intramuscular injection of 20 c.cm. of convalescent herpes zoster serum on the day after the case arose; the other 6 were used as controls. (Case D. R., with no previous history of varicella, was admitted to the ward in error on June 21. He was given 20 c.cm. of the serum intramuscularly next day.) The results of the experiment are set out in the Table.

Table of Results

Original Case	Age (Years)	Date Serum Given	Date of Varicella	No. of Vesicles
A. O.	6	—	31/5/42	59
Previous history of varicella—no serum given:				
V. C.	4	—	15/6/42	56
K. E.	3	—	16/6/42	80
H. P.	3	—	—	
M.C.	2	—	—	
V. H.	2½	—	—	
S. T.	6	—	—	
No previous history of varicella—no serum given:				
J. A.	1½	—	23/6/42	(No count)
L. C.	2	—	12/6/42	108
R. H.	6	—	—	
A. C.	5½	—	15/6/42	63
M. W.	2	—	19/6/42	106
L. W.	3	—	—	
No previous history of varicella—serum given:				
J. Y.	3	1/6/42	20/6/42	9
P. M.	1½	1/6/42	—	
J. C.	4½	1/6/42	—	
D. L.	2	1/6/42	—	
V. W.	5½	1/6/42	—	
C. E.	2	1/6/42	—	
I. M.	1	1/6/42	—	
D. R.	3	22/6/42	—	

All the children (except one, J. A.) who subsequently developed varicella were photographed after cropping had ceased, the lesions having been painted with gentian violet to improve visibility. The lesions (except scalp lesions) were counted and the numbers are shown in the Table. It is interesting that the one child (J. Y.) who had no previous history of varicella, and was given serum and developed the disease, was only very mildly affected.

I wish to thank the Medical Director for permission to publish this account.

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Two Cases of Subcutaneous Rupture of Jejunum: Recovery

The following case records are thought to be interesting enough to merit publication.

CASE I

A girl aged 11 was knocked down on the evening of March 30, 1940, by a barrow, the handle of which had been thrust against the abdominal wall in front. She complained of abdominal pain, which had come on immediately; afterwards she had vomited. When seen the next day the abdomen moved poorly on respiration, and both recti were rigid, with tenderness especially in the lower halves. The child was conscious and did not seem to be suffering from shock. The pulse was rather rapid (120) and slightly irregular, the temperature normal, and respiration 24. Nothing unusual was found in the urine.

On the evidence of the history and the clinical signs operation was decided on without further delay—24 hours after the accident. It was performed under general anaesthesia consisting of gas-and-oxygen and minimal ether (Dr. P. Singer). There was some turbid fluid but no free blood in the peritoneal cavity. A transverse tear involving half the circumference of the gut was found in the jejunum 10 in. distant from the ligament of Treitz; the neighbouring peritoneum was soiled with flaky exudate indicative of incipient peritonitis. The rent was sutured, and small abrasions situated lower down in the small intestine, together with one on the wall of the transverse colon, were peritonized. The abdominal wall was then closed and a suprapubic drain inserted. There was pyrexia of 101 to 102° for 6 days after the operation; the pulse was rapid (150) for 5 days, and then gradually subsided. Both wounds discharged for a time and there was some post-operative bronchitis. An appropriate dose of soluseptasine was given intramuscularly at operation and repeated in two hours; this was followed by a course of sulphanilamide rectally and by mouth. Graduated feeding by the mouth replaced rectal salines as the condition improved, and was well tolerated. No abdominal distension occurred, and 8 days after operation the child was taking light diet well.

