As I have shown elsewhere, the cause of the septic inflammation in the case of failure to secure primary union of the flaps is the unwelcome cultivation of staphylococci in the area of operation. Let me here tell you of a case on which I operated last spring which was temporarily wrecked by the incubation of staphylococci. From the notes of this case, which were kindly supplied by Mr. Templeton, F.R.C.S. Eng., I find that the child, a boy, was five years old when I operated on him on May 26th. The cleft involved the soft palate and the back of the hard, being $\frac{3}{4}$ in. broad and $1\frac{1}{4}$ in. long (Fig. 4). Within a day or two of my operating on the

FIG. 4.

Actual size of cleft which broke down after first operation but was successfully closed three weeks later. (After a sketch by Mr. Templeton.)

cleft the temperature went up and the boy was covered with a punctiform (septicæmic) rash. The wounds were covered with thick muco-pus and the suturing broke down entirely. A fortnight after the operation the wounds looked clean and the child's general health was good, so I arranged to perform the operation again the following week, hoping that the child had established in himself an immunity against another staphylococcic attack. On June 16th, therefore, with knife, raspatory, and scissors, I brought the freshened edges of the flaps together and adjusted them by wire sutures. The operation turned out a success, the child being sent home three weeks later with the cleft completely closed.

I venture to think that the report of this case will prove interesting to surgeons who are in the habit of operating on cleft palates—that is if, as I suspect is probable, every now and then they suffer the keen disappointment of seeing a carefully executed operation ruined by septic inflammation. Hitherto it had been my custom in such circumstances to send the child away into the country and to operate some months subsequently, but in this instance I was anxious to see if the septic outbreak had not rendered the child temporarily immune against further attack of a like nature. So soon, therefore, as the effects of the local storm had passed away I re-did the operation and I shall certainly adopt this course should circumstances at any future time suggest it. In private as well as in hospital work it will be an advantage to make the second attempt when the child is well broken in and amenable, and in private when the nurses are still in the house and the child has become accustomed to them. I think it not improbable as time goes on that a child on whom a staphylorrhaphy is to be done will have an artificial immunity established in him by the injection of anti-staphylococcus serum. But for my own part I shall be unlikely to have recourse to it. I shall still be content to let the children run the chance of septic inflammation rather than court unknown risks. And, as a matter of fact, now that I am very strict in the carrying out of the simple preliminary methods of asepsis to which I referred at the beginning of this lecture I rarely find the line of suture breaking down or the wounds becoming coated with that foul, stringy muco-pus which used formerly to be a not infrequent herald of a more or less complete failure and disappointment.

WEST CORNWALL INFIRMARY AND DISPENSARY.—The annual meeting of the West Cornwall Infirmary at Perzance was held on Jan 19th under the presidency of Prebendary Hedgeland. The report stated that 145 in-patients had been treated and the institution was practically working at the full available capacity. The accounts showed an expenditure amounting to £842 and receipts amounting to £749; there was an adverse balance of £93. The committee had received £600 from the late Mr. J. C. Wren and £500 from Mr. W. E. T. Bolitho.

IDIOPATHIC DILATATION OF THE COLON,

ILLUSTRATED BY A CASE IN WHICH THE ENTIRE RECTUM, SIGMOID FLEXURE, AND DESCENDING COLON WERE EXCISED.

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OF late years there has crept into medicine the term "idiopathic dilatation of the colon." This term has been applied to certain morbid conditions in which a few common clinical manifestations appear to have given expression to varied and possibly diverse pathological states. Whatever may be the structural changes which give rise to this dilatation of the bowel the clinical phenomena included under the term are more or less definite and unvaried. The main features are these. The colon, and especially the lower part of it, is enormously dilated. It is tympanitic and distended with gas to a degree that in some instances almost surpasses belief. The patient suffers from certain mechanical effects of this distension and notably from shortness of breath, palpitation of the heart, œdema of the legs, and possibly albuminuria. The patient may be unable to move and the difficulty of breathing may be such that the face and extremities become livid. Marked constipation is usually a conspicuous feature, while vomiting and troublesome hiccough are not uncommon. The particular term "idiopathic dilatation" is based upon the assumption that the distension of the bowel is not due to any obstruction in its lumen. It is therefore necessary to exclude from the present category all cases of dilatation of the colon due to volvulus, to the impaction of faecal masses or foreign bodies, to the lodgment of concretions, and to the existence of stricture of any type. In like manner would be excluded examples in which the colon or rectum has been narrowed or occluded by the pressure of a tumour having its origin without the bowel wall.

