was suggested as likely to offer a chance of relief if other remedies failed.

14th.—The sickness has become almost constant, but the vomited matter is not stercoraceous; the abdomen is very much distended; the pain is very great, and she has had no sleep; pulse 108 and weaker.

15th.—The sickness, the pain, and the obstruction continuing, my colleague, Mr. Bulteel, saw the patient in consultation with me. He concurred in the propriety of performing colotomy. The operation was performed in the afternoon.

The colon was opened in the left loin, and a very large quantity—nearly a washhand-basiful—of liquid fæces escaped. The bowel was very dark and friable, presenting all the appearances of strangulation; the superficial veins were much enlarged, varying from about one-sixteenth to one-eighth of an inch in diameter, and full of blood. It was fixed in the usual manner to the edges of the superficial wound, the wound itself, however, not being brought together with sutures, but merely covered over with lint soaked in diluted carbolic acid.

The progress of the case towards recovery has been uninterrupted. Sickness ceased from the day of the operation; pain has been easily relieved with small doses of opium. In two days the bowel began to regain its natural colour. On the third day a few ounces of fæcal matter came away from the anus, some portion of it being hard and lumpy; and about once a week ever since there has been about the same quantity. For the first two days the pulse remained at 114; on the third day it fell to 96, and it has not been higher since. The catheter had to be used for a few days. The wound healed rapidly, and on August 19th, thirty-five days after the operation, she had so far recovered as to come downstairs dressed; a plug in the artificial anus enabling her to move about with a wonderful amount of comfort.

In all cases of obstruction of the bowels the great difficulty is to localise the seat and to define the cause. In the case just narrated we were led to the belief that the obstruction was in the large intestine and in the sigmoid flexure by the following reasons:—Firstly, by the slow but gradually increasing distension of the abdomen; secondly, by the occasional character of the sickness in the beginning of the attack, and its increasing frequency as time went on; thirdly, by the inability to pass the long tube beyond the sacrum, and the small quantity of injection retained; fourthly and principally, by the fact of the late development of dulness in the left iliac fossa, pointing to an accumulation of fæcal matter above the obstruction; and lastly, by the general aspect and condition of the patient. The only exceptional symptom was the small quantity of urine passed. Then as to the cause of the obstruction. Dr. Fagge, in the Guy's Hospital Reports for 1868 has enumerated six heads under which most cases of intestinal obstruction may be placed. They are—1. Plugging of the bowel by its contents. 2. Intussusception or invagination. 3. Strictures situated in the coats of the intestine. 4. Contraction situated exterior to the coats. 5. Volvuli, folds, or twists of the intestine. 6. Internal strangulations. Accepting this classification as being the best for all practical purposes, under which of the heads were we to place the case? The habitual costiveness of the patient with the attack twelve months previously pointed to plugging by the contents of the bowel; the prolapse of the rectum for the last two or three months indicated intussusception; and the great liability of the sigmoid flexure to volvulus made it a very possible cause. The previous history and the symptoms in the present attack clearly excluded stricture in the bowel, contraction outside of it, and internal strangulation. Intussusception was eliminated because of the great rarity of its occurrence in the rectum, and by a careful digital examination. Of the two remaining causes it is difficult to decide which had most to do with the obstruction. Probably there may have been some amount of plugging of the bowel by its contents; but that a condition of volvulus supervened is almost certain, when we take into consideration the very fluid state of the fæces in the colon.

The dark colour of the muscular and mucous coats of the intestine was an unexpected, though it ought not to have been an unlooked-for, result of internal pressure from the large fæcal accumulation. The appearance was exactly that of the bowel in some cases of strangulated hernia; and

until fæces began to flow there was some doubt whether strangulation, external to the intestine, had not taken place. The fact that death of the intestine may be caused by internal as well as external pressure cannot be too clearly borne in mind, and is very important when we consider the question of colotomy and the right time to perform it. In this case, in fifteen days the condition of the tissues showed that relief had not come a day too soon. Perhaps in a younger subject with more perfect capillary circulation, and in others with less accumulation and therefore less pressure, the changes towards death of the tissues might not take place so rapidly; still, the danger of early death and early rupture of the intestine, from internal pressure in cases of obstruction, ought to be sufficiently weighed and considered when delay is recommended, and nature or medicine is trusted to yield relief. The operation is not very difficult, and, apart from concomitant circumstances, would not be very fatal. At any rate it is encouraging to find that even—as in this case—at the advanced age of seventy-five recovery is possible.

Devonport.

OVARIOTOMY FIVE WEEKS AFTER CONFINEMENT; ALBUMINURIA; DEATH ON THE THIRTY-NINTH DAY.

BY JOHN C. GOODING, M.D. EDIN.

