scirrhous from columnar epithelioma by the naked eye appearance alone. In these cases the new formation is of very slow growth, and before complete obstruction supervenes there is a period during which symptoms referable to the intestinal canal present themselves, and the importance of which at the time they occur is not often recognised. It is interesting to learn that Mr. Lammiman's patient exhibited symptoms of intestinal derangement previous to the occurrence of her fatal illness.

2. I fail to appreciate the advantage of administering, as Mr. Lammiman says that he did, a "competent purgative" when symptoms of acute obstruction are present. Such treatment would appear to me likely not only to increase the present peril of the patient, but would interfere greatly with the chance of recovery if operative measures were subsequently undertaken.

3. There is a point upon which I can throw some light—viz., the passage of the rectal tube for such a long distance, while the stricture was comparatively a small way only from the anus. During the month of February, 1881, I assisted Mr. Pitts at an operation for the relief of intestinal obstruction. The cause of the obstruction was discovered, after making a small median incision of sufficient size to allow the hand to be passed into the abdominal cavity, to be a hard annular stricture of the sigmoid flexure exactly as described by Mr. Lammiman. Previous to the operation I had easily passed the rectal tube for eighteen inches, and at the operation, simply as an experiment, the instrument was used again, and, on reaching the stricture, was seen to bend upon itself, and to return the way it came.

Mr. Pitts' case was published in the St. Thomas's Hospital Reports, and he was the first, I think, to suggest the operation of colectomy in such cases. Mr. Pitts also pointed out the ease with which colotomy can be performed after gastrotomy, by cutting upon the finger placed within the abdominal cavity, and, further, that in this way a colotomy incision through the abdominal parietes an inch in length is quite sufficient, and that both the colotomy and gastrotomy wound can be kept completely aseptic until union between the deeper tissues be accomplished.

That colectomy will in the future in a great measure take the place which in the past has been held by colotomy I have no doubt; but I am not so well assured that in this country we shall ever attempt the cure of stricture or gangrene, artificial anus or fæcal fistula, by complete resection of the gut and immediate union of the divided ends with such confidence as continental surgeons. It would appear that the English as a nation are not constitutionally so well fitted to bear operations as the people of some other countries. Last winter I read before the Medical Society of London a case of Vesico-intestinal Fistula following Dysentery, which I had treated by colotomy. I ventured to suggest colectomy for the treatment of like cases when the fistula was not due to malignant disease, and when there was good reason to suppose that the intestine was implicated somewhere below the upper part of the descending colon. By this method the contents of the bowel would escape entirely by the artificial opening, and thus the fistula would have rest from the passage of fæces, and might ultimately close. When there is any uncertainty as to the cause of the trouble in patients with obstruction of the bowels, and therefore the possibility that colotomy would fail to afford relief, I think it infinitely preferable to make a small incision in the median line so as to explore the abdominal cavity. With thorough antiseptic precautions the danger of such a proceeding is reduced to a minimum. Not only is there no disadvantage arising from such a proceeding; but, on the contrary, I should look upon it as the pathway of safety. If such a case were to occur to me as that in which Mr. Lammiman performed colectomy in the loin, and the patient would submit to the operation at a period when a satisfactory issue might be anticipated, I should certainly choose the abdominal incision, bring the stricture out through the wound, ligature the bowel on each side of it, excise the stricture with every care to keep the parts aseptic, and then attach the proximal portion of the gut to the margins of a small incision made by cutting down upon the finger placed within the abdominal cavity through the iliac or lumbar regions of the abdominal parietes. Colotomy, again, is often performed on patients suffering from cancer of the rectum to remove obstruction, or for the relief of the pain produced by the passage of fæces over an ulcerated surface. It is well known that a portion of the contents of the bowel still passes by the natural channel; it will therefore be obvious that the interruption of the continuity of the gut by liga-

ture or division below the artificial opening would be a great improvement upon the old operation. Colotomy is without doubt a very imperfect method of practice, but it must still find a place in surgical procedure. The hope, however, may be expressed that the day is not far distant when colectomy, or perhaps complete resection of the intestine, will supersede it in many instances.

Harley-street, W.

NOTES OF A CASE OF UTERINE FIBROID REMOVED BY ABDOMINAL SECTION.

PEDICLE TREATED WITH SILK; HÆMORRHAGE IN TWELVE HOURS; REOPENING OF ABDOMEN, AND APPLICATION OF KÖEBERLÉ'S SERRE-NOUD; RECOVERY.

By J. CRAWFORD RENTON, M.D. EDIN.,
SURGEON TO THE DISPENSARY OF THE WESTERN INFIRMARY;
SURGEON TO THE EYE INFIRMARY, GLASGOW.

