Out of 50 inguinal colotomies: 36 inguinal ordinary operations, 14 supplementary operations; 17 mesentery was long, 25 mesentery was medium length, 8 mesentery was short; 9 cases was no spur; 17 prolapse took place; 5 out of the 17 from upper end alone, 6 out of the 17 from lower end alone, 6 out of the 17 from both ends together. The gut was twisted when fixed up, so that the bowels acted from the lower of the two openings in 7 out of 50 cases.

7. *The Result of the Operation and the After-Duration of Life.*—The results of inguinal colotomy may be divided into several classes. If the patient lives for fourteen days after the operation he may be said to have recovered from the effect of the operation pure and simple, as in inguinal colotomy generally the wounds heal quickly. As a matter of fact, the duration of life is very difficult to ascertain, for patients often go away, and there is therefore no possibility of learning whether they have died speedily or have lived for a considerable period. Applying the fourteen days' limit, I have lost only 2 cases, namely, Cases 21 and 32.

In Case 21 the mesentery was very short, and there was great difficulty in fixing it to the skin. Moreover, a few days later the patient, who was very fat, developed bronchitis. In a fit of coughing some bleeding took place from the wound, and the house-surgeon, who was unable to find the bleeding vessel, applied pressure; thereupon, from the pressure and the coughing combined, the gut was torn away from the inguinal opening and fell back into the belly. Faeces then escaped into the abdominal cavity, and in a few hours the patient died of peritonitis.

I now think that in Case 32 it would have been wiser to have done lumbar colotomy. From the five weeks' obstruction the intestines were greatly distended; hence from the distension of the large intestine it was next to impossible to get the gut well to the surface from the small inguinal opening. Further, the distension made it almost impracticable to sew the gut to the skin without perforating the mucous coat, and thus allowing flatus to leak into the peritoneum. Fortunately I escaped this misadventure; but after the operation, in consequence of the patient vomiting, the small intestines in their distended state were forced through the wound, tearing away the sutures which fixed the large intestine to the inguinal incision.

In these cases of great distension it is imperative to open the gut at once, and thus there is a danger of faeces finding their way into the peritoneal cavity. Now when lumbar colotomy is performed in such cases, the gut is pushed into the loin, and the posterior part, which is uncovered by peritoneum, is freely exposed by the distended gut separating its peritoneum at the back part. Thus the intestine can be opened on its non-peritoneal surface without any dread of the peritoneum being damaged, and as soon as it has been opened and relieved of its distension it can be drawn to the loin and stitched there.

I have now pointed out all the difficulties which I have experienced in these my first 50 cases of inguinal colotomy. I have reason to hope that my observations and inferences may be of interest and of practical use to others.

INFLUENZA: NOTES ON A RECENT EPIDEMIC AT JAMES MURRAY'S ROYAL ASYLUM, PERTH.

By FRANK HAY, M.B.,
Assistant Medical Officer.

In the beginning of last November influenza, then so prevalent in the district, came within the asylum bounds, and during that and the following month attacked 55 persons out of a resident population of 191. Within the same period there were 20 cases of quite a rudimentary or abortive type, which, though doubtless due to the same infection, were of such trifling import, being what one might term "influenzoid," that they have been omitted in the following record. Whether *post hoc ergo propter hoc* or not it is hard to say, but we noted during these months a vast increase of petty ailments—colds, headaches, neuralgias, in one case the awakening of a dormant chronic rheumatism, and in another there was a long-con-

tinued subnormal temperature, ending in dry pleurisy, without rise of temperature above the normal point.

The average resident population at the time was thus divided:

	Males.	Females.	Total.
Insane	51	56	107
Sane { Adults	29	38	67
{ Children	5	12	17
Total	85	156	191

Of these attacked were:

	Males.	Females.	Total.
Insane	15 (29.4 percent.)	21 (37.5 percent.)	36 (33.6 percent.)
Sane { Adults	4 (13.8 "	9 (23.7 "	13 (19.4 "
{ Children	6 (17.6 "	13 (26.0 "	19 (22.6 "
Total	21 (24.7 percent.)	34 (32.0 percent.)	55 (28.3 percent.)

Here it will be seen at a glance that the percentage of females attacked is greater than that of males; and still greater is the comparison between that of the insane and sane—a disproportion more striking if the children be omitted.