In dealing with this present subject it will be well to inquire first of all into the circumstances under which portions of the alimentary canal become dilated in the absence of any obstructive cause, and in the second place to consider what conditions may underlie certain of the reported cases of "idiopathic dilatation of the colon." With regard to the first matter it may be said at once that any part of the alimentary tube may become dilated without there being the least obstruction in its lumen. At one time it was supposed that whenever the stomach was dilated there was some obstruction at the pylorus which prevented the escape of the gastric contents and allowed the organ to be dilated by the gaseous products of decomposition. In like manner in marked tympanites of the bowel it was loosely assumed that the bowel was distended with gas which could not escape owing to some obstruction in the distal part of the canal. These assumptions have long since been shown to be without foundation. Obstruction in the lumen of the intestine is not the most ready means of inducing meteorism. Interference with the innervation and blood-supply of the bowel wall will cause a much more speedy tympanites. In animals the ligaturing of the main mesenteric vein is followed by quite intense meteorism and one of the most extreme examples I have seen of tympanites of the small intestine in the human subject was due to thrombosis of the superior mesenteric vein.

From a clinical point of view it is desirable to recognise most fully that distension of any portion of the alimentary canal may be entirely disassociated from any obstruction in the lumen of the tube. Certain phases of "idiopathic dilatation" immediately suggest themselves. One of the most interesting is provided by the condition known as "ballooning of the rectum." Here on introducing the finger into the anus the rectum is found to be apparently dilated to its utmost. It may be dilated in the same way as one speaks of the iris as dilated, but it is certainly not distended, and the term "ballooning," which suggests extreme inflation with gas, is entirely misleading. The ballooned rectum is not distended with gas, but its condition is due to some phase of paralysis. If two fingers be introduced into such a rectum so to allow gas to escape the ballooning remains the same. It is the muscular wall of the gut which is at fault and not its contents. On the other hand, if the patient be anaesthetised the ballooning vanishes. This ballooning is met with

in many conditions. It is often associated with stricture of the lower colon, with tumours about the pelvic brim, with conditions indeed which may, through pressure, effect the innervation and blood supply of the terminal part of the gut. I have met with a very marked example of "ballooning" in an old man who was suffering from what proved to be a fatal attack of sub-acute perityphlitis. Those who are concerned with the physiology of idiopathic dilatation of the bowel may well commence with the study of ballooning of the rectum.

Idiopathic dilatation of the colon of moderate degree is well seen in what may be termed masked peritonitis. Indeed, a little inflammatory focus within the abdomen (and without the pelvis) is a common cause of persisting dilatation of bowel. As an example of masked peritonitis I may take such a case as the following. An abdominal section—such as the removing of a diseased vermiform appendix—is performed. For a day or two all goes well and then appear the phenomena of masked peritonitis. There is great distension of the epigastric region due apparently to dilatation of the transverse colon. The patient is very frequently sick and can retain little or nothing in the stomach. He has obstinate and often most persistent hiccough. There is no pain or next to none, no tenderness of the abdomen, and no board-like hardness of the abdominal muscles. The abdomen may be perfectly soft in all parts, there is no rise of temperature, the bowels respond to enemata and to such an aperient as calomel, but the dilatation of the colon, the irritability of the stomach and possibly the hiccough persist. After the bowels have acted there is some little diminution in the epigastric distension, but it is only temporary. The symptoms may last for many anxious days and at last end in recovery. It may be mentioned that in this condition no drug answers so well as strychnia administered hypodermically.

