slight: there were anorexia, restlessness, and general feeling of malaise, but no rise of temperature. General tonic treatment was prescribed, together with full doses of arsenic. The blebs were pricked and dressed with boracic acid and vaseline. Improvement soon took place, but blebs occasionally appeared, and the disease did not entirely disappear until five or six weeks after the confinement. Following the patient's last three previous confinements, she has had exactly similar attacks; they have usually commenced about the fourth day after delivery, and have lasted for several weeks. The first attack lasted ten weeks; the second also about ten weeks; the third lasted fifteen weeks, and was the most severe of all; the fourth and last was the mildest, and accompanied with less general disturbance than the others.

Leeds.

AN UNUSUAL CASE OF MUCOUS CYST.

By F. W. GIBBON, L.R.C.P.E., L.S.A., &c.

ON Sept. 9th I attended Mrs. G—— in confinement of a fine healthy female child. The following morning the nurse informed me that the infant had not passed urine, and drew my attention to a "tumour" filling up the vaginal cavity, which she attributed as the cause, especially as she said it came down very much when the child cried. On examining the child, I found a large cystic tumour, about the size of a pigeon's egg, which appeared full of pus; and on manipulating it and pressing it to one side the bladder relieved itself. I was puzzled, first, as to its situation, coming from a space between the clitoris and the meatus urinarius; and, secondly, as to its size and consistence, as it could not have arisen in fourteen hours, the time after delivery. However, with a bistoury I slit it up, and the contents were discharged (pure pus), the tumour disappeared, and four days afterwards the walls of the cyst came away. The child has had no other symptoms.

Tyne Dock, South Shields.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

LONDON HOSPITAL.

A CASE OF GASTROSTOMY FOR ŒSOPHAGEAL OBSTRUCTION WITH SUCCESSFUL RESULT.

(Under the care of Mr. M'CARTHY.)

THE following account of a case of successful gastrostomy—successful not only so far as the operation itself was concerned, but also in the relief afforded by it—is interesting; and we hope to be able to publish further details when the case has terminated. Already five months have elapsed, during which the patient has enjoyed comparative comfort, being saved from the dread of impending starvation, and able to make such good use of the opening as to gain flesh and strength. The operation was one specially indicated by the condition of the stricture, which was impassable to even the smallest bougies.

A wharf labourer, aged forty-seven, was admitted on the medical side of the London Hospital, under the care of Dr. Sansom, on April 6th, 1887, for inability to swallow. He said that he had had trouble in swallowing for about ten weeks, but that for the last few days solid food seemed to lodge a little way down his throat, and was then vomited; and that of liquids only a small quantity passed into his stomach, and the greater part was thrown up soon after it had been swallowed. Notwithstanding his assertion that he had lost flesh considerably, he was by no means emaciated, and weighed 137 lb. Examination of the throat, internally and externally, disclosed nothing. His heart was normal, and there was no evidence of thoracic aneurysm. Hepatic dulness extended for two inches below the ribs, and there was increased resistance to pressure in the right

half of the epigastrium. All attempts to introduce bougies failed. Even the smallest-sized instrument was arrested about two inches from the commencement of the œsophagus. Nothing could be ascertained from his family and personal history to elucidate his condition. He stated that he had never had syphilis, and there was no indication of that disease. He was occasionally subject to epileptic fits. For three weeks he was fed with nutrient enemata, as any food taken by the mouth was vomited, and many attempts were made ineffectually to pass bougies.

As the man had then lost six pounds in weight, and was becoming very weak, Mr. M'CCarthy was requested to accept the case for operation. Accordingly on April 27th the operation was performed. The patient having been anaesthetised, an incision two inches long was made parallel and about three-quarters of an inch internally to the left costal cartilages, the middle of the incision corresponding to the convexity of the ninth cartilage. The skin and fascia having been divided, the skin was drawn inwards so as to expose the sheath of the left rectus abdominis muscle. This was then divided vertically for two inches, and, the muscular fibres having been separated with the handle of the scalpel, the posterior layer of the sheath and the peritoneum were opened vertically for about one inch and a half. Through this opening Mr. M'CCarthy introduced one finger and explored the right half of the epigastrium. A hard nodular tumour, about the size of a pullet's egg, could be felt in the upper surface of the liver, but it was quite out of sight. The stomach was then attached to the anterior wall of the abdomen in the usual manner by two rows of sutures round the opening: one of carbolised silk, about three-quarters of an inch from the margin of the opening; and the other of silkworm gut, at the margin itself. The part was then dusted with iodoform and covered with a wood-wool pad.

