

CASE 5.—On May 19th, 1881, I performed the operation on a male with malignant rectal disease. The local distress had caused him to seek relief. Fifteen days after the operation the patient returned to his home, ten miles off, and when heard of last summer he was following his occupation of engine tenting, and although feeling acutely the disagreeable incident to an artificial anus, still free in a great degree from the distressing and almost constant bowel pains.

CASE 6.—On June 9th, 1882, in a case of pelvic tumour, which had developed malignancy, and almost entirely occluded the bowel, I formed an artificial opening. The patient had become so exhausted from the local distress, coupled with the ravages the disease had inflicted on her general nutrition, that when the operation was agreed to death seemed imminent. The shock of the operation almost killed the patient, and although she lived for sixteen days perfectly freed from pain, still the wound never put on healing action.

CASE 7.—Four days after the above case, I again did the operation on a woman between sixty and seventy years of age for malignant rectal obstruction. Her recovery was interrupted and rapid, and relief from suffering most marked. The other day she called on me, grateful for what had been done for her.

Remarks.—Up till date these seven cases complete my experience of colotomy. In all the left lumbar operation was performed and the incision was oblique, running from the margin of the last rib across the quadratus lumborum to and in front of the anterior superior iliac spine. No particular difficulty was experienced in any of my cases, and the loss of blood was but trifling. In one instance a fold of sub-peritoneal fat so simulated the flaccid bowel that I had actually transixed it before finding out my mistake. There is a danger of making the incision too far forward. This I did in Case 6, and in consequence wounded the reflected peritoneum, but no harm was done the patient thereby. Carbolised catgut was used in my first two cases to fix the edges of the opening to the skin, but because of its solution before firm union had taken place it was abandoned for Chinese silk. Colotomy is not practised so often as it ought to be. By diverting the fæces and so giving rest to diseased parts it may be directly curative in its action, as illustrated by Case 4. For such cases its more general adoption would prove a great gain in the treatment of cases which otherwise are intractable to treatment. The repugnance which patients frequently manifest even at the thought of such an operation would in great measure be removed when the temporary character of the artificial opening was explained, and the strong reasons for its production. When cure is altogether out of the question, owing to the malignant nature of the disease, we can replace intense, even in many cases incessant, pain by comparative comfort, and, unless the operation is delayed too long, prolong life. This is abundantly shown in the cases above recorded, and by an operation the mortality from which is very small. If patients suffering from malignant disease were seen sufficiently early, a combination of colotomy, as a temporary measure until healing of the parts had taken place, and excision of the diseased portion of bowel would offer the best chance of ultimate recovery. But unfortunately such patients as a rule come too late.

Nottingham.

A RAPID METHOD OF DEMONSTRATING THE TUBERCLE BACILLUS WITHOUT THE USE OF NITRIC ACID.

By HENEAGE GIBBES, M.D.,

CURATOR OF THE ANATOMICAL MUSEUM, KING'S COLLEGE.

THE following method, which I have used for some time with great success, will I think prove useful to those requiring the demonstration of the tubercle bacillus for diagnostic purposes in a rapid manner. The great advantage consists in doing away with the use of nitric acid. The stain is made as follows: Take of rosanilin hydrochloride two grammes, methyl blue one gramme; rub them up in a glass mortar. Then dissolve anilin oil 3 c.c. in rectified spirit 15 c.c.; add the spirit slowly to the stains until all is dissolved, then slowly add distilled water 15 c.c.; keep in a stoppered bottle.

