Clinical and other Notes.

Fæcal Fistula of Transverse Colon—Operation.
By Major D. Lawson.
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F. A. was admitted into Netley on August 4th, 1908, with a large fæcal fistula leading into the transverse colon in the middle line of the abdomen. In June, 1908, he had laparotomy performed elsewhere for acute intestinal obstruction due to volvulus. At the operation the colon was opened and drained for some days. On admission into Netley the fistula was large enough to admit the thumb. If he took a purgative a considerable amount of the resulting motion was passed through the fistula, and if he was given a simple enema most of the enema passed through it. He was very weak and emaciated, and whilst he was being fed up, the bowels were kept acting by glycerine enemata, and only 5 or 6 ounces of semi-solid fæcal matter then came away daily through the fistula. On August 19th he was placed on such a diet as would leave very little residue.

On August 21st he was anaesthetised with C.E. mixture. An elliptical incision, 3½ inches long, was made just to the left of the mid-line of the abdomen, enclosing the fistula. The large and some coils of small intestine were found to be adherent to the abdominal wall, and were separated. An intestinal clamp was placed on the transverse colon in the direction of the length of the intestine. An elliptical incision was made in the length of the transverse colon, enclosing the fistulous opening and adherent skin, and this was cut away. The clamp was then loosened, and without taking it off was shifted so as to clamp the colon transversely, bringing the edges of the opening of the intestine into close proximity. The opening into the intestine was then sutured transversely to the length of the gut. The edges were first united by a continuous suture passing right through all coats and slightly inverting the edges; some difficulty was found in inverting the mucous membrane. A second continuous suture, passing only through peritoneal and muscular coats, was then passed. Pagenstecher's thread was employed for both sutures. When the clamp was removed only one bleeding point required to be ligatured. The abdomen was closed with silkworm-gut sutures through all the layers. The patient made an uninterrupted recovery, the abdominal wall healing by primary union.

The diet after the operation, for the first five days, was such as would leave little residue. On the seventh day he was given an oil and glycerine enema, and the bowels were kept acting by enemata till the seventeenth day, when he was given cascara. He has since had daily doses of
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cascara; the bowels act easily without pain. Since the operation he has put on a considerable amount of flesh. He was discharged from hospital on September 16th, 1908.

FRACTURES OF THE METACARPAL BONES AS THE RESULT OF "BOXING OR FIGHTING."

By Lieutenant M. P. Leahy.

Royal Army Medical Corps.

With an Introductory Note by Major F. E. Gunter.

Royal Army Medical Corps.

Introductory Note.

In an interesting article on "Punch Fractures" in the British Medical Journal of March 28th, 1908, Mr. Harold Burrows calls attention to the frequency with which a metacarpal bone is fractured when a resisting object is struck with the closed fist.

Fracture of the metacarpal bones is extremely common. In our experience at the Military Hospital, Curragh, it is the commonest of all fractures. Of 100 consecutive fractures of the extremities treated here, eighteen were fractures of one or other of the metacarpal bones; of this number twelve were caused by boxing or fighting. Of these twelve, four were of the first metacarpal (in every case of the base), five were of the second (all but one transverse of the shaft), three of the fourth. There were no fractures of the third or of the fifth metacarpals. The commonest cause of these fractures, as Lieutenant Leahy points out, is a blow on the point of the opponent's elbow.

The reason why the base of the first metacarpal is so frequently broken is probably that it is driven forcibly against the base of the second metacarpal, which is well protected by its bony relations and is more or less fixed.

The following skigrams illustrating the different forms of fracture, and the photographs, are by Private J. S. Thorburn, R.A.M.C., skia­

graphist.

Article by Lieutenant M. P. Leahy.

Fractures of the first and second metacarpal bones, when caused by boxing, are due to direct violence in the vast majority of cases. They are most commonly produced by either swinging or hooked blows. Blows landing on the point of the elbow or the poll—that is the top and back part of the head—are the most frequent cause of these injuries.

Before going further it may be well to define what is meant by "hooked blows" and "swings." A hook is a blow delivered with a bent and rigid arm. The force is derived from a quick, short twist of the body, the arm being kept bent throughout. The idea is to plant all four knuckles simultaneously on some part of the opponent's anatomy. Hooks