As regards the stomach it is needless to say that certain forms of dilatation of that organ are described in which there is no evidence of any obstruction of the pylorus. There is a good deal to suggest that some forms of rapid dilatation of the stomach may depend upon nerve influences which have their starting point in some infective or inflammatory process. In one of the two fatal cases of "acute gastric distension" described by Dr. Fagge a sloughing abscess was discovered behind the duodenum after death. Acute dilatation of the stomach of the ordinary type is said by Dr. Clifford Allbutt to only occur as the sequel of certain acute and debilitating diseases such as acute rheumatism, active forms of pulmonary tuberculosis, malignant endocarditis, and septicaemia. I have seen acute dilatation of the stomach follow upon severe and extensive contusion of the abdomen from which the patient ultimately recovered and in which there was no evidence that there was at any time an obstruction of the pylorus. So far, then, it may be safe to say that in certain portions of the alimentary canal extensive dilatation may occur which is independent of any obstruction in the lumen of the tube. To such forms the somewhat vague term "idiopathic" may, with a scarcely less vague reason, be ascribed.

When we turn to the series of clinical cases which are collected under the title of "idiopathic dilatation of the colon" it is evident that we have to deal with conditions which are much less ephemeral than the casual states of distension to which allusion has just been made. An examination of this collection of cases at once raises the question as to how far they are accurately described by the term "idiopathic." Certain of the reported examples are, as Dr. Hale White¹ has pointed out, apparently instances of extreme faecal accumulation. In a case under the care of Dr. Bristowe,² for example, the patient, a girl aged eight years, had had no action of the bowels for seven weeks before her admission into hospital. She had always been the subject of constipation and at her death the entire colon was found to be enormously distended with faeces to a point within two inches of the anus. In another case³ selected by Dr. Hale White the patient was a man, aged twenty-eight years, who had been always constipated and who had had several attacks due to faecal accumulation. The distension of his abdomen was enormous and there was oedema of the legs, pelvis, and scrotum. The colon had a diameter of from 6 in. to 8 in. and contained no less than fifteen quarts of faecal matter.

When the other cases come to be examined it is at once evident that they can be divided into two classes. In one series of cases the patients are adults, are mostly males, and are over fifty years of age. In the other series of cases the patients are children and symptoms of abdominal trouble have been more or less apparent from birth.

I do not propose to discuss in this paper the cases of dilatation of the colon met with in elderly subjects beyond to venture the remark that the idiopathic nature of the dilatation is not by any means made manifest. In certain of the cases the dilated bowel—practically always the sigmoid flexure—was much hypertrophied and it is evident from such hypertrophy that it had been engaged in overcoming some obstruction. The history of these cases suggests that the habitually overloaded sigmoid flexure hanging down in the pelvis had become bent upon itself at its meso-colic extremity so that the distal end of the loop had become occluded by kinking. The account of habitual constipation, of previous attacks attended with absolute obstruction and immense distension, the circumstance that during such attacks enemata are unavailing and the condition of the parts found after death strongly support this suggestion. Indeed, one might go so far as to say that the majority of the examples of so-called "idiopathic dilatation of the colon" occurring in elderly subjects appear to be examples of simple dilatation of the bowel above an imperfect but definite obstruction. With regard to the cases of "idiopathic dilatation of the colon" in children it appears to me that they have even less claim to the title "idiopathic" than have the instances just disposed of.

The evidence obtained from the perusal of these cases very strongly suggests that the great majority of them at least depend upon a congenital narrowing of the lower extremity of the large intestine. At the end of this paper I have given an account of a small child who exhibited in a marked degree the features of "idiopathic dilatation of the colon" as shown by the enormous distension of the abdomen, the obstinate constipation, the hypertrophy of the lower part of the colon and the practical failure of all purgative measures. The case indeed may be taken as a quite typical example of the trouble described under this questionable title. In the present instance the patient was treated by operation and the whole of the bowel below the transverse colon removed together with the anus. The child made an easy recovery. The examination of the bowel, however, made it evident that the distension was not "idiopathic" but was due to a congenital narrowing, regular and uniform in degree, of the lower end of the colon. Indeed, the rectum and sigmoid flexure were found to be defective in length and to be represented by a narrow and contracted tube of uniform calibre.

