the negative pole, and quinine hydrochloride for the positive pole, give good results. Sulphides are very irritant, and many skins will not stand them. After diathermy or ionization passive and active movements should be practised.

Massage is mainly of value for restoring muscle tone before more active methods can be applied. Passive and active movements at first, later followed by gymnastics, should not be practised until the starting pains of active arthritis have disappeared. Where there is much limitation of movement the joint should be carefully broken down under anaesthesia; it should be remembered that the bones of old-standing cases are fragile. Useful local treatments are the application of irritant liniments, and turpentine with capsicum. Iodine applied as frequently as the skin will stand without vesication is of value chiefly in neuritic types of young adults. A well applied Scotch dressing is often very soothing for superficial joints; it is a remedy much less widely used than it deserves; unfortunately only about 80 per cent. of skins will stand it without vesication.

Treatment of arthritics is best started in the spring or summer; in winter changes of weather cause confusion. If possible, palliative treatment and residence in a more equable climate should be considered until the winter has passed.

The value of spa treatment is difficult to estimate; there appears to be little proof that the metabolism and infections of these patients are modified by any natural mineral water, apart from the flushing, which can be practised at home. The successes of spa treatment may well be due to the more energetic treatment given. As a mental stimulant I advise Vichy water to those patients who have a belief in the efficacy of mineral waters.

REFERENCES.

- ¹ Roger, H.: *Presse Méd.*, 1926, 59, p. 929. ² Haden, R. L.: *Amer. Journ. Med. Sci.*, 1926, clxxii, 6, p. 885. ³ Rosenow, E. C.: *Surg., Gynecol. and Obstet.*, 1921, 33, 19; and *Journ. Infec. Dis.*, 1923, 33, 3, 248; also cf. ⁴ Danyasz, M.: *Origine, évolution et traitement des maladies chroniques non contagieuses*, Ballière et fils, 1920. ⁵ Meyer Bisch, R.: *Klin. Woch.*, 1922, 12, 575. ⁶ Cawadias, A.: *BRITISH MEDICAL JOURNAL*, 1925, ii, 602. ⁷ Bürgi, E., and Gordonoff, T.: *Klin. Woch.*, 1926, 11, 465; and Campanacci, D., and Balducci, R.: *Ibid.*, 1926, 46, 2166. ⁸ Pico, C. E.: *Compt. rend. Soc. de Biol.*, 1924, 91, 1049. ⁹ Cumberbatch, E. P., and Robinson, C. A.: *BRITISH MEDICAL JOURNAL*, 1926, i, 612.

CHRONIC FIBROUS EPILOITIS.*

BY

R. CHARLES B. MAUNSELL, M.B.DUBLIN,
F.R.C.S.I.,EX-PRESIDENT ROYAL COLLEGE OF SURGEONS IN IRELAND, SURGEON TO
MERCER'S HOSPITAL.

I WISH to record briefly a pathological condition which I have never previously seen and about which I cannot find anything in surgical or pathological literature.

An ex-soldier, aged 54, was admitted to Mercer's Hospital on February 18th, 1927, suffering from intestinal obstruction, which was temporarily relieved by enemata. He gave the following history. In 1916, while serving in Gallipoli, he contracted an illness which was characterized by severe colicky pains in the abdomen, diarrhoea, and the passage of blood. He says that he was told that he was suffering from dysentery and that this diagnosis was written on his chart. It is not easy to reconcile this diagnosis with his further statement that he was "operated upon for the cure of haemorrhoids" about a month after the onset of his illness. From that time until February, 1926, his bowels remained free, with occasional attacks of diarrhoea, but he does not think that he passed any blood. From February, 1926, he became constipated and took salts constantly. If he allowed the constipation to persist for a few days he suffered from severe gripping pains and could feel "hard lumps" in his abdomen. On six occasions during the past twelve months he developed symptoms of subacute obstruction and was treated, in various hospitals, by enemata as he always avoided operation. He thinks that he has lost weight during the past three months.

