fruitful coitus either as regards alternate periods or as regards the early or late ovum of one period. The theory that one ovary produces males and the other females has long since been discarded.

A CASE OF INTESTINAL OBSTRUCTION WITH COMMENTS.

By V. ZACHARY COPE, M.S.

A MAN, aged 32, consulted me on December 1, 1928, on account of abdominal pain and loss of weight. The pain had troubled him for a year, during which time he had lost 26 lb. in weight. Recently the pain had been more constant and vomiting had occurred. For some months diarrhoea had been troublesome, and he from time to time "heard noises inside the abdomen."

A glance at the man showed that he was really ill. Examination of the abdomen revealed some distension, and a tender lump was palpable in the right iliac region where borborygmi could be felt and heard. X-ray examination, after a barium meal, showed a normal stomach and duodenum, but dilatation of the end of the ileum.

At this stage put down on paper the possible causes for obstruction of the end of the ileum.

I arranged for the patient to be admitted to hospital within a few days, but before a bed could be obtained the symptoms became much worse, and on December 6 he was admitted in a very collapsed state with a rapid feeble pulse, systolic blood-pressure of about 90 mm. mercury, and the general appearance of a dying man. He had been vomiting fæculent material and the abdomen was distended.

What would you have done in these circumstances?

It was quite evident that the patient was dehydrated and poisoned by absorbed toxins, and that any but the slightest surgical interference would inevitably cause death. Saline infusions were given, and under local anæsthesia the abdomen was opened below the umbilicus, and a distended coil of lower ileum brought out. Ileostomy was then performed by means of a rubber catheter sewn into the bowel. By this means the poisonous contents of the small bowel were gradually emptied, and owing to this, the injection of antigas-gangrene serum and general restorative measures, the patient's condition rapidly improved. He was still, however, too feeble to allow of radical measures for dealing with the cæcal swelling, yet one did not want him to lose the contents of the intestine now that they were normal.

On December 14, therefore, under general anæsthesia, the ileostomy was closed and an anastomosis was made between the ileum (above the ileostomy) and the transverse colon. From this time great improvement took place.

On January 9, 1929, a setback occurred, in that a very severe hæmorrhage took place from the rectum. There was no local lesion in the rectum, and the presumption was that the bleeding had its origin in the diseased bowel in the right iliac fossa. The loss of blood was so great that the patient was in great peril.

What would you have advised to be done?

A blood-transfusion was first given, and then the abdomen was opened (under general anæsthesia) in the right lower quadrant. There was a large œdematous mass involving the cæcum and ascending colon from which the bleeding obviously came.

The ileum was divided near to the cæcum and an attempt made to resect the diseased cæcum. This was found to be impossible owing to the dense adherence to the posterior abdominal wall. A clamp was therefore put on the ileo-cæcal mesentery and both ends of the divided ileum brought out of the wound.

From inspection of the diseased cæcum and the surrounding parts it was clear that we were dealing with a case of tuberculous cæcum with deep ulceration burrowing into the posterior abdominal wall.

No more bleeding occurred after this, and in a few days the clamp on the ileo-cæcal mesentery was taken off.

In March the proximal end of the ileum was closed. Nothing was done to the distal end which had receded within the sinus. By October, 1929, the patient had gained 2 st. in weight, and looked so different that I did not recognize him when he came to see me. A very small fistula, which occasionally discharged a little fæcal material, was still present.

I have seen this patient again this year (1932), and he remains well and able to do his work.

This case furnishes a good example of the surgical truth that the perfect and complete operation is often not the wisest procedure to adopt. An
Comments. ileostomy was obviously the only thing that could have been done successfully in the first place. It was then necessary to preserve the patient's fluid to himself and to short circuit the obstruction by the ileo-colostomy. It would have been out of the question to excise the cæcum at this stage. The hæmorrhage was so severe as to make interference (after a transfusion) advisable. Resection proved impossible, so rest was brought to the ulcerated part by diverting on to the surface of the abdomen the contents of the ileum which passed the lateral anastomosis. After the tuberculous cæcum was given rest in this way natural cure appears to have taken place. Excision of the cæcum would have been ideal, but the fact that the patient has kept well for over three years makes it clear that the less radical operation was sufficient.

Though tuberculosis of the ileo-cæcal region is not by any means uncommon, it is
Note. very seldom that acute obstruction is caused by this condition. This case must therefore be accounted rather a rare surgical occurrence.

BRACHIAL PLEXUS ANÆSTHESIA FOR OPERATIONS ON THE UPPER LIMB.

AN EXTRACT FROM A LETTER FROM AN AMERICAN POST-GRADUATE.

“ . . . the first rib, when viewing the supraclavicular region from the side, rises apparently perpendicularly above and behind the clavicle. This is important, as it represents the lowest point to which the properly guided needle can penetrate. The operator does not experience that uncomfortable feeling of inserting the needle to a great depth, without feeling any resistance and not knowing the location of the point of the needle. The first rib crosses the clavicle at about its centre, which is the spot where the most important wheal must be placed. In the median line the arch of the subclavian artery is also recognized, as it extends above the clavicle and above this the