

abscess *might* be due to suppurative changes in hydatid cysts previously existing in the liver. This, however, has never been proved. Davidson in his "Geographical Pathology" makes no mention of India in his account of this disease and, strangely, the articles in Quain's Dictionary on this subject give no details as to the distribution of the parasite. The above case, however, proves beyond a doubt that hydatid cyst can occur in a native of India who has never left his own country.

Bhagalpur.

NOTE ON A NEW MEDIUM FOR THE GROWTH AND DIFFERENTIATION OF THE BACILLUS COLI COMMUNIS AND THE BACILLUS TYPHI ABDOMINALIS.

By ALFRED THEODORE MACCONKEY.

(From the Thompson-Yates Laboratories.)

IN this medium advantage is taken of two well-known facts: (1) that the salts of bile are precipitated by acids, and (2) that bacillus coli communis produces acid in the presence of lactose while bacillus typhi abdominalis does not. The composition of the medium is sodium glycocholate,¹ 0.5 per cent.; peptone, 1.5 per cent.; lactose, 0.3 to 0.5 per cent.; agar, 1.5 per cent.; and tap-water, q. s. The lactose is added after filtration.

If stab cultures be made in this medium with bacillus coli communis and bacillus typhi abdominalis and incubated at 42° C. for from 24 to 48 hours it will be found that the tube inoculated with bacillus coli communis has become cloudy while the tube containing bacillus typhi abdominalis remains quite clear. If glucose be used instead of lactose both tubes become cloudy, but the cloudiness due to bacillus coli communis begins from below and that due to bacillus typhi abdominalis from above. In plates made with the glucose medium incubated for 48 hours at 42° C. and then left for from three to four days exposed to the light at room temperature the colonies gradually become orange coloured.

Though my experiments are not quite concluded I venture to draw the attention of bacteriologists to this medium because it has a more marked inhibiting effect than carbolised media upon the growth of ordinary soil and water organisms and may prove useful to those who are engaged in examining water, soils, and food-stuffs.

¹ The sodium glycocholate was supplied by Messrs. Baird and Tatlock and is, I understand, a mixture of the glycocholate and taurocholate.

THE EPILEPTICS AT WITHINGTON.—The Chorlton Board of Guardians are not at ease about the sane epileptic patients in their charge. From want of accommodation they are at present compelled to occupy the same wards as the imbecile and insane patients. This is obviously a state of things that should be remedied as soon as possible, for to some sane people, even though paupers, such association would be absolutely cruel. Dr. Rhodes said that the guardians were not responsible and that the blame should be laid on the Local Government Board who "were in default through their delay in giving sanction to the scheme which would make provision for these unfortunate people." Other places had the same complaint to make. Few will be found to contradict his further statement that "the methods of the Local Government Board were far too slow." He said he called a few days before at their offices and complained of the manner in which the Board treated the guardians, giving quite "a bit of his mind" to the, no doubt, astonished officials—i.e., if they could be astonished, for by this time such complaints must have lost all their novelty. "He considered the present methods of the Local Government Board were neither satisfactory nor even courteous to the guardians and were certainly not creditable to the former authority. He hoped the guardians would not further delay the provision of the additional accommodation at Withington workhouse. The treatment of epileptics was a matter concerning not merely the guardians of the Chorlton Union but almost every board in the country."

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.

ROYAL FREE HOSPITAL.

A CASE OF OBSTRUCTION DUE TO NEW GROWTH OF THE SIGMOID FLEXURE; INGUINAL COLOTOMY, FOLLOWED LATER BY RESECTION OF THE GROWTH; RE-ESTABLISHMENT OF THE INTESTINAL TRACT; RECOVERY.

(Under the care of Mr. W. H. BATTLE.)

AT the present day the treatment of malignant growths of the large intestine presents a very great contrast to that which was recognised as advisable even a few years ago. We seldom receive any intimation that a malignant growth is forming in the colon until symptoms of subacute or chronic intestinal obstruction arise. When such a case presents itself what treatment should be followed? Twenty, or even ten, years ago it was customary to remain satisfied with the performance of a colotomy, no attempt even being made to interfere with the primary cause of obstruction. At the present time much better results are obtainable. If the symptoms of obstruction are very severe a preliminary colotomy may be advisable, but in the less acute cases by far the best treatment is to resect the affected portion of bowel and re-establish the intestinal channel.

A man, aged 41 years, was admitted into the Royal Free Hospital on March 11th, 1900, complaining of intestinal obstruction. A fortnight before admission he had severe pain all over the abdomen and on March 1st his bowels were opened, but there had been no motion since, though some flatus had passed. As the abdominal pain steadily grew worse he took to his bed on the 4th. He was treated by a medical man but the pain did not abate. On the 6th vomiting commenced and had continued at intervals; he described the vomited matter as resembling coffee-grounds. He had been able to take nothing but milk and water since the 5th. There was nothing remarkable in his family history.

On admission the patient looked thin and ill; the abdomen was distended and tympanitic on percussion, but no distinct swelling could be made out and no peristaltic movements were visible. On examination per rectum nothing abnormal was discovered. Obstruction of the large bowel was diagnosed and, in the absence of Mr. Battle, Mr. T. P. Legg, the senior resident medical officer, decided to operate.

The skin of the abdomen having been washed and the patient anaesthetised an incision three inches long was made at right angles to a line drawn from the umbilicus to the anterior superior iliac spine, one-third of the distance from the spine, with the centre of the incision on the line. The incision was deepened until the peritoneum was reached; when this had been incised the large intestine was found and the sigmoid flexure was drawn out into the wound. The bowel was greatly distended and was secured to the edges of the wound by two stitches which did not penetrate the intestinal wall. Another stitch drew together the edges of the incision under the bowel, passing through the mesentery; this was in order to form a well-marked spur. The bowel was then covered with protective and gauze and the wound was dressed. On the next day the patient felt a little better and had no vomiting, but the bowels did not act. On March 13th he vomited a little. The intestine was opened and a Paul's tube was inserted for drainage; his temperature had not exceeded 100° F. Much faecal matter came away, but he vomited no more. The patient's condition steadily improved and the wound looked well. By April 5th he was allowed to get up every day.

On April 6th Mr. Battle decided to explore the abdomen for the purpose of discovering the cause of the obstruction and removing it if possible. The skin having been cleansed