The patient is a thin, pale, but hardy looking man. When

I saw him he was in pain and it was quite easy to see two prominent swellings in an otherwise flat abdomen. One swelling was in the region of the caecum and the other was almost symmetrically placed on the left side. These swellings were resonant on percussion and almost disappeared, with much gurgling, when massaged. Examination of the rectum gave no help, neither did an x-ray examination. The urine was normal and the blood was negative to the Wassermann test.

He was treated by dieting, purgatives, and enemata until March 11th, when I opened the abdomen by a right paramedian incision. When the peritoneal cavity was exposed no intestines were visible; nothing could be seen except a smooth pearl-white membrane with slight prominences where the intestinal swellings had been felt during clinical examination. The membrane was continuous above with the peritoneum covering the stomach, was adherent to the parietal peritoneum on either side outside the colon, and was attached below along the lines of Poupart's ligament and in front of the bladder. At no point was there any adhesion to the anterior abdominal wall, the peritoneum covering which appeared normal in colour and texture. There was no free fluid. The distribution of the membrane was as if a towel had been laid over the intestines and carefully glued at the bottom and sides to the parietal peritoneum.

An opening was made through the membrane, in the mid-line, when it was found to be adherent to the intestines, but separable from them by careful dissection and sponging. It soon became evident that there were three strong fibrous bands incorporated in the membrane: one was adherent deep down in the pelvis and constricted the upper part of the rectum, one compressed the lower part of the descending colon, and the third constricted the ascending colon, just beyond the caecum. When these bands were divided gas could be felt gurgling through the intestines. The membrane was now removed in sections as far as the greater curvature of the stomach, over which viscus the peritoneum appeared whiter and felt thicker than normal. The intestines, when freed from the membrane, were found to be universally adherent to one another, but could be separated by sponging just as an adherent prepuce, in a child, can be separated from the glans. Here and there drops of blood oozed from the surface of the intestines and mesenteries, but on the whole the peritoneum appeared intact. No trace of anything like omentum was found.

I cannot give a description of the peritoneum covering the liver and spleen nor a detailed description of the stomach, as the operation lasted so long that I did not feel justified in enlarging the incision for the purpose of exploration. The appendix, which was very much kinked and bound down to the caecum, was removed and the abdomen was closed.

The patient made an uneventful recovery; he is now free from discomfort of any kind and does not need aperients.

Several portions of the membrane were sent to the pathological laboratory in Trinity College, and Dr. John Lait made the following report:

"On microscopical examination these fibrous-looking membranes are found to be composed on the surface of dense hyaline fibrous tissue, while in the deeper layers the tissue is softer and contains many vessels, similar to those found in a late granulation tissue. There is no covering layer of cells on the surface. It is possible that these membranes may be the result of a fibrinous exudate organized into dense fibrous tissue, or else they may represent a chronic inflammatory condition of the omentum, but there is no histological evidence to show that the tissue is omentum."

The portions of membrane were about the thickness of a sheet of Morocco leather.

I have not seen a description of anything similar to the above condition, so I have provisionally named it "chronic fibrous epiloitis." My reasons for thinking that the tissue was originally omentum are the position in which it was found and the fact that no other structure was discovered to represent the omentum.

The conditions most closely allied to this are the thickening of the capsule of the liver or spleen which is sometimes found at a post-mortem examination, and the thickening of serous membranes which occurs in those rare cases called polyserositis.

There is no evidence that the condition was tuberculous in origin, and the Wassermann test negatives syphilis. It is hardly conceivable that the condition arose from an acute or subacute inflammation, due to dysenteric or other forms of ulceration, as there were no adhesions to the anterior abdominal wall and there was no fluid present which might prevent such adhesions.

The only conclusion which can be come to is that the process was very gradual and may possibly have arisen in a similar manner to the gauze-like membrane, known as Jackson's membrane, which is so commonly found over the ascending colon.

* Communicated to the Section of Surgery of the Royal Academy of Medicine in Ireland on May 15th, 1927. A report of the meeting will be found at page 1059.