successful group. Patients who state that although relieved of the symptoms for which the operation was done they do not enjoy normal health owing to other troubles are labelled partial successes or failures according to whether their general health and working efficiency appear to have been improved or not. The disappearance of one set of symptoms and the substitution of another set in their place with the result that comfort and working efficiency have not been materially improved is regarded as evidence of failure. Further, as Dr. Kauffmann points out, no allowance has been made for the entirely new troubles which may reasonably be expected to develop in a certain number of cases over an interval of several years. The report, therefore, may be taken as indicating in a conservative way the proportionate effect of the operation in raising to a normal standard of health patients who were in a state of chronic invalidism.

The following may be said to summarize the results of Professor Kauffmann's investigation of 163 cases, operated upon at intervals of from six and a half to one and a half years prior to the inquiry (13 of these patients were men and 150 were women).

Successful	...	...	...	...	71=43.6 per cent.
Partially successful	...	...	...	...	41=25.0 "
Failures	...	...	...	...	51=31.4 "

A BEDSTEAD FOR USE IN TREATING CARDIAC PATIENTS SUFFERING FROM CONGESTIVE FAILURE.

BY

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For many years the need of a bedstead specially constructed to suit cardiac patients suffering from congestive failure has been felt. Such patients are usually orthopnoeic and require propping up with bed-rests or a pile of pillows;

from these they are apt to slip down at night, an accident usually occasioning distress and loss of sleep, and sometimes avoided by the rather clumsy device of tying a bolster across the bed below the buttocks. Some of the patients are oedematous, and drainage into the legs from the trunk, or from the legs by tubes or incisions, is required sooner or later. Drainage necessitates the sitting posture, and the patient must be moved into and nursed in a chair. Many of the patients are restless unless frequent changes of posture are allowed them; many prefer to sleep in a chair rather than in a bed at night.

To nurse patients suffering from congestive failure often means very heavy work, and, unless special devices are used, these patients are apt to exert themselves much more than is good for them. It is sound to insist that patients of the class considered should make no muscular effort that

These results, taking into consideration the kind of patients operated upon, though by no means justifying a claim that nephropexy is a panacea for neuasthenia and functional disturbance when complicated by renal mobility, are satisfactory. The patients had all undergone prolonged treatment, and were referred to me because of their failure to benefit by it. They were the neurotic flotsam and jetsam who are the despair of their friends and medical attendants. Nearly all were in early adult life with many years of activity in front of them. Most of them were under the necessity of earning a livelihood or managing a household, and the change from chronic invalidism and inefficiency to normal health and efficiency that has been effected in nearly half of them would seem to justify the performance of an operation which is almost free from risk and which is essentially plastic in character.

Looking back over the long series of cases of nephropexy that have come under my observation, in only about one-third of which I have operated, I cannot help feeling that the results would have been better had the condition been effectively treated at an earlier stage. In no branch of surgery can the best results be expected in the later stages of disease and in the medical failures, and nephropexy is no exception to the general rule.

can reasonably be avoided; they should be supported constantly, and should never support themselves. They should never move themselves, or put forward effort in assisting a nurse to move them. Experience shows that under such a regime improvement is more likely or is more rapid than under a less rigid system of treatment.

Very many of the difficulties of nursing otherwise encountered are overcome by using a bedstead that has been built for me by Messrs. Whitfield's Bedsteads, Ltd., of 10, Dane Street, High Holborn, W.C.1. This bedstead can be used completely flat or can be converted within a minute or two into a chair, as shown in the illustration. The back-rest *a* is raised into the position shown, or to any other desired angle, by a detachable crank handle moving a quick-thread screw at the head of the bed. A second

and independent screw, also at the head of the bed, raises the thigh-rest *b* to any desired position; this second rest prevents the patient from slipping downwards. Both these movements are executed quite smoothly, and the corresponding rests are at once stable at any angle to which they have been raised. The third movement, the lowering of the leg-rest *c*, is accomplished by hand, the leg-rest being adjusted at any desired angle on two strongly toothed racks, which drop upon a stiff steel bar. The foot-rest *d* is adjustable on the leg-rest to suit legs of different lengths.

The bed has four legs on the main rigid frame, and two additional legs *e*, carried on the end of the leg-rest and falling under the bed when the leg-rest is dropped. The additional legs were not included in the original design, but have since been added to support, not the patient, but the occasional visitor or student who throws his weight on to the end of the bed. The mattress is made in three

* Working on behalf of the Medical Research Council.

pieces to fit the three parts of the bed, the three pieces being hinged together. The bed has been in use in my wards for two years, and is much favoured by both patients and nurses. Patients can be moved frequently and without effort; they are more comfortable and are more completely rested than formerly.

The original model of this bedstead was built with funds generously given for the purpose by Frederick Faust, Esq.

THE ACUTE PELVIS.*

BY

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THE object of the present short communication is to bring forward some points of interest in the diagnosis and treatment of cases presenting symptoms suggesting acute pelvic conditions. The observations are based on cases in my own experience. They may be conveniently grouped into those presenting symptoms accompanied by fever and those which present symptoms accompanied by shock. The symptoms may be associated with bilateral signs in the pelvis or by signs localized to one or other side.

Symptoms suggesting Acute Pelvic Lesions accompanied by Fever.

