Individually, it is true, we may be as dust before the forces arrayed against us. Intrenched behind a barrier of misconception and self-interest, the public, whether represented by the individual or the State, will never help us in the matter. During the past forty years many spasmodic efforts have been made to bring about a reform, but, greatly owing to want of united action on our part, so far without success. I trust the coming race of doctors in the twentieth century may accomplish what those of the nineteenth have failed to do. Depend upon it, if the difficulties ever are to be solved, it will only be through the agency and with the assistance of some greatly enlarged association of medical men, foreshadowed in the British Medical Association of our own day.

Until that day arrives let us initiate changes here and there, which ought to be within our reach. For instance, I should be the last person to underrate the very valuable services rendered by many devoted laymen to our hospitals; but if they give up their time, so do we; if they give of their money, so do we, and valuable time and skill, which is more than money; and therefore in our general hospitals, which are often wrongly spoken of as "public" institutions, when they are nothing of the kind, for they are absolutely private ventures for the public good, started and supported by the money of a certain number of subscribers and donors and worked by the medical profession free of all charge. I say in these hospitals those who do the work for which the institution exists, and those who administer the housekeeping, financial, and other business departments connected with a large establishment should at least be placed upon an equal footing, and therefore, as an important recognition of this law of elementary justice, in all voluntary hospitals manned by an honorary staff, the medical officers should be equally represented with the lay governors on the Board of Management. In an institution solely maintained for the relief of the sick, to exclude as far as possible from its management those who have the greatest stake at issue in the good reputation of the place is not only unreasonable, but is a policy only to be looked for in a Gilbert-Sullivan kingdom of topsy turveydom. I ought in fairness to say that of late years this act of reasonable justice is gradually making its way amongst our hospitals both in London and the provinces. But old prejudices die hard. Another reform is that it should be understood that the doctor is the only possible person to decide as to the fitness or otherwise of an applicant for free treatment in the hospital. Poverty alone is no sufficient reason, for for this class the Poor-law medical officers exist, I will not say are paid. Governors' letters ought not to be the key either to open the portal; the points can only be justly settled by weighing a combination of circumstances, and taking into account the nature of the case in its relation to the patient's social position and competence to provide for the proper treatment of his case in his own home. Then, with regard to benefit clubs, a reform which calls for speedy accomplishment is the separation of medical aid from club benefits. Let the benefit clubs spread their most important and useful work as widely as possible (as instruments of providence they are invaluable) but the contract payment for medical services ought to be a distinct question, to be left entirely in the doctor's hands as a matter to be settled between him and the individual applicant, both as to the terms of the contract and also to the persons with whom he is willing to make such a contract. The subject is one ripe for action, and cannot much longer remain in a position often so galling to the person chiefly concerned.

When we look back on this nineteenth century and think on the one hand of the application of steam and electricity on an immense scale to machinery, the enormous extension of telegraphs, railways, and other means of rapid communication, and then, on the other hand, call to mind the great gifts made to suffering humanity in the same period by our profession, in the prevention of disease, the abolition of pain in surgical operations, and in the crowning gift of the antiseptic system by the present Lord Lister, we may without exaggeration say that hereafter the chief glories of the Victorian era will be shared by the engineer and the doctor.

These, gentlemen, are our rich heritages, and let us by the probity of our conduct, the scientific truthfulness of our observations, and the unaffected personal charity of our practice hand them on untarnished to our successors.

SOUTH-EASTERN BRANCH.

ON ACUTE ABDOMINAL LESIONS.

By THOMAS EASTES, F.R.C.S.,

Folkestone.

AFTER some words of welcome Mr. Eastes turned to the subject of his address.

