

have been his persuasive eloquence, though he did not unduly try to influence them. He thought they felt that they were going to get very poor support from the public if at this stage they refused to negotiate, whatever might happen at a later stage. It must be admitted that they had not had a very good Press up to now. He himself held the view strongly that at this stage it was their duty to negotiate.

The meeting then terminated. It was attended by 150 Fellows, and although no vote was taken the volume of applause suggested that there was a large majority against negotiation.

PRIORITY SUPPLIES OF MILK TO INVALIDS

On Oct. 29 the Minister of Food made a statement on milk certification. He implied that there had been laxity by doctors in issuing their certificates and announced that all certificates issued before Nov. 3 must be renewed on or after the 30th of that month unless their time expired before that date. It will be recalled that the matter was discussed at the November Council Meeting and a strong protest issued.

The Minister's announcement was made in the Press, in the *British Medical Journal* (Nov. 2, p. 661), and over the wireless, but this method of notification resulted in a certain amount of confusion. Doctors had not been notified personally, and consequently only those who saw or heard these announcements were aware that certificates must be reissued. The result has been that doctors have been annoyed by frequent demands from their patients for renewed certificates, and patients have been unable to obtain their priority needs of milk.

Practitioners are reminded that patients are unable to obtain their priority supplies of milk unless they submit a certificate issued after Nov. 3.

Reports of Societies

TREATMENT OF ACUTE PERITONITIS

At a meeting of the Section of Surgery of the Royal Society of Medicine on Nov. 6, with Mr. E. F. FINCH in the chair, Prof. JOHN MORLEY said that he would confine himself largely to the diffuse or general infection of the peritoneum rather than deal with the localized abscess. Surgical opinion had passed through various stages since Lister laid the abdomen open to surgery. When surgeons at last put aside their unreasoning dread of the peritoneum their reaction was to treat it with far too little respect for its delicate defence mechanism. At one time there was a great belief in the drainage of the peritoneum, and the abdomen after an operation would be left bristling with tubes. A great step forward from the vigorous and ill-advised flushing was made when gentle sponging of the peritoneum with swabs wrung out of normal saline took its place, later to be replaced by suction. The greatest advance in treatment was the realization of the important part played by dehydration in peritonitis, the loss of water and sodium chloride from the blood, and the practice of replacing this fluid by normal saline given at first by the rectum and subcutaneously and later by the intravenous route. A further step forward came with the introduction of the Ryle tube, and the crowning mercy was chemotherapy. As the vast majority of the cases of peritonitis were secondary to perforations of the alimentary tract, he would put first among the principles of treatment the closure of the ulcer or removal of the appendix. The operation itself, necessary though it was, did inevitably add somewhat to the risk of paralytic ileus, which was in its essence a defence mechanism. He preferred the term "inhibition ileus" as emphasizing the initial state when treatment could do some good; later, when the gut was distended with gas and fluid and oedematous or inflammatory changes had taken place and there was a failing circulation, the wall of the gut became truly paralysed and a stage was reached when the paralysis was irreversible. The fundamental difference between inhibitory or paralytic ileus and mechanical ileus must be emphasized. Peritonitis, of course, often led to mechanical ileus by causing

fibrous adhesions which resulted in kinking, torsion, or compression of the bowel. Operation should be carried out with the least possible trauma, and that was the main reason why, in addition to spinal anaesthesia, an adequate incision and suction should be used rather than sponging to cleanse the peritoneum of infected fluid.

Should the Peritoneum be Drained?

Should the peritoneum be drained? The answer in perforated peptic ulcer was emphatically "No." He had not drained a perforated peptic ulcer, except in an occasional late case with subphrenic abscess, for twenty years; drainage was unnecessary and was likely to give rise to dangerous adhesions. In peritonitis from a gangrenous appendix he seldom drained unless an abscess cavity was present which was prone to bleed, but always drained the abdominal wall if it was heavily contaminated. In general, drainage of the peritoneum did very little good, though when in doubt there was no great harm in draining for a day or two. On the subject of chemotherapy there was still no unanimity as to which was the best drug to use or the best manner of its application. It was bad practice to apply masses of sulphonamide powder within the peritoneal cavity; a much sounder method was to introduce it in suspension in normal saline. It was a matter for discussion whether intraperitoneal applications of the sulphonamides should be supplemented by sulphonamides given by the intravenous route or by penicillin.

Within recent months two vigorous tugs had been made at the pillars of the house of surgical orthodoxy—namely, Spalding's attack on the time-honoured Fowler position and Hermon Taylor's advocacy of the non-operative treatment of perforated peptic ulcer. The belief that Fowler's was the best position to protect the patient from subphrenic abscess formation did not emerge unscathed from Spalding's attack. Without subscribing to all the arguments about the hydraulics of the peritoneal cavity the contention concerning the limitation of breathing when the patient was propped up in the Fowler position was impressive and Prof. Morley felt that Spalding had made out a good case against it. Hermon Taylor's plea for the expectant treatment of perforated peptic ulcer was less convincing. In a patient who was a bad operative risk owing to old age or chronic bronchitis it was preferable to try expectant treatment, but in the average risk, if one got the perforation early—within the first six hours—he would not advise it. It was wrong to regard the present operative mortality as serious. In the last 24 cases of perforation on which he himself had operated there was only one death (of a man who had perforated five days before and had a subphrenic abscess), and in his unit in Manchester Royal Infirmary during the last five years in 100 cases of acute perforation there had been only 8 deaths, all of them in patients who were either bad risks by reason of bronchitis and emphysema or in whom the perforation had taken place more than twenty-four hours before.

Protein Balance

Mr. C. G. ROB said that recovery from established acute general peritonitis, while depending to some extent upon the skill of the operating surgeon, was governed to a far greater degree by the pre- and post-operative care which the patient received, and one factor in ward care was protein balance. From the investigations on protein metabolism during the late war some surprising facts about the easily estimated plasma proteins came to light. For example, the patient with chronic long-standing wound sepsis usually had a normal plasma protein level although considerable protein loss had occurred. In burns or acute peritonitis the plasma protein level might fall before the tissue protein could be mobilized to replace the loss. Patients with established acute general peritonitis suffered from reduction of body proteins which occurred in four principal ways: (1) exudate from the surface of the peritoneum; (2) into the lumen of the distended intestine when paralytic ileus had occurred; (3) into the subserous and serous layers of the peritoneum, and (4) owing to associated reduction of protein digestion. Mr. Rob entered upon a description of the mechanism involved, leading up to a fact of great clinical importance, namely, the need of giving a