invalidism, which will mean an enormous bill to be paid by the country for pensions. Now practically all these cases can not only be kept off the pension list, but can be made fit for further service by suggestion-therapy, and every case which can be relieved by rest and medicine can be cured by suggestion-therapy in a fraction of the time.

This is the reason why I am putting in this plea for a fuller recognition of suggestion-therapy, that it may be given a fair chance to prove its value in saving the usefulness (and often the reason) of many a poor soldier, and in saving the country from a very large and unnecessary expenditure in pensions.

MULTIPLE SEVERE INJURIES FROM A BOMB-EXPLOSION:
OPERATION; RECOVERY.
BY CAPTAIN NORMAN DAVIDSON,
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The following case deserves attention on account of the multiplicity of the wounds, their seriousness and the good recovery following operation.

Pte. J. W. P., aged 25, while practising bombing on December 17, 1916, threw a bomb which burst prematurely at about a distance of a little over a yard from his head. This occurred about 11.30 a.m. He was dressed by the medical officer of his battalion and was brought at 12.45 p.m. by ambulance to this military hospital where he was examined immediately on admission. He was quite conscious and complained much of abdominal pain; he said he was quite blind. Pulse 120, temperature 97°4 F. Respiration 20. He showed a considerable amount of blanching and was suffering from great shock. His wounds were as follows:

1. Wound of the scalp two inches long on the vertex down to the bone.
2. Perforating wound entering the abdominal cavity at the junction of the ninth costal cartilage with its rib on the right side.
3. Wound of left thigh entering the left groin one inch below Poupart's ligament in a line with the vessels and with its exit below the left knee, apparently smashing the head of the tibia and tearing the patellar ligament.
4. Wound in the right groin one inch below Poupart's ligament.
5. Small superficial wounds of right and left arms, abdominal wall, etc.

Operation.—The patient was brought to the theatre at 3 p.m. the same day and anaesthetized by ether. He had already had 1/4 grain of
Clinical and other Notes

Morphine hydrochloride and 500 units of antitetanic serum. With the assistance of Lieutenant J. F. Gill, R.A.M.C., the skin around the wound over the ninth costal cartilage was excised and it was seen that the cartilage had been half torn through and a fragment had perforated the peritoneum. This wound was then sewn up. The abdomen was immediately opened in the hypogastrium by splitting the right rectus sheath and pulling the rectus towards the middle line, the nerves to that muscle being preserved by pulling downwards. The abdomen was found to contain about a pint of blood and blood-stained serum. This was mopped out and an examination was made of the abdominal contents. The liver was found to be intact, as was the stomach. The duodenum was found to have a perforating wound at the middle of the second part, practically in the centre of its anterior surface; this was closed with a Lembert stitch of linen thread. The jejunum was next followed and there was found, about twelve inches down, a perforation at the free edge and another on the mesenteric edge with a small chunk of bomb case-lying in the mesentery. The missile was removed and the three holes closed by Lembert sutures of linen thread. No further abdominal lesion was found though it was noticed that gauze which had been placed near the duodenal lesion had a little bile on it, but search failed to reveal any injury. As the patient was in a very exhausted condition the search was not prolonged; a rubber tube rolled up in gauze was inserted down to the duodenum and another at the lower angle of the wound down to the recto-vesical pouch and the abdominal wall closed in layers. Attention was then turned to the left groin, the skin wound excised and there was found to be considerable arterial oozing from the depth of the wound, so it was opened up freely, the sartorius muscle retracted inwards, and the track of the foreign body was followed. This caused more bleeding. Digital pressure was put on the femoral artery and by following the track of the haemorrhage, one quickly came on the femoral artery and vein at the upper end of Hunter's canal. The artery was isolated and ligatured above and below with stout catgut. On removal of digital pressure there was only a little venous oozing but on lifting up the artery there was quite a rush of venous blood. Pressure was applied above and below, the artery lifted up again when it was seen that there was a small longitudinal tear in the vein. This was stitched up with a fine linen stitch for want of better material, as it was considered that ligation of both artery and vein would be sure to invite the risk of gangrene. The sides of the wound were then drawn together at each end and the centre packed with gauze soaked in eusol. The wound in the knee was excised, the track followed down about eight inches to the adductor muscles. A
counter opening was made, the track well scraped out and a rubber tube placed along it. The scalp wound through an oversight was not excised and the patient was returned to bed with the right leg enveloped in cotton wool and placed in an elevated position. On recovering from the anaesthetic he was placed in the Fowler position. The next day the patient was very ill indeed. Pulse 130. Respiration 30. Temperature 99°F. He was given morphia freely. He had ½ grains morphia hypodermically in the twenty-four hours and salines per rectum which he retained, also a turpentine enema to relieve some distension. 19th: He was better and had had a good night. Dressings were soaked through so he was dressed. There was no discharge from the lower abdominal tube but a free discharge of bile from the upper one, free oozing from the left knee wound, and no signs of gangrene in the foot. 20th: To-day the foot showed dry gangrene of all the toes. Circulation was apparently good up to the knee. The abdominal tubes and gauze were removed and the tubes only replaced. General condition satisfactory. Had bowels open but abdomen seemed distended. Good night. Pulse 96. Less bile escaping, tube shortened. Line of demarcation now begun to form at the middle of the calf. 25th: Patient doing well, but there was pain in the left leg and oedema above the line of demarcation. January 1, 1917: Complained of a great deal of pain during the night. Amputation was decided on and morphia hydrochloride ¼ grain and atropine sulphate 1/200 given. The operation was performed with anterior and posterior flaps. The bone was sawn through two inches above the knee. At the same time an opportunity was taken to draw together the edges of the wound in the left groin which had become a large granulating area, and the head wound scraped of redundant granulations. January 2: Patient says that he feels better than he has done since he came into hospital. No bile escaped to-day. Tube removed. January 7: All wounds healing well. January 17: Patient was quite convalescent and went to a concert on a wheeled chair. Wounds healed.

To sum up, the patient was injured at 11.30 a.m. and was operated on three and a half hours later. The interval between the accident and the operation was to the patient's advantage as he was in better condition at 3 p.m. than on admission. Morphia, salines and warmth were all that was used to combat the shock.

I have to thank Lieutenant Gill, R.A.M.C., for his able assistance and advice, and Sisters Geeve and Frewin, Q.A.I.M.N.S.R., for their care of the patient.