MRS. D—, aged thirty-two, has always enjoyed excellent health. Married two years and eight months; was delivered by forceps on May 1st, 1873, after a lingering labour (the pains almost ceasing at last), of a healthy female child. The convalescence was quite satisfactory until May 8th, on the evening of which day she was seized with rigor and vomiting, followed by fever. For this I could discover no obvious cause; there was no abdominal nor other pain. Under treatment the febrile condition subsided by the 13th. During the attack the lochia were suppressed, but returned and were offensive, necessitating the use of injections. On the 14th there was another rigor followed by febrile symptoms, attributed by her to exertion with the baby, as the first had been to some unpleasantness with the nurse. On careful internal examination I could detect no cellulitis nor other local inflammation, nor tenderness anywhere; but in the right iliac region there was a globular, painless, elastic swelling. The febrile condition again subsided, but on the 21st rigor for the third time recurred, and high fever followed. Between the 14th and 21st the tumour in the iliac region steadily increased, fluctuated, was movable and still painless; it closely simulated a distended bladder, only it was to the right; the catheter drew off two or three ounces of urine. The fever did not again subside, nor was the rigor repeated. I came to the conclusion that the symptoms were due to an inflamed ovarian cyst, probably secreting pus. On the 28th there was pain and tenderness for the first time over the centre of the tumour, which now reached to the median line and as high as the umbilicus.

I told the friends my opinion, and that I considered the only chance of recovery lay in the removal of the tumour; and suggested, in so grave a state of things, the desirability of a consultation. On the 30th Dr. Evans, of Gloucester, saw her, and agreed in the diagnosis of inflamed ovarian cyst. We determined to try the effect of counter-irritation, morphia subcutaneously, and other antiphlogistic treatment; and, should there not shortly be evidence of amendment, to give the patient the chance of life by operating.

From May 30th to June 5th there was no improvement. The temperature ranged in the morning from 100° to 102°, in the evening from 103.1° to 104.1°; the pulse from 116 to 126. There was profuse sweating; scanty urine loaded with lithates; and not infrequently vomiting, although the patient was able to take moderate quantities of beef-tea, milk, and iced champagne. The strength was fast failing. The tumour continued to enlarge, reaching by June 5th five inches to the left of, and four above, the umbilicus. So quickly did it increase, and so distinct was the fluctuation,

that the fear of spontaneous rupture was constantly before me.

On June 5th, thirty-five days after her confinement, Dr. Rooke administered chloroform, and, kindly assisted by Mr. Hawkins and Mr. Newton, I proceeded to operate. A four-inch incision between the umbilicus and pubis exposed the characteristic pearly cyst. A few ounces of clear serum welled up, and were pressed out. Some recent adhesions to the anterior wall were easily broken down. The contents were then evacuated, and the cyst gently drawn out; with it came thickened omentum, to which, over a surface four inches by three, it was adherent; this was easily separated, and the moderate oozing controlled by pressure between the hand and sponge, and the omentum replaced. The pedicle, of good length and narrow, was clamped and the cyst cut away. The uterus was of normal size. The wound was closed with silver sutures, and supported by cotton wool and strapping. There was no traction on the clamp.

The cyst contained nine pints of turbid, offensive fluid, in which floated flakes of pus. Its interior was lined by a layer of pus which could be peeled off in strips. There was a secondary cyst as large as an egg, and two or three smaller, all similarly lined. The empty cyst weighed one pound; its walls were not attenuated, but appeared thinnest where adherent to the omentum.

The patient rallied well, and at 6.30 P.M. the pulse was 99; temperature 101.2°. Two ounces of clear urine were drawn off. At 12.30, pulse 108; temperature 101.2°. Three ounces of healthy urine. Skin warm and moist; takes ice freely; expresses a wish for milk.

June 6th.—Patient slept well after thirty minims of nepenthe; feels comfortable; has passed urine voluntarily on several occasions; skin warm and moist; no sweating; tongue slightly furred and moist. Was a little sick in the evening and somewhat irritable. In the morning the pulse was 102; temperature 99.8°. In the evening pulse 112; temperature 101.7°. Given a third of a grain of morphia subcutaneously.

8th.—Has taken chicken-broth and other light nourishment with relish. Tongue nearly clean; urine free and clear. Slept well after the morphia. Flatus passed. In the morning the pulse was 108; temperature 103°. In the evening pulse 102; temperature 101.8°.

9th.—Wound dressed to-day; it had been free from odour, and was not previously disturbed. The clamp was surrounded by thin offensive discharge. The deeper structures had firmly united, but there was no union of skin. In the morning the pulse was 108; temperature 102.2°. In the evening pulse 120; temperature 103.2°.

10th.—Bowels acted twice. No appetite. In the morning the pulse was 92; temperature 100.2°. In the evening pulse 120; temperature 103°.

11th.—Bowels acted again. Two stitches next to clamp were removed. In the morning the pulse was 96; temperature 100°. In the evening pulse 126; temperature 103.8°.

12th.—Feels better, and takes nourishment more kindly. In the morning the pulse was 92; temperature 98.5°. In the evening pulse 98; temperature 99.5°.