Classification.—The most rapidly fatal of all cases of this class are some from internal hæmorrhage, ruptured extra-uterine pregnancy, or, much more rarely, ruptured aneurysm; next, in order of severity, perforation of the stomach, or bowels, or appendix, or bladder, whether from disease or injury. I shall not include cases resulting from taking poison. Then we have the whole series of strangulation, and volvulus, and obstruction of the bowels, which of themselves constitute such a formidable array, and the somewhat allied cases of rotation and consequent strangulation of tumours and the cases of appendicitis without actual perforation, which, although of a distinct character pathologically, may be difficult or impossible to distinguish clinically. Cases of suppurating mesenteric glands, and cases of ruptured cystic tumours, ovarian or hydatid, must be mentioned. Then less serious actually, but very difficult to distinguish clinically at first, are the various kinds of colic, intestinal, renal, and hepatic, and the less serious kinds of hæmatocele. The three great dangers to be guarded against may then be summed up as hæmorrhage, peritonitis, and distension. In rupture of an extrauterine pregnancy the first danger is from hæmorrhage; therefore, of course, the first consideration in treatment is to stop that hæmorrhage. In another large class of cases it is the presence of an irritant in the peritoneum setting up acute peritonitis. In such cases, if not contraindicated, the irritant contents should be removed, and the aperture closed from which they escaped, and frequently a drain must be left in the peritoneal cavity for a time. In another class the cause of death is great distension of the bowel, whether the so-called paralytic distension or distension from actual obstruction. The chief symptoms of acute abdominal lesion are pain, vomiting, collapse; and, where peritonitis follows, general abdominal distension and immobility, with constipation.

Abdominal Pain.—This should, I think, always be looked upon as a danger signal. It is most remarkable how many severe abdominal cases have an early stage when there is no complaint whatever except pain. I must confess for myself that when I am sent for to a fresh case of great pain in the abdomen it is always with some dread of an impending catastrophe that I first investigate the cause and course of the symptoms. I think the first important point is to try to ascertain whether the symptoms are connected with any special viscus or any special region of the abdomen. For this purpose the seat and character and course of the pain are most valuable facts. The original seat of severe pain may indicate where the source of a general peritonitis is to be found. Pain, at first over the cæcum or at the umbilicus, will suggest the appendix, and the suggestion will be corroborated by finding a tender spot between the right anterior superior spinous process and the umbilicus, and if we have a history of similar previous attacks recurrent appendicitis is probable. If the onset of pain was referred to the upper part of the right side of the abdomen beneath the right costal margin, we shall at once think of the gall bladder, and previous attacks of pain passing backward to the right infra-scapular region followed by jaundice will confirm the opinion that that viscus is the seat of the pain, and we shall have to judge as to which of the various lesions found about the gall bladder and its ducts is existing in the case before us, such as blocking and perhaps consequent ulceration of the duct or empyema of the gall bladder. Severe pain starting in the upper part of the abdomen at the pit of the stomach, with tenderness on pressure, will suggest a gastric lesion, and if there is much collapse and a history of pain after food and long-standing dyspepsia, perforated gastric ulcer will be probable. In women pain in the lower abdomen, right or left, with a referred pain in the corresponding inframammary region, will suggest the ovaries or tubes as the cause of the trouble. In localised peritonitis the pain is usually referred

to the region affected, but radiating according to the organ involved. Thus when the liver is involved in some local peritonitis there will probably be right shoulder tip pain as well as pain or tenderness over the liver itself. The character of pain is also important. The pain of colic is usually intermittent and relieved by pressure, whereas inflammatory pain is usually continuous and intensified by pressure.

General Abdominal Distension and Immobility.—These are two most important symptoms, though, of course, somewhat later in appearance. They are of grave significance as regards diagnosis, prognosis, and treatment. They may appear in from two to twenty-four hours after the onset of any acute abdominal lesion. Their presence in slight degree only has made one give a good prognosis in cases that have justified it by their recovery, when the consideration of other signs alone would have compelled one to fear the worst. Early distension is not necessarily peritonitis; it may be reflex, and due to irritation of the peritoneum or abdominal sympathetic. If not relieved it may itself be fatal, or it may go on to general peritonitis. In either of these events the termination may be painfully sudden. General distension which does not yield to a tube or turpentine enema on the second or third day indicates progressive disease, and the case will probably require operation. In suspected appendix cases, general distension without localised tumour, without dulness, and with great pain and tenderness, has a grave significance, and if the temperature be continuously raised the case is still more grave, and may require operation as soon as forty-eight hours after the onset. To observe the distension well, see that the body is lying flat, and that there is a good light on the surface of the abdomen. Kocher gives us the pathology of that form of distension, which I will call paralytic distension or pseudo-ileus:

Post mortem you will find very important lesions in the wall of the distended intestine—circumscribed necrosis of the mucous membrane going on to sharply circumscribed ulceration through the whole thickness of the wall, and giving rise eventually to perforation. The cause of these ulcerations is the over-distension of the bowel. In this state, without the slightest interference with the circulation in the mesentery, the bowel gets quite blue by venous stasis. In consequence of this ecchymoses may form in the mucous membrane, the nutrition is altered, and the protective influence of the epithelium, which has been proved to be of such importance, is destroyed, and the mischief is done; absorption of the bacteria and of the toxic products of the faecal contents begins from that very moment, and if you do not step in in time your patient will die either from general intoxication, with symptoms of weakness of the heart and collapse, or he will die from local intoxication with necrosis of the mucous membrane, first at the places of the above-mentioned ecchymoses, going on to ulceration and perforation. There is no peritonitis without micro-organisms, and micro-organisms only go through the intestinal walls when there is interference with local circulation and nutrition.

