oozed liquid faecal matter; the long axis of the aperture was parallel to the long axis of the intestine, and the mucous membrane was everted. The intestines were congested and glued together by yellow lymph. The gut was clamped above and below by finger and thumb, and the segment thus isolated washed out with 1 in 100 carbolic lotion, two rows of continuous Lembert sutures were applied, the mucous membrane being carefully tucked in. Subsequently two interrupted Lembert sutures were used where the union was considered weak. Green catgut was employed. On relieving the bowel no leakage took place,

so after thoroughly irrigating the abdomen with 1 in 100 carbolic lotion, the fingers agitating the intestines and liberating pocketed serum, the sutured portion was reintroduced. The wound was closed by four silkworm gut sutures and a small glass drainage tube inserted.

The groin wound was again cleansed and sutured. The dressings used were wood wool tissue over cyanide gauze. At the end of the operation, which lasted 35 minutes, the patient was in good condition.

SUBSEQUENT HISTORY.

No opium was given; sips of warm water or weak tea were ordered if asked for. If any collapse occurred small doses of brandy were ordered, but this was not required. Next morning at 3 A.M. the patient vomited some milk, which had been taken before admission. On the third day redness was noticed around the groin wound. The stitches were removed, some cellular tissue sloughs (probably caused by the putrid serum) removed, and the surface swabbed with pure carbolic acid. This ended the cellulitis. Flatus passed, and the abdomen much less distended.

On the fourth day, the glass tube was removed; 5 ounces of milk were allowed in twenty-four hours. On the sixth day half a pint of beef-tea was added to the diet. On the tenth day the bowels were well moved by enema. On the eleventh day fish was added to the diet. From this day recovery was uninterrupted. She was kept in bed for a month, then allowed up wearing an abdominal belt, to which was attached a firm horsehair pad covered with leather, and buckling around the thigh as a femoral truss.

TEMPERATURE.

On the night of operation the temperature was 100.2° F., next night 99.6°, subsequently it was only once above 99°; this was on the sixth day, when it was 99.2°.

REMARKS.

The case presents some interesting features: 1. The slight accident. 2. The opportunity it presented for examining a case of radical cure. 3. The absence of symptoms in so severe a case of septic peritonitis, only distension and tenderness being present. 4. The intense faecal odour of the serum that escaped from the femoral wound made the diagnosis of ruptured intestine certain. 5. The use of carbolic lotion, on account of the great septicity, without any untoward result. 6. The bowel being normal around the aperture made the suggested tearing away of bowel adherent to site of radical cure improbable.

For assistance at the operation I am indebted to Mr. Agnew, and for the notes to Mr. F. E. Marshall, surgical dresser.

DRS. MICHAUX and De Marbaix of Brussels have started for the Congo. Dr. De Marbaix's mission is purely scientific; he is to be at the head of the laboratory of bacteriology and experimental pathology which the Belgian Government is about to establish at Boma.

RESIDENT MEDICAL OFFICER FOR THE CITY HOSPITAL, ABERDEEN.—The Public Health Committee have agreed to recommend the Town Council to appoint as the resident medical officer at the City Hospital a graduate in medicine at a salary of £50 per annum, with board and lodging. The gentleman appointed will have to devote his whole time to the duties of the office, Dr. Matthew Hay being recognised as the head of the hospital. It cannot be said that the salary recommended is at all extravagant.

MEDICAL MISSIONARIES.—At a meeting of the guild of St. Luke held in St. James's Hall a paper was read by the Rev. Watson King Ormsby on Medical Missions, in which he strongly supported the necessity of sending out only fully qualified persons as medical missionaries. He thought also that they should not be asked or expected to give a lifelong service; it would be wiser, he said, to encourage our young men, after completing their studies and obtaining their diplomas, to go out, say, for five, three, or even two years to a foreign station, and then return to practise at home. Evidently there was a lack of recruits, and he thought their difficulty would be best met by raising the standard, and stamping out the unqualified so-called medical missionary. This is an interesting corroboration of the view we have always held on the subject.