perhaps all, is impossible. Treatment of acute rheumatism with an autogenous vaccine at the beginning of the illness has a definite effect in decreasing the tendency towards cardiac and other complications, and hastens recovery in other cases which might lapse into chronic deformity or tend towards hyperpyrexia.

Protein shock treatment is limited to rheumatoid arthritis; massage, hydrotherapy, and electrical treatment may be utilized in all rheumatic affections, but are usually only required after the acute stage is past.

I am indebted to Dr. C. E. Jenkins (pathologist to Salford Royal Hospital) for the preparation of the vaccines, and would refer those who desire further information about the dosage to articles by him in the *BRITISH MEDICAL JOURNAL* (1921, ii, p. 846; 1922, i, p. 596) and the *Lancet* (1922). I have also to thank Dr. J. Dudgeon Giles, medical superintendent of Hope Hospital, Pendleton, and Dr. Henry Carre, medical superintendent of Woodilee Mental Hospital, Lenzie, for permission to make the experiments and publish the results.

PRESSURE BY THE MESENTERIC ROOT UPON THE DUODENUM WITH ABSENCE OF "DUODENAL ILEUS."

BY

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The following case is instructive in view of the mechanical pressure theory of duodenal ileus held by some surgeons, and which I at much length have already attempted to disprove.¹

A multipara on the fourth day following the birth of her last full-time child got out of bed and soon felt giddy. A severe headache followed, and was accompanied by severe vomiting. No pyrexia existed. These symptoms continued for four weeks. Her doctor, who visited her daily, was at a loss to understand her condition. Vomiting was "propulsive" in type, of daily occurrence, was usually accompanied by headache, seldom by nausea. The vomit was partly digested food, and was occasionally bilious in character. By the end of a month the patient became very emaciated, and fits of a cerebellar type developed and became frequent. At this stage I saw her in consultation with her doctor. She was then considered too enfeebled for operation, and very soon she died. During the course of the illness only slight rises of temperature (the highest being 99.6° F.), and at many days' interval, were noted. As a rule the temperature was normal or subnormal, and the pulse rate very slow.

Autopsy showed (1) a tuberculoma, the size of a walnut, of the left cerebellum; (2) extensive tuberculous disease of the abdominal lymph glands. There was not a lymphatic area unaffected. Many of these caseous glands were as large as a small hen's egg, most were somewhat smaller. The mesenteric root was very thick and heavy with large caseous glands. There was not even a suggestion of "duodenal ileus."

The main factors that have been emphasized as capable of producing this mechanical obstruction were certainly present in this case—namely: (a) A very heavy and gross thickening of the mesenteric root where it crosses the duodenum. (b) A severe downward drag of the mesentery as a whole, the mesenteric lymphadenitis being very extensive. (c) A general visceroptosis. The intestines had been suddenly relieved from pressure by the birth of the child. The feeble lax abdominal wall of this multipara, nearing death from extensive tuberculosis, could furnish little support to the viscera.

Had the cerebral symptoms not supervened a surgical enthusiast might have been tempted to anastomose the duodenum to the jejunum. Here much dexterity would have been necessary to perform this operation *secundum artem* and still surmount the almost neoplastic mesenteric root.

Had an autopsy not been made a case showing all the main elements of production of duodenal ileus (obstructive) might have been lost.

The *British Journal of Surgery* for October, 1925, contains a very excellent article by H. P. Winsbury White (London), entitled "The pathology of hydronephrosis." In this contribution a careful and experienced observer has summarily disposed of the attractive but none the less fantastic theory of dilatation of the renal pelvis by the

normal and "abnormal" renal vessels—artery and vein. In the production of duodenal ileus the superior mesenteric vessels have an even smaller part to play than those renal vessels have in causing a hydronephrosis, for so far as I am aware nobody has claimed anatomical abnormality of origin for the superior mesenteric vessels when they are supposed to obstruct the duodenal lumen.

REFERENCE.

¹ Acute Dilatation of the Stomach and Intestinal Tube with a Consideration of "Chronic Duodenal Ileus," *Surg., Gynecol. and Obstet.*, February, 1925, p. 206.

Memoranda: MEDICAL, SURGICAL, OBSTETRICAL.

INTESTINAL OBSTRUCTION BY GALL STONE.

THE following report may be of interest in connexion with the series of cases of obstruction of the small intestine due to gall stones recorded by Mr. Bennett in your issue of March 27th (p. 565).

On March 10th I was asked to see a lady, aged 66, suffering from abdominal pain and vomiting. The history was as follows: For some months she had been treated from time to time by her doctor for gall stones; owing to her general condition being very poor no operation had been advised. She had had typical attacks of gall-stone colic, clay-coloured stools, and dark urine. On March 3rd she noticed that her motions were black, and she was suffering from generalized abdominal discomfort not severe enough to call her doctor. On March 8th she vomited, and had intermittent attacks of colicky pain centred round the umbilicus; the pains lasted about five minutes and recurred about every fifteen minutes. On the morning of March 8th she had a good action of the bowels.

The vomiting became more frequent, and I saw her on March 10th; the vomitus consisted of foul small intestine contents, and her bowels had not been open since March 8th. An enema gave no result. The abdomen was distended and was tender all over. A diagnosis of acute intestinal obstruction was made, and she was admitted under my care in the West Cornwall Miners' and Women's Hospital, Redruth, for an immediate operation. When I arrived at the hospital I found that only five minutes before she had passed a small motion, formed and somewhat pale. Her general condition being very bad, and as she had not vomited since admission, it was decided to wait.

At 4 a.m. on March 11th, after a fairly comfortable night, she passed by the rectum a huge gall stone, 2 inches long and just over 1 inch through, and barrel-shaped. After passing this she felt very fit; there was no sickness and no pain. She was discharged from hospital two days later, and is now perfectly well.

This case is interesting in that, although a positive diagnosis was impossible, yet she had definite symptoms of gall-stone trouble, and also because of the fact that she escaped operation by passing a small motion five minutes before she would have gone on the table.

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ARTHRITIC PURPURA AND PANCREATITIS FOLLOWING MUMPS.

THE following case seems to be of interest on account of the unusual symptoms following an attack of mumps.

On January 29th, during the recent epidemic, a school teacher, aged 26, contracted mumps. The parotid and submaxillary glands of both sides were affected, and there was rather severe and persistent gingivitis round the lower molars lasting for fifteen days. On the eighteenth day she sat up for an hour for the first time without any untoward results, but on the following evening, after sitting up for a short time, she was seized with severe pains in the neck and limbs, and almost simultaneously noticed a heavy petechial rash on both feet. The rash extended from the ankles over the dorsum of the feet and under the arch of the foot, and was followed briefly by fine scaling of the skin. There was no urticaria or rash elsewhere. No swelling of the joints was manifest, but pressure over either shoulder-joint, or raising the arms, caused considerable pain. The patient was kept in bed for four days, during which time the joint pains disappeared and the rash faded. On the next day she was up for about half an hour and felt quite well, but on the following day there was a faint purpuric rash on the feet, which, however, soon faded, and there were no joint pains.

On February 26th, just four weeks from the onset of the illness, on waking up she was suddenly seized with intense pain in the left loin. She vomited, and became very restless with pain and seemed to be rather collapsed. The attack seemed very similar to renal colic; the urine contained a heavy cloud of albumin, and on palpation there was great tenderness in the left loin, and