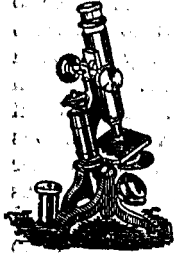


Medical Matters.

SOME POINTS IN THE ANATOMY AND PATHOLOGY OF THE VERMIFORM APPENDIX.



Among the points discussed by Mr. W. McAdam Eccles, F.R.C.S., in the third Hunterian lecture is that of hernia of the appendix. In such cases the question which first arises is; how does the appendix come to enter a peritoneal pouch protruded beyond the abdominal wall? The normal appendix, some three or four inches in length, with a complete meso-appendix, is free to move within the abdomen within a certain range around its attachment to the cæcum, but it cannot be brought down to, much less forced or dragged through, either the right inguinal or right femoral ring. One of two conditions, then, is necessary for its descent. In the first place, it may be considerably in excess of its usual length. This can be either the outcome of congenital elongation or of a stretching the result of adhesion. In the second place, the cæcum may be abnormally free because of the presence of a long meso-cæcum, with the result that the appendix may thus approach dangerously near to a hernial aperture. A further point comes up for investigation in the query whether the appendix alone can be the primary and the final contents of a hernial sac. It is undoubtedly possible for it to be extruded into the sac of a so-called congenital right inguinal hernia, for in such a case there is a naturally patent processus vaginalis into which any viscus lying near may be forced. It is certainly somewhat difficult to understand how such a small part of the alimentary tract, having so little of surface area, would be able of itself to form a sac by pressure. If we suppose that other of the abdominal contents besides the appendix have been the cause of the hernial sac, it is difficult to account for the very small pouches, and these often with narrow necks, which are found not infrequently as the coverings of prolapsed appendices. Doubtless this argument is open to the rejoinder that it is quite possible for the original multiform contents of the sac to have been reduced all but the appendix (which might alone have become adherent) and then for the mouth and neck of the sac to contract around the small structure passing through

them, and beyond this it is perhaps feasible that strangulation, or, at least, some constriction of the appendix, may thereby occur. Or, again, the appendix might slip into a sac which had not previously contained it, but which had been occupied by some other viscera.

HEAT-STROKE.

Dr. Andrew Duncan, London, in the Edinburgh *Medical Journal*, March, 1903, divides heat-stroke into two varieties: A. Heat-collapse; B. Heat-stroke, which again is subdivisible into (a) direct heat-stroke, or sun-stroke proper, and (b) indirect heat-stroke. In the author's experience indirect heat-stroke is the more common form. Warm days in the cool season of the year are especially dangerous. Moist air, absence of wind, and hot winds all favour the onset of attacks. New arrivals in a hot climate are particularly predisposed to attack, as are also the plethoric and intemperate, those suffering from fatty heart, or who have had syphilis.

In all cases where a traveller is exposed to a hot sun, alcoholic drinks should be eschewed and tea or coffee be the chosen beverage. The good effect of tea is clearly perceptible when we consider that the sun's action diminishes the action of the skin, lessens nervous activity, causes less carbon dioxide to be exhaled, and induces cardiac paralysis. In their action tea and coffee have exactly opposite effects; and, moreover, they both counteract the onset of fatigue, so deadly a factor in heat-stroke. Neutral-tinted eye-glasses should be worn. A thick woollen pad should be sewn into the coat to protect the spinal cord. The dress should be loose, the material of light wool, and the lining orange red in colour.

On the occurrence of heat-stroke the patient should be moved into the shade, his clothes opened, and cold applied to his head and neck. Ammonia should be applied to the nostrils, a large mustard poultice to the chest, and a turpentine enema should be administered. In Italy, in cases of direct heat-stroke, the administration of a solution of trinitrin (1 to 100), 20 drops, to water, 4,500 minims, every quarter of an hour until the complete disappearance of the symptoms has been found successful.

The author does not agree with Dr. Sambon, as to the microbic origin of sunstroke, and he leans to the side of those who uphold the chemical view of heat-stroke. To the increasing number of nurses working in tropical countries these points are of much interest.

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