Correspondence.

"Audi alteram partem."

THE CLOSURE OF COLOTOMY OPENINGS.

To the Editor of THE LANCET.

SIR,—Mr. P. Lockhart-Mummery's contribution to this subject in your issue of March 10th calls for comment. His assertion that "a temporary colotomy is a rare condition in civilian practice" is far from being correct. The general recognition on the part of surgeons that obstruction in the large intestine is best dealt with by a proximal colostomy, to be followed in suitable cases, after an interval, by resection of the offending segment of the bowel, and, later still, by closure of the artificial anus, has produced many such operations. Moreover, the established value of the three-fold operation in cases of obstruction has led many surgeons to adopt the procedure as a routine practice in dealing with cancerous growths of the colon where obstruction is not a feature of the case. My chief object, however, in writing this letter is to call attention to a method of closing colostomy openings which I have adopted in upwards of 30 consecutive cases without a single fatality and with uniform success. The method was fully described by the late Greig Smith in his work on "Abdominal Surgery," vol. ii., p. 727.

The aim of the operation is to close the artificial anus without opening the general peritoneal cavity, and this is managed by detaching from the parietes, all round the anus, sufficient peritoneum to permit of delivery of the gut through a parietal incision without separating it from its adhesions to the peritoneum. The opening is temporarily closed by a gauze plug. Incisions, each 1½ inches in length, are made above and below it through the skin and abdominal muscles down to the parietal peritoneum. They begin immediately outside the junction of the skin and mucous membrane, and may be either vertical or oblique. A finger is introduced and the muscles are gently raised from the underlying peritoneum on either side of the incisions. It is best to begin the separation at the end of the incision farthest from the anus because there are no adhesions here. Next the skin all around is divided with a scalpel one-eighth of an inch from its circumference; then with scissors the muscles are separated, taking care not to puncture the underlying peritoneum. When this has been done the colostomy opening and the adjacent colon can be lifted out of the wound to almost any desired extent. Gauze is packed in the wound all around the protruding anus and its muco-cutaneous margin is cut off. The refreshed edges of the anus are now united transversely to the long axis of the bowel by a suture of fine catgut, which should take a firm grip of both the musculo-peritoneal and mucous coats. The gauze packing and the surgeon's gloves are changed, and the area thoroughly cleansed with a stream of warm saline solution. A superimposed suture of fine silk is passed through the peritoneal and muscular coats, so as to bury the catgut suture. The loop of bowel is then pushed inside the abdominal wall, and the peritoneal wound closed by closely placed through-and-through silkworm-gut sutures. A small rubber drain-tube is placed in the centre of the wound and the usual dressings applied. The drain-tube is removed at the end of 48 hours, and in the vast majority of cases primary union results. Very occasionally a small fæcal fistula appears at the end of a week, but in every such case closure follows after a short interval. Every now and then the parietal peritoneum has been punctured, but in no case has this made any difference. Inasmuch as there is nearly always a bridge of healthy bowel wall, varying from one-third to two-thirds of its circumference, on the mesenteric side, there is not the slightest risk of a stricture forming at the site of operation

Greig Smith's operation is applicable to the vast majority of colostomy openings, including fæcal fistulæ from gangrenous umbilical hernia and those following operations for gangrenous appendicitis. In view of its safety and the uniform success following its adoption, I may be pardoned for expressing the conviction that enterotomes and similar contrivances should be relegated to surgical instrument museums. Two of my most recent cases were soldiers who had been shot in the abdomen. They were operated on a few hours later by Captain J. Frazer, who in both cases, after suturing multiple wounds of the intestines, established an artificial anus in the transverse colon. In both the colostomy opening concerned quite one-half of the circumference of the colon. Both healed without suppuration. Mr. Paul Bernard Roth in your issue for to-day describes what he calls "a simpler method of closing colostomy openings." Admitting its ingeniousness, one is bound to recognise that it involves the resection of a segment of the colon *within* the peritoneal cavity. This procedure, owing to the relatively septic condition of the mucous membrane and the poor blood-supply as compared with the small intestine is, when every precaution has been taken, one involving a very definite risk to life, and with Greig Smith's operation as an alternative I do not hesitate to say that, in my opinion, it is quite unjustifiable.

Just a word as to after-treatment. Mr. Lockhart-Mummery recommends that the bowels should be made to act daily after the operation. Surely this is bad advice. Here, more than elsewhere, one of the essentials to good healing is rest. Care should be taken to have the bowels well emptied before operation, but thereafter for a few days the less peristalsis the better. As a matter of fact I never give an aperient in these cases until the end of the first week.

I am, Sir, yours faithfully,

SINCLAIR WHITE,

March 17th, 1917. Professor of Surgery, Sheffield University.