Vomiting.—Vomiting is present in most acute cases, especially where a sudden onset occurs. It is immediate, and subsides with the pain, and is followed by repose, and this repose will continue a variable time, even till the last few hours of life. The greater the amount of sedative given the longer the delay. Vomiting is more persistent in strangulation than in perforation. In perforation vomiting occurs early, subsides rapidly, and a period of repose follows. As a symptom at the onset vomiting signifies severity or suddenness. If it recurs after careful feeding, rest, and a sedative, it is an alarming symptom, and generally demands immediate surgical interference. It is still more important if it returns when all food is withheld.

The Period of Repose.—Charters Symonds¹ has applied this term to the stage which in nearly all acute cases is reached soon after the onset. It is marked by the cessation of all acute subjective symptoms; the patient passes unaided by sedatives into a condition of repose. The relief from pain and sickness, and the general sense of comfort experienced may be interpreted as signs of improvement, and this interpretation may lead to disaster, and if deepened by the regular administration of sedatives will almost certainly do so. It is, in its early stage, a period of safety in which operation is successful. But the temperature, if the case is one of inflammation, and the pulse and the general distension will show that there is no real improvement. The importance of this cannot be exaggerated, and it is most important for all of us who are in general practice to bear it in mind. If operation is put off because of this repose until it is broken by a return of vomiting, it is almost certainly too late to operate with much chance of success, and yet that is what is constantly being done. To make the terrible announcement to the friends that an illness

of only one or two days' duration may be speedily fatal unless a serious operation is performed, and perhaps in spite of it, requires much moral courage on the part of the doctor. Take, for instance, the case of a married couple come down to a seaside resort for a short holiday; the husband is taken ill with acute abdominal symptoms, a doctor is called in, and finds him suffering from acute intestinal obstruction, and the only thing that can save him is a serious operation, and even then perhaps the cause may be difficult to find or to relieve, or the operation may be apparently quite successful, and yet recovery may not follow. There is scarcely any more painful position than that of this doctor. The people are quite strangers to him, he does not know how much confidence they may have in him, and yet he is bound to tell them that the husband's life is suddenly in danger, and that they must make up their minds at once to have a serious operation performed, and must decide whom they will allow to do it, and must be prepared at once to get ready for all the preliminaries of a major operation. It requires a high degree of moral courage to take this difficult step, without loss of time, as soon as it is necessary, and that is where the stuff a doctor is made of becomes evident. We are always liable to such responsibilities; when they arise we must face them like men, for such is our duty. It is much easier to tell the friends that a patient is very ill when they can see it for themselves, but by that time the favourable opportunity for successful operation may be gone never to return.

Diagnosis.—I have already alluded to the importance of the site of early pain in all cases. The history of the onset must be carefully studied, the relation of pain to pressure whether increased or diminished, the appearance of the patient; signs of collapse, rapidity of pulse, and the blanched features from loss of blood must be looked for and have due consideration in making the diagnosis; and here I must refer to the importance of waiting in very early doubtful cases where colic or the more serious lesions are in question, because the period of repose after a few hours will generally decide the diagnosis and be the most favourable time for operating in all cases except those of obvious ruptured extrauterine pregnancy, perforated gastric ulcer, and the most acute and worst cases of perforation of appendix. In clear cases of any of these lesions no time must be lost if the patient is to be saved; all other cases may wait for the period of repose. There may be but few signs or symptoms in some very serious cases of quite early rupture of an extra-uterine pregnancy. Sudden abdominal pain, vomiting and collapse, rapid small pulse, blanched features, slight dulness at the lower part of the abdomen with sometimes slight fluctuation, and on vaginal examination a boggy swelling felt in the pouch of Douglas may be all that can be detected. In such cases no time must be lost by waiting for a period of repose, or the repose will be that of death. Here is a picture of another class of case. A woman, middle-aged, has had varying signs of some kind of tumour, and, perhaps, colicky attacks now and then. Suddenly one day she has a worse attack of pain, with vomiting and collapse; local distension of the abdomen is found with dulness and tenderness, and generally evidence of a tumour which cannot be very well defined. The distension, dulness, and tenderness all increase, but the general constitutional symptoms may abate somewhat, as in other cases. Now, if the local symptoms are increasing nothing must make us put off operating, for we shall probably find a tumour of some sort, most frequently ovarian, sometimes fibroid, with a twisted pedicle and consequent strangulation going on rapidly to gangrene, and if delay occurs the local peritonitis will soon become general, and the operation may be too late to save life. I recall two typical cases, in one of which delay was answerable for the death and in another early operation saved the life of the patient. In the diagnosis of doubtful cases of colic one must look carefully for signs connected with the special organ in which the colic occurs, not forgetting the lead line on the gums in lead colic, jaundice or hæmaturia in gall stone or renal colic respectively.

