I have not seen her for some time now, but she comes in to the hospital every little while, and Dr. Boland says she is gaining weight and doing very well.

Examination of the resected gut showed a polypus almost completely filling the lumen of the bowel. This was undoubtedly the cause of the intussusception.

TWO CASES OF INTESTINAL OBSTRUCTION DUE TO CONSTRICTING BANDS.¹

BY JOHN WHEELLOCK ELLIOT, M.D., BOSTON,

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CASE I. CONSTRICTION AT THE ILEUM BY MECKEL'S DIVERTICULUM.

THE patient, a young girl of 17 years, was operated on for chronic appendicitis on July 22, 1898. Three months later, Oct. 20, she was taken with dull pain in the left hypogastric region. The patient had failed to menstruate as was expected, and this attack was at first supposed to be due to suppression of the flow.

When I first saw her, on Oct. 24, in consultation with Dr. Maurice Clarke of Haverhill and Dr. Bancroft of Wellesley, the bowels had not moved for two days, in spite of frequent administration of cathartics and enemata. The abdomen was distended, tender and tympanitic. No gas had passed that day. The patient had vomited several times. Cathartics were discontinued, and opiates given. In spite of this change of treatment, vomiting and distension continued. No gas passed. The operation was done on Oct. 26. On opening the abdomen bloody fluid escaped. The ileum was found to be tightly constricted by an adherent Meckel's diverticulum about four inches from the ileocecal valve. The intestine just above the constricting band was much dilated, deeply injected, of a dark purple color. The obstruction was quickly relieved by dividing the band. The abdominal wound was closed with drainage on account of the doubtful condition of the dilated intestine. The operation was finished with the patient in a critical condition. Recovery was rapid and uneventful. It was noticeable that the seat of the pain was remote from the actual lesion,—the latter was to the right of the median line, the former in the left hypogastric region.

CASE II. CONSTRICTION AT THE SIGMOID FLEXURE BY A BAND.

The patient was a married woman 35 years old, and was brought to the accident room of the Massachusetts General Hospital on March 1, 1901. She had always been constipated and had been obliged to use cathartics for the past year to secure movements of the bowels. Five days before coming to the hospital she had been seized with pain in the left lower abdomen and vomited several times. Since that day she had been unable to retain any food. On the first day of the

attack her doctor, by means of cathartics and enemata, had succeeded in inducing three large watery movements of the bowels; since that time nothing but gas had passed. The pain had subsided, and when the patient made no attempt to take food she was comparatively comfortable, except for the weakness due to lack of food. The patient thought she had lost weight during the past year. She had never noticed blood or mucus in the stools. The abdomen was everywhere soft, somewhat distended and tympanitic. There was some tenderness on deep pressure over the sigmoid region.

The operation was done on March 2. On opening the abdomen the bowels were found enormously distended. With great difficulty the distended large intestine was traced down to the pelvis, where it was found to be constricted. The patient was placed in the Trendelenburg position, and a transverse incision made part way across the left rectus muscle to give a better view of the pelvis. The descending colon was punctured with trochar, and the neighboring distension relieved by the escape of gas, the points of puncture being closed with intestinal sutures. When a good view of the constricted part was finally obtained, a small hard band was found to be wound completely round the intestine and adherent to a venous plexus on the side of the pelvis. One of the convolutions of the intestine, adherent to this band, had been drawn out toward the pelvis in such a way as to make it look like a true diverticulum. The band, however, was probably due to old adhesions, as more adhesions were found deeper down in the pelvis behind the uterus. When the band was cut the collapsed intestine below immediately filled, and the obstruction was relieved. The patient made a good recovery. The bowels moved well after a small enema on the first day after the operation. There was no pain, and the distension was quickly relieved. The wound healed by first intention, and the crosscut of the rectus muscle gave no trouble.

Medical Progress.

REPORT ON PROGRESS IN OPHTHALMOLOGY.

BY MYLES STANDISH, M.D., AND WM. DUDLEY HALL, M.D., BOSTON.

THE SIGNIFICANCE AND PATHOLOGY OF THE ARGYLL-ROBERTSON PUPIL.

WILFRED HARRIS¹ states that this sign is met with most commonly in tabes and general paresis,—diseases which are due largely, if not entirely, to syphilis. He believes the loss of pupil contracting to be an almost certain sign of congenital or acquired syphilis. He has met this pupil also in juvenile locomotor ataxia and general paralysis with history of acquired syphilis, progressive muscular atrophy, lead poisoning, aortic aneurysm, hemiplegia, syphilitic meningitis, ataxic paraple-

¹ Read before the Surgical Section, Suffolk District Medical Society, May 1, 1901.

¹ British Medical Journal, Sept. 29, 1900.