On turning to the recorded cases one finds that such a condition has been noticed as a congenital defect in other parts of the intestine and the narrowing has been found to involve now and then a considerable extent of bowel.

Dodd,⁴ for example, gives an account of a male infant who lived for twelve weeks suffering all that time from much intestinal distress. The necropsy showed that the ascending and transverse parts of the colon were throughout but little larger than an ordinary lead pencil. In another instance Atkin⁵ discovered the rectum and colon of a child who lived for two days to be no larger than an ordinary quill.

On reviewing the recorded cases of "idiopathic dilatation of the colon" in children the following particulars call for attention. Osler⁶ narrates the histories of three cases occurring in young children. One was a boy, aged ten years, who was thin but who presented an enormous abdomen. He had attacks of abdominal pain with vomiting. Peristaltic movements were visible through the parietes. Frequent washing out of the bowel with a long tube led to some slight relief. Laparotomy had to be performed. There was no stricture; the sigmoid flexure was 18 in. in circumference; the caecum was half this size and the bowel progressively increased in size from the caecum to the sigmoid flexure. The distended bowel was folded upon itself, but not so as to cause any obstruction. An artificial anus was established. In another case a boy, aged three years, who had been troubled with constipation from birth, presented after death an enormously dilated colon which held fourteen pints of water. The

¹ Clifford Allbutt's System of Medicine, vol. iii., p. 968.

² Brit. Med. Jour., vol. i., 1885, p. 1085.

³ Dr. Peacock's case—Transactions of the Pathological Society of London, vol. xxxiii.

THE LANCET, June 11th, 1892, p. 1299.

⁵ THE LANCET, Jan. 31st, 1885, p. 203.

⁶ Archives of Pediatrics, 1893, p. 111.

greatest dilatation was about the sigmoid flexure. Death had been due to acute colitis. The third case was that of an infant, aged seven months, whose abdomen was much distended and whose bowels never acted unless an injection was given. If the injection was not administered daily the swelling of the abdomen increased and the child vomited.

Walker⁷ records the case of a child who died from emaciation and exhaustion at the age of eleven years. Since a few weeks after birth enlargement of the abdomen had been noticed and this continued to increase as the child grew up. There was persisting constipation. At the necropsy the transverse and descending colon measured 23 in. in circumference and looked "like a large leg and thigh." The commencement of the cæcum and the distal end of the sigmoid flexure are described as normal. The diaphragm was so pushed upwards that its dome was only two and a half inches from the supra-sternal notch.

Formad⁸ gives an account of a man, aged twenty-nine years, whose abdomen was so enormous that he was exhibited under the title of the "balloon man." The condition was congenital and death was due to sudden syncope. The colon was as large as that of an ox. Marked constipation had been the symptom during life.

Rolleston and Haward⁹ record the case of a boy, aged twelve years, who had suffered from distension of the abdomen and very troublesome constipation since he was two months old. On one occasion the bowels had not acted for nine weeks. The boy when seen was much emaciated, the abdomen was of enormous size, and through the thinned parietes peristaltic movements could be seen. The abdomen was in all parts tympanitic. He had repeated obstructive attacks and in one of these he died. The colon was found at the necropsy to be of enormous size. The distension mainly concerned the descending colon and sigmoid flexure. The rectum is said to have been of normal size. The colon was much hypertrophied. Rolleston and Haward refer in their paper to certain other cases of "congenital idiopathic dilatation of the colon."

