of the family had suffered from sore-throat, and diphtheria was hardly known in the district.

Later (in 1895) I inquired into another outbreak of rouph in a lark, and found that the outbreak was produced by pigeons, of which a large number was attacked and the death-rate had been high and chiefly among young birds. None of the family had suffered from sore-throat and diphtheria was hardly known in the district.

\textbf{Morbil anatomy.}—The following particulars may be taken as typical of an outbreak as recorded in a letter to the Lancet.

The bird under examination was a bantam hen standing about, or walking lazily when aroused, highly inflamed, and at the angle on one side was a piece of tissue, which, when sectioned and stained, showed a highly congested membrane. It was covered by yellowish membrane, while in others it showed a granular disintegration. The epithelium was healthy in some parts, while in others it showed a granular disintegration. Large cells with one, two, or three nuclei were also seen in the epithelium.

The bird from which these specimens were obtained had a very unhealthy appearance, but it emitted no nosey smell. In another hen-run one bird which made a very roupy noise was examined. The mouth was congested and covered with a whitish sticky membrane. The entrance to the air-passage was highly congested and swollen and this latter probably accounted for the roupy noise. In other birds the membrane was tough, whitish-grey, and possessed a foul odour; in others the mouth, nostrils, gullet, and entrance to the windpipe were deeply injected and were covered with a membranous membrane, while others, whose eyes appeared to suffer severely. In none of the cases was any paralysis observed, but this may have been owing to the rapidity of the fatal result.

\textbf{Conclusions and deductions.}—1. Rouph-like diphtheria (including the somewhat indefinite term "croup") varies in its malignancy, sometimes being mild with only one or two deaths in a large hen-run, while the next epidemic may give rise to diphtheria in the human subject. Its primary cause is a bacillus similar to Loffler's but far less virulent. This disease differs from the second one which is known as fowl diphtheria both in its symptoms and in its etiology but has nothing corresponding to human diphtheria except its name. The following case is published not on account of any clinical interest which it may have, but solely to put on record the fact that hydatid cysts are found, though very rarely, in natives of India who have never left their homes. The same writer even stated that many cases of liver abscess appeared to me to be cysts which had suppurated. The abscess appeared to me to be a cyst which had suppurated. Though not unknown, it is very rare to find this disease in India. Several cases have been recorded, but generally in Europeans or natives of India who have lived for some time in other countries. There are four specimens in the Calcutta Medical Museum from Europeans and two from persons of unrecorded nationality. Dr. Drury found hydatid post mortem in the body of an Eurasian who had lived in Australia. The Lahore Medical College Museum also contains a few specimens, but the nationality of the patients from whom they were taken is not known. Chevers writes: 'Our only evidence that hydatid disease can originate in India rests upon the debatable case of a low caste woman of Bhopal (Central India) who died with a large abscess in her right lobe of the liver. On cutting into this a considerable quantity of thin clear limpid fluid poured out containing numerous small cysts of a mother-of-pearl colour. The great cyst was about an inch and a half in diameter; recognising it to be a hydatid cyst and knowing the extreme rarity of this affection in natives of India I did not further disturb the parts, but sent the liver to the professor of pathology at the Medical College, Calcutta, Dr. F. J. Drury, who reported to me as follows: "It is undoubtedly a hydatid cyst, containing a number of daughter and grand-daughter cysts and numerous degenerated scolices."

The following case is published not on account of any clinical interest which it may have, but solely to put on record the fact that hydatid cysts are found, though very rarely, in natives of India who have never left their homes. A native of the district of Bhagalpur was sent to jail in August, 1896, pending trial for rioting and murder. He complained at once of fever and pain in the right side and was admitted to hospital. On examining him I discovered a large abscess-like tumour in the right flank. No point of the examination fitted: the region was deeply congested, and the pocket (from 102° to 103° F.) up to the time of his death two days after. Death, I believe, was due to septic poisoning from the contents of the suppurating cyst. The abscess did not communicate with the peritoneal cavity. The post-mortem examination showed that a few hours after death showed a large abscess cavity extending from the middle line, below the costal arch, up to the spinal column. All the other organs were found to be normal, but on removing the liver a yellow-white patch of cartilage-like tissue was seen on the deeper diaphragmatic surface of the right lobe of the liver. On cutting into this a considerable quantity of thin clear limpid fluid poured out containing numerous small cysts of a mother-of-pearl colour. The great cyst was about an inch and a half in diameter; recognising it to be a hydatid cyst and knowing the extreme rarity of this affection in natives of India I did not further disturb the parts, but sent the liver to the professor of pathology at the Medical College, Calcutta, Dr. F. J. Drury, who reported to me as follows: "It is undoubtedly a hydatid cyst, containing a number of daughter and grand-daughter cysts and numerous degenerated scolices."

The abscess appeared to me to be a cyst which had suppurated. No cysts were found in any of the other organs. Though not unknown, it is very rare to find this disease in India. Several cases have been recorded, but generally in Europeans or natives of India who have lived for some time in other countries. There are four specimens in the Calcutta Medical Museum from Europeans and two from persons of unrecorded nationality. Dr. Drury found hydatid post mortem in the body of an Eurasian who had lived in Australia. The Lahore Medical College Museum also contains a few specimens, but the nationality of the patients from whom they were taken is not known. Chevers writes: 'Our only evidence that hydatid disease can originate in India rests upon the debatable case of a low caste woman of Bhopal (Central India) who died with a large abscess in her right lobe of the liver. On cutting into this a considerable quantity of thin clear limpid fluid poured out containing numerous small cysts of a mother-of-pearl colour. The great cyst was about an inch and a half in diameter; recognising it to be a hydatid cyst and knowing the extreme rarity of this affection in natives of India I did not further disturb the parts, but sent the liver to the professor of pathology at the Medical College, Calcutta, Dr. F. J. Drury, who reported to me as follows: "It is undoubtedly a hydatid cyst, containing a number of daughter and grand-daughter cysts and numerous degenerated scolices."

