To take a few trades which are usually classed as light work, and which are in most cases suitable for those who have compensated valvular lesions:

1. Tailoring.—As a rule, we are apt to associate this occupation with bad ventilation, but of course there is no reason why the ventilation should be bad, and during the past few years all factories have been greatly improved in this respect; still, owing to the very sedentary nature of the work, men easily feel the cold and want windows shut, so that, to that extent, the ventilation is not such an easy problem. The work itself is, in general light enough, the only heavy part being the ironing; the iron generally used weighs from 14 to 20 lb., and may sometimes weigh even as much as 30 lb. No doubt there is a great deal of knock in the use of these irons, so that the weight may not seem much to a man accustomed to the trade.

2. Boot repairing is another occupation which is not unreasonably classed as “light work,” but here again the ordinary boot repairing known as “bolting,” as opposed to finer boot repairing, involves standing upright at the bench for long hours at a stretch, which of course puts a strain upon the circulation, and I have on several occasions met with men having compensated articular lesions who had to give that kind of work up to the long hours of standing required, though they might have done intrinsically harder work which did not happen to involve so much standing.

3. Boot-making is also classed as “light occupation,” and so it is; but it will be found unsuitable for most forms of heart disease, as it involves much use of the arms both in carrying the iron and wide stitching, which nearly always puts a strain upon the heart; the posture of boot-makers is also bad for all kinds of chest complaints.

4. Basket-making.—This might seem eminently suitable for those suffering with minor affections of the heart, but this will not always be the case, for there is a great variety in basket-making, which differs much in different localities, and the making of a large basket involves a wide extension of the arms, and so puts an undue strain upon the heart.

5. Leather Work.—Many kinds of light leather work are well adapted for most forms of heart disease, the patient can get about easily, but for such occupations a man should be fairly handy and intelligent. Often a trade which seems quite light, and indeed so in a general way, may incidentally involve quite heavy work. Thus, for instance, portmanteau sewing would seem quite suitable for many cardiac cases, but unfortunately it frequently involves having to lift heavy weights, so that one has been obliged to knock off a man from such work, though superficially it was entirely suited to his condition.

6. Scavenging.—Then, again, one has met with scavengers for a borough council who could quite well do ordinary scavenging work, such exertion involves a lot of unnecessary wearing down of the legs and the knees. On raising the depressed fragment I encountered that copious stream of haemorrhage which a large number of those cases in the sinuses excretions involves, but by packing gauze between the sinus wall and the skull, and then sutured the rent. The case recovered and I was very pleased with myself, and decided that I knew how to deal with large, longitudinal sinus. There my knowledge of wounds of the sinus remained until the Somme fighting. Then, having lost one case of torn sinus which I had sutured, I considered myself with packing the next one with gauze and leaving in the packing—as a matter of fact, this case recovered. But it was the last I packed, because another surgeon asked: "Why didn't you 'postage stamp' it?"

Haemostasis.

I had been familiar with Horsley’s use of muscle grafts for arresting haemorrhage from cerebral vessels, but I did not know that it had been applied to torn sinuses, though this had, I understand, been done for some years before the war by Cushling, who, I believe, always uses a muscle graft cut from the calf for his “postage stamp.” Short of assistance, as one often was in the war, I (and I fancy many other surgeons) tried cutting grafts from the aponeurosis of the scalp flaps. The graft should be cut about the size of a postage stamp, and as soon as cut placed over the rent and pressed down by gauze. This is better than gauze, as the graft is apt to stick to the gauze and come away with it. In twenty to thirty seconds the graft is usually securely stuck and all the haemorrhage

CIVIL LESSONS OF THE WAR FOR THE TREATMENT OF FRACTURES OF THE SKULL.