For four days the patient was fed solely with nutrient enemata. On the fifth day Mr. M'CCarthy made a small incision in the stomach wall, and through this, when it had been dilated with a pair of dressing forceps, a soft rubber tube was introduced, and about two teaspoonfuls of egg-and-brandy mixture were injected. The patient at once complained of severe pain in the left shoulder and supra-clavicular region, which gradually abated after two or three hours. When the house-surgeon, Mr. Walker, repeated the injection at night, similar pain was felt, but after some days the patient ceased to complain of it. During the ensuing forty-eight hours the patient had five epileptic fits, and then became for some days furiously delirious. It was subsequently ascertained that he had been at one time in confinement for insanity. When the delirium subsided, the patient became very apathetic and his conjunctivæ were deeply jaundiced. The stomach was contracted and irritable, and the patient had a troublesome cough, so that for some time very little of what was injected was retained in the stomach, and nutrient enemata were still requisite. Gradually the stomach became more tolerant of food, and the patient improved so much that by the end of May he was able to leave his bed. He was then weighed, and had lost from the time of the operation 22 lb., weighing only 108 lb. The obstruction in the œsophagus had also diminished, for he was now able to swallow milk, arrowroot, and custard pudding easily. This improvement in swallowing was very temporary, and at present (Oct. 19th) he can only swallow a small quantity of fluid, and this is sometimes immediately vomited. From the end of May his progress has been uninterruptedly good, and his gain in weight considerable, his present weight being 156 lb. His general condition is very good, and his only trouble is some excoriation of the skin round the gastric opening, from leakage of fluid from the stomach.

WORCESTER GENERAL INFIRMARY.

CASE OF PERFORATION OF AN ULCER OF SMALL INTESTINE DUE TO A FALL, ASSOCIATED WITH FRACTURE OF FOUR RIBS BY DIRECT VIOLENCE.

(Under the care of Mr. HYDE.)

THE notes of the case were taken by Mr. T. P. Gostling.

Joseph S——, aged sixty-six, was admitted on Sept. 20th, 1887, at 7.30 A.M. He stated that between 11 and 12 P.M. on Sept. 19th he was walking home from Worcester, a distance of three miles, in the road, and stepped on one side to avoid a carriage. As soon as this had passed he stepped into the road again, and turned half round to look after it, when he

was immediately struck in the side and knocked down by the pole of a carriage which was following close behind the first. He got up and walked, with assistance, to his house, a distance of three-quarters of a mile. Up to the accident he had been quite well.

On admission, seven hours and a half after the accident, he complained only of pain on breathing in the mid-axillary region of the right chest, and of vomiting brownish fluid. He was quite conscious. The extremities were cold, pulse scarcely perceptible, and temperature subnormal. There was slight bruising of the front of the right shin, side of the right thigh, and of the scrotum. In the line of the right anterior axillary fold, over the third, fourth, fifth, and sixth ribs, there was a slightly marked bruise two inches in diameter. No emphysema was observed in the region of this bruise, but crepitus was extremely well marked. There was no cough. There was no bruising of the abdomen, which was flat, very rigid, and scarcely moved in respiration. Two ounces of urine were drawn off from the bladder; it was quite clear, and contained no blood. Vomiting was almost constantly present, everything given by the mouth being returned at once; the vomit being of a dark yellowish-brown colour, and giving the bile pigment reaction. Attempts to give food and stimulants by the rectum failed, as the injections were at once returned. There was a slight incised wound on the left eyebrow. At about 11 A.M. (twelve hours after the accident) the patient complained of slight pain in the right inguinal region, which was relieved by hot fomentations; but about 8 P.M. this returned, and became severe and general all over the abdomen, and the patient died half an hour afterwards.

Necropsy, fourteen hours after death—Rigor mortis well marked. On the surface of the body there were some slight bruises, as described above. On reflecting the soft parts from the chest, blood was found to be extravasated into the tissues which cover the third, fourth, fifth, and sixth ribs in the line of the right anterior axillary fold, and these ribs were each fractured in two places—i.e., about two inches from the attachment of the cartilages and just in front of their angles. On opening the chest, no adhesions were found on the left side, but there were a few old adhesions between the front of the right lung and the chest wall. Both pleural cavities contained about five ounces each of blood-stained serum, and the bases of both lungs were of a dark-red colour. On opening the abdomen, no extravasation of blood was found in the abdominal wall. The intestines were found to have lost their shiny appearance, and the vessels in them and in the great omentum were everywhere very much congested, especially on the right side, where there was a little fresh lymph between the coils of intestine. The abdominal cavity contained about fifteen ounces of thick yellow fluid, which had a faecal odour. Before removing the intestines they were examined, and a small oval opening about one-third of an inch across was found in the ileum about six feet above the caput cœcum coli. On removing the intestines and slitting them up, it was found that the edges of the opening were slightly raised, rounded, and smooth, and they did not present the least appearance of having been torn. No other ulcers were found. The liver was fatty, and there were old adhesions between it and the abdominal wall.

