

intussusception than in other forms of obstruction, and this record may therefore prove instructive. The hope that the invagination may slough and come away is a very delusive one; for, as Mr. Treves has pointed out, only a small proportion of patients in whom this occurs actually recover. Obviously in this case the obstruction would still have existed, even though the intussusception had sloughed off. The greater the number of cases recorded, the more will knowledge advance; and the more knowledge advances, the more will the principles that guide the treatment of internal and external strangulated hernia tend to assimilate.

### CROYDON INFIRMARY.

#### A CASE OF ACUTE INTERNAL STRANGULATION.

(Under the care of Mr. F. W. CLARK, L.R.C.P., M.R.C.S.).

F. B.—a Polish Jew, aged twenty-nine, was admitted into the infirmary on Tuesday, July 6th, 1886, at 5 P.M. He was a fairly well nourished man, a painter by trade, and on admission he complained of great pain in the abdomen and intense thirst. His face had a drawn and anxious expression; there was pallor of the surface; the tongue dry and coated; and he lay in bed on his back with his knees drawn up, and was evidently in great suffering. The abdomen was distended and tympanitic, and was tender all over, but especially so over the hypogastric region. The pulse was small, hard, and rapid—"wiry,"—and the respiration thoracic. The patient dated the onset of his illness from the previous Saturday (four days), on which day he had partaken largely of some tinned salmon, and since that meal he had suffered from pain in the abdomen, which had gradually increased. There was no history of vomiting, but it was elicited that his bowels had not been opened since the onset of the pain in the abdomen. There was no external hernia. The patient asked repeatedly for a catheter; a No. 10 silver English catheter was accordingly passed into the bladder without any difficulty, and four ounces of clear, high-coloured urine were drawn off, containing no traces of blood. Turpentine stupes were at once applied to the abdomen, and he was given a grain of opium by the mouth; and was ordered two drachms of brandy every half-hour, diluted with small quantities of warm water. During the night the patient twice got out of bed to get to the night-stool, and, with much straining, he passed about two ounces of very dark-coloured fluid blood. Vomiting set in at 8 P.M. the patient bringing up at this time the brandy which had been given him, and he continued to vomit intermittently until his death at 1 A.M., eight hours after admission, the vomited matters not becoming stercoraceous until within an hour of his death.

At the necropsy, made thirteen hours after death, a large mass of gangrenous small intestine was found lying in the pelvic cavity, while the rest of the bowel was matted together by recent lymph. The gangrenous bowel was found to have been strangulated by a rounded fibrous cord, about an inch and a half in length, stretching between two adjacent coils of small intestine in such a manner as to form a loop through which the strangulated bowel had passed. This band had evidently been formed by the stretching of an old peritonitic adhesion of the intestine.

*Remarks by Mr. CLARK.*—Apart from the comparative rarity of such cases of acute internal strangulation, this case, I think, presents several features which are of especial interest. One is so apt to look upon faecal vomiting as inseparable from strangulation of the bowel, whether external or internal, that the marked absence of this symptom in the present case until the patient was *in extremis*, rendered the cause of the peritonitis at first very obscure. The persistent reference by the patient of all his pain to the bladder, coupled with the marked tenderness over the hypogastric region, suggested a rupture of that viscus as the possible cause of the peritonitis, but the result of the catheterisation completely negatived such a conclusion. Another feature which adds an interest to the case is the nature of the strangulating band. It is well known that fibrous adhesions of adjacent segments of bowel, the result of an old peritonitis, will, under the influence of the peristaltic contraction of the bowel, gradually elongate to form bands of fibrous tissue stretching across the peritoneal cavity, and these bands or cords may, as in the present case, occasionally prove the direct cause of an in-

ternal strangulation. It is most probable that, had the patient been seen earlier—for he had been ill for four days before admission, yet had sought no medical advice,—and had the condition been correctly diagnosed, an abdominal section, followed by the division of the strangulating band, might have been the means of saving his life. Other points of interest in the case are: firstly, the fact that the patient was a painter by trade, and so liable to attacks of intestinal colic; and, secondly, the suspicion of irritant poisoning, which was excited by the history that the symptoms dated from the time at which he had partaken largely of some tinned fish.

### DORSET COUNTY HOSPITAL.

#### A CASE OF SUPRAPUBIC LITHOTOMY.

(Under the care of Mr. A. EMSON.)

FOR the following notes we are indebted to Mr. F. J. Malden, house-surgeon.

R. W.—, a quarryman, aged sixty, residing at Portland, was admitted on Oct. 14th, 1886, with symptoms of stone in the bladder. The symptoms had not been severe, but had been present over a period of four years. It was only a few days before he came to the hospital that he was obliged to give up his work, on account of frequency of micturition, hæmaturia, and pain after the act of micturition.

At the time of admission the urine was alkaline, specific gravity 1020, no albumen, muco-purulent. The stone was readily detected by means of a No. 8 sound with small curve, and the ring heard distinctly. The stone, which seemed to fit in the concavity of the sound, was situated in the right lower part of the bladder. The attempt to pass the grooved "staff" on two previous occasions having failed on account of the enlargement of the prostate, it was determined to remove the stone by the suprapubic instead of the lateral method. The operation was performed on Jan. 11th, 1887. The rectal bag was first inserted, and twelve ounces of warm water introduced with a syringe; the bladder was then distended by means of eight ounces of carbolic lotion (1 in 1000), and the penis tied with a soft rubber catheter. An incision was now made about three inches long in the middle line, coming well down on to the front of the pubes; after this the tissues were separated by means of a director, handle of scalpel, and finger nail until the wall of the bladder came in view. There was no hæmorrhage to speak of, no vessel needing ligature. The hook used in this case for elevating the walls of the bladder was one found particularly serviceable (it was made by Ferguson, and intended for cases of laryngotomy); on the convex surface of it is a groove (like a miniature staff), into which the point of the scalpel was inserted, and an incision in the bladder wall made direct from the point of puncture of the hook large enough to admit the finger. The stone was easily felt, and removed by means of a small pair of lithotomy forceps. A drainage tube was inserted into the bladder, but it slipped out during the night, and was not replaced. No sutures were placed in the walls of the bladder, but two in the upper part of the abdominal wound, which was dressed with absorbent cotton wool.

On the day of operation the evening temperature was 101°; next day, morning 100·4°, evening 101°; the following morning 99·6°, evening 100·4°. From this time the temperature remained about normal. There was a free discharge of urine through the wound. No catheter was passed until Jan. 25th, when a soft rubber one was tied in; this after the second day, however, set up urethritis, and was discontinued. The after treatment consisted in placing the patient alternately on one side or the other as much as possible, to encourage drainage. The wound was dressed with boracic lotion (1 in 80), and the urine absorbed by means of sponges and absorbent cotton wool. The patient's progress was satisfactory, but slow; the wound granulated, but cicatrization took place slowly. On Feb. 6th (twenty-seven days from operation) twenty ounces of urine were passed through the urethra, being the first time it had flowed naturally since the operation. The abdominal wound now began to contract more rapidly. The stone was a mulberry calculus covered with phosphates weighing five drachms. The handle of the scalpel used was made of tortoiseshell rounded off at the end and bevelled to form an edge, and was admirably adapted for separating the tissues in this case.