C. M. KENNEDY, M.B.E., F.R.C.S. Eng.,
Assistant Surgeon, South Devon and East Cornwall Hospital;

At first sight it would not seem that gunshot wounds of the head could teach us any lessons of use in dealing with the ordinary fractures of the vault in civil life. Certain points in the treatment of fractures of the vault—none of them really new—have, however, been firmly established by experiences in the war. On such of these as appear to be of use in civil practice I wish to touch.

The advantages of total excision of scalp wounds before dealing with underlying fractures is so firmly established during the war that this procedure is likely to become a routine instead of an occasional step in operations upon civil compound fractures.

Early insertion of perforated metal tubes for dealing with the appalling septic results of leaving head wounds to be operated on at the base. These tubes will, I think, find a really useful place in the drainage of cerebral abscesses; for it is often difficult to keep a rubber tube in position in the brain. To overcome this difficulty I successfully used a tracheotomy tube to drain a cerebellar abscess in a boy in the East London Children's Hospital. Now I should under similar circumstances use a Sargent’s tube.

But I think that the most important point which has been fully established in connexion with the treatment of fractures of the vault is the efficient treatment of wounds of the great blood sinuses. Wounds of the superior longitudinal sinuses are not, I fancy, very common in civil practice, but any depressed fracture in or near the middle line of the vertex may be complicated by such a wound.

In the summer of 1910 I operated on a depressed fracture in the mid-line of the vertex. The fracture, which was caused by a falling brick, had caught the upper ends of both Rolandic fissures, and had torn the dura and both great veins of the vertex. The lining of the skull was torn, and the dura was opposed to the brain. The case was of the general type of cases of fracture of the skull, with thick dura, and the deep sinuses torn. There was, however, no subdural haemorrhage.

The treatment was to open the dura and really to perform a trepanning operation. The dura was cleared of its blood clot, the sinus wounds dealt with, and the sinuses were carefully packed with gauze and left to granulate. The case recovered, and it is probably the best treatment of a case of this kind I have ever performed.
has ceased. These fascial grafts are quite as good as much for the cranial surface of the dura as for the very
which are the only ones likely to be met with in civil
practice, and they have the advantage of being cut quickly
and without leaving the field of operation. That these grafts
are extremely firm and not likely to come from the examination
of two fatal cases at post mortem.
If, however, the rent runs around the corner or to a
cerebral surface of the sinus it is difficult to get fascial
grafts to stick, and they are usually required reinforcing sutures
which is not always easy to apply. In such cases a "plug"
of muscle is the most satisfactory method of arresting
haemorrhage, for the muscle graft with its power of causing
rapid haemostasis before haemorrhage is established.
Moreover, bleeding is apt to start again when the gauze
is removed. Another point which we learnt was to beware of
fractures near the mid-line of the vertex, and to nibble away sufficient bone to expose the
sinus sufficiently to allow the gauze to be
fully to expose the sinus before displacing any fragments
likely to have penetrated it. It is no easy matter to stop bleeding from a sinus which is not fully exposed.
If bleeding has started before the sinus is fully exposed it is
best to place a finger of the left hand on the bleeding
point and nibble away until the dura is exposed all
round that haemostatic finger before attempting to apply a
graft. In order to get at a rough idea of the frequency of this
complication I have been through such statistics as I possess
from the Royal Free Hospital, which are the total number of gunshot wounds
in fractures of the vault (whether the dura was
perforated or not) operated on in No. 12 Casualty
Clearing Station between November, 1916, and November, 1917, and
47 cases operated on by myself in the Somme fighting. There were 614 gunshot wound fractures of the vault,
with thirty wounds of the superior longitudinal sinus, or
rather less than 5 per cent. superior longitudinal sinus
injuries. Of these 20 cases 15 recovered and 12 died. Included in these figures are 11 cases personally operated on (7 recoveries and 4 deaths) out of 215 gunshot wound fractures of the vault, or rather over 5 per cent. Probably the incidence of this complication in civil fractures is less
than 5 per cent.; 2 per cent. to 3 per cent. would probably be
nearer the truth. If this be so, I think that, apart from
the opportunities given here in the war, few surgeons can
have had sufficient experience of wounds of the superior
longitudinal sinus to become at home with them. That is
why I have ventured to give the results of my experience
in this field. I am convinced that any one who is
prepared to tackle a depressed fracture should be familiar
with the "postage-stamp" method of dealing with this
emergency, for it is a complication which may easily cost
the patient his life if the surgeon is not prompt and sure
in his method of haemostasis. Armed with the knowledge
of the "postage-stamp" method, the arrest of haemorrhage
from a sinus is hardly ever a matter for anxiety.