To the Editor of THE LANCET.

SIR,—In your issue of March 10th Mr. P. Lockhart-Mummery describes two methods of closing temporary colotomy openings. He recommends the use of the enterotome or alternatively direct suture after intraperitoneal resection. Of the enterotome I know nothing. There is little temptation to employ a method which relies for success on imperfectly regulated pressure-necrosis when better results can be obtained by measures equally safe and more precise.

I have closed a number of these openings with unqualified success both in military and civil practice and have never found it necessary to subject a patient to whatever risk may be attached to intraperitoneal resection or suture. The mode of procedure adopted has been direct extraperitoneal suture with preliminary use of the drainage-tube device of Mitchell Banks. The method is described in Greig Smith's "Abdominal Surgery," 1897, vol. ii. The description is so full and the modifications introduced in practice so trivial that nothing further than the reference is required. It would appear that this extraperitoneal method is neither so well known nor so widely practised as its merits deserve. It can confidently be recommended as of universal application, absolutely safe, and absolutely certain.

I am, Sir, yours faithfully,

Harley-street, W., March 18th, 1917. PERCIVAL P. COLE.

RATIONS GUIDE: FOOD REQUIREMENTS OF CHILDREN.

To the Editor of THE LANCET.

SIR,—In the admirable series of recommendations on rationing and "How to Save Food" recently issued by the Food Controller, there are certain recommendations made with regard to the diet of children that appear to call for revision. The recommendations of the Food Controller are based on the following statement: "Children need plentiful food. A child of 8 needs half as much as a grown-up; a girl of 12 three-fifths as much; a girl of 16 needs as much as her mother, and a boy of 16 may eat as much as his father."

I am aware that this represents the teaching of standard text-books on the subject, though I have never been able to ascertain the exact data on which the original recommendation by Atwater was founded. I venture to think, however, that this teaching is wrong and is to be deprecated as a guide at the present time. My opinion is based both on practical observation and special investigation. The food requirements of a healthy schoolboy, say of 12 years, can be fairly accurately gauged from observation and a comparison with those of his parents on the same régime. If this test be applied, it can, I think, safely be said that the average boy of 12, in a household of the professional class, eats as much as his father. Corroborative information is obtained

from the laboratory standpoint. Some time ago I made a detailed study of the actual amount consumed by healthy children in a series of medical families, every precaution being taken to ascertain the exact amount of food consumed. The ages of the children ranged from 4 to 6 years. The result showed a daily average of: Protein, 71 grms.; fat, 67 grms.; carbohydrates, 198 grms.; the total calories amounting to 1725. The supply of protein—the main food element in the dietary of children—consumed by a child of 6 years and under is shown to be greater than that allowed for by the Food Controller for a boy of 12.

Fully grown subjects may with safety and positive advantage to health accept the standard laid down for the average adult by the Food Controller. It is, however, not advisable to restrict the feeding of children to the extent indicated in the Food Controller's recommendations. A wise economy in regard to the feeding of children should be looked for in the selection of foodstuffs rather than in a reduction of quantity below the pre-war standard.

I am, Sir, yours faithfully,

Edinburgh, March 17th, 1917. CHALMERS WATSON, M.D.

THE DIFFERENTIATION OF HEART MURMURS.

To the Editor of THE LANCET.

SIR,—I fail to understand why Professor David Drummond, in his letter in your issue of Feb. 17th, should think it strange my questioning his remarks on "The Differentiation of Heart Murmurs." In the whole range of his cases I note he gives no post-mortem results, and in the absence of such surely our opinions are apt to be wide of the mark. May I remind Professor Drummond of a very interesting article with post-mortem results in THE LANCET, 1895, vol. ii., by Dr. A. G. Phear, quoting Dr. Ringer's cases. Professor Drummond apparently considers that murmurs which disappear are due to vibrations of the chest wall. In answer to this, I think Dr. Theodore Fisher rightly observes, "It is difficult quite to gather his meaning." For, as Dr. Fisher says: "The chest wall being the medium which, through the stethoscope, conveys murmurs to our ears must vibrate in all cases, but neither with functional nor organic disease can murmurs, it seems to me, originate in the chest wall." I trust I am not unduly trespassing on your valuable space in prolonging this discussion, and I would like to assure Professor Drummond I am more anxious to learn than in any way to put forward my own ideas.

I am, Sir, yours faithfully,

Bournemouth, March 19th, 1917. A. KINSEY-MORGAN.

ACUTE DILATATION OF THE STOMACH FOLLOWING GASTRO-ENTEROSTOMY.

To the Editor of THE LANCET.

SIR,—The question as to the cause of acute dilatation of the stomach following gastro-enterostomy raised by Dr. F. Godfrey in THE LANCET of March 3rd is a very interesting one, and is my excuse for publishing the following experience.