Prognosis and Treatment.—The prognosis in all the acute abdominal lesions to which I have referred is serious, and there is no doubt that the tendency with eminent surgeons is to advise operation as giving the best results in all those

cases where medicinal and expectant treatment will probably lose from 50 to 95 per cent., or more. Perhaps the battle of medical *versus* surgical treatment has been fought most vigorously over cases of appendicitis. I find that surgeons are becoming more and more convinced that the mortality would be diminished if all cases were operated on as soon as the diagnosis is tolerably certain. Mayo Robson says:

It may seem somewhat radical, but I speak from conviction after considerable experience, when I say that I believe the early operation undertaken as soon as appendicitis is diagnosed, first advocated by Dr. McBurney, would lead to a far greater percentage of recoveries than the method of individualising which we in England generally adopt. The points that we should impress upon ourselves are these: Let us try at once to make as accurate a diagnosis as possible. If the diagnosis makes it probable that the case is one of the class to which I have alluded, where the best chance for the patient is surgical interference, let a surgeon see the case without delay, and before any strong drug treatment is carried out unless the pain makes it necessary to give one-fifth or one-fourth of a grain of morphine. If that is done then the best time for the surgeon to see the case if it can wait would be about four hours after the morphine, and he should come prepared to operate, if necessary, then and there. Mayo Robson, in a paper on *The Dangers of Delay*, says:

Perhaps in no class of cases is delay in surgery attended with so much danger as in abdominal diseases. I hold that every case of intestinal obstruction is a case for consultation, and should be seen at an early stage by a surgeon, not necessarily for operation, but that he may be prepared to interfere as soon as ordinary remedies have failed, and before the system has become poisoned by the fermenting contents of the gut above the seat of obstruction. Moreover, at an early stage the diagnosis of the nature and seat of obstruction can be more easily made out.

I must again quote freely from Charters Symonds's paper:

Suppose we are called in at the period of onset and cannot decide between the perforative class and the colics, what is our best line of action? If the pain be moderate and subsiding, the best plan is to apply hot fomentations and dispense with sedatives, give no medicine of any kind, and make a second visit in four hours or less. The importance of this early second visit cannot be over-estimated. Over and over again a patient has been ordered a purge for an apparent attack of colic at the first visit, and at the second a graver diagnosis has had to be made. Having given a hypodermic injection, if necessary, we enter upon the second stage of the case. Repose follows, and everything depends upon the accurate observation of symptoms and the correct use of sedatives. No words are too strong in which to condemn the prescription of opium to be given by an attendant at regular intervals. The only safe plan, and one I would urge as a routine practice, is to give the sedative when the visit is made. We can time the second visit to see our patient free from the effects of the drug. No further sedative is required when the period of repose has set in. When a second dose is required after twelve, or still more after twenty-four, hours the case looks serious, and we can put aside many possibilities. How may we know that a case is doing well? Relief from pain in the absence of sedatives will be one of the leading signs but may be a misleading one. The pulse is better and tenderness diminished. In appendix cases there will be diminution of distension, we can localise the swelling though it may be very tender, and the temperature will be lower. The patient does not require any further sedative, sickness has not returned, and if distension exists it yields to an enema or tube. Such cases will get well straight away, or with the formation of a local abscess, giving plenty of time to form an opinion and to direct treatment. When a case is not doing well one of the most valuable of early signs is the general distension of the abdomen, then tenderness, the absence of local swelling and of local dullness, with rise of temperature and pulse. In perforating gastric ulcer, if we cannot form an opinion at the first visit and have followed this line of treatment, the first sign of distension or renewed pain indicates the commencement of peritonitis.