CASE II

On Dec. 28, 1943, a man aged 22, while attending to a "shaping" machine, was caught between the iron plate and the machine by a double impact which hit him in the back. After the blow he suffered intense abdominal pain, central in position, constant but eased by "stretching" out. There was no vomiting and the spine and skin over the back (where he was hit) appeared normal. After the accident he walked 30 yards to a shelter; at no time did he lose consciousness. During conveyance to hospital by ambulance he noticed pain in the left shoulder for the first time. On admission he was obviously distressed and in pain, but was only slightly shocked; his face was a little cyanosed and respiration was laboured. There was generalized abdominal rigidity on examination, with maximum tenderness in the left upper quadrant of the abdomen: in this area the skin was marked by superficial abrasions. The pulse was 64, temperature 97.8°, respiration 20, and blood pressure 120/80. The urine was clear. The diagnosis seemed to rest between ruptured intestine and ruptured spleen.

The abdomen was opened by a left upper paramedian incision, 2½ hours after the accident, under general anaesthesia, using cyclopropane, gas, and oxygen through an endotracheal tube by the closed-circuit technique (Dr. D. M. M. Carr). When the peritoneum was incised free blood issued from the peritoneal cavity. The spleen was palpated and found to be unharmed. The intestine was then searched, starting from above, and at a point 12 in. from the duodeno-jejunal flexure the jejunum was seen to be completely torn across, its edges contused, somewhat swollen, and everted. The lumen appeared empty, and except for blood in the neighbourhood there was little soiling of the peritoneum. The mesentery was only slightly torn and the vessels were scarcely harmed (see Fig.).

The open ends of the gut were ligated and invaginated, and a lateral anastomosis was then performed. The mesentery came together well, and was left unsutured. Sulphacetamide (albucid) was applied to the suture line and the abdomen was closed without drainage. Anaesthesia was smooth, and the patient's condition was satisfactory throughout: consciousness was regained before leaving the operating-room. Post-operative intravenous serum and glucose-saline were given. Stomach suction was maintained for 60 hours, but feeding by mouth began on the second day—first clear fluids, then opaque fluids (fifth day), and on the eighth soft solids. The pulse, though of good volume, remained around 130/140 for two days, dropped to 100 in the next two days, and then returned to normal. The wound healed well. There were no chest or other complications.

COMMENT

As a rule this injury is said to be the result of a sharp impact, crushing the intestine against the vertebral column, before the abdominal muscles have time to be on guard. In the first case this may be the explanation, but in the second the force seems to have been applied to the back from behind.

In view of the high mortality rate associated with cases of 12 hours' duration—stated to be as high as 70%—the child, who was not operated on until 24 hours afterwards, may be regarded as having made a fortunate recovery.

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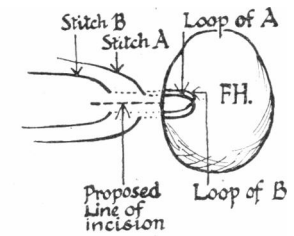
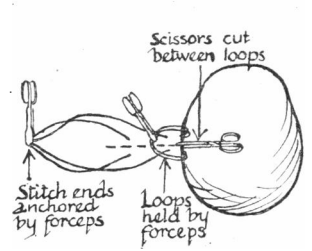
A Technique for Episiotomy

In the comparatively rare instance in which this little operation is indicated the following method has been found useful: When the vulva is stretched by the presenting part a director is passed to lift the rim slightly away from the advancing parts and stitches are then quickly passed, encircling the proposed line of incision (see diagram). Anchor the free ends lightly with artery forceps; draw the looped ends from under the edge of the vulva and anchor with a second pair of artery forceps. As the presenting part crowns (and a perineal tear is seen to be inevitable), draw the looped ends upwards, slightly retracting the edge of the vulva, and make a scissors cut between the loops (see diagram). After the birth and cleansing of the vulva, the wound edges are readily approximated by tying off the stitches. Further stitches can be inserted if necessary. This technique permits of an accurate approximation of the wound edges, and there is no need to give chloroform after the birth to relieve the pain of stitching up. For the sake of clarity the incision shown in the diagram is a lateral one.





Borrowash, Derbyshire. G. S. NEILSON DOW, M.B., Ch.B.