A PLEA FOR THE HABITUAL PERFORMANCE OF AUTOPSIES IN GENERAL PRACTICE.*

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LEEDS.

[AFTER forecasting the ideal of scientific efficiency, professional co-operation, and public enlightenment which, *inter alia*, should render autopsies a matter of course, the subject was discussed as follows from the general practitioner's point of view:]

The great majority of us must surely often feel that as members of the scientific profession of medicine we at present often do let slip, from one cause or another, valuable and perhaps unique opportunities of adding to the knowledge of important facts upon which our science and art is built up. How frequently the practical difficulties—the sentimental opposition of the patients' relations, or our own lack of time, energy, or technical skill—condone us in abstaining from a task probably thankless and unpaid for! But let the general practitioners as a class realize that unless we march forward in efficiency, with the progress of knowledge we are doomed to practical extinction. Between the consultants and specialists on the one hand, and the prescribing druggist and amateur quack on the other, there will soon be little scope for us unless we maintain our position by thorough work, up to date of advancing science, and not a whit behind the best intelligence of an enlightened public, on whose patronage we subsist. I do not go so far as to say that the frequent performance of *post-mortem* examinations will at once ingratiate us in the minds of a grateful public, but I maintain that in the long run all that promotes our efficiency will do so. The new facilities for clinical research, and the special forms of new treatment may be helps—or hindrances if the public have learnt to expect them of us, and find us wanting. And in like manner the utilization of our opportunities for observing the morbid anatomy of many common diseases and the results of treatment, will be better appreciated by an intelligent public.

Some may say: There is abundant pathological material in our hospitals, and such as the general practitioner could furnish is not missed. In reply I would merely instance three diseases which he has the most frequent opportunity of observing, and of the morbid anatomy of which he could supply specimens very valuable to the pathologist. Others will no doubt occur to us, for do we not frequently note in textbooks a lamentable lack of trustworthy data of the actual lesions and their causes in studying the commoner diseases?

1. *Hemiplegia*.—If the injured brains in all these cases could be handed over to the skilled neurologist after death—whether occurring soon after the vascular breakdown, as in most hospital cases that reach the *post-mortem* room, or after months or years—together with notes of the symptoms, how much useful knowledge might be collected as to the localization of function, and the processes of repair in the brain! At the same time the examination of the vessels, heart, kidneys, livers, etc., that served these brains might shed light on prophylaxis against these terrible accidents.

2. *Cancer*.—Who knows but such specimens as the rank and file of us could contribute might materially hasten the solution of this problem?

3. *Tuberculosis*.—Even the general public, so apathetic in most medical matters, are now roused to take part in the battle against this other great scourge. Might not light be thrown upon the relative success or failure of various systems of treatment if there were more general and accurate record of *quiescent*, *cured*, and *latent* tuberculous lesions in various organs—for instance, where death takes place from other causes and, perhaps, no suspicion of tubercle was felt. I hope I have proved the desirability of progress in the direction spoken of; the practical point is "ways and means." What methods can be set on foot, for instance, by our Association, to forward this work? I venture to suggest:

(a) A recommendation might be adopted and sent down to all our rank and file commending the practice.

(b) A grant of money might be made to provide some payment for the making of autopsies, and reporting

records of the same under certain conditions. This might be more effective than the mere expression of a pious opinion.

(c) An organization for the collation of records and promotion of the work might be set on foot, something like that for the collective investigation of disease, perhaps.

(d) Co-operation and division of labour should be secured as far as possible. The help of specialists—pathologists, histologists and bacteriologists, should be enlisted. In urban centres a number of practitioners and hospital men might arrange to divide the chief fields of pathology between them. Thus, A might be observing the lesions of the alimentary canal, B, of the brain, C, cancer, etc.

Backed by such an organization, it should be possible for individual practitioners to secure many very valuable specimens of morbid anatomy and many useful pathological observations, and also to get them utilized by our scientific leaders instead of lying buried in their case records. The disagreeable duty would not be so hopeless to undertake, with prospect of practical fruit, and of some sort of a fee; whilst it would no longer cause any unpleasantness with the patient's relations to suggest it when the onus was shared by the whole profession; and I think we should not so frequently meet with a blank refusal, for we know that when the coroner orders an autopsy little is heard of the objection of the friends, and no animus attaches to the doctor who performs the duty.

TRAUMATIC RUPTURE OF THE LARGE INTESTINE: OPERATION: RECOVERY.

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TRAUMATIC rupture of the large intestine is such a rare injury that there were only 5 cases recorded in the surgical reports of St. Thomas's Hospital for the twenty years which preceded the date on which the following case was admitted. Of these, two recovered after operation, in both of which the lesion was found on the right side, once in the caecum, and once in the ascending colon, the bowel having given way directly into the peritoneal cavity. In a case of rupture of the transverse colon due to the kick of a horse, operation was not successful in saving life, for the patient died from collapse. Two patients died without operation from septic peritonitis; in these the lesions were in the sigmoid flexure and in the transverse colon respectively. Altogether 30 patients were admitted during the period mentioned, suffering from traumatic rupture of the intestines; of these, 5 died without operation, 6 recovered after operation, whilst in some others success was almost attained, life being considerably prolonged. The situation of the lesion was as follows: Duodenum 4, jejunum 10, ileum 11, large intestine 5.

A. L., a married woman, aged 33, was admitted on July 14th, 1907, at 12.15 a.m., having been run over by a horsed omnibus shortly before. It was stated that a wheel had passed over the abdomen at the level of the lower ribs, having struck the left side first.

Condition on Admission.

She was in a collapsed state with a feeble pulse, and complained of abdominal pain on the left side, where there was considerable tenderness. The urine was normal, and did not contain blood. She had not vomited. During the night she rallied from the condition of extreme shock, but complained greatly of pain, and vomited once. At 10 a.m. much of the shock had passed off, and the patient was lying somewhat propped up in bed, with quickened respiration (32) and pulse (100). She was complaining of pain on the left side of the abdomen, over the lower ribs, and the abdomen did not move well on respiration. There was rigidity, especially marked on the left side, with extensive tenderness towards the pelvis from the site of injury, following the line of the descending colon. She complained of some thirst. Urine had been passed, but nothing had come from the bowel. Temperature 98.6°.

The diagnosis of rupture of the large bowel with a commencing inflammation along the course of the descending colon was made, and operation performed as speedily as possible.

Operation.

A longitudinal incision was made through the outer part of the rectus sheath on the left side, and the peritoneum

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