Infection and Incubation.—In the main building, on the female side, the epidemic was a month in advance of the male side; and though isolation and disinfection were observed, was most irregular in distribution. On the male side, however, there was more regularity, and, in a well-ventilated gallery of 13, 9 were attacked in an equal number of days, 8 of these being the first victims in this department. In one of the lodges the whole family (7) were laid up, while in other parts, in space as limited, only one or two of about half-a-dozen occupants suffered. Despite our advantages of observation we can arrive at no conclusion with regard to the duration of the incubation stage. One case, the first in a branch establishment, manifested symptoms three and a-half days after the last exposure to infection. At the first signs of *malaise* the temperature was taken, and thereafter regularly noted in anticipation. Thus, in one case, the temperature rose, etc., after a week of *malaise*; in two others, two and a-half days prior to the malady, there was vomiting and faintness; in one of these in addition there was marked mental deterioration. Another patient, during a period of moderate excitement, became dull and listless for two and a-half days before symptoms were established; and two others vomited and felt faint thirty-six hours previously. In the remaining 48 cases there was nothing remarkable.

Onset.—This, regarding the above as incubatory rather than as examples of suppressed pyrexia, was in all more or less sudden, and was ushered in with the usual febrile symptoms. In 10 cases vomiting (in 1 most urgent) was a prominent initiatory symptom. In 3 during the first evening there was delirium—all temperate subjects; in 1 case there was epistaxis.

Progress.—All the well-known symptoms were present in irregular combinations, which, as none could be regarded pathognomonic, it would be worthless to detail. The duration even of "uncomplicated" cases was most varied, and ranged from 24 and 36 hours to 17½ days. In the prolonged cases there were several marked remissions, lasting for 12 hours and longer. Taking an average of the times at which the first remission occurred, we found it to be just before the fourth day, significantly the time when the fever usually subsides.

Temperature etc.—In more than half the cases this was highest on the first day, in the next greatest number on the second, and in a few scattered cases between the third and eighth. The course of the pyrexia was, as a rule, only moderately febrile, and the average of the highest temperatures reached in each case was 102.2°. This calculation does not include the children, in whom the pyrexia was highly febrile. In three cases the temperature became markedly subnormal at the end of the

attack; in one, at the first remission. While the temperatures were 100° and above the pulse and respiration rates were recorded, and these (averaged) stand in the ratio of 85.5 to 25 to an average temperature of 101°, the average ages of the subjects being somewhat over middle age. As regards quality, the pulse was often full and strong at the beginning but soon degenerated, and dicrotism was of frequent occurrence. In cardiac patients intermittency and irregularity were either induced or markedly aggravated. There were no examples of rash.

Fatal Cases.—Four cases ended fatally, the chief points of which are tabulated below:—

Sex.	Age.	Mental Disease.	Bodily Condition.	Duration of Illness.	Maximum Temperature.	Average Temperature.	Average Pulse.	Average Respiration.
F.	33	Melancholia with commencing dementia.	Amenorrhœa; low vitality	4 days	103.5°	102.44°	107.5	46
F.	68	Dementia with delusions	Heart disease; obese; low vitality	4 "	103.6°	101.89°	115.5	29
F.	67	Senile dementia	Heart disease; extremely feeble	9 "	103.0°	101.44°	106	57
M.	30	Imbecility	Low vitality	4 "	103.4°	103.79°	130	47

Complications developed during illness.	Necropsy.
Intra-abdominal pain; slight bronchitis; fearful and apprehensive of death	None.
Slight bronchitis; extremelividity; very poor pulse; presentiment of death	None.
Slight bronchitis; early failure to expectorate; talked more than usual; slight wandering	None.
Talked a little more than usual; slight bronchitis; harsh breathing, followed by pneumonia; at the end pleurisy	Rigor mortis and <i>post-mortem</i> lividity fairly marked; pia congested; muscles dark; blood dark and liquid; both lungs congested; commencing red hepatisation of half of left base; fibrinous deposit between pleura on right side anteriorly.

Complications.—In 36 of our cases there was the complication of insanity. Of the insane, 14 were senile, 6 had heart disease, and in 1, in whom there was a suspicion of phthisis, hæmoptysis occurred during the attack. Among the sane there were 2 cardiac cases, and a woman and child in indifferent health. Of complications developed during the fever there were 13 cases in which the mind was influenced; an imbecile and a quiet dement talked more than their wont; some refused food or medicine; one became more highly delusional; some were excited, some depressed; and in one of these latter depression was followed by sexual excitement contemporaneous with profuse menstruation. In a few instances rough breathing was heard over limited areas without dulness; in 1 of these a circumscribed patch of pneumonia developed in the left base, and was peculiar in having no antecedent crepitation. There were 2 cases of dry pleurisy. Earache was present in a few cases, but was not severe.

