for fractures of the limbs, walking. He emphasized the importance of preserving the function of the limb while the bone was repairing, and pointed out that splintage was often unnecessary.

Major J. S. Jeffrey, R.A.M.C., showed:

1. A case of haematocele and generalized bruising of the scrotum due to a blow during physical jerks.

2. A case of burns which raised the question as to what method should be adopted in the primary treatment of burns when the case will have to be transferred later to hospital at a base. Treatment by any method of tanning, to be successful, must ensure that the area is kept aseptic, which is achieved normally by leaving the patient naked under a large shock cage. If the tan is covered by dressings and blankets, as is necessary during the journey to the Base, the burn almost invariably becomes septic. The value of tanning in burns under thirty-six hours is too great to warrant discarding that method of treatment, and it is suggested that the tan that will best tolerate coverings is one that is pliable and antiseptic, e.g. a weak solution of tannic acid, or 10 per cent. silver nitrate with alternate applications of one of the aniline dyes such as 1 per cent methyl rosaniline or gentian violet. Once the burn has become frankly septic the tan is best removed and the wounds dressed with an ointment of equal parts of lanoline, vaseline, and eucalyptus.

A CASE OF STRANGULATION INTO WALDEYER'S POUCH.

By LIEUTENANT-COLONEL R. COYTE,

Royal Army Medical Corps.

Pilot Officer C., aged 21, was admitted to Hatfield House Military Hospital with a diagnosis of chronic appendicitis.

Previous History.—The patient complained of attacks of pain in the right iliac fossa at intervals since childhood, particularly after violent exercise such as football and tennis. These attacks varied in severity, the pain was sometimes very acute and associated with vomiting. The pain never lasted longer than half an hour, and recently he was diagnosed by his medical officer as appendicular colic and recommended for appendicectomy.

He was admitted to this hospital on February 12, 1940. At that time he was slightly tender in the right iliac fossa on deep pressure, but had no tenderness per rectum. I considered him to be a case of chronic appendicitis, and arranged to do an appendicectomy on the morning of February 14. At 11 o'clock on the night of February 13 the patient was seized with violent abdominal pain, with vomiting and collapse. I saw him at 11.30 p.m. and found his abdomen only slightly rigid and distended, although at that time he was in great pain and vomiting constantly. I arranged to do a laparotomy at once on the assumption that he was one of the rare cases of fulminating appendicitis.
The patient was taken to the theatre and given a general anaesthetic. On arriving on the operating table a circumscribed swelling was seen to have formed rapidly in the right iliac fossa spreading upwards above the level of the umbilicus.

I made a Battle incision. The appendix was seen to be normal. I then discovered a large swelling lying behind the upper part of the caecum and the lower part of the ascending colon. The latter was reflected inwards and immediately a large tumour of slightly bluish colour was observed. This appeared to be a sac containing fluid. I thought that it would prove to be a very large distension of the pelvis of the right kidney as a result of occlusion of the right ureter by a stone. Such a condition would have explained all the previous symptoms.

The surrounding tissues were carefully packed off and an incision made into the sac. There was an immediate escape of about five to six ounces of a thin purulent fluid, closely followed by coils of small intestine of a deep blue colour, indicating recent strangulation.

The condition was now certainly one of strangulation into an intraperitoneal pouch, and by passing a finger inwards I could feel a tight constricting band at or about the level of the mid-abdominal line.

After reflecting the ascending colon laterally, the opening of the pouch was discovered with the superior mesenteric vessels stretched tightly over its anterior surface. The diagnosis of the rare condition of strangulation into a Waldeyer's or parieto-mesenteric pouch was at once established.

By stretching the opening, about four feet of mid-jejunum was soon returned to the general peritoneal cavity and the intestine rapidly resumed its normal colour. By this time the opening of the pouch was widely stretched and no repair operation was deemed necessary.

A tube was left in the pouch for forty-eight hours, because the fluid which escaped appeared to be turbid.

The patient had rather a stormy forty-eight hours and has since made an uninterrupted recovery.

The previous attacks of pain were clearly due to subacute obstruction which had always ended in spontaneous release.

It is worth mentioning that the late Lord Moynihan carefully described this condition and stressed its rarity.

I have to thank Colonel W. R. Ward, Officer Commanding the Hospital, for permission to send this case for publication.

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A USEFUL FORM FOR RECORDING CASUALTIES.

By Colonel T. H. Scott, D.S.O., M.C.

During the War of 1914–18 and during battles, it was the habit of many General Officers Commanding to send round to field ambulance dressing stations to ask for the numbers of casualties admitted and also how certain of their units had suffered.