the only one in the series in which the temperature was raised, and it is supposed that the primary condition accounted for it.)

Commentary

It was noteworthy in these cases that little, if any, visible damage was done to the surface granulations during the removal of the bandage. After the first or second bandage had been used the ulcer base was almost invariably clean and healthy in appearance. This contrasted strongly with the bleeding surface seen when changing the acriflavine dressing, and the raised, indolent edges following application of B.F.I. powder in Case I. It is manifest that some amount of protection of the capillary loops is necessary for the healing of all cutaneous sores, but more particularly is this so in the case of "nutritional ulcers," to which type bed-sores belong. The granulations may be injured not only by the act of removing a dressing which is adherent to the ulcer base, but also by friction caused by the dressing in position. These sources of injury are obviated when elastoplast is used, the former by reason of the discharge which separates the ulcer from the bandage, and the latter by the bandage being adherent to the surrounding skin and, in consequence, not movable on the ulcer surface.

It seems to me that the retained discharge has considerable proteolytic power, and that it helps to liquefy the necrosed tissue on the base and about the edges of the ulcer, and to remove it. In addition, epithelial proliferation proceeds at an extraordinarily rapid rate, though whether this is due to stimulation or opportunity it is difficult to say. It may be, therefore, that certain biological and chemical properties of the discharge are responsible for these effects, and are the main factors in the production of the good result, but in the absence of proof that this is so I prefer to stress the physical advantages of its presence.

Ordinary non-elastic adhesive plaster was not tried because it cannot be applied accurately to rounded or irregular surfaces—for example, the elbow, heel, shoulder-blade. Its edges are sharp, and it wrinkles unless the part is immobilized. The following objects are served by the use of two-layered plaster: (*a*) the discharge does not readily soak through; (*b*) the two layers, plus the discharge over the ulcer, serve as an effective cushion, protecting the granulations by distributing pressure; (*c*) where incontinence of urine or faeces is present the ulcer surface is less readily contaminated from this source.

Itching under the bandage is usually complained of, and much attention is required to keep the patient from scratching the bandage off. In my experience itching has never been so pronounced as to demand cessation of this form of treatment.

Summary

Ten cases of bed-sore were successfully treated by the application of elastoplast dressing. Fifteen days was the longest time taken for healing, and no case proved intractable. No systemic reaction, due to retention of discharge about the ulcer, was observed. The application of elastoplast in two layers is advised.

The Birmingham City Council, which two years ago by a small majority declined to sanction a public birth-control clinic, reconsidered the matter on January 8th, and by a majority of five approved the principle of providing lawful facilities for giving advice and instruction in contraceptive methods to married women. This was to be limited to cases where pregnancy would be detrimental to health. The resolution instructed the Public Health Committee to report upon the appropriate means of providing such facilities.

Clinical Memoranda

Idiopathic Torsion of the Omentum

Torsion of the omentum, with its accompanying pathological cause, as in umbilical hernia, is comparatively common; but torsion of the omentum in the absence of any such cause is perhaps sufficiently rare to justify the recording of the following case.

CASE RECORD

A farmer, aged 42, 6 ft. 2 in. in height and over 15 st. in weight, was seen on June 2nd, 1934. The family history was unimportant, and he did not remember any illness sufficient to keep him in bed for a day, though at times he had had slight indigestion and occasionally flatulence after meals. On the previous day, while at work, he had suddenly been attacked with severe abdominal pain, not attributable to any undue strain or muscular effort. The pain, which was very severe and griping in character, commenced in the upper abdomen, but later became localized on the right. He had vomited once, and had one small action of the bowels, after which he had been unable to pass either stool or flatus. His temperature was 99° F., and his pulse rate 96. From his general appearance there was no doubt that he was suffering acute pain. He lay very still, and all abdominal movements were reduced to a minimum. There was no evidence of hernia. The abdomen was distended and there was general tenderness on palpation, the area of greatest tenderness being the right upper quadrant. Pressure over the left side induced pain on the right side, and the area of least tenderness was in the left lower quadrant. There was general abdominal rigidity, but most marked over the middle third of the right rectus muscle; the whole abdomen was resonant to percussion. There was no area of hyperaesthesia. A diagnosis of acute appendicitis with an abnormal position of the appendix was made, and an immediate laparotomy was decided upon.

Operation.—Under anaesthesia the abdomen was again palpated; on the left nothing could be felt, but on the right the hypogastric region felt empty, and there was a definite fullness over the right upper quadrant, where an ill-defined swelling was detected. An acute intussusception now seemed probable, so the abdomen was opened by a right paramedian incision. On opening the peritoneum a little blood-stained free fluid was noticed. The caecum was pulled upwards, and both caecum and small intestine were distended; the appendix was normal; the transverse colon was collapsed. When the hand was passed into the abdominal cavity a soft mass was felt in the right upper segment, adherent by very fine adhesions to the parietal peritoneum and the under surface of the liver. When the adhesions had been freed the mass, composed entirely of omentum, was easily brought outside the peritoneal cavity, and was found to be attached by a pedicle with five distinct turns. This pedicle was securely ligatured and divided and the omental mass removed, thus relieving the obstruction. The abdomen was sutured in layers without drainage. Except for some ether bronchitis, which caused anxiety for a few days, the patient made a good recovery.

The mass removed was 11 in. long and 8 in. round its thickest part. The pedicle was 1½ in. in length, and had five distinct turns in a clockwise direction when viewed from the cut end. It consisted of more than half of the omentum. On section there was no sign of any cyst or growth, but the whole mass was engorged and oedematous.

The causation of omental torsion has been fully discussed at one time and another in the literature on the subject. In this case a massive deposit of fat in the omentum was probably responsible for the initial twist, and the process later accentuated by the engorgement and oedema following the first turn.

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