Paralytic Distension.—I wish to speak now more in detail of paralytic distension, its prevention and treatment. A patient with slight peritonitis from any cause whatsoever may gradually develop general distension, and vomiting, and constipation. A patient liable to constipation may in one of his attacks be much more constipated than usual, and gradually general distension and vomiting develop. A case of abdominal section, quite simple and apparently quite successful, may, at any time from the second to the tenth day, develop the same symptoms. Now, if unrelieved, all these cases will die, the symptoms increasing, and fatal collapse coming on remarkably rapidly at the end. I know of no more disappointing termination to an apparently quite successful abdominal operation. These symptoms must, therefore, always be looked out for most carefully. They are most to be dreaded in patients who have previously been habitually constipated. I find surgeons are getting in the way of ordering an aperient as early as the first or second night after the operation. Every day, in cases where this condition may arise, feel the pit of the stomach to make sure there is no undue tympanites. At the first sign of this try to get a free action of the bowels at once; calomel is probably

the most satisfactory aperient to give. Five grains in a severe case, followed by a castor-oil enema, and a long flatulence tube. As soon as vomiting sets in stop all feeding by the mouth absolutely, and feed entirely by rectal enemata 4 ounces every four hours, only allowing the patient to rinse the mouth out with water not to be swallowed. By adopting these methods promptly at the first sign of danger the patient's life may be saved.

Surgical Treatment.—There is no need for me now to go into the details of surgical treatment; but I may just allude to some guiding principles. For instance, in intraperitoneal hæmorrhage it is best to wash out the peritoneal cavity with warm saline solution, the clots being better removed by washing out than sponging. For general suppurative peritonitis use the same method or a weak solution of boracic acid. In localised septic cases do not wash out the cavity, but sponge and mop out the infected region. In great distension of the bowel do not be satisfied with simply relieving the obstruction and closing up the wound, but always incise the bowel above the obstruction and empty it as far as possible, drawing it out and passing it through the hand if necessary, as that will cause it to contract better. In all cases of abdominal operation operate quickly but carefully. Take special precautions against shock and chill. Use hot bottles between the legs, have the room warm, have an enema of brandy and hot water ready to give at once if necessary; have a hypodermic injection of strychnine ready, and if it seems advisable leave half a pint of saline solution in the peritoneal cavity.

REFERENCE.

¹ Address before the Hunterian Society.

MIDLAND BRANCH.

THE LESSONS OF THE CRIMEAN WAR.

By ED. M. WRENCH, F.R.C.S., V.D.

Surgeon Lt.-Colonel and V.B. Sherwood Foresters.

THE Crimean campaign was described by the pioneer of war correspondents (Dr. Russell) as "the most ruinous, most cruel, and least justifiable of all modern campaigns." Of the vast host of over a million men that for nearly two years fought for the occupation of the beautiful harbour of Sebastopol, I possess the qualification of being one of the now comparatively few survivors, and I trust that the narrative of some of my personal experiences may be interesting, and, though egotistical, help to explain why the Crimean war has left such an indelible mark on the minds of those who were youths in the Fifties. Although the medical establishment of the army was considerably increased when war was declared in the spring of 1854, the mortality from battle (nine surgeons were killed in the campaign), and disease from overwork, was so alarming that in the autumn surgeons were hurried to the East as rapidly as possible.

I obtained my nomination on Monday, was examined on Tuesday, and started for the Crimea on Friday. I arrived there a few days after the hurricane in November to find the harbour of Balaclava strewn with the wrecks of 17 ships, and was immediately placed in charge of a ward in the hospital located in the Russian Military School, a substantial building, but quite devoid of hospital conveniences, and with every window destroyed by the recent hurricane.

I had charge of from 20 to 30 patients, wounded from Inkermann, mixed with cases of cholera, dysentery, and fever. There were no bedsteads or proper bedding. The patients lay in their clothes on the floor, which from the rain blown through the open windows, and the traffic to and from the open-air latrines, was as muddy as a country road.

There were no nurses, no washing conveniences, either personal or for clothing. Two old soldiers, called orderlies, did their ignorant best to attend to the wants of the patients, but were chiefly occupied in rude cooking and burying the dead.

There was no bread except hard ship's biscuit—of course no milk. I cannot remember if there was any tea, but I believe not, only the famous green coffee. There was certainly no beef tea. Liebig's extract, and the substitutes of the