MEDICAL JOURNAL (1909, vol. i, p. 464). I have not tried hot air, which is well spoken of and should prove valuable. I have been in the habit of applying ethyl chloride to some 15 or 20 venereal sores every morning for the past two months, and it is a distinct advance on dressings with mercury perchloride and lotio nigra, whether with or without iodoform. The patient is allowed up from noon to 6 p.m. after the first two applications, and then all day if exercise is not taken; this limits buboes. The cost is slight, as the price of a tube of ethyl chloride is about 2s. 6d., and will suffice for 15 patients for two days. This is roughly a penny a day each. After two or three days a healthy healing ulcer results, and small ulcers do not usually develop into large ones as with some other methods.

I do not say that the method is applicable to every chancre, but it is valuable in the majority. I would like to learn whether freezing kills the *Spirochaeta pallida* as effectually as it does Ducrey's bacillus, the cause of non-infective (soft) chancre, and the pus organisms so favourable to the extension and growth of venereal sores.

H. C. FRENCH,
Major, R.A.M.C.

Malta.

MINERS' NYSTAGMUS.

IT seems to me that the cause of this condition is a necessity for movement of the eye in order to be able to see with the fovea. I have shown that the fovea is blind when there is no visual purple in it, and this diffusion of the visual purple into the fovea is caused either by light falling on an adjacent portion of the retina containing rods or by movement of the eye. In the conditions usually obtaining in a mine sufficient light does not fall upon adjacent portions of the retina, and so the eye is in continual movement. It is easy to see how the repetition of this unnatural movement may cause nystagmus. I should be glad to hear from workers on the subject how this explanation of nystagmus on my theory of vision agrees with the facts observed by them, also whether the arrangement of the light in accordance with the above suggestion is beneficial.

The Institute of Physiology,
University College, London.

F. W. EDRIDGE-GREEN.

ABDOMINAL ANGINA.

THE importance of the rather puzzling condition called "abdominal angina" is my apology for placing on record one other case that seems to suggest the view that such a condition is more frequently met with than understood.

At the present time I have a male patient, aged 55, suffering from typical angina pectoris; sometimes, however, instead of the pain being related to the heart it is limited to the umbilical region, the patient imagining that he has a pain in his stomach. Occasionally the patient has severe pain of neuralgic type in the rectum.

I have no doubt that the rectal and abdominal pains are related to the anginal condition, as the attacks are much less severe since the blood pressure has fallen from 190 to 150, and are at all times relieved by amyl nitrite.

Bournemouth.

WILLIAM JOHNSON SMYTH, M.D.

THE TREATMENT OF GLEET BY IONIZATION.

I WOULD like to describe a simple means for the ionic treatment of gleet, which I have lately found most efficacious. I went to many electric instrument makers hoping to find suitable applicators, but could procure an instrument for the anterior urethra only. As chronic gleet springs especially from the posterior urethra, something beyond a short straight instrument is required. It is only needful to procure a stout zinc wire some nine inches long, and bend it to catheter shape, a loop being made at its proximal end. A soft rubber catheter is perforated by a sharp punch here and there for a few inches at its distal end, or for about seven inches if the entire urethra is to be acted on. One perforation is made at the proximal end. Into this perforation the zinc rod is pushed as far as the loop. The positive pole of a galvanic battery is connected with the loop, and the negative applied to the suprapubic or other skin area by means of a moistened pad. The solution used (usually zinc or alum sulphate) is made to flow slowly through the catheter, and the apparatus is complete in action. An expensive battery is not required; a few Leclanché cells will do.

London, E.C.

JAMES MACMUNN.

Reports

ON

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

MANCHESTER ROYAL INFIRMARY.

CASE OF RETROGRADE INTUSSUSCEPTION OF THE ILEUM ASSOCIATED WITH MECKEL'S DIVERTICULUM.

(By W. H. KAUNTZE, B.A., M.B., Ch.B.Vict., House-Surgeon.)

THE patient in the following case, a boy aged 10 years, was brought to the infirmary on February 20th, with a history to the effect that he had been taken ill suddenly two and a half days before with acute abdominal pain and vomiting, and that both had persisted up till the time of admission. The patient began to vomit soon after the onset of pain, and this continued throughout, being at one time, according to the parent's statement, faecal. The pain was first of all situated round the umbilicus, and later settled down in the hypogastric region. The bowels had not been opened for four days, although enemata and purgatives had been given freely. No blood or mucus was passed per rectum throughout the illness. It was also stated that, though the patient had never been a very strong boy, he had had very fair health except for occasional attacks of colic. These attacks came on at intervals varying from four to six weeks. They were usually associated with diarrhoea, and the pain was relieved by defaecation.

Condition on Admission.—The general aspect was typical of acute intestinal obstruction in an advanced stage. The eyes were sunken, the cheeks fallen in, and the skin yellowish-grey. The patient was much wasted. Pain was localized in the lower part of the abdomen, principally on the right side, but there was a good deal of tenderness in the left iliac fossa. The abdomen was greatly distended, and the outline of coils of intestine could be plainly observed. The umbilicus was everted.