MRS. A—, aged thirty-five, married, no family, was sent to me in October, 1882, by Dr. Allan. She complained of a swelling in her abdomen, which she stated had existed for ten years: recently it had grown somewhat, and had given her pain and inconvenience, so that she was anxious to have it removed if possible. On Nov. 10th she was admitted to the Training Home for Nurses. On examination per hypogastrium, a round doughy tumour was found, movable, with obscure fluctuation; measurement round umbilicus thirty-two inches. Per vaginam: The uterus is high up in the pelvis, but movable, and seems to move along with the tumour; probe passes easily. Per rectum: The tumour is felt passing into Douglas' space; menstruation regular. Had not had attacks of menorrhagia. Dr. Allan and Dr. Beatson examined the patient with me, and we were of opinion that we had probably to deal with a uterine outgrowth closely attached to the uterus. The woman was otherwise in good health and with no history of serious peritoneal pains, and as the mass gave rise to great discomfort we recommended her to have it removed.

On Nov. 18th, assisted by Drs. Allan, Beatson, and Nairn, I performed the following operation. An abdominal incision, four inches in length in the median line, was made, and the surface of the tumour exposed. No adhesions were found except one or two at the right side; a trocar was passed into the growth, and as only a little blood escaped, it was evident that we had to deal with a solid tumour. The abdominal opening was enlarged two inches upwards and downwards, and the tumour was found growing from the uterus and attached by a distinct pedicle, which was six inches in circumference and two and a half in thickness. The tumour was turned out and a Foulis's band, fitted with hooks instead of the ordinary catch, was applied to the pedicle. This controlled the large vessels in it; and on Dr. Beatson's suggestion I passed a skewer through the pedicle above the band and then cut off the tumour with the ovaries attached. I now secured the pedicle with four strong Keith's silk ligatures below the band, and having done so I removed it and cut off with the cautery an inch and a half of the pedicle, which was now dropped into the abdominal cavity, the wound closed with silk sutures, dressings applied, and the patient placed in bed. The operation lasted an hour and twenty minutes from the commencement of chloroform inhalation to the time the patient was in bed, the length of time being accounted for by the fact that cutting through the pedicle with the cautery was very tedious. Evening: The patient is weak. Pulse 132; temperature 99°. — 19th, 10.30 A.M.: The patient collapsed; pulse hardly perceptible; pain in the abdomen, some distension. Hæmorrhage had evidently occurred; and, with the approval of Drs. Allan and Beatson, ether was administered both by inhalation and subcutaneously, and I opened the wound. I found that the pedicle was bleeding freely, shrinking having taken place and the ligatures ceasing to act. The pedicle was drawn up, and Köeberlé's serre-nœud, which I had obtained through the kindness of Dr. H. Cameron, was applied firmly round it and left fixed in the lower angle of the wound, the clots were cleared out, and the wound again closed. The form of clamp used was most convenient, as it can be gradually tightened as the pedicle shrinks. Stimulants were freely given and ether injected subcutaneously; but the pulse con-

tinued frequent and weak. The patient took stimulants and soup, and subcutaneous injections of ether were continued, as they always appeared to improve the pulse.—20th, 11 A.M.: Pulse continues to be very rapid, and at times barely perceptible, patient weak and collapsed looking; it was therefore quite evident that unless some improvement took place soon our patient would die. I accordingly determined to perform transfusion unless there was some improvement by two o'clock. At Dr. Allan's suggestion we gave her warm milk in half teacupfuls every half hour, and this she retained, so that by 2 P.M. her pulse was perceptible and not so rapid. This seemed to be the turning-point, for notwithstanding certain alarming collapses she gradually improved, and was soon able to take any form of simple nourishment. The wound healed at once, and the clamp separated on the 28th day, the aperture closing a few days afterwards, and the patient was dismissed well on January 6th, 1883.

Remarks.—The result of the operation fully justifies the procedure adopted; at the same time I feel that but for the splendid nursing she received in the training home, she could not have survived the double operation. It may be argued that there was no urgent bleeding to call for the tumour being removed, but the discomfort and mental annoyance it caused, along with the acknowledged safety of such operations, were sufficient for agreeing to perform it. Whether removal of the ovaries would have been sufficient I cannot say; but in future cases I shall be inclined to try; especially if the patient is weakened by loss of blood. As regards the tumour, it weighed five pounds, and was a distinct outgrowth, and on section presented a very definite fibroid appearance. Dr. Newman examined the specimen, and found that it presented all the characteristics of a uterine myoma.

Glasgow.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

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

SEAMEN'S HOSPITAL, GREENWICH.

TROPICAL ABSCESS OF LIVER; FREE INCISION; ABSENCE OF PERITONEAL ADHESION; RECOVERY; REMARKS.

(Under the care of Dr. CARRINGTON and Mr. JOHNSON-SMITH.)

FOR the following notes we are indebted to Mr. W. T. Hodge, clinical assistant.

H. H—, boatswain, aged thirty-two, was admitted on Aug. 9th, 1883. The patient had been frequently in tropical climates. He contracted dysentery three years previously in Calcutta, but got quite well of this. Two months before admission he had an attack of severe pain in the "pit of the stomach." This was continuous and aching in character, and went off after twenty-four hours. The present illness commenced on Aug. 4th, 1883, when the patient was seized with severe pain in the epigastrium, which was followed shortly afterwards by pains between the shoulders and in the lumbar region. He had suffered in this way up to his admission. He had no rigors, but constant sweating, great thirst, and loss of appetite. The bowels acted about six times in the twenty-four hours, the evacuations being rather light in colour.