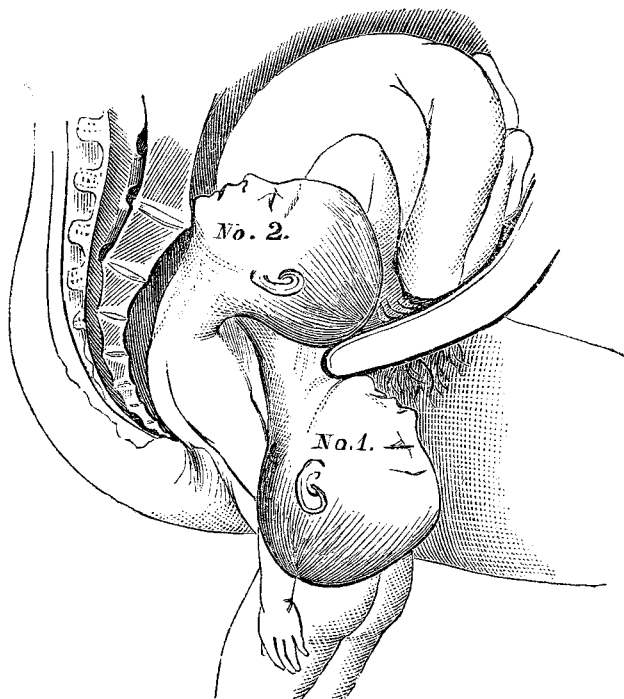
To use the stain: The sputum having been dried on the cover-glass in the usual manner, a few drops of the stain are poured into a test tube and warmed; as soon as steam rises pour into a watch-glass, and place the cover-glass on the stain. Allow it to remain for four or five minutes, then wash in methylated spirit until no more colour comes away; drain thoroughly and dry, either in the air or over a spirit-lamp. Mount in Canada balsam. The whole process, after the sputum is dried, need not take more than six or seven minutes. This process is also valuable for sections of tissue containing bacilli, as they can be doubly stained without the least trouble. I have not tried to do this against time, but have merely placed the sections in the stain and allowed them to remain for some hours, and then transferred them to methylated spirit, where they have been left as long as the colour came out. In this way beautiful specimens have been made, without the shrinking which always occurs in the nitric acid process. The stains may be procured from Messrs. R. and J. Beck, 68, Cornhill, E.C., either in crystals or in solution, ready for use.

AN INTERESTING MIDWIFERY CASE.

By FRED. C. CORY, M.D.

A SHORT record of the following complex case of midwifery may be interesting to the readers of THE LANCET.

A poor woman (multipara), the wife of a mechanic, was being attended by an uncertificated midwife for two days prior to my seeing the case. I could not get from this woman any clear statement of how such a condition of things had taken place. She was confused in her mind, having a constant craving for stimulating her nerve centres, which rendered her incapable of answering any questions, or even taking care of herself, much more of the patient. Of course this votary of Bacchus was very quickly dismissed from her post. The accompanying woodcut presents a rough



sketch of the position of each child in and out of the uterus, as far as I could ascertain by their external appearances. These children were in a high state of hæmic congestion, amounting almost to blackness. The child whose head was expelled, and whom I shall for the sake of distinction call No. 1, had the face towards the maternal pubes, the chin resting thereon, with its neck pressed closely under the arch by the back and shoulders of No. 2; the body was above the brim. No. 2 had the body from the arms and shoulders downwards expelled; the chin of this child rested on the brim of the maternal pelvis by the right sacro-iliac synchondrosis, the occiput impinging on the upper edge of the pubis to the right of the symphysis. The greatest difficulty was experienced in getting the index-finger upwards, so that

I could make out the different positions of the children. I think their relations to each other will be fairly represented in the rough drawing, although the neck of No. 2 was more elongated than is shown in the sketch. The woman was much exhausted by her long and continued efforts, begging to be helped out of her difficulty. I gave her some brandy with an egg well whipped up, which soon had the effect of improving her pulse, and cheering her with a few encouraging words of speedy help, for her spirits were much depressed by the midwife telling her she could not possibly live or get over it. I had great difficulty in introducing the perforator between the two bodies up to the occiput of No. 2, and perforating the head, when, by drawing down the shoulders during the acme of a pain, the head passed into the cavity of the pelvis, and was soon expelled. The body of No. 1 quickly followed. The placenta was easily thrown off, and the uterus contracted well, there being little or no hæmorrhage. The poor woman was thus freed from her peril, and made a good recovery.

Buckhurst Hill.

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.

LONDON HOSPITAL.

DISLOCATION OF THE HIP-JOINT BACKWARDS; REDUCTION BY MANIPULATION; REMARKS.

(Under the care of Mr. RIVINGTON.)

GEORGE W—, aged twelve, was admitted on March 23rd, 1883. He had been running, and suddenly slipped and fell, his left leg shooting forwards and outwards. He felt something give way at his left hip-joint, and was in great pain for a few minutes. He was unable to rise or walk, and was brought to the hospital in a cab.

On examination, the left leg was found to be one and a half to two inches shorter than the other. It was adducted, flexed, and rotated inwards, the lower part of the left femur passing over the lower third of the right femur, and the toes resting on his right instep. There was very little mobility; the trochanter was elevated, and the head of the bone could be felt some little distance behind the acetabulum and below the dorsum ilii. Mr. Rivington was sent for, and the lad was placed under an anæsthetic. The senior dresser was asked to reduce the displacement. The thigh was flexed on the abdomen, adducted, and brought down without effect on the displacement. It was then flexed, slightly abducted, rotated outwards, and extended, care being taken not to carry these movements too far, when the head of the bone at once slipped into the acetabulum with an audible snap. A splint was applied to prevent the reproduction of the dislocation, and was retained for a fortnight. He was kept in bed for a week or two longer, then allowed to get up, and was soon discharged cured.

