

of an hour, and has taken some brandy and beef-tea without a return of the hiccough.—Mid-day: Pulse 120; temperature 98°6'; skin moist; thirst continues; abdomen much distended, but little or no pain is felt on pressure.

Fifth day.—The patient feels comfortable, though he has not slept much during the night. Pulse 100, of better volume. An ounce of castor oil, taken yesterday, had opened the bowels.

Sixth day.—Pulse 116, of good volume. He slept during the first part of the night. There has been another attack of hiccough. The urine passes freely through the wound, the surface of which looks dry and sloughy.

Seventh day.—The patient has passed a bad night; he looks anxious. Pulse 120, and small; respirations 35, shallow and irregular; temperature 99°6' F. The urine passes through the wound, which still looks dry and sloughy. Within the last twenty-four hours he has taken about four ounces of brandy, with sago, arrowroot, and milk.—Mid-day: He is unconscious; the pulse is very small and intermittent; respirations shallow and irregular. Death ensued at 3 o'clock.

The following morbid appearances bearing on the case were discovered at the post-mortem examination:—The mesentery and omentum were loaded with fat; no lymph, either old or recent, could be found in the peritoneal cavity. When the knife was passed through the peritoneum into the pelvis, a quantity of pus welled up from a large patch of diffuse cellular inflammation, which extended from the side of the wound backwards to the part behind the rectum. The left kidney was of natural size, pale and soft; the capsule non-adherent; the calices, pelvis, and ureter were dilated, and filled with purulent urine. The right kidney was imbedded in a large quantity of fat, was somewhat smaller than natural, and pale and soft; the calices, pelvis, and ureter were very much dilated; at one spot the capsule was adherent, and the cortical substance was wasted to about the thickness of a line. The liver was large and soft, and broke down under slight pressure. A few small vegetations were found on the cusps of the mitral valve. About a pint of purulent fluid occupied the left pleura. The corresponding lung was compressed, but otherwise healthy.

#### TWO CASES OF INTESTINAL OBSTRUCTION TREATED BY COLOTOMY.

(Under the care of Mr. SAVORY.)

We are indebted for the following cases to Mr. P. Butler Stoney, house-surgeon:—

CASE 1.—A. W.—, a woman fifty-six years of age, was admitted with constipation of six, and vomiting of five days' standing. She suffered every few minutes from severe griping pains, which were relieved by pressure, and stated that the last motions she had passed had been no thicker than her little finger. She had never been the subject of hernia, and, although both the rectum and the vagina were carefully explored with the finger, no evidence of any such affection could be detected. Her abdomen was somewhat distended. Her vomit was not stercoraceous, and consisted of recently-taken food.

On the seventh day of constipation (the day after admission) five grains of calomel with a grain of opium, and an enema consisting of two ounces of gruel and one of castor oil, were administered. The latter brought away a small shred of mucous membrane, but no trace of faecal matter was voided, and on the following (eighth) day, though there was less vomiting, the tongue was found to be dry and coated with white fur, and the face drawn and slightly thinner. A drachm of sulphate of magnesia, with ten grains of the carbonate, was ordered to be taken in an ounce of spear-mint water every six hours.

The use of this draught was discontinued on the thirteenth day, when a final dose of half an ounce of castor oil was administered. In the meantime no action of the bowels had been obtained, and the vomiting, with an intermission of twenty-four hours, had continued. Gas had been passed daily per anum, the pulse had remained low, and, with the exception of a rise to 102°2' on the ninth day, the temperature had varied between 98°2' and 99°4'.

On the fifteenth day the pulse was 116, weak and thready; the temperature 98°4'. The tongue was thickly coated and very dry, and the patient complained of abdominal pain, which was increased on pressure.

Mr. Savory then took the opinion of his colleagues as to the advisability of performing colotomy, and the side on which the opening should be made. On the latter point there was some difference of opinion, but, as he suspected that the seat of obstruction was somewhere in the colon itself, he decided to operate on the ascending portion. The opening in the gut gave passage to a large quantity of faecal matter and gas.

On the following day the patient expressed herself as much relieved, though she had not slept much, and was occasionally sick; her temperature was 100°. On the second day after the operation she complained of a return of the abdominal pain, and at three o'clock in the afternoon very aggravated vomiting came on; an hour and a half later a motion was passed through the natural passage, although large quantities of faeces passed through the artificial opening as well. The patient suffered from abdominal pain and vomiting until she died, at eight o'clock. She had taken about eight ounces of brandy since the operation.

*Post-mortem examination.*—The body was well nourished, the rigor mortis well marked. There was considerable distension of the abdomen, with well-marked tympanites in the flanks. The abdominal cavity contained limpid and flaky puriform lymph; the exposed surfaces of the peritoneum indicated recent acute inflammation. There were no traces of faecal extravasation. About eight inches above the rectum was found a firm, annular, and apparently malignant stricture of the gut, on either side of which the mucous membrane was considerably thickened and thrown out into fringe-like polypoid projections. Above the stricture, the intestine was much distended with faecal matter; and, on examination of the small intestine, Peyer's patches were everywhere found to be destroyed, and more or less contracted by old ulceration. Immediately above the ileo-caecal valve there were several sharply-defined ulcers of about the size of a pin's head. The mucous membrane of the caecum was much excoriated, and in some places was so thin as to break on the slightest touch. There was some atheroma of the aorta; but all the other organs were healthy.

CASE 2.—This patient was a man, fifty-eight years of age, who stated on admission that his bowels had not acted for more than a fortnight, except after taking aperient medicine, when a small quantity of liquid faeces had passed. The finger discovered that the calibre of the rectum was obstructed by a soft mass on one side of which a small aperture could be felt. An average-sized rectum-tube was therefore introduced and made to convey a quantity of water, which brought away a large amount of faecal matter. This operation was repeated for six days, when, with the consent of his colleagues, Mr. Savory opened the colon in the left loin, in order that a free exit for the contents of the bowel might be established before the patient's health began to suffer. On the following day the patient felt much better; his pulse was 100, his temperature 99°2'; he had had a good night; and the faeces passed freely through the artificial opening. On the third day he suffered from hiccough, and complained of having had a bad night: twenty grains of chloral were ordered for a night draught. On the twenty-sixth day he was discharged in a good condition.

#### ST. GEORGE'S HOSPITAL.

##### REMOVAL OF A CIRCULAR FILM ADHERENT TO THE PUPILLARY MARGIN.

(By Mr. BRUDENELL CARTER.)

AMONGST a number of others, the following operation was performed on the 17th inst. on a child who, up to nine years of age, had enjoyed good sight. One eye then became damaged, and the other destroyed, by quick lime. The patient had also since suffered from keratitis and iritis, which had not been treated, and which there was good reason to believe was due to an inherited syphilitic taint. On admission the damaged eye presented a considerable central opacity of the cornea, and an opaque lens, which was found to be covered anteriorly with a layer of inflammatory lymph, which had become adherent to the margin of the iris. In his first operation, Mr. Carter had performed iridectomy downwards, and withdrawn, by mouth-suction, the damaged lens. The film had, however, remained ad-

herent to the margin of the pupil. Its removal was effected by the operation we witnessed, in the