

be several generations before this object could be thoroughly accomplished, but by assiduous attention and hereditary transmission I imagine it would be quite feasible.

These are a few unconnected thoughts which a consideration of the case related above has suggested to my mind; and I feel that many of them are but empty theories on a subject lying more in the domain of psychology than physiology, and the solution of which may never be attained.

ART. XIV.—*A Case of Sloughing of the Rectum.*^a By W. M. A. WRIGHT, M.D. Univ. Dubl.; Medical Officer, Killiney Dispensary; late Demonstrator of Anatomy, University of Dublin.

THE notes which I am about to lay before you are of a case of sloughing of the rectum in its third stage, which appeared to me to present features of sufficient interest in its history, course, and result to warrant my bringing it under the notice of the Academy of Medicine.

CASE.—On January 22nd, 1884, I was sent for to see a lady, aged sixty-five, a widow. Her history was as follows:—She was the mother of a large family, eight children, and had always led a most active and healthy life, taking great pleasure in outdoor amusements—as gardening, &c. She had only once suffered from any serious illness, when, after the birth of one of her children, for two months she was confined to her bed by an attack of inflamed piles; but ever since the birth of her last child, twenty years ago, she was annoyed by these piles, which never bled, but frequently slipped down while she was at stool, and required to be replaced by her fingers, a little operation which she was generally able to perform without difficulty. She stated emphatically that her bowels had always acted most regularly, and that she seldom or never required to take aperient medicine.

On visiting her I found her in bed, with temperature 100° and pulse 100, complaining of great pain from the piles, which had come down the day before, after a copious stool, and which she had not been able to replace. On examination I found a ring of piles outside the anus, tightly gripped by the sphincter, intensely congested, and very tender. Oiling them, I endeavoured to reduce them, and partially succeeded, but was soon compelled to desist, owing to their swollen condition and to the intense pain the attempt caused. I then prescribed soothing

^a Read before the Medical Section of the Academy of Medicine on Friday, Feb. 27, 1885.

treatment, opium stupes, &c., locally, to relieve pain, and opium and belladonna internally. On the 25th the inflammation appeared to have extended to the vagina, the vulva becoming tender, and a profuse leucorrhœa setting in. On the 27th retention of urine came on, and for eight days I had to relieve the bladder by the catheter.

On the 28th she told me that she was suffering from diarrhœa, and the nurse showed me what passed from the bowels—thickish, yellow, semi-liquid fæces, with no sign of mucus, or of solid lumps. On this day the skin covering the buttocks on either side of the anus became red, glazed, and erysipelatous-looking, and felt very tense, the inflammation being much more marked on the right side.

On Feb. 1st the skin gave way on the right side, about an inch from the anus, and through this opening liquid fæces commenced to pass. By the 3rd of Feb. the external opening appeared as large as a threepenny piece, and almost all the fæces passed through it, hardly any escaping by the anus.

On the 4th she regained power over her bladder, and the tenderness from the inflamed piles had so much diminished that I was able, for the first time, to make a rectal examination. On introducing my finger I passed it into the largest mass of impacted fæces that I ever met. Before withdrawing my finger I broke up as much of it as I could reach, and then gave a copious enema of soap and water, passing an O'Beirne tube as far as possible—about five inches. The enema brought away a number of scybala, most of which passed by the fistula. Next day I repeated the same treatment, again breaking up the mass, which seemed unreduced in bulk, with my finger, and then giving an enema. The result was, to use the nurse's expression, "a bucketful." The following day again the same enema and result, and now I could clearly define the internal opening of the fistula. At the right side of the rectum, about one and a-half or two inches above the anus, a portion of the wall of the gut had sloughed clean away, leaving an internal opening as large as a half-crown piece.

At this time my friend, Dr. C. B. Ball, saw the case with me, and while examining her was able, with his finger, easily to press some scybala, quite as large as walnuts, through the fistula. He suggested the use of enemata of olive oil and oil of eucalyptus, which proved most effective, but their smell was so much disliked by the patient that I had to discontinue them. By daily copious enemata, from 4th to 10th Feb., I at last got the bowels free from the fæcal accumulation, and my patient gradually improved in strength, but still complained much of pain over the gluteal region on the right side, where the skin remained tense and red, until the 14th, when an abscess which had formed under the skin there opened into the fistula, causing a copious discharge of odourless, healthy pus. After the evacuation of this abscess

my patient's recovery was uninterrupted, and by the end of March she was able gradually to resume her former active habits.

