several ounces of thin yellow pus welled up beneath the cecum, and between it and the abdominal wall. There were no adhesions between the latter and cecum.

Without further disturbing relations, the small bowel was crowded away, and the following unique picture presented:

The appendix, retrocecal, had become adherent by its tip to the posterior portion of the parietal peritoneum about on a level with the head of the cecum. It was much thickened and markedly inflamed along its entire length, and the tip had become gangrenous and sloughed off. An opening the size of a dime was present at this point in the peritoneum, the edges of which were ragged and sloughing, and into this the appendix dipped, discharging its contents retroperitoneally.

When the peritoneum was opened along the inner border of the cecum and the ascending colon, a large retroperitoneal pocket extending as high as the lower pole of the right kidney was found. This contained pus, fecal concretions and sloughing tissues. The ascending colon was negative. The same pocket was then exposed in a downward direction behind the pelvic peritoneum. Here it was found that the pus, flowing over the iliac muscle, had extended into the thigh beneath Poupart's ligament through a kind of necrotic trough in the muscle, just external to the anterior crural nerve.

The incision started on the abdomen was carried down the right thigh, well below the knee. Pus in great quantities poured from the incision, which extended to the deep fascia. All of the superficial muscles anteriorly, laterally and two or three of the deeper ones posteriorly, were necrotic, a dirty grayish-brown color and of the consistency of butter. The finger could readily be pushed through them. The muscles closer to the femur were unaffected except for edema; in several places, however, the pus had begun to seep along fascial plains to deeper structures.

The periarticular structures of the knee were almost liquefied, and from there extension upward into the fatty subcutaneous tissues had occurred. The knee-joint was filled with a clear serous fluid. The hip-joint was unaffected. Neither femur nor tibia showed any changes externally or in the medullary canal. No evidence of embolus or thrombus could be found in artery or vein. The pelvic viscera were normal in every respect. The heart showed swelling and pericardial hemorrhages. Other viscera showed nothing of consequence. The causative organism was a colon bacillus.

TORSION OF THE SPERMATIC CORD

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Torsion of the spermatic cord, a fairly rare condition, was first described by Delasiauve in 1840. Seudder in 1901 published the report of a case¹ and reviewed the thirty-one other cases that had been reported in the literature up to that time. No doubt many cases have been reported since but I have been able to find the records of only fifty-four cases, most of them in the foreign literature. Many cases are probably overlooked as the patients recover spontaneously, and some are probably operated on for strangulated inguinal hernia, as were the patients in some of the reported cases. The rarity of the condition and the difficulty of differentiating it, in diagnosis, from strangulated inguinal hernia lead me to report the following case.

Patient.—H. H., boy, aged 15, was seen March 21, 1912, at 4 p. m. He complained of severe pains in the right groin, which began at 3 p. m. He had shoveled a heavy snow from the sidewalk at 1 p. m.; went to school as usual and felt well. He was called on to recite at 3 p. m.; had his foot twisted behind his chair and in attempting to arise was seized with a sudden severe sickening pain in the right groin. Patient said he felt all gone. He could not move his right leg without causing excruciating pain; had to be carried to a carriage and taken home. He had eaten nothing unusual that day. Bowels had moved well day before. There

was no history of injury and no trouble with urination. He had always been well. He had had enlarged cervical lymph-nodes several years ago. Two slight attacks of appendicitis three years ago. Family history was negative.

Examination.—(4 p. m.).—Well-developed boy, in bed apparently in severe pain. Temperature 99.6; pulse 110. Right leg drawn up; severe pain caused by motion of leg. Heart, lungs and abdomen negative. Inguinal canal, in its lower third, extremely tender. The right testicle cord and scrotum so tender that examination was impossible. No impulse on coughing. Introducing the finger into the right external abdominal ring caused severe pain but did not reveal any hernia. No apparent swelling of the testicle or cord, although examination was unsatisfactory. Rectal examination negative except for large amount of feces in rectum. No urethral discharge.

Treatment and Results.—An enema was ordered and hot application of lead and opium wash applied to the scrotum. Scrotum was swung in an adhesive hammock. At 8 p. m., five hours after onset, patient was comfortable. He suffered no pain except when he attempted to move. Examination showed the right epididymis and testicle swollen to about twice the size of the left, cord also considerably swollen, both very tender, epididymis and testicle in proper relation to the other parts. The testicle was fully descended. Treatment was continued as before. On the following day examination showed the same condition: patient comfortable except when testicle was handled; very tender to touch. Two days later swelling had disappeared, but tenderness still persisted. Patient returned to school the following day.

Five months later, August 23, patient had a similar attack. He was sitting at a table playing cards when on shifting his position he was seized with the same sort of pain. Another physician attended him that evening. I saw him the following morning and he presented the same condition as previously described. This, however, cleared up entirely the following day and the boy was about playing as usual.

On examination since, the boy shows no abnormality of the testicle except for a slight varicocele on the left side. There does not appear to be any atrophy.

I believe this to be a case of true torsion of the spermatic cord, one in which the twist became untwisted in both attacks before any permanent damage was done to the testicle.

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INCONTINENCE OF FECES (NON-ORGANIC)

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Incontinence of feces analogous to incontinence of urine, the origin of which can be traced to neuroses, general anemia or local parasites, is quite rare, judging from a review of the literature. In this disorder there is a relaxation of the sphincter ani, but not a paralysis. The muscle fibers respond to stimulation and are controlled at will, but formed stools pass through without the knowledge of the individual, as often as five or six times a day. No amount of moral suasion will control the disagreeable evacuations. Vegetable astringents, taken internally, are of no avail. Ergot, strychnin and hematic tonics have given success in the hands of others, but not until weeks have elapsed. To the list of reported cases I wish to add one occurring in my practice.

Case A. H., aged 8, whose father was a dipsomaniac, and mother very neurotic, had good control of the sphincters early in childhood. Last year he developed an acute nephritis, with general anasarca, which subsided on the administration of diuretics and other eliminative measures. After convalescence the mother noticed that he had lost control of the sphincter following a diarrhea. I was then consulted and prescribed vegetable astringents such as kino, krameria, gambir and others. The diarrhea stopped, but the incontinence of formed stools persisted. Night as well as daytime evacua-

1. Seudder, C. L.: Strangulation of the Testis by Torsion of the Cord, *Ann. Surg.*, 1901, xxxiv, 234.