13th.—Removed last two stitches, as they had cut through the skin. Abdomen has at no time been distended, or the clamp depressed. In the morning the pulse was 102; temperature 99.6°. In the evening pulse 104; temperature 100.5°.

15th.—Has slept well and taken food better. The wound begins to show granulations. The clamp came away at the evening dressing. In the morning the pulse was 104; temperature 100.4°. In the evening pulse 110; temperature 100.2°.

16th.—Has been troubled all day by a neighbouring skittle-alley and the heat; is flushed and feverish. Stump depressed about an inch. The tongue is clean; appetite bad; urine free and healthy. In the morning the pulse was 100; temperature 100.3°. In the evening pulse 120; temperature 101.2°. Ordered wine and quinine.

19th.—Sleeps well and takes nourishment. Is more comfortable in a larger room to which she has been removed. In spite of care a bed-sore threatens. The wound granulates very slowly; there is no union of skin yet. To-night the skin is dry and hot. Pulse 140; temperature 103°.

22nd.—The temperature came down one degree each night; but it is 103° again to-night. The urine is scanty,

and contains blood. The pulse is quick and the skin dry. She feels discomfort rather than pain in the loins. Ordered to omit wine, and morphia injections; hot poultices to loins, and to take solution of acetate of ammonia, antimonial wine, and tincture of aconite in a mixture.

23rd.—Was sick during the night. Urine clearer, but is loaded with albumen. Tongue clean. A narrow slough an inch long is separating over sacrum. Evening: Pulse 126; temperature 100.4°.

24th.—Green fluid vomited on several occasions to-day, for which effervescing mixture was ordered with iced champagne. Perspires freely. Frequent desire to pass urine, which is muddy. Morning: Pulse 110; temperature 99.8°. Evening: Pulse 116; temperature 100.4°.

27th.—Sickness was relieved, and nourishment fairly taken. Healthy action of bowels yesterday. Perspires freely. Urine freely passed, albumen in quantity; microscopic examination of the scant deposit shows abundant hyaline and granular casts, pus-globules, and crystals of uric acid. Bed-sore cleaning. Wound healing. Morning: Pulse 124; temperature 100.2°. Evening: Pulse 120; temperature 102.4°.

29th.—Ordered twenty grains of bitartrate of potash every six hours, as the urine had diminished in quantity, and the patient did not appear so well. Morning: Pulse 120; temperature 101°. Evening: Pulse 108; temperature 102.5°.

July 3rd.—There is nausea; the patient gradually loses strength. About one pint of urine, unchanged in quality, is passed in twelve hours. She perspires, especially at night. There was yesterday twitchings of the extensors of the fingers. The bowels acted four times to-day; the bitartrate was therefore omitted. The poultices have been continuously applied. For the last three nights the temperature had been above 103°; pulse 120.

7th.—Temperature has continued high, and little difference between morning and evening—upwards of 103°. Muscular twitching of the arms, forearms, and face have gradually become more frequent; so that it is now incessant. She wanders, and is drowsy. Pulse exceedingly feeble; perspires freely; passes urine and stools unconsciously. Condition desperate. Ordered half a drachm of bitrate of potash every four hours.

8th.—The twitchings have been scarcely perceptible to-day, and she wanders less; but continues to pass evacuations unconsciously. There is not so much albumen in the urine. Skin acts well. Morning: Pulse 120; temperature 101.6°. Evening: Pulse 115; temperature, 101.5°. Bitartrate of potash every six hours.

13th.—The slight amendment was only temporary after the bitartrate; and this had to be discontinued because of diarrhoea. The twitchings and drowsiness returned; vomiting of green fluid became frequent. Prostration ensued, and slowly came death.

During the last few days the wound, which had, except the narrow centre of the stump, completely cicatrised, opened up; but the peritoneal cavity remained closed. At no time was there anasarca or local oedema.

Cheltenham.

NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

The annual meeting of this Society was held on the evening of Sept. 29th, in the library of the Newcastle Infirmary. Dr. Philipson, President, occupied the chair. The following is a list of officers appointed for the ensuing year:—President: Dr. Philipson. Vice-Presidents: Drs. Burnup, L. Armstrong, Peart, and Mr. Broadbent. Honorary Secretary: Mr. Henry E. Armstrong. Committee: Drs. Denham, Humble, Arnison, B. Bramwell, and Page, Messrs. C. Carr, Hawthorn, Russell, and Redmond.

AN anonymous donor has placed a large sum in the hands of the Committee of the Birmingham and Midland Institute, for the foundation of a Lectureship on the Laws of Health, and also for a prize fund in connexion with the class. Dr. Corfield has been offered the post for this year, has accepted it, and will deliver an inaugural lecture in the Town Hall, Birmingham, on Thursday, October 9th, at 8 P.M., on "Sanitary Progress." The course will begin on Tuesday, October 14th, at 8 P.M., and be continued on succeeding Tuesdays until some time in April. It is intended more especially for the working classes, and both men and women will be admitted.—*Nature*.