right rectus. As in the previous case the peritoneum was stained by hæmorrhage. There were many adhesions and bleeding was going on pretty freely, obscuring the view—a difficulty referred to by Mr. J. W. Taylor in his Ingleby lectures in 1898.² With some difficulty the dilated tube was defined by the touch to be bent backwards towards Douglas's pouch. Large clamp forceps were placed on the ovarian artery and its uterine branch, which controlled the hæmorrhage and allowed the parts to be thoroughly inspected. The tube was unruptured and on the forceps being removed the bleeding was found to come from the open ostium of the tube. The tube and the ovary were isolated, ligatured, and removed. Some three or four ounces of clot were removed from Douglas's pouch, the pelvis was carefully sponged out, and the abdominal wound was closed in the usual way. The patient made an uninterupted recovery.

These two cases have a very great resemblance to each other. In both of them vaginal hæmorrhage was sufficiently severe and continuous to produce distinct anæmia and it did not yield to treatment. Both cases had a fair amount of blood in the peritoneum; in the first case oozing was still going on, whilst in the second case this hæmorrhage was free at the time of the operation. A diagnosis of tubal gestation with hæmorrhage going on necessitates operative interference. In both of the cases recovery was rapid and the patients were soon able to resume their ordinary habits of life.

Exeter.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF ILEO-COLIC INTUSSUSCEPTION ASSOCIATED WITH TUBERCULOUS ULCERATION OF THE INTESTINES.

BY LLEWELLYN A. MORGAN, M.D. DURH., M.R.C.S. ENG.

THE following case is of interest for four reasons—firstly, it was ultra acute, death taking place in 39 hours; secondly, two important symptoms were absent—viz., severe pain and tenesmus; thirdly, tuberculous ulceration in an early stage was found post mortem; and fourthly, it was of the rare ileo-colic variety.

The clinical history was as follows. The patient was a well-nourished boy, aged one year and eight months. The previous history was good with the exception of an attack of ulcerative stomatitis four months previously. He was well on March 16th, 1903, but having eaten freely of some cake he was given a dose of castor oil as a precautionary measure by his mother. During the night an action of the bowels followed, accompanied by some mucus. On the 17th at 1 P.M. the child vomited and "went as pale as death," to use his mother's expression. I saw him at 2 P.M. He was listless and apparently free from pain nor had there been any. The abdomen was flaccid and no tumour was to be felt. There were no tenesmus and no blood per rectum. Colour was returning to the cheeks. The temperature was 98° F. and the pulse was 100. I saw the child again early on the 18th; he was obviously very ill and was dull and listless. I was shown some blood that he had passed at 4 A.M.; it was about an ounce in quantity and was free from fæces. He had vomited three or four times. There had been no marked pain and no straining. The abdomen was flaccid; no distinct tumour was to be felt but some dulness was present in the left flank. Per rectum I thought I detected high up a mass, but no "os" was to be made out; the finger returned coated with blood. The temperature was 100·4° and the pulse was 110. I diagnosed intussusception. Mr. R. W. Murray of this city saw the child with me later in the day and, agreeing in the diagnosis, opened the abdomen. An ileo-colic intussusception was found, the knob-like extremity being reduced with difficulty some four or five inches above the ileo-cæcal valve. The mesenteric glands were noticed to be enlarged. The child

rallied for a time, but eventually died some 12 hours after the operation and 39 hours after the invagination.

A general post-mortem examination was refused but I was allowed to open the wound and removed the cæcum and some eight inches of ileum. At what had been the apex of the intussusceptum the coats of the bowel were much thickened and there was a marked congestion from this point to the valve. On opening the gut several commencing tuberculous ulcers were noted and at the spot which had been the apex of the intussusceptum the mucous coat was commencing to slough. The entire mucous membrane was much congested.

I should suggest that the ulceration present caused partial paresis of the bowel and that this portion being distended with flatus the part above was thrust into it by the peristalsis set up by the action of the purgative. I can find no mention of tuberculous ulceration and intussusception in the literature.

Liverpool.

A CASE OF RUPTURE OF A DUODENAL ULCER SUBPHRENIC ABSCESS; DUODENAL FISTULA; LAPAROTOMY AND SUTURE OF THE DUODENUM.

BY ARTHUR H. BURGESS, F.R.C.S. ENG., M.B., M.Sc. VICT.,

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THE patient, a man, aged 34 years, while at dinner on June 24th, 1902, was seized with a sudden violent pain in the upper part of the abdomen, shortly followed by vomiting and collapse. He was carried home, where he remained in bed, feeling very ill all the time, and on July 17th was taken to the Manchester Union Hospital. On admission his general condition was extremely grave, the temperature being 104° F., and the pulse being 150, feeble, and flickering. The epigastric region was distinctly prominent and on palpation a deeply seated fluctuant swelling could be felt. A median laparotomy was performed in the epigastric area, the swelling was exposed, the rest of the peritoneal cavity being protected by gauze pads, and eight ounces of thick, creamy pus were withdrawn with an aspirator. A large drainage-tube was inserted, the purulent cavity washed out with sterilised salt solution, and the abdominal wound partly closed, drainage being carried out by a rubber tube surrounded with iodoform gauze. The general condition began rapidly to improve and the wound quickly closed with the exception of a small fistula which persisted at its upper end, discharging daily a few drops of a clear fluid which caused irritation of the surrounding skin, the fistula itself allowing of the passage of a fine probe for a distance of five inches. Accordingly, on Nov. 18th the abdomen was reopened and the fistulous track was traced in a backward direction along the under surface of the right lobe of the liver towards the duodenum which was buried in firm adhesions. On separating these and freeing the anterior surface of the first part of the duodenum a circular aperture half an inch in diameter was discovered, situated one inch to the right of the pylorus. This was closed by two superimposed layers of Lembert's sutures of fine silk, some difficulty being experienced from the great depth of the duodenum and necessitating the division of the right rectus muscle. A gauze drain was inserted leading to the line of suture of the duodenum and the rest of the incision was closed. A good recovery followed; the wound healed completely and has since remained so.

Manchester.

A CASE OF CARBOLIC ACID POISONING DUE TO EXTERNAL APPLICATION.

BY J. A. RAUBENHEIMER, M.B., CH.B. EDIN.,
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THE patient, a child, aged six years, was admitted to the Royal Infirmary, Liverpool, on March 4th, 1903. She was suffering from genu valgum on both sides. Her general health was good except that she had adenoids. On the 20th at 11 o'clock in the forenoon she was prepared for operation by one of the nurses. The process of preparation was as

² THE LANCET, May 28th (p. 1447) and June 4th (p. 1515) and 18th, 1898 (p. 1668).