Sequela.—Tedious convalescence was almost general. The continuance of dry hard cough for a week or thereabouts was common. Severe bronchitis followed in 1 case, and in 1 dry pleurisy. There were 3 cases of diarrhœa, 1 with tenesmus. Mental deterioration was marked in 1 case. In 2 sleep was more profound. Many suffered from neuralgia. In 1 case there was successively severe neuralgia, suppuration in the middle ear, œdema of the ankles, and tonsillitis, ending in abscess. In 1 patient a mitral systolic *bruit* developed, and soon after there was dropsy of the ankles and legs. A case of acute mania in a young woman, with no predisposing heredity,

was admitted during the epidemic in which insanity was a sequela of influenza.

Protection.—Of the 191 persons above instanced, 10 had already had influenza, and 2 of these were again attacked in the present epidemic—one passing through the symptoms twice at the interval of a month.

Treatment.—The infirmaries blocks were reserved for influenza cases, which at the first declaration were removed there, and did not return to their respective galleries till from a week to a fortnight after the attack. Disinfection with Sanitas and eucalyptus was carried out. There was perfect ventilation, and a uniform temperature of 60° was maintained. Dietetic: This consisted of milk and potash water, home-made beef-tea, calves-foot jelly, gruel, and arrowroot, often supplemented with Valentin's Meat Juice and Brand's Essence of Beef. Medicinal: Salol, bicarbonate of potash (with marked but not miraculous effect), sulphate of quinine, and eucalyptus were tried, and acetate of ammonia, etc., as indicated, for cough. Stimulants were employed when their use became necessary, or when such was anticipated by a knowledge of the previous health of the patient. Our observation with regard to treatment was that, while relieving the symptoms, it seemed not to influence the course of the malady, as we had many parallel cases treated alike but varying widely as to duration. The usual tonics were employed during convalescence.

NOTE BY DR. URQUHART.—In the former epidemic of 1890 the patients were attacked less generally and less severely than the staff. There were 42 female patients, of whom 3 had influenza; and 50 male patients, not one of whom was seized. There were 28 male officials, of whom 9 had influenza; and 27 female officials, of whom 3 had influenza. One death occurred in the case of an elderly female patient, who had previously and repeatedly suffered from pneumonia. The form of mental disease was chronic melancholia, and pneumonia soon ensued with fatal result. Gastro-intestinal complications were common in that epidemic, with severe backache and headache.

A CASE OF LOOSE BODY IN THE KNEE-JOINT DUE TO DETACHMENT OF ARTICULAR CARTILAGE,

WITH REMARKS ON THE FREQUENCY OF SUCH AN OCCURRENCE.

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IF we exclude such rare causes as synovial apoplexy, masses of effused fibrin, tuberculous disease, and the like, there are three large divisions into which we may group loose bodies in the knee-joint, according to the pathological conditions that give rise to them.

GROUP 1. Osteo-arthritis.—In sixty-nine cases of which I have detailed notes, symptoms of this disease were present at the time of operation or developed later in fifteen, and I have little doubt that if the history of the cases were followed up far enough, the figures would be larger.

GROUP 2. Direct Detachment of Articular Cartilage by Violence.—That cases of this kind do occur is beyond a doubt. The case narrated below is an instance in point.

In August, 1890, a young man, aged 24, came under my care, and gave the following history. Three days previously, he attempted to vault over a gate, and in doing so his left knee came into violent contact with the top rail, and he fell to the ground. The knee was semiflexed at the moment it was struck, and the force of the blow was so great as to make him feel quite sick from the pain. He asserted quite definitely that the knee was struck on a level with, and to the inner side of, the patella. On attempting to rise from the ground, a sharp pain, "like pins and needles running into the knee," was experienced, and this recurred whenever he attempted to move the joint. During the next three days, the limb became swollen and discoloured, and he was confined to bed. At the end of this period I saw him. The knee was bruised, especially over the inner side, and there was much synovial effusion. On palpation, an acutely tender spot was found over the inner condyle. The pain thus produced was likened by the patient to something sharp being driven into the bone, and the reason that he sought advice was that he thought that a splinter of wood from the gate had been driven into the joint. After a few days' rest, the swelling had sufficiently subsided to allow a more thorough examination of the joint to be made. The pain on pressure over the inner condyle was as marked as before, but on this occasion deep palpation detected slight crepitus immediately beneath it. Three