About six years ago I performed posterior gastro-enterostomy on a man aged 40 years, for duodenal ulcer and as there was a suspicion of gall-bladder trouble, the incision was made about one and a half inches to the right of the mid-line. The patient, unfortunately for the procedure, had a well-developed abdominal wall, with powerful muscles which no effort of the anæsthetist could relax; and it was found when the stomach and jejunum were drawn out and approximated for suture that there was a little tension which necessitated a slightly firmer grip of the clamps than is customary. The operation was completed, following the Moynihan technique. All went well until the fourth day, when the patient vomited slightly and complained of discomfort in the abdomen. On examination I found a distended splashing stomach. A tube was passed and about four pints of watery fluid siphoned off, which gave marked relief. Next day the procedure had to be repeated, with a similar result. The patient now looked ill and shrunken, although he was absorbing a large quantity of saline per rectum, and fearing a kink or other cause of obstruction I decided to reopen the abdomen. On doing so I found the anastomosis perfect, but the intestine on either side for a few inches was contracted, rigid, and friable, it was much discoloured and the coats thickened by inflammation. The stomach near the anastomosis was similarly affected. It was obvious that peristalsis in this area was quite impossible and the condition of the patient was thus easily accounted for. I have no doubt the state of the intestine and stomach was caused by the clamp pressure and possibly by tension on the mesentery during the operation. The abdomen was closed and the stomach-tube passed frequently to prevent accumulation until the intestine recovered tone, which it did about the eighth day. The patient then quickly recovered.

I saw him about a year afterwards; he was in excellent health and joined the Army at the beginning of the war. I have no doubt the stomach-tube saved his life. I have not heard or read of clamp pressure as a cause of atony, but I am convinced that this case is not unique, and it helps to explain at least some of the cases where vomiting occurs on the third or fourth day and the patients recover after the free use of the stomach-tube.

I am, Sir, yours faithfully,

Clonmel, March 14th, 1917. P. J. BYRNE, F.R.C.S. Irel.

TUBERCULOSIS AND THE WAR.

To the Editor of THE LANCET.

SIR,—After reading Dr. H. A. Ellis's letter on the above subject in THE LANCET of March 10th it occurred to me that it gave an explanation of the uselessness of treating patients in sanatoriums, for it would seem that a sanatorium is regarded by many as a place for throw-outs from dispensaries. If, of course, this is the intention of these institutions it is useless to deplore the absence of early cases for treatment, as the dispensary would appear to be a very efficient sieve, preventing the treatment of pulmonary tuberculosis until the patients were chronic, and probably chronics which had become acute. It is quite clear to me that if a man is unable to do anything but light work he should be sent to a sanatorium at once in order that he may be permanently cured. I would suggest, therefore, it might be a good plan to commence sending cases in Class I. at once, without the intervention of a dispensary, to properly conducted sanatoriums. I have never here found the least difficulty in treating discharged soldiers for periods of five months: my only difficulty is that many have been kept out when in what may be called Class I., with deplorable results. The least we can do for our soldiers is to provide them with real sanatorium treatment at a stage when it is possible to cure them permanently.

I quite agree with your annotation that the general practitioner should be the chief factor in looking after the tuberculous; whether the visits of a tuberculosis officer to practitioners will do any good will, of course, depend on the capacity and training of that gentleman.

I am, Sir, yours faithfully,

EDWARD E. PREST.

Ayrshire Sanatorium, New Cumnock, March 12th, 1917.

AN APOLOGY.

To the Editor of THE LANCET.

SIR,—We have the concurrence of the solicitors to the *Evening Standard* in requesting you to give space in THE LANCET to the following expression of explanation and apology to Dr. Henry Dutch which appeared in the issue of the *Evening Standard* dated March 2nd:—

THE WHITE CITY CASE.

An Explanation and an Apology to Dr. Dutch.

Our attention has been called to an unfortunate inaccuracy in the report of these proceedings appearing in our issue of February 27th. From our report it would appear as though Mr. Muir said that Dr. Dutch had told Sauge "to drop the Sergeant-Major a quid."

As a matter of fact, Mr. Muir, in making the statement quoted above, was referring to quite a different person and made no aspersion whatever upon Dr. Dutch. We much regret the inaccuracy in our report, and we are pleased to take the earliest opportunity of correcting any misapprehension and express our unqualified apology to Dr. Dutch for any annoyance caused to him.

We shall therefore esteem it a favour if you will publish this letter in your next issue.

We are, Sir, yours obediently,

HEMPSONS,

Bedford House, 33, Henrietta-street, Strand, March 15th, 1917. Solicitors for Dr. Henry Dutch.