Instances of early death—within eighteen months of birth—in cases associated with extreme dilatation of the colon are given by Hirschsprung¹⁰ and Oestreich.¹¹

All these cases have certain very striking features in common. Distension of the colon and obstinate constipation have been noticed practically from birth; the distension has been extreme and has mainly involved the lower sections of the colon; the wall of the dilated bowel has been greatly hypertrophied; movements of the hypertrophied coil have been visible through the parietes; relief of the bowel has been effected almost solely by enemata. Certain secondary conditions, such as catarrh and ulceration of the distended gut, with possible tearing of its walls in extreme cases, have been noted. All the cases, except perhaps one in which an artificial anus was established, appear to have ended fatally. The general circumstances of these cases do not seem to be consistent with the idea of an "idiopathic dilatation of the colon." The very prominent feature in every example of the trouble has been some obstruction in the lower part of the large intestine. The conditions presented are not comparable with those met with in idiopathic dilatation of other parts of the alimentary canal to which attention has been directed. In the case which is here reported there was a distinct, even, and extensive congenital narrowing of the lower extremity of the colon. The symptoms produced were most typical and entirely agreed with those detailed in the reported examples.

I venture to think that there is strong evidence to support the suggestion that all cases of "idiopathic dilatation of the colon" in young children are due to congenital defects in the terminal part of the bowel, that there is in these cases an actual mechanical obstruction and that the dilatation of the bowel is not idiopathic. The marked hypertrophy of the distended gut suggests in the most emphatic way that there is an obstruction to be overcome and such hypertrophy is quite inconsistent with the conception of an "idiopathic" dilatation of the bowel. I am not aware of a previous instance of the treatment of this condition by a radical operation.

An illustrative case.—A little girl, aged five years and nine months, was brought to me on Jan. 5th, 1897. She was the

daughter of perfectly healthy parents, was living in a country district under favourable conditions and had been all her life the subject of the most anxious and careful attention. She was suffering from severe constipation which was becoming almost insurmountable and which was attended by frequent attacks of intestinal obstruction. The child was frail and delicate looking, her face was pallid and she was thin almost to emaciation. The abdomen was of enormous size and was distended like a balloon. It was everywhere uniformly tympanitic and exhibited precisely the condition described under the title of idiopathic dilatation of the colon. Through the thinned parietes an enormous coil of intestine, evidently colon, could be seen. It appeared to occupy almost the whole abdominal cavity. It was the seat of certain visible peristaltic movements which, however, were occasional only. The tongue was foul and the breath was offensive. The appetite was excellent. The bowels never acted naturally and a motion was only obtained by passing a rigid tube some ten inches beyond the anus and then administering an enema. There was considerable pain in the abdomen. The anus was very small and a digital examination without an anæsthetic was quite impossible.

The history given was as follows. The child was born in March, 1891. Two days after birth vomiting commenced and continued off and on for several days, the bowels ceased to act and some distension of the abdomen became evident. Aperient medicine had no effect and relief was ultimately obtained by enemata. Like attacks, marked by vomiting, absolute constipation and distension of the abdomen, occurred in July, August, and September of the same year. At the end of 1891 there was a very severe attack, in which the patient's life seems to have been in danger. The distension of the abdomen became excessive and permanent, the bowels only acted after enemata and when enemata failed vomiting and increased distension appeared until relief was obtained. Aperient medicines proved to be valueless and were finally quite abandoned. Massage and other measures were tried but without effect. In August, 1894, relief of the bowel was attempted by means of enemata given through a long rigid tube passed some ten inches into the bowel. This measure was so successful that for ten months the child had only two or three obstructive attacks although the distension of the abdomen persisted and remained very considerable. In July and November, 1895, there were severe and alarming attacks of intestinal obstruction which finally yielded to enemata by means of the long tube. Up to this time there had been comparatively little complaint of abdominal pain. In 1896 the child began to suffer from cramping pains in the abdomen which increased in severity as time went on and which were evidently due to disorderly peristaltic movements in the now much hypertrophied bowel. Gurgling and bubbling sounds could be heard in the abdomen and sounds as of the dropping of water. The attacks of obstruction became more frequent and were of longer duration. The distension of the abdomen became enormous and when the distension was at its maximum the child was unable to move. Enemata, no matter how administered, were now losing their effect, no aperients could be tolerated, and the condition of the child when she came under my notice was certainly very deplorable.

