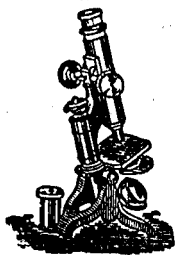


Medical Matters.

THE RESUSCITATION OF THE APPARENTLY DROWNED.



We briefly referred last week to the report of a Committee of the Royal Medical and Chirurgical Society on the above subject. This report was presented by Professor Schäfer at a meeting at which Mr. A. Willett, F.R.C.S., presided. The first part dealt with experiments carried out by the Committee to determine the amount of air that can be taken into or forced out of the lungs by various methods of artificial respiration. Ten methods of artificial respiration were tested, including (1) the "traction" method as recommended by Dr. Silvester, which consists in enlarging the chest by raising the ribs, the arms being dragged forcibly forwards and upwards by the side of head; (2) "compression" methods as recommended by Dr. Howard and Dr. Marshall Hall, depending on the principle of squeezing air out of the thorax by pressure upon its parietes and allowing fresh air to pass in by means of the elastic reaction that follows removal of the pressure; and (3) combinations of the above with modifications of the position in which the patient is placed.

The results showed that all the methods employed were competent to effect a sufficient exchange of air to maintain the oxygenation of the blood. The least amounts were yielded by the traction method pure and simple; but the combination of this with alternating pressures gave results in some cases much larger than, in others very nearly, if not quite, as large as, the amount of tidal air. It appeared that the prone position was advantageous in assisting the effects of pressure. In all the positions it appeared that intermittent pressure alone was an adequate means of effecting respiration. An even more striking feature of the experiments was the testimony they offered to the efficacy of the rolling method, combined with pressure on the back. This was very simply performed, and it had the further advantage that the movement from the latero-spinal to the prone position offered facilities for the escape of water and mucus from the mouth. It appeared to the Committee that both this method and the even simpler one of rhythmic pressure on the back with the subject placed prone should occupy a prominent place in all the recom-

mendations made for the resuscitation of the apparently drowned.

Dr. Silvester, who was present, suggested some objections to the employment of living subjects for experiments in artificial respiration, and expressed the opinion that the Committee's recommendations were based on inconclusive evidence.

SOME RARE FORMS OF CHRONIC PERITONITIS.

We essay the following review from a paper by A. G. Nicholls, M.A., M.D., read before the American Medical Association and reproduced in the Journal, in which the author calls attention to a peculiar form of chronic peritonitis of progressive development.

All peritonitides may be divided into primary and secondary forms. A primary peritonitis is a condition in which the inflammation, usually diffuse, of the serous cavity takes place without the mediation of any of its contained organs, and independently of any surgical operation on its part. Chronic peritonitis may be developed from an originally acute disease, either by a succession of relapses or a gradual amelioration in the severity of the attack, or it may develop insidiously from the first; the vast majority of cases arise by the extension of disease from some organ in close anatomic relation to the peritoneal membrane.

According to the nature of the exudation produced, chronic peritonitides can be conveniently divided into three main forms:—

1. *Chronic exudative peritonitis*, in which there is considerable outpouring of serous, sero-fibrinous, or fibrino-purulent fluid with loose plastic adhesions.

2. *Chronic exudative and adhesive peritonitis*, presenting less exudation, but with more numerous and firmer adhesions, often leading to sacculations of the contents.

3. *Chronic hyperplastic peritonitis*, in which there is sero-fibrinous or fibrino-purulent exudation, but more or less generalised adhesions are the rule, together with the formation of firm nodules, or continuous sheets of hyaline fibrous tissue. This form is much rarer than the other two, and some of these cases appear to be due to trauma, while it has been stated that local thickenings of the peritoneum may arise from the irritation of a simple ascites. Probably in every case infection is at work.

While most of such cases originate in the peritoneal cavity, in others the peritonitis arises by extension from the pericardium or pleuræ:

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