Remarks by Mr. RIVINGTON.—This case illustrates the great facility with which dislocations of the hip are produced when the leg is abducted. Mr. Morris has shown that the direction which the head of the bone will take after escaping from the rent in the lower part of the capsule depends upon what may be termed the secondary postures. If the thigh is flexed and rotated inwards, a backward displacement will result; if extended and rotated outwards, a forward displacement is produced; and if extended without rotation, the displacement will be in the downward direction. What was the exact disposition in the present case was not clear from the description of the patient. It is probable that Mr. Morris's views in regard to the production of dislocations at the hip during abduction will receive strong support from cases occurring at an early period of life. One case of dorsal dislocation in a lad of seven, whose foot slipped backwards and outwards in walking, he has recorded in his paper in Vol. lx. of the *Medico-Chirurgical Transactions*; and I find an instance of thyroid displacement related by Mr. Russell

in the *British Medical Journal* for Nov. 2nd, 1878, as occurring to a lad of fourteen. The youth, W. B—, was playing at football and jumped on the back of a playfellow, when they both came to the ground. W. B— alighted on his feet, but they slid asunder, and the dislocation downwards was produced. The case further shows the ease with which properly directed manipulation will reduce an ordinary dislocation in which the capsule is freely torn below. The great point to attend to in reducing sciatic and thyroid displacements is not to carry the manipulations too far in any direction, as these forms of dislocation are readily convertible into each other. Bigelow recommends the conversion of the obturator into the dorsal displacement, which is easy of reduction. This conversion occurred in Mr. Russell's case involuntarily, and in a case of my own, reported in THE LANCET, Sept. 7th, 1878, when I was trying to avoid it. The dorsal displacement is much less likely to be transformed into an obturator displacement than the obturator into the dorsal; and I have not seen it occur in any of the cases which have come under my observation.

GLASGOW ROYAL INFIRMARY.

THREE CASES OF DISEASE OF THE STOMACH AND INTESTINES.

(Under the care of Dr. MATTHEW CHARTERIS.)

WE are indebted to Dr. James McNish for the following notes:—

CASE 1.—John McN—, aged forty-two, a labourer, was admitted on October 2nd, 1882, complaining of pain, with tenderness on pressure, in the epigastrium, and vomiting. The pain was most severe at a point about two inches to the right and one inch and a half above the umbilicus. The symptoms first appeared three months before admission, and had gradually increased in severity. At first they were those of simple indigestion, heartburn, &c.

On admission the patient was pale and emaciated, but not distinctly cachectic, and his countenance bore an anxious and pinched expression, indicative of abdominal trouble. No tumour or induration could be made out, but there was very considerable tenderness on pressure over the area mentioned above. He vomited frequently after food, and this seemed to some extent to alleviate the pain. The vomited matter consisted of a brownish sour fluid, which the patient said had a very disagreeable taste. The bowels were constipated, never acting without the aid of purgatives or enemata; the appetite was bad; the tongue coated with a thick white fur on the dorsum, but red and glazed at the tip and edges, showing also signs of indentation by the teeth. On exertion the patient suffered considerably from dyspnœa, but on examination the lungs and heart were found to be healthy. On October 10th and 11th he had severe attacks of hæmatemesis, which weakened him a good deal. From this date he gradually sank, and died on October 22nd. The treatment consisted of the use of aperients and enemata to overcome the obstinate constipation, sedatives internally and externally to relieve the pain, and the subcutaneous use of ergotine to arrest the hæmorrhage.

Necropsy, forty-four hours after death.—The smaller curvature of the stomach was found to be firmly adherent to the under surface of the liver; the latter organ being firmly united to the diaphragm, so that it was with difficulty separated from it. At the point where the stomach was most adherent to the under surface of the liver—viz., immediately to the left of the longitudinal fissure—there was a transverse constriction of the former organ, not sufficient, however, to divide it into two distinct parts. The pyloric end of the stomach was greatly distended, and the cardiac orifice of the œsophagus was approximated to the pylorus, as a result of contraction of the lesser curvature. The explanation of the approximation was that there was a large deep ulcer on the smaller curvature corresponding to the point at which the outer wall of the stomach was adherent to the liver. Close to the left edge of the ulcer there were two small openings, which on examination were found to be the open ends of bloodvessels. The floor of the ulcer was covered with small, soft, elevated nodules, which, on being examined with the microscope, were found to be purely inflammatory in nature, without a trace of malignant disease, being composed of cicatricial tissue and without evidence of recent ulceration.