I performed laparotomy on Jan. 13th, 1897, opening the abdomen in the median line below the umbilicus. There immediately presented a gigantic coil of colon which looked and felt like the adult stomach and which appeared to fill up the whole of the abdomen. This coil was at once emptied of its gas through a small incision. The wall of this intestine was smooth and much thickened by hypertrophy and the actual diameter of the collapsed loop was eight inches. It was this coil which had practically alone caused the distension of the abdomen. Further examination showed that the lower part of the bowel corresponding to the rectum and sigmoid flexure was represented by a straight solid-looking tube about the size of an adult's forefinger and some eight or nine inches in length. This tube was without saccululation and its longitudinal muscular coat was very marked. It was of uniform diameter. It was provided throughout with a short meso-colon. There was scarcely a trace of fat within the abdomen and as a result the blood-vessels of the intestine were easily identified. The left colic artery, much increased in size, went to the dilated loop of the colon, while the sigmoid branch of the inferior mesenteric artery ran to the narrowed tube below the dilatation. The junction between the dilated gut and the narrow tube was quite abrupt. I enlarged the little opening I had made into the colon and

⁷ Brit. Med. Jour., vol. ii., 1893, p. 230.

⁸ Annals of the Universal Medical Sciences, vol. i., 1893.

⁹ Transactions of the Clinical Society of London, vol. xxix., p. 201.

¹⁰ Annals of the Universal Medical Sciences, vol. i., 1893.

¹¹ Berliner Klinische Wochenschrift, 1893, p. 852.

introduced the finger to examine the interior of the great pouch. Its walls were smooth and a flap-like fold of mucous membrane occupied the orifice that led into the narrow tube. This opening readily took the forefinger. The fold of mucous membrane may have contributed to certain of the obstructive attacks and may explain the retention of certain enemata. In examining the parts, however, it appeared more probable that the attacks of obstruction would be due to bending or kinking of the bowel at the point where the tube and the great sac joined. The length of the narrowed part of the bowel corresponded to the length of tube which experience had shown was necessary to produce any emptying of the great pouch. The even contraction of the lower part of the bowel may have been in some degree due to the constant use of this tube. I passed a gum-elastic tube of large calibre through the anus and along the narrowed rectum well into the interior of the dilated bowel. The tube measured twelve inches. I had some hope that if it would be kept in position for some time the distension would be relieved and a more normal action of the bowels would be possible. I closed the opening I had made into the descending colon, but brought the suture line into the centre of the parietal wound so that an artificial anus could be established at any moment. This fixing of the bowel would, I hoped, tend to prevent it from becoming kinked or bent. The wound in the parietes was then closed in all but its central parts.

For some days the abdomen remained free from distension and the child from pain. Some faecal matter was passed, but in due course the tube became blocked and could not be freed; another tube could not be properly introduced, the child felt the worry of a foreign body in the bowel, and at the end of seven days the use of the tube was abandoned and an artificial anus established in the centre of the median wound. Through this artificial opening all the motions were passed for the next nine months. Practically nothing came by the rectum. The distension was relieved and the child was free from the continued spasmodic pains. There was, however, some difficulty in keeping the artificial anus open, as there always is with such openings when made as the present one was made. This necessitated the introduction for so many hours each day of a bent rubber tube which kept the orifice quite patent but which occasioned the child a good deal of distress. In October, 1897, I resolved to attempt the excision of the colon from the splenic flexure to the anus, as this appeared to afford the only possible prospect of giving complete relief to what was still a distressing condition.

