The salt, being insoluble, is used for injection purposes suspended in olive oil, liquid paraffin, or, as I have it made up, in the creo-camph. and palmitin basis, when it is quite painless. So far in the course of close upon 500 injections of this preparation I have not seen a single case showing toxic signs. I give $\frac{3}{4}$ grain on the first day, repeat it on the third, after which a weekly injection of $1\frac{1}{2}$ grains is given, until a total of eight injections have been given.

In certain selected cases inunction is resorted to, and when done is carried out very thoroughly—in fact, *à la Aachen*. As a mode of administering mercury there is none better than that of inunction when "properly" done, but unfortunately it requires specially trained rubbers and the personal supervision of a medical officer to secure its being efficiently done, for which reason it is palpable that, except as an exceptional measure, this line of treatment will never become a routine one. Inunction is no doubt advocated by some in preference to all other methods, and in doing so they speak of it as if it were free from the many drawbacks which beset it; but I cannot help thinking that these advocates are thinking more of the inunction method as it is carried out in England than of the way it is done at Aachen and Wiesbaden. Comparing inunction with injections as a routine method of treatment, all that can be said is that the latter is feasible, whereas inunction is not.

A PLEA FOR SHORTENING THE PERIOD OF CONFINEMENT TO BED AFTER ABDOMINAL OPERATIONS.

By Major F. J. W. PORTER, D.S.O.
Royal Army Medical Corps.

The prevailing custom of keeping patients confined to bed for a period of three weeks appears unsound.

In the Service, the most common abdominal operations are those for the removal of the appendix and the radical cure of hernia. As regards the first operation, it is usually done through a skin incision not exceeding 2 inches in length, close to the anterior superior spine, and the muscles are split in a direction parallel to their fibres. The abdominal wound is closed in layers, and some lasting material, such as kangaroo tendon or silk, is generally used.

In the case of the radical cure of hernia, the sac is stripped up as far as the internal ring, ligatured, twisted, pulled up through a hole in the internal oblique, and sutured in the twisted position. The canal is narrowed when necessary, and the superficial structures are securely sutured by a lasting material, care being taken to tighten up the external oblique by rolling it in. The great majority of patients are able (if permitted) to sit up on the third day, and they experience no pain or

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discomfort in their wounds. Old traditions die hard, but it would appear that strain or damage would evidence itself by pain and discomfort.

During my last tour at Colchester, over 150 removals of the appendix were performed. At first one kept every patient in bed for three weeks. The men became very discontented after the first week, and their general health certainly was not improved by such confinement. I then gradually shortened the period, and seeing no ill-results, eventually let them all get up all day on the eighth day after the operation.

Shortly before I left, I operated on a lady for appendicitis. She was up on the sixth day, and walked two miles on the fourteenth.

Lately I operated on a healthy girl of fifteen years for chronic appendicitis. She sat up in bed on the third day, and got out to have her bed made. On the sixth day she sat in a deck chair for twelve consecutive hours. She walked about after the seventh day, and rode her bicycle at the end of the third week.

Under such a plan of treatment, the muscles, especially those of the back and legs, do not waste, as they certainly will do if not used for three weeks, and no time is lost in convalescence.

As regards hernia, I see no reason against a similar line of action. If one can depend on the strength and lasting properties of the suture material one uses, and the patient refrains from trying to lift weights for at least three months after the operation, there can be no risk in allowing him up even before the sixth day.

There is another fallacy which also requires exploding. I refer to the custom of not allowing *ordinary patients* to turn themselves in bed for several days after an abdominal operation. It hurts a patient far less to allow him to turn himself over in bed, than if he is seized by the hips and shoulders and turned by a nurse. In the former case, he instinctively keeps the damaged section of his abdomen quite rigid, and the absence of pain during the movement is, I think, a proof that no injury is being sustained.

APPENDICITIS—WITH THE RESULTS OF FORTY-FIVE CONSECUTIVE OPERATION CASES.

By Captain J. G. CHURTON.
Royal Army Medical Corps.

In order to adopt some sort of order, I will begin with the series of cases of appendicitis operated upon during what is familiarly termed the intermediate stage or quiescent period. That this is the stage *par excellence* at which to operate I think everyone will agree. The importance, however, of endeavouring to tide patients over the acute stage is what I would wish to emphasise. Of course I am fully aware that there are times when operations during the acute stage must be undertaken—

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