On palpation the abdomen was extremely tense, though there was little true muscular rigidity. In the right iliac fossa, a mass could be distinctly felt, which was fairly definitely limited, extending upwards to the level of the umbilicus, backwards into the right flank and inwards to within an inch of the middle line. The mass gave a distinct fluid thrill and was dull on percussion. There was also dullness in both flanks, which moved when the patient's position was changed, and indicated free fluid in the peritoneal cavity. The abdomen elsewhere gave a tympanitic note.

A rectal examination was made. This showed a soft but solid mass in the recto-vesical pouch of peritoneum, and at one point of the mass the tip of the finger could be introduced into a small depression apparently at the apex of this mass. During the course of the examination the patient vomited two or three times. The vomit showed no faecal characters, but contained much mucus, and some material, resembling coffee grounds, which was changed blood.

The temperature was 100.8° F., and the pulse 136.

Operation.—Mr. Rayner, under whom the case was admitted, decided that an immediate operation was necessary. A general anaesthetic was administered, and the abdomen opened by a vertical incision, 3 in. long, just to the right of the middle line, and going through the lower part of the right rectus muscle. When the peritoneum was opened a quantity of turbid fluid escaped. The gut was distended and paralysed, and dark purple in colour. Lying in the pelvis a large intussusception was discovered, and with some difficulty brought out of the abdominal wound. It was then seen that it was a retrograde enteric intussusception, involving the last 2½ ft. of small intestine, the neck being situated 1 in. from the ileo-caecal valve. The small intestine for a foot above the intussusception showed small patches of gangrene. The whole intussusception, together with the gangrenous piece of ileum, was excised, leaving an inch of ileum attached to the caecum.

As the child's condition was so bad as to contraindicate any prolongation of the operation, and as, furthermore, the gut was so distended and inert as to make it impossible to suture it, a Paul's tube was ligatured into each end of the severed gut. About 1½ pints of faecal material were drained away at the time, and the wound was then closed temporarily with a view to establishing an anastomosis forty-eight hours later.

As soon as the patient had recovered from the anaesthetic, salines alternating with nutrient enemata were administered through the tube leading into the large gut. The patient was also allowed liquid food by mouth (beef tea and Benger's food).

Result.—Unfortunately some sixteen hours after the operation the patient, though apparently doing well up till then, suddenly showed signs of collapse, and, despite all treatment, died four hours later. Permission for a *post-mortem* examination could not be obtained.

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After the operation was over, the intussusception was examined, and sketches of its appearance are reproduced.

The first figure shows the gut when just taken from the body while distended with fluid. The whole intussusception is formed by small intestine. A marks the position of the cut end of the gut, where it was separated from the caecum. Here the neck of the intussusception D is situated. At B the gut is somewhat dilated, and it was in this part that the intussusception lay curled up when removed; B is continuous with the rest of the ileum E. In addition to a retrograde intussuception the specimen shows the presence of a Meckel's diverticulum, C; this was about two inches long, and attached to its apex was a fibrous band, F, which ran with the mesentery into the intussusception. The Meckel's diverticulum was distended with liquid faeces. The adjacent peritoneal surfaces of the intussusception were united by adhesions.

The second figure shows the specimen laid open. Here the whole intussusception is seen, lying more or less coiled up in the part of the gut marked B. The apex of the intussusception is at G. The other letters are used as in the first figure.

The case seems worthy of report, in the first place, owing to the rarity of the retrograde variety of intussusception in the small intestine. As far as I am acquainted with the literature of the subject, Leichtenstern records 593 cases of intussusception, of which 8 were of the retrograde type. He is dissatisfied even with these 8, since in all of them peritonitis was present, and retroperistalsis had already been established. D'Arcy Power has recorded

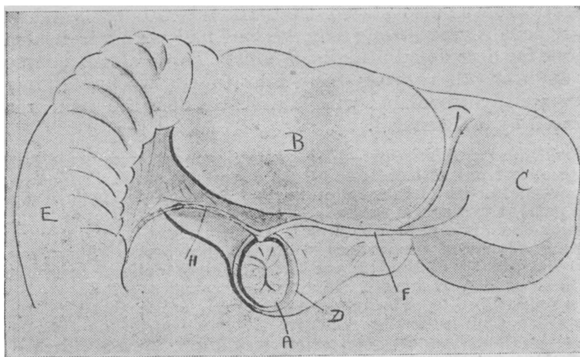

Fig. 1.—A, Distal end of ileum; B, dilated portion of ileum lodging the intussusception; C, Meckel's diverticulum; D, neck of intussusception; E, proximal portion of ileum; F, fibrous band attached to apex of Meckel's diverticulum; H, cut edge of mesentery.

an ordinary ileo-caecal intussusception associated with a retrograde intussusception which had apparently surrounded the former. He also records one in the colon (transverse into ascending colon), and Jones (quoted by Nothnagel) also one in the colon (descending into transverse colon), which survived eight weeks. Hektoen and Rigby each record a case in which a retrograde intussusception of the small intestine had occurred.

