clear, but it may have been the result of his severe anaemia, the predisposing causes of which were malaria and syphilis, from which he had suffered; the syphilis only received symptomatic treatment by the mouth. The strangulated condition of the hernia can only be accounted for on the supposition that the straining induced by the purgatives had forced the appendix epiploica into the inguinal canal, and that while in this position the left colic artery became occluded by a thrombosis, in consequence of which an extreme degree of engorgement of the colon and its appendices was set up, resulting in a condition of strangulation. The revitalization of the bowel, of which a considerable portion was black at the time of operation, is interesting and shows the very free anastomosis of the blood-vessels of this part of the lower bowel.

There is a considerable amount of literature on the subject of superior mesenteric thrombosis, but I have failed to find more than a mere mention of the possibility of thrombosis of the inferior mesenteric artery.

A CASE OF PENETRATING WOUND OF THE CHEST: OPERATION—RECOVERY.

By Captain W. L. BENNETT.
Royal Army Medical Corps.

This case is recorded on account of the peculiar complications, both as a result of the injury and following on operation.

Private G. S., 2nd Bedfordshire Regiment, employed in the shoemakers' shop, was cutting the sole of a boot towards his chest, when the knife slipped, penetrated his leather apron and entered the chest. He fell down and was carried to hospital at 2.30 p.m. on April 30th, 1910. Half an hour after the accident I saw him, when his condition was as follows: Pale, very collapsed, and with a cold sweat all over him, he exhibits signs of active haemorrhage, with rapid fluttering pulse. There is no movement of the right chest, but breath sounds are to be heard faintly. Over the fourth interspace, about one inch from the right sternal margin is a linear wound, almost horizontal, which carefully probed goes into the chest 1½ inches or more. Shirt blood-stained, but not excessively so considering the wound was a cut ¼ of an inch long. The wound was stitched, a full dose of ergotin injected hypodermically, and the patient placed in bed with the foot raised; the chest was firmly strapped on the injured side. He improved, but as the shock passed off and the circulation was restored, the right chest became progressively dull. At 8.30 p.m., remembering a previous experience at Edinburgh, where I found post mortem a small cut in the right auricle which might possibly have been sutured, I determined to operate with a view to stitching the wound in the lung, or tying the internal mammary artery, which I felt sure was bleeding. His condition was grave in the
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extreme: great pallor, respiration very shallow and embarrassed, and pulse feeble and intermittent. With Major Cochrane giving chloroform, and the assistance of Colonel Culling, I rapidly made a crescentic flap of the muscles, convexity towards the sternal margin, and reflected everything, including the wound. The intercostal space was rapidly divided and search made for active haemorrhage from the chest wall, but none found. On removal of the finger, the wound being retracted, fierce haemorrhage, the worst I have ever seen, occurred. It welled out from a wound in the lung plainly seen, but the haemorrhage became quickly so terrible that nothing could be done. It as suddenly ceased with collapse of the lung and cessation of respiration. We all thought the patient was dead, and I rapidly stitched up, but after an injection of ether and strychnine he showed some signs of returning animation. Warm salt solution was run into the flank, and after an interval he was put back to bed. At the end of five hours he rallied, breathing easily and quietly, with a steady but feeble pulse.

May 1st.—Salt solution injected into the right deltoid. Steadily improving.

May 2nd.—The patient shows signs of reaction. Salt solution discontinued in the evening.

May 8th.—Removed stitches, wound completely healed, no leakage.

May 15th.—Right chest dull up to apex. Potain's aspirator applied in axillary line as low as possible, and 30 ounces of altered blood removed. Patient's blood examined for leucocytosis, but none found.

June 3rd.—A puffy swelling now appeared in the right axilla, and in two days invaded the whole right front of the chest to mid-abdomen and upwards over the right side of the neck and face. I punctured with an aspirating needle and drew air.

June 17th.—Swelling subsiding. His face is now cyanotic and he has frequent attacks of dyspnoea. Condition grave, pulse appears to be failing, heart apex displaced well over to left axilla. Evening temperature, 102.4°F.

June 23rd.—Making little progress. The patient's blood has been repeatedly examined for leucocytosis by Major Cochrane, but the count has remained normal. From repeated explorations of the chest with an exploring syringe it is apparent that he is suffering from the effects of a large blood-clot in the pleural cavity. The question of rib resection and evacuation of this was considered unjustifiable in view of his serious general condition.

June 28th.—Pulse feeble, cough troublesome with tinged expectoration. Ascites is now developing rapidly. This, it is considered, is due to obstruction to the blood return, by pressure on the inferior vena cava. No signs of oedema anywhere else. Saline purges and digitalis in mixture given.

July 22nd.—Abdomen more distended. The question of tapping was considered but negatived. General condition as before.
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August 20th.—Much improved. Expectoration less, abdomen with less fluid. He is in every respect better. Marked collapse of the right chest with retraction of intercostal spaces. Breath sounds clear at apex, but very distant at base.

August 24th.—Abdomen practically normal.

September 15th.—Temperature normal for the first time since the accident. Allowed up in a chair.

November 18th.—Brought before an Invaliding Board. His condition is now fairly good and he can do light work. He is somewhat anemic, and has marked retraction of the right chest, with almost wooden dulness, but the breath sounds are clear at the apex, and faint at the base. Heart-apex still well to the left of the nipple line.

A large venous communication (anastomotic) is evident between the right common femoral, through the superficial external iliac and a large plexus of veins over the back of the right chest. All the superficial veins of the right side are apparently enlarging.

I have, in conclusion, to thank Colonel Culling and Major Cochrane for their very kind assistance.

ether in the tropics.

By Captain V. T. Carruthers.
Royal Army Medical Corps.

Why is not ether used more in the Tropics? One is told, to begin with, that it is not necessary, as chloroform is so safe. This was the argument formerly advanced in Scotland; and we see that it has been obliged at last to make way before advancing knowledge, until ether now bids fair to become the routine anaesthetic, as in London and America.

As a matter of fact, chloroform is probably no safer for Europeans in the East than it is at home. White people frequently die of it in both places. In five years six deaths occurred on the table from chloroform in the practice of Scotch surgeons known to me; and without making any special inquiry, I am informed, by onlookers at the operations, of two recent European deaths in India and Ceylon in the practice of Royal Army Medical Corps officers. Such cases are not published. Many occur which are not heard of except by the special inquirer.

Also, I think it cannot be contended that the risk of delayed chloroform poisoning is less in the Tropics. Considering the prevalence of hepatic disorders, it is reasonable to believe that this risk is even greater than in England. Also the well-known superiority of ether as a preventive of shock (so emphasised by Crile) must hold good whatever the climate.

An objection to ether often put forward is that the apparatus perishes in the heat. This drawback to bag-inhalers applies all over the world.