Note by Mr. HYDE.—The chief interest of this case is found in the existence of a single small ulcer of the intestine, the base of which had become sufficiently thin to be ruptured by a severe fall, and the very slight symptoms caused by the peritonitis present.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

The Condition and Management of the Intestine after Abdominal Section.

THE first ordinary meeting of the winter session of this Society was held on Tuesday last, Mr. G. D. Pollock, F.R.C.S., President, in the chair.

Mr. J. D. MALCOLM contributed a paper on the Condition and Management of the Intestine after Abdominal Section, considered in the light of Physiological Facts; of which paper the following is an abstract. The author directs attention to the origin and distribution of the nervous supply of the intestine, and to its influences on the

production of peristalsis, of intestinal secretions, and of intestinal gases. He concludes that all the functions of the intestine are under the control of automatic nervous plexuses in its walls, and that these are closely associated with the central nervous systems, but are also affected by all stimulations acting directly upon them. It is shown that stimulation of the motor plexus produces increase of its activity, followed by exhaustion and paralysis of its function in proportion to the severity of the stimulus; but that the influence of the nervous system on the production of secretions and of gases in the intestine is not so well understood. It is suggested that the chemical action of one intestinal secretion on another may be a source of the excessive flatulence of certain diseases, which has not been satisfactorily accounted for, but which "seems to be in some measure connected with defective or deranged innervation." (The above portion of the paper was illustrated by numerous and full quotations.) The author proceeds to show that in every abdominal section the intestine is abnormally stimulated, and the result is compared to that which causes the "after-constipation" of purgatives. Evidence is adduced of paralysis of the bowel after these operations, passing into paresis, and gradually recovering at the end of from four to six days; and it is observed that the excessive development of intestinal gases which occurs at this time is "connected with defective or deranged innervation." The importance of the escape of these gases is remarked on, and the causes of their retention are detailed and considered. Intestinal paresis is shown to be an important factor in the production of obstruction of the bowels in these cases, and a possible sole cause of death with symptoms of obstruction. (Cases were quoted, related, and explained.) The symptoms of obstruction of the bowels after abdominal section and the mode of death from this cause are examined, and the post-mortem appearances are referred to. It is shown that excessive or irritating discharges retained in the peritoneal cavity quickly produce symptoms of obstruction and of peritonitis. The author assumes that a local peritonitis must occur whenever the peritoneum is divided and does not heal by first intention, but he believes that general peritonitis—in the absence of septic influences—is one of the rarest of the primary complications of these operations. Septic peritonitis is described as a combination of peritonitis, blood-poisoning, and paralytic obstruction of the bowels, the intestinal symptoms being considered secondary to the paralysis of the gut induced by the peritonitis. The condition of the mental power and of the urine, and the post-mortem appearances, are contrasted with those in aseptic conditions. In the management of these cases the necessity of having the bowels cleared of all accumulations before operation is insisted on, and the greatest care is advocated in avoiding all unnecessary exposure and manipulation of parts during operation. The importance of securing immunity from infection of any kind is considered paramount; but the stimulating and chilling effects of carbolic acid and of Lister's spray producer are mentioned as dangers. After operation, the necessity for intestinal rest is urged, and the use of opium commended. Treatment of vomiting and abdominal distension by the early administration of purgatives is advised, unless the evidence of peritonitis is distinct; and the explanation is offered that purgatives act beneficially simply by stimulating the exhausted bowel to perform its functions. It is advised that irritation from discharges in the peritoneal cavity should be prevented by means of Keith's method of drainage, and that general or extensive peritonitis, when it does occur, should be treated by drainage, rest, and suitable nourishment administered by the bowel. Treatment of peritonitis by purgatives is condemned as dangerous, irrational, and inefficacious.—Mr. ALBAN DORAN did not think that flatulence was necessarily due to the operative interference, for there were many causes of flatulence, and the mere lying in bed of individuals who were unaccustomed to this mode of life might cause flatulence. Nightmare might occur after ovariectomy, and might be mistaken by the nurse for more serious disturbance; it was largely due to the supine position often adopted by the patient after operation. He considered that opium might be useful, but often tended to produce a feeling of depression accompanied with dyspepsia. Further, the formation of scybala should not be favoured, and opium undoubtedly predisposed to this formation.—Mr. KNOWSLY THORNTON was in general agreement with the opinions expressed in the paper, which dealt with a most important subject. The flaccid condition of the intestine after the operation was of pretty general occurrence, and the causes were, he believed, as Mr. Malcolm had indicated.