Condition on admission:—The patient lay upon his back, with anxious expression and somewhat restless. The skin was hot and dry; the tongue was thickly coated with yellow fur. There was dulness on percussion in the right hypocondriac and epigastric regions, extending as far as two inches below the free margin of the ribs, and reaching across the median line as far as the eighth costal cartilage. The upper limit could not be defined on account of the excessive tenderness. Pressure over this area caused great pain, more especially at a point three inches above the umbilicus, a little to the right of the middle line. Neither pain

nor gurgling was elicited by pressure on the right iliac fossa. Respiration 30, thoracic, shallow, with a catch at the end of inspiration; breath-sounds normal in front and axillary regions; heart normal; pulse 98; urine albuminous; temperature 104° 8'.

On August 10th there was perceptible bulging at the part that was so markedly tender on the previous day. Poultices were applied over the right hypocondriac region, with the result of much diminishing the pain and tenderness, so that the swelling could on Aug. 11th be freely touched and handled, whilst formerly the slightest touch made him wince. On the 12th an exploratory puncture was made at a point two and a half inches from the median line, and half an inch below the margin of the ribs, the needle being passed upwards and backwards. When three inches had been inserted pus was discovered; it was perfectly sweet.—Aug. 10th: Morning temperature, 101° 8'; evening, 101°.—11th: Morning temperature, 99°; evening, 100° 4'.—13th: Morning temperature, 98° 4', before the operation; evening, 101° 8'. On the 13th the patient was placed under the influence of ether, and Mr. Johnson-Smith introduced an exploring needle just below the right ribs, and again drew off pus; under the carbolic spray he then made a vertical incision two inches long, passing through this spot. A director was passed into the abscess, and a free incision made into the cavity by a blunt-pointed bistoury passed along it. About a pint of pus and broken-down liver substance, mixed with blood, escaped. The finger introduced through the incision passed through about an inch of liver into a large abscess sac, and it could also be freely passed into the peritoneal cavity, for no adhesions existed. A large drainage-tube was introduced. The abdominal wall was pressed down upon the liver by two large sponges bandaged on, and the wound was dressed with antiseptic precautions. On the 14th the patient felt quite comfortable. The wound was dressed, and there was a large quantity of discharge upon the dressings. This was perfectly sweet. There was no cozing of pus from the wound. The cavity was not washed out, for fear of destroying newly formed adhesions. Morning temperature, 98° 4'; evening, 98° 2'.—15th: He slept well last night, and this morning was in no pain. The wound was dressed to-day, and the abscess cavity syringed out. It was looking very healthy. Morning temperature, 98°; evening, 99°.—16th: Patient has been going on well. His appetite has returned. Fish diet ordered. Morning temperature, 98° 2'; evening, 98° 8'; pulse, 92.—17th: His wound was dressed to-day. There was a large quantity of perfectly sweet discharge. The drainage-tube was shortened and the sponges discontinued. Morning temperature, 98° 4'; evening, 98° 4'.—18th: Dressed. A large quantity of sweet discharge. Morning temperature, 98°; evening, 98° 4'.—19th: Dressed. Condition unchanged. Morning temperature, 98°; evening, 98° 4'.—20th: Dressed. The discharge has slightly diminished. Morning temperature, 98°; evening, 98° 4'.—21st: Dressed. Discharge quite sweet. The drainage-tube is more and more extruded from the wound each day, and cannot be made to pass any further into the cavity. It was shortened to-day.—22nd: Dressed. Morning temperature, 98°; evening, 98° 4'.—23rd: Dressed. Discharge diminished in amount. Morning temperature, 98°; evening, 98°.—24th: Dressed. The discharge does not now amount to more than one or two ounces. The wound is looking very well. Morning temperature, 98°; evening, 98°.—26th: Dressed. There was very little discharge. The drainage-tube was shortened by about an inch. No pus came out on syringing the cavity. Morning temperature, 98° 4'; evening, 98°.—28th: Dressed. About three-quarters of an inch of the drainage-tube was cut off. Morning temperature, 98°.—29th: The patient was allowed to get up.—30th: Dressed. Discharge less.

Sept. 2nd: Dressed. Spray dispensed with.—4th: Dressed. Drainage-tube shortened by half an inch. No discharge on syringing out, and very little in dressings.

The patient now gets up every day, and walks about without feeling any pain in his side. The wound is now simply a sinus, which is healing up steadily from the bottom.

Remarks by Dr. CARRINGTON.—The case seems worthy of record, both from its rapidly favourable termination, and from the fact that, in spite of the entire absence of adhesions between the liver and abdominal walls, no ill-effects ensued from the free incision of the abscess. It is the custom now at the Seamen's Hospital to freely excise all hepatic abscesses under the carbolic spray, and it is rare to find adhesions shutting off the peritoneal cavity absent.