It has been stated that retrograde intussusception only occurs during the death agony, when violent peristaltic waves in all directions lead to abnormal conditions in the abdomen. This case, however, completely disproves the truth of this statement, since in the first place symptoms lasted over two days; secondly, the boy, though very ill, was not moribund; and, lastly, peritonitis had led to the formation of adhesions between the adjacent peritoneal surfaces of the intussusception.

An interesting feature of the present case was the absence of the passage of blood and mucus per rectum and the presence of altered blood in the vomit. It would seem that this was an important fact for the diagnosis of the case, since we know that the blood in the case of an intussusception comes from the mucous surface of the intussusceptum. In the ordinary form of intussusception there is no bar to the passage of blood downwards in the gut. In the retrograde form, however, the blood is prevented from passing downwards by the intussusception shutting it off from the lower part of the bowel, hence when retroperistalsis is set up blood is naturally vomited along with the other contents of the small intestine above the obstruction, as in this case.

It may further be noted that a Meckel's diverticulum was present. This in itself is not so extraordinary as to occasion remark, but the fact that apparently it had no causal connexion with the intussusception is most interesting, since so many cases of a Meckel's diverticulum causing an intussusception have been reported. It is possible that the recurrent colicky attacks associated with diarrhoea noted in the history of the case are explained by the presence of this diverticulum, but there is another explanation which still more correlates the sequence of events in this case. It has been noted that the fibrous band attached to the apex of Meckel's diverticulum was found to run with the mesentery into the intussusception. It is possible, and even probable, that this fibrous band had some attachment to the gut, leading to kinking of the bowel. This kinking would explain the recurrent colic. Then the kink would become so bad as to lead to actual intestinal obstruction with the setting up of retroperistalsis in the gut, thus bringing about a condition of affairs which favoured a retrograde intussusception, the kink in the bowel forming its apex. This seems a theory which is probably correct since it explains all the essential features of the case.

Mr. H. H. Rayner, to whom I am indebted for permission to publish this report, has kindly added the following note:

When I saw the patient, a few hours after admission, his condition was desperate, so much so that I had some doubt as to the advisability of operating at all.

The intestine for several feet above the intussusception was

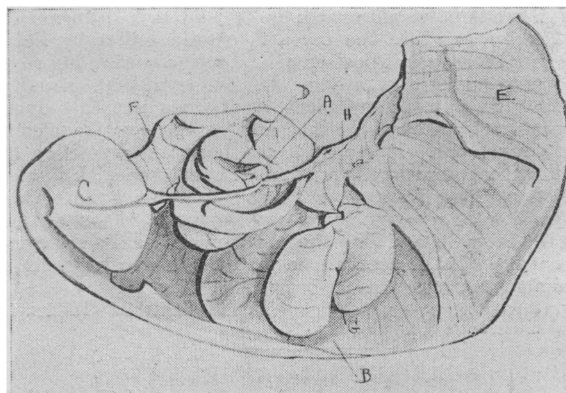

Fig. 2.—A, Distal end of ileum; B, dilated portion of ileum lodging the intussusception; C, Meckel's diverticulum; D, neck of intussusception; E, proximal portion of ileum; F, fibrous band attached to apex of Meckel's diverticulum; G, apex of intussusception; H, cut edge of mesentery.

extremely distended, and had that bluish-black appearance so suggestive of a fatal termination; furthermore, the presence of gangrenous patches in the bowel wall for several inches above the mass necessitated a resection of some 3 ft. of intestine in all. A considerable quantity of faecal fluid and gas was drained away in the course of the operation, and for some hours following it.

It would, I thought afterwards, have been better to have tied a full sized rubber catheter into the distal end of the bowel instead of the Paul's tube, so as to facilitate the injection of saline into the large bowel. However, a satisfactory quantity of fluid was administered through the Paul's tube in the lower end of the bowel, though not so easily or conveniently as might have been done had a catheter been used.

GEH.-RAT. PROF. BAELZ, the well-known expert on tropical diseases, who passed a number of years in Japan, and who claims a number of the most eminent Japanese bacteriologists as his pupils, has been compelled on account of ill health to resign his position as President of the German Tropical Society. His place will be taken by Professor Nocht, the Director of the Tropical Institute in Hamburg. Professor Nocht is well known by many bacteriologists in this country, and enjoys a world-wide reputation as a sound investigator and cautious critic.

WE feel a certain amount of diffidence in venturing to express an opinion as to the value of a new *Centralblatt* dealing with the subject of psycho-analysis. The subject is beset with difficulties and perhaps even dangers, and while the voice of the medical world has not yet spoken the last word on this subject and time will tell whether Freud's views are sound or not, it seems that the publication of a monthly journal dealing exclusively with this matter is a little premature. The journal appears in monthly numbers and the general editor is Professor S. Freud. It costs 15s. per annum, and is published by J. F. Bergmann of Wiesbaden and F. Bauermeister of Glasgow.

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