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NOTE ON A NEW MEDIUM FOR THE GROWTH AND DIFFERENTIATION OF THE BACILLUS COLI COMMUNIS AND THE BACILLUS TYPHI ABDOMINALIS. 

BY ALFRED THEODORE MACCONKEY.

(From the Thompson-Yates Laboratories.)

In this medium advantage is taken of two well-known facts: (1) that the salts of bile are precipitated by acids, and (2) that bacilli coli communis produces acid in the presence of lactose while bacillus typhi abdominalis does not. The composition of the medium is sodium glycocholate, 0.5 per cent.; peptone, 1.5 per cent.; lactose, 0.3 to 0.5 per cent.; agar, 1.5 per cent.; and tap-water, q.s. The lactose is added after filtration. If glucose be used instead of lactose both tubes become cloudy, but the cloudiness due to bacillus coli abdominalis from above. In plates made with the glucose medium incubated for 48 hours at 42°C. and then left for 24 hours at room temperature the colonies gradually become orange-coloured. The sodium glycocholate was supplied by Messrs. Baird and Tatlock and is, I understand, a mixture of the glycocholate and taurocholate. It was recognised as advisable even a few years ago. We seldom receive any intimation that a malignant growth is forming in the colon until symptoms of subacute or chronic intestinal obstruction arise. When such a case presents itself, what treatment should be followed? Twenty, or even ten, years ago it was customary to remain satisfied with the performance of a colotomy, no attempt even being made to interfere with the primary cause of obstruction. At the present time much better results are obtainable. If the symptoms of obstruction are very severe a preliminary colotomy may be advisable, but in the less acute cases by far the best treatment is to resect the affected portion of bowel and re-establish the intestinal channel.

A man, aged 41 years, was admitted into the Royal Free Hospital on March 11th, 1900, complaining of intestinal obstruction. A fortnight before admission he had severe pain all over the abdomen and on March 1st his bowels were opened, but there had been no motion since, though some flatus had passed. As the abdominal pain steadily grew worse he took to his bed on the 4th. He was treated by a medical man but the pain did not abate. On the 6th vomiting commenced and had continued at intervals; he had been able to take nothing but milk and water since the 5th. There was nothing remarkable in his family history.

On admission the patient looked thin and ill; the abdomen was distended and tympanitic on percussion, but no distinct swellings could be made out and no peristaltic movements were visible. On examination per rectum nothing abnormal was visible. On the 11th the sigmoid flexure was drawn out into the wound. The sigmoid flexure was then covered with protective and gauze and the wound was closed. On the 16th he vomited a little. On the 12th he was more comfortable and had no vomiting, but the bowels did not act. On the 13th he vomited a little. The intestine was opened and a Paul's tube was inserted for drainage; his temperature improved and the wound looked well. By April 5th he was quite well and had no vomiting. On April 6th Mr. Battle decided to explore the abdomen to see if there was any retroperitoneal movement. On April 6th Mr. Battle decided to explore the abdomen for the purpose of discovering the cause of the obstruction and removing it if possible. The skin having been cleansed

A Mirror of HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Royal free hospital.

A case of obstruction due to new growth of the sigmoid flexure; inguinal colotomy followed later by resection of the growth; re-establishment of the intestinal tract; recovery.

(under the care of Mr. W. H. BATTLE.)

At the present day the treatment of malignant growths of the large intestine presents a very great contrast to that which was recognised as advisable even a few years ago. We seldom receive any intimation that a malignant growth is forming in the colon until symptoms of subacute or chronic intestinal obstruction arise. When such a case presents itself, what treatment should be followed? Twenty, or even ten, years ago it was customary to remain satisfied with the performance of a colotomy, no attempt even being made to interfere with the primary cause of obstruction. At the present time much better results are obtainable. If the symptoms of obstruction are very severe a preliminary colotomy may be advisable, but in the less acute cases by far the best treatment is to resect the affected portion of bowel and re-establish the intestinal channel.

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On admission the patient looked thin and ill; the abdomen was distended and tympanitic on percussion, but no distinct swellings could be made out and no peristaltic movements were visible. On examination per rectum nothing abnormal was discovered. Obstruction of the large bowel was diagnosed and, in the absence of Mr. Battle, Mr. T. P. Legg, the senior resident medical officer, decided to operate. The skin of the abdomen having been washed and the patient anaesthetised an incision three inches long was made at right angles to a line drawn from the umbilicus to the anterior superior iliac spine, one-third of the distance from the spine, with the centre of the incision on the line. The incision was deepened until the peritoneum was reached; when this had been incised the large intestine was found and the sigmoid flexure was drawn out into the wound. The bowel was greatly distended and was secured to the edges of the wound by two stitches which did not penetrate the intestinal wall. Another stitch drew together the edges of the incision under the bowel, passing through the mesentery; this was in order to form a well-marked spur. The bowel was then covered with protective and gauze and the wound was closed. On the next day the patient felt a little better and had no vomiting, but the bowels did not act. On March 13th he vomited a little. The intestine was opened and a Paul's tube was inserted for drainage; his temperature had not exceeded 100°F. Much focal matter came away, but he vomited no more. The patient's condition steadily improved and the wound looked well. By April 5th he was able to get up and go about the house.

On April 6th Mr. Battle decided to explore the abdomen for the purpose of discovering the cause of the obstruction and removing it if possible. The skin having been cleansed