vertebræ, or in any other part of the body. The brain and its membranes were perfectly healthy. The state of the other organs of the body need not be detailed, since beyond the general effects of high temperature nothing abnormal was seen.

There was, therefore, suppuration between the vertebræ and dura mater limited to the posterior part of the membrane. The relation of the external abscess formations to the suppuration inside the spinal canal cannot, in this case, be considered doubtful. One cannot believe that two suppurations, one in the lumbar and the other in the cervical region had formed primarily on each side of the vertebral column, and had both pierced the spinal canal. The rational explanation is that the spinal suppuration, being most intense in the neighbourhood of the cervical lumbar enlargements, had here made its way between the laminae of the vertebræ amongst the muscular planes. The interest of the case is mainly pathological. Yet there may be noted amongst the clinical features the presence of excessive perspiration, together with an extremely high temperature and the blueness of the skin of the extremities. In Dr. Spencer's case there was also excessive perspiration, and the skin of the chest and abdomen showed a purplish mottling. The absence of cerebral inflammation and symptoms is probably explained by the much firmer attachment of the dura mater to the bone in the upper cervical region, approaching to the condition of the cerebral dura mater. This anatomical formation would probably hinder the spread of inflammation.

Seymour-street, W.

ACUTE INTESTINAL OBSTRUCTION; EARLY OPERATION; SUCCESSFUL RESULT.

By W. J. PENNY, F.R.C.S.,

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IN November of last year Mr. Luffman of Bristol kindly asked me to operate for him on a case of acute intestinal obstruction. The patient, a healthy, well-nourished boy of four, had an attack of diarrhoea on Nov. 2nd. While straining at stool he complained of a sharp pain in the abdomen. After that he had frequent desire to defecate with straining, but passed no motion. In the course of a few hours sickness supervened, primarily of the contents of the stomach; the vomiting increased in frequency and intensity, and the ejected material gradually assumed stercoraceous characters. When I saw him on Nov. 4th his countenance was pale, with dark rims under the eyes, and he had an anxious, pained expression. He was very restless, tossing about the bed and complaining of pain in the abdomen. His tongue was furred and rather dry. Pulse 136. The abdomen was flaccid, with a very slight appearance of fulness in the right iliac region. There was no particular abdominal tenderness except at this part. The appearance of fulness extended diagonally from the right flank towards the spine of the pubes.

Mr. Luffman and Dr. Newnham of the General Hospital (who gave the anæsthetic) examined the rectum for me; both found it clear, but both described a feeling of fulness in the right side of the pelvis. The abdominal symptoms beyond the constipation and sickness were not well marked. An exploratory operation was decided on, the chief grounds for this being the sudden onset of the symptoms and the appearance of the patient, who had previously been in robust health. After this had been settled the patient vomited again, the material being decidedly stercoraceous. A two-inch incision was made in the middle line, and the finger passed at once to the right iliac fossa. A tangled mass of intestine was met with, and something was felt to slip, giving me the impression that the lesion was an intussusception, though the shape did not accord with this. To be quite clear, I brought the mass to the surface, and then found that about ten inches of the lower part of the ileum had passed through a hole in its own mesentery and subsequently become twisted on itself. The strangulated part was of a darkish-claret colour, but retained its lustre. It was easily replaced, and the abdominal wound sutured. The entire operation lasted less than ten minutes. In the evening the patient's pulse dropped to 100. The tempera-

ture, which before operation was subnormal, rose to 100° F. The sickness ceased.

On Nov. 5th the boy's expression was more natural; pulse 100; temperature 99°. He had passed a good night, and had not vomited since the operation. The bowels had not been opened. There was no abdominal tension, pain, or marked tenderness. From this time he progressed rapidly towards recovery. The bowels were opened on the fourth day. On the seventh day the wound was dressed, and all stitches removed. On bidding him adieu, he answered my farewell greeting with a lively childish retort—a very satisfactory indication of restored health. There was an obscure history of a fall from a ladder a few days before the illness. The rent in the mesentery however, did not give me the impression of being a recent lesion, as the edges were rounded. The patient was in such a weak condition that I completed the operation as quickly as possible.

The case illustrates the value of early operation. About a fortnight afterwards I had occasion to make a post-mortem examination, on a case of intestinal obstruction, at the hospital. The patient had been treated for a fortnight by medicines and applications to the abdomen, evidence of which existed in the blistered condition of the skin of that region. She was admitted to the hospital under the care of my then colleague, Dr. Markham Skerrett, a few hours only before she died. In this case the abdomen was also flaccid. The lower part of the jejunum and almost the whole of the ileum had become strangulated under a thin fibrous band passing from the lower part of the jejunum to the ileum, two inches above the ileo-cæcal valve. Evidence of old pelvic cellulitis existed; the left ovary was adherent to the uterus, suppurating and discharging pus through a sinus which existed between it and the rectum. The undistended condition of the abdomen in this case was probably due to the lesion involving the intestinal tract at such a high level. The duodenum and upper part of the jejunum were rather distended, and the rest of the intestines collapsed. Before opening the abdominal cavity, I passed my finger through a small median incision and came at once on the band. This case could easily have been remedied by operation, and for lack of it the patient died. One so often hears of cases in which the diagnosis of some obscure abdominal condition is only cleared up on the post-mortem table that I do not think it is sufficiently appreciated that an exploratory operation through a small incision, with antiseptic precautions, is often less hazardous than delay. In many of these cases delay means death, while the risk of an exploratory incision is infinitesimal. In the earlier stages, before peritoneal effusion and intestinal distension have occurred, operative measures are comparatively simple, the finger can be passed freely round the abdominal cavity, without embarrassment from either the mechanical impediment caused by the distension or the stickiness of the intestines and peritoneum, and the operation can be completed in a few minutes—a very important point. When these troublesome conditions are present operation is difficult, and enterotomy has frequently to be resorted to as a palliative measure, instead of the more satisfactory plan of removing the primary cause of the trouble.

Clifton.

DISORDERS OF SPEECH IN THE INSANE.

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I HAVE selected for report three cases illustrating aphasic phenomena occurring in asylum inmates, which appeared to present some features of interest. The investigation of such morbid conditions, when manifested by an insane individual, is sometimes far less easy than in the case of a person of sound mind. In the former it has seemed difficult to separate the mental symptoms from those properly attributable to physical causes: to judge, for example, how far an aphemia may be merely the outcome of delusion, how far it may be the manifestation of damage to speech centres; to discriminate between inability to comprehend spoken or written language due to defect of memory and general mental failure from true sensory aphasia (word-deafness, word-blindness). In Case 1 one of these difficulties finds, I