I last examined her on the 22nd of April, and found the fistula had so closed that it would with difficulty have admitted a small-sized probe; the piles remained external, but their mucous surface had become hardened and insensible to pain. I may add that all through she steadily refused to permit any operative interference.

Remarks.—First, as to the exact nature of the case, there can be little doubt that the primary cause of the acute trouble was the presence of the enormous fæcal accumulation, which had formed without the slightest suspicion of the fact on the part of the patient. My opinion is that the irritation and pressure caused by this mass set up the inflammation of the rectum and of the hæmorrhoids; that the continued pressure caused the sloughing of the bowel, just as the continued pressure of a foetal head during the second stage of a tedious labour may cause sloughing of the vaginal walls. The rectum having given way, the escape of the fæces into the cellular tissue of the ischio-rectal fossa accounted for the peri-proctitis, the erysipeloid condition of the skin over the buttock, and its ultimately giving way to form the external opening.

Probably the retention of urine was due more to reflex irritation than to any direct extension of the inflammation to the bladder.

I regret that I was able to make only a very hurried search into the literature of the subject, and could not find any cases at all similar to mine recorded, except in *The Lancet* for June, 1866, where there is an account, by Mr. T. W. Nunn, of two cases of "Gangrene of the cellular tissue of the ischio-rectal fossa," which resembled my case in the erysipeloid state of the skin over the buttock, but which differed in that in both cases there was no ascertainable connexion with the rectum, that there was a distinctly gangrenous smell from the cellular tissue, and that there was great constitutional prostration (with brown furred tongue, &c.). While in my case there was a large opening from the rectum into the fossa, at no period was there any more objectionable smell than that of fæces; even the pus from the abscess which formed under the skin of the buttock, and which communicated with the fistula, was odourless; and, lastly, the constitutional disturbance was remarkably slight, considering the gravity and extent of the local mischief and the age of the patient. At no time was her tongue much furred, or her temperature over 101° F.

With regard to the treatment it must be remembered that the

patient was most reluctant to permit local measures, and refused surgical interference, relying on the fact that on a former occasion she had recovered from an "attack of piles" without any local treatment except warm stupes. Looking back, there is one thing I regret that I did not insist on—a vaginal examination at the beginning of the case when, of course, I would have detected the presence of the fæcal mass, but even had the cause of the attack been patent from the very first, efficient steps for its removal could not have been taken until the time when I actually commenced them, when the first intensity of the inflammation had somewhat subsided.

In conclusion, I am happy to say when last I saw my patient she informed me that she felt as well as ever she had in her life. She thought the fistula must have quite closed up, as it gave her no trouble whatever; the piles still remained external, but were smaller, and did not annoy her; that her bowels acted daily and freely, and that she would not allow any operation to be performed on her.

ART. XVI.—*Cases of Osteotomy for Deformity of the Lower Limbs.*

By L. HEPENSTAL ORMSBY, F.R.C.S.I., M.D. Univ. Dubl.;
Lecturer on Clinical and Operative Surgery, and Surgeon to the
Meath Hospital and County Dublin Infirmary; Surgeon to the
Children's Hospital, Dublin.

I. OSTEOTOMY — SUPRA-CONDYLOID OPERATION FOR GENU VALGUM, DETAILING STEPS PRIOR, DURING, AND SUBSEQUENT, TO THE TRANSVERSE SECTION OF THE FEMUR IMMEDIATELY ABOVE THE CONDYLES.

II. THE HISTORY AND PROGRESS OF TWELVE SELECTED CASES OF OSTEOTOMY FOR DEFORMITY OF THE LOWER LIMBS.

I. OSTEOTOMY.

OSTEOTOMY is now an operation which every practical surgeon performs, although for some years it was confined to the specialist. I believe that the operation, if it is done under the spray, and with full Listerian precautions, is perfectly safe, and not liable, in dexterous hands, to be followed by any untoward results. The patients on whom osteotomy is performed generally belong to a rickety, strumous diathesis. However, during a few weeks before