Case No. 5 did not have the ordinary medical treatment, but simply
the vaccine as stated on the chart; he had been inoculated three years
ago before admission, and gave a negative Widal's reaction with Bacillus
typhosus and B. paratyphosus.

Case No. 6.—Date of admission, June 3rd, 1910. Duration of fever, fourteen days.

<table>
<thead>
<tr>
<th>DATE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAY</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Case No. 6 was treated in the same way as No. 5. He had not been
inoculated, and gave a positive Widal's reaction, serum diluted 1 to 40, and
was a typical case of enteric with numerous spots.

In conclusion, the point that struck me most was the absolute
difference in appearance of the cases of enteric treated with vaccine to
other cases I have seen; they all looked so much fresher and more robust,
with no anxious appearance, and all volunteered the information that they
felt decidedly more comfortable after the injection.

The output of urine was not measured and no marked increase or
decrease was noted.

A CASE OF TRAUMATIC RUPTURE OF THE JEJUNUM.
By Captain M. W. Falkner.
Royal Army Medical Corps.

History.—Lance-Corporal M., 18th Hussars, was admitted to the
Military Hospital, Curragh, at 1 p.m., January 11th, 1910, with a history
of having been kicked in the epigastric region by a horse at morning
stables.

Patient was seen at 3.30 p.m., and presented the following symptoms
and physical signs: Severe and continuous pain in the umbilical region;
difficulty in breathing, which was thoracic in character; face pale and
drawn; no mark on the surface, although he stated that he received the full force of the kick in "the pit of the stomach"; pulse 120 and feeble in character; abdomen moderately distended and very rigid; liver dulness not apparent on percussion; no vomiting; normal urine passed through a catheter. A diagnosis of rupture of some hollow viscus was made, and from the history it was thought this was situated in the epigastric region. Morphia 1/2 grain hypodermically was now given, and preparations were made for operation. Owing to the theatre being under repair the operation was not commenced till 7.30 p.m.

Operation.—After the usual surface preparation, the abdomen was opened by a vertical incision 1 inch to the left of the middle line, and extending from the lower end of the sternum to just above the umbilicus. On retracting and pressing back the omentum a fair quantity of blood-stained fluid was seen in the region of the liver and hepatic flexure of the colon. The anterior surface of the stomach was normal, and the organ moderately distended. The gall-bladder was seen to be uninjured. The peritoneum between the stomach and transverse colon was divided vertically and retracted. The posterior surface of the stomach, duodenum, pancreas, spleen, and liver were now seen to be normal. The hand was passed round the convex upper surface of the liver to see if that organ was ruptured, because a fair quantity of blood was seen and after mopping this up as much as possible it seemed to come from behind the posterior border of the liver. After a negative search in this region, the peritoneum between the stomach and colon was sutured with fine catgut. Next the transverse colon and large omentum were turned off the upper part of the wound into hot abdominal cloths. On examination of the small intestine a transverse rent was discovered about the centre of the jejunum. This extended across the bowel, except a small strand opposite the mesenteric attachment. The rent extended through the mesentery back to the spine, thus explaining the origin of the hemorrhage seen in the first part of the operation. Several hematoma were seen in the mesentery, but fortunately these were small and not likely to interfere with the attached segments of bowel. A large-sized Mayo-Robson's bobbin was inserted into the torn bowel, and the latter sutured over it with fine catgut, taking up all the coats of the bowel. Next a continuous Lembert suture, sero-muscular, of fine silk was inserted outside the line of the catgut sutures. The torn mesentery was repaired with a continuous catgut suture, as there was no visible extravasation of intestinal contents, the immediate vicinity of the rupture was sponged with swabs soaked in hot normal saline. It was now considered advisable to surround the part of the bowel containing the bobbin with a thin layer of gauze, the ends being brought out of the lower extremity of the wound. This procedure was specially indicated in this case, as there was a certain amount of contusion of the bowel in the vicinity of the rupture, and the peritoneal cavity would be thus shut off after twenty-four hours, and if
View of elbow-joint from outer side after accident.

Photo of the fragments removed.

Skiagram taken after operation.

To illustrate "Fracture of the Upper End of the Radius through Indirect Violence." By Captain J. B. Clarke, R.A.M.C.
leakage occurred the worst would be a faecal fistula. The upper portion of the wound was closed by silkworm gut, taking up all the layers of the abdominal wall. All known precautions were taken to overcome shock before, during, and after the operation.

After-treatment.—The patient’s condition was so bad after the operation that he was left for thirty-six hours in the operation theatre, which was heated up to 70° F. When he recovered from the anaesthetic he was placed in the Fowler position. The gauze was removed from the lower portion of the wound in thirty-six hours, as it was no longer required, and was causing a little pain and sickness from irritation of the peritoneum. At the same time the remaining portion of the wound was closed. There are no other points of interest except that a faecal fistula formed on the fifth day, but this closed in a few days under the usual treatment. The patient was discharged on two months’ sick furlough on March 10th, completely recovered.

Special Points.—There was no sign of injury on the surface of the abdominal wall, which points to the fact that the muscles did not get time to contract and take some of the force of the kick. From the appearance of the injury to the bowel and mesentery it is probable that they were caught between the horse’s hoof and the vertebrae. The patient was positive he was kicked just under his sternum, and yet the injured part was found at the umbilicus. After receiving the injury he walked from the stables upstairs to his barrack-room. The ruptured segment was protected by spasm of the segment above it.

FRACTURE OF THE UPPER END OF THE RADIUS THROUGH INDIRECT VIOLENCE.

By Captain J. B. Clarke.
Royal Army Medical Corps.

On July 13th, 1909, Lance-Corporal J. W., 2nd Battalion the Royal Scots, was admitted to the Military Hospital, Edinburgh, suffering from an injury to his left elbow.

On the previous afternoon he was vaulting a fence when his foot caught in the top rail and he fell forward on to his extended left hand. He immediately felt a sharp pain in his left elbow-joint, which began to swell rapidly.

On examination the joint was too swollen to make much out, and the slightest movement caused much pain. The relation of the bony points did not appear to be disturbed.

On June 17th the limb was skiagraphed. The screen showed nothing, owing to the density of the parts. The skiagraphs revealed an oblique fracture of the upper end of the radius, extending from just above the bicipital tubercle, downwards and backwards; it was situated below the