The second operation was performed on Oct. 29th. By means of an elliptical incision in the skin I isolated and removed the artificial anus, entering the abdomen on each side of the opening. The orifice in the colon I closed by a series of substantial sutures. I found that the gut, which had at one time been so enormously distended, was now of more moderate dimensions, and its point of juncture with the narrow tube which represented the lower part of the colon was still abrupt. The narrowed tube had shortened somewhat as the result of removing the distension. The dilatation of the colon extended up to the splenic flexure. Beyond that point the colon was practically normal, although it had evidently been to some degree distended and still showed some hypertrophy of its walls. The colon on the right side was normal and the whole of the greater bowel had a very free meso-colon. Having found that I could bring the left extremity of the transverse colon to the anus I isolated and ligatured the left colic artery and having clamped the bowel divided it at the splenic flexure. I then isolated the sigmoid artery and the superior hæmorrhoidal vessels and ligatured them. The absence of fat in the retro-peritoneal tissue rendered this proceeding very simple. At the same time I ascertained that the distribution of the middle and right colic arteries was normal. I then excised the gut representing the descending colon, the sigmoid flexure, and the upper part of the rectum. I divided the bowel low down in the pelvis below the entrance of the superior hæmorrhoidal artery. A few bleeding points made manifest by the excision required ligatures. The child was now placed in the lithotomy position and having made an elliptical incision around the evidently narrowed anus I proceeded to remove the anus together with the lower and remaining portion of the rectum. The separation of the rectum from the slender vagina was a somewhat tedious matter. The middle hæmorrhoidal vessels were secured and the lower end of the rectum removed without difficulty. I returned to the

abdominal cavity and brought the transverse colon down to the anus where I secured it by a series of close sutures. The gut was conducted into position by four pressure forceps which were passed into the abdomen through the hole in the perineum. The operation was concluded by closing the wound in the abdomen without drainage.

The child made a speedy and excellent recovery. No sedative of any kind was needed as little pain was complained of. She was once sick. The only complication was represented by some suppuration between the new rectum and the vagina. This was no doubt due to accidental infection of the tissues while drawing the transverse colon into place. As soon as the child began to run about again this discharge ceased entirely. It is probably safe to conclude that the patient will in due course obtain control over the new anus. Be that as it may it was clear that the condition previous to the second operation was not consistent with other than a very short life.

It is quite clear that in this particular instance the dilatation of the colon was due to a congenital narrowing of the lower extremity of the bowel as represented by the segment supplied by the inferior mesenteric artery. This narrowed part exhibited no structural change. The specimen is in the Museum of the Royal College of Surgeons of England. Little idea of the immense degree of dilatation of the colon can be gathered from the preparation as it now appears. The junction of the narrowed portion with the dilated part is not so abrupt as it appeared to be before the intestine was removed. At this point of junction there is no mechanical obstruction and no disease of either mucous or muscular coats. In mounting the preparation the structures which formed the anus have been removed.

Wimpole-street, W.

A CASE OF COMPLETE REMOVAL OF A MULTILOCULAR CYST OF THE PANCREAS; RECOVERY.¹

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I WAS asked by Mr. Manley Sims to see the subject of the following notes on Oct. 5th, 1897. The patient, a married woman, forty-five years of age, had first noticed a swelling in the abdomen about seven months earlier, her attention having been drawn to the part by a slight tenderness. She stated that the swelling had grown very rapidly. By palpation with one hand behind and the other over the front of the abdomen the growth was easily felt in the left loin. It appeared to be from five to six inches in diameter and of a more or less uniformly rounded shape. Its greatest bulk was below the costal margin, but it was freely moveable and could be pushed with particular ease upwards and backwards until about three-fourths of it were overlapped by the ribs. The percussion note over the upper part of the anterior and outer aspects of the growth was dull, over the lower and inner parts the note was resonant. The percussion note was slightly duller over the ordinary position of the spleen than over the neighbouring lung tissues, this impaired resonance being quite separate from the abnormal dullness over the tumour in the abdomen. The right kidney was palpable and appeared to be of normal size and somewhat moveable. The tumour had no connexion with the pelvis. Mr. Sims had repeatedly examined the urine and had invariably found it free from albumin and sugar. In all other respects the patient was perfectly healthy and there was no history of any injury. During her first pregnancy she suffered from severe eclampsia. The child lived, and two other children were born without trouble of any kind. The patient had lost flesh to some extent but she was very well nourished and had been doing her best to reduce her weight. The family history threw no light on the nature of the tumour.

I believed the growth to be renal. I thought it was solid, and I inclined to the opinion that it was a sarcoma. It was arranged that another consultation should take place a month or six weeks later, and that in the meantime the patient would not take violent exercise or expose herself to any

¹ A paper read before the Medical Society of London on Dec. 15th, 1897.