When a bilateral tumour or marked tenderness, situated at both sides of the uterus, is discovered in a woman of the child-bearing age the diagnosis of a pyosalpinx or acute salpingitis is suggested. The interest of the condition lies more in the matter of treatment than diagnosis, and centres round the time of election for operation. Comparison between the pathology of acute salpingitis and that of puerperal peritonitis illustrates the value of delaying operation until the inflammatory process has become well established.

In the very fatal peritonitis following labour or miscarriage the abdomen is found at laparotomy more or less filled with purulent discharge, and pus is seen issuing freely from the open mouths of the abdominal fimbriae. This suggests that salpingitis and pyosalpinx formation is a protective mechanism, and that it is in part the reaction in the Fallopian tube which prevents every ascending infection from becoming generalized. If this is granted it affords the indication for surgical intervention during the acute stage of salpingitis—that is, when there is evidence that the limiting process has failed and the disease is spreading, or when there is uncertainty as to the diagnosis. It may be true that surgery in the early stages will accelerate the convalescence, but the recuperative powers of the Fallopian tube are too well known further to remark upon, and the value of conservatism is nowhere better seen in gynaecology than in the treatment of disease of this structure.

Bilateral tenderness in the pelvis, apart from definite tumour formation, is included because of the occurrence of acute pneumococcal peritonitis, which may be found in adults in the primary form and may simulate an attack of salpingitis. It is mentioned because the symptoms in the earliest stages may be referred to the pelvis rather than to the general abdominal cavity. When the signs are unilateral the difficulties of diagnosis are greater. If the symptoms are accompanied by signs on the right side of the pelvis, the main point in the differential diagnosis will be to distinguish between appendicitis and salpingitis, in view of the divergence in the treatment of the two conditions. Either of them may present such a variable picture that a diagnosis based upon the inflammatory phenomena as they affect these two neighbouring viscera is bound to fail quite frequently.

In contradistinction to appendicitis, salpingitis is the last stage in a morbid process, and if attention is focused on the whole of the genital tract, the evidence of this will generally be found by the presence of signs of inflammation in the lower part of the tract.

Although less common, more interest attaches to cases with left-sided physical signs, owing to the fact that diverticulitis, with peridiverticulitis, frequently gives rise to signs and symptoms suggesting a lesion of the left tube or ovary. While the condition may occur during the child-bearing period, it is more usually a post-climacteric disease.

Inflammation is the commonest pathological change around the sac, and the accompanying inflammatory oedema and hyperplastic inflammation in the bowel wall lead to the formation of a definite tumour, while the formation of adhesions to the pelvic viscera adds to the difficulty in differential diagnosis. The development of a pyosalpinx after the climacteric, on the other hand, is very unusual, as the records of the gynaecological department of Charing Cross Hospital show.

The x-ray appearances after a barium enema are of considerable diagnostic aid, and further serve to distinguish the condition from malignant disease of the bowel, with acute symptoms superadded.

The treatment of these cases of diverticulitis is of very considerable interest, but space does not allow of its inclusion.

Symptoms suggesting Acute Pelvic Lesions accompanied by Shock.

In women of the child-bearing age the complications of ectopic pregnancy come first to mind, and seldom present difficulties in diagnosis or management. Some new diagnostic tests have been described within the last few years, but they do not materially aid in diagnosis.

One of these is called the phloridzin test. A positive reaction depends upon the production of glycosuria following the injection of phloridzin, and indicates only the condition of pregnancy. I have no personal experience of it, and two factors materially reduce its value in acute conditions. First, considerable time and the facilities of a laboratory are necessary for its performance. Secondly, after rupture and the formation of a haematocele the test becomes negative, according to some observers, even if previously positive.

Another is the "shoulder pain" test. Rubin has called attention to the occurrence of the same sign when gas enters the peritoneal cavity in the course of a tubal insufflation. It depends presumably on the presence of some irritating foreign substance, such as blood, in the upper part of the peritoneal cavity. It is an unreliable sign. While it may be found with ruptured ectopic pregnancy, yet the abdominal cavity may contain much blood and the sign be absent.

Cullen has described a sign which is known by his name, and, if found, is considered to be pathognomonic of a ruptured ectopic pregnancy. It consists of a bluish discoloration of the skin around the umbilicus, and has been noted from time to time by different observers. It is a sign which is only occasionally present, and I have not myself ever observed it.

The subject of the treatment of the gravid tube, whether by salpingectomy or by the more conservative salpingostomy, must still be considered an open question. It will presumably remain so until the etiology of ectopic gestation is known. In this connexion the increasing number of cases of repeated ectopic pregnancy reported in the literature is interesting.

The rare condition of haemorrhage into the ovarian tissue and the formation of a pelvic haematocele, which may accompany delay in ovulation, is only of academic interest. The etiology is unknown, and the differential diagnosis from ectopic pregnancy cannot be made prior to operation so far as I am aware.

A difficult differential diagnosis is presented when symptoms occur suggesting torsion of the pedicle of an ovarian cyst. It is well known that patients with an ovarian cyst may develop acute symptoms due to some other intra-abdominal or pelvic condition, and I recall three cases which well illustrate the point. In one of these the acute symptoms were due to acute haemorrhagic pancreatitis, in another they were due to volvulus of a portion of small intestine during early pregnancy, and in the third to acute appendicitis.

My experience leads me to believe that the importance of the urgent symptoms attending torsion of the pedicle

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