Lumbar Puncture.
Lumbar puncture was amongst the procedures which
aroused considerable interest during the war. As a means of
diagnosis in gunshot wounds it is seldom if ever needed.
Post-operative lumbar puncture was very useful for reducing
cerebral hernia. It acts slowly, producing its maximum
effect in about twenty-four hours. One draught to three
draughts was withdrawn according to the pressure, and
the patient was not made conscious for more than
hours. Occasionally there was a marked recession in
place of the hernia after one puncture, and for this reason
puncture should not be employed until the hernia is at
any rate quite shallow. Our treatment since using
antiseptic lotions (usually Dakin's) till sphen was well
in hand; then lumbar puncture every second or third day till
the hernia was reduced, and then a plastic operation to
cover the raw surface. Covering the raw surface with
Tiarchalk grafts is not satisfactory, as it leaves a very poor
acar.

Headache with a tense wound is relieved by lumbar puncture.
But headache with a lowered pressure is made
worse by lumbar puncture. Also if too much fluid is
removed headache is caused by lumbar puncture. We
had no success in treatment of meningitis by lumbar
puncture where streptocoocci had been demonstrated in
cerebro-spinal fluid.

Fits soon after operation occurred in about 5 to 10 per
cent. of cases where the dura had been perforated. They
were usually associated with the sudden increase in
fluid pressure. They are very satisfactory, and might be used for most of such
cases in civil practice. The adrenaline greatly diminishes the
bleeding from the scalp flaps, and so saves a good deal of
time and irritation.

CONCLUSIONS.
I would suggest that experience during the war has
established:
1. The advantages of excision of scalp wounds.
2. The value of metal tubes for draining cerebral
abscesses.
3. The ease with which sinus haemorrhage can be
stopped by a "postage-stamp" graft.
4. That lumbar puncture is useful in certain complications
of fractures of the skull.
5. The value of local anaesthetics in cranial surgery.

THE ETIOLOGY OF DIVERTICULITIS.
BY
C. H. WILLEY, M.D., D.Sc.Edin.,
CONSULTING SURGEON, SHEFFIELD CHILDREN'S HOSPITAL.

The very full description of diverticulitis given by Dr.
Maxwell Telling in the British Journal of Surgery of
January, 1917, called my attention at the time to what
appeared to be a newly discovered disease, and the
interesting discussion on the subject at a meeting of a
subcommittee of the Royal Society of Medicine, and
reported in the British Medical Journal of January
17th and 24th of this year, revived speculations as to the
causes of this condition. The theories advanced on
those occasions were largely based upon appearances
found after death. I venture to think, however, that
when we are able to collect the previous histories of a
sufficient number of cases it will be found that the
two causes will be more truly deduced from the living.
Although the three cases which I have been able to
observe ended in recovery, their clinical history and
symptoms nevertheless have suggested some speculations
upon the etiology of the disease. I think, in order to
realize fully the causes and early stages, we must
consider the whole of the medical history before the
appearance of the local lesions encountered at operation
true cause. We must regard diverticulitis as the result of
and in this respect certain types of build and temperament appear to be strong
predisposing elements.

In opening the discussion Dr. Telling assumed that the
disease is primarily confined to the colon in the rather
that, as is the case of the appendix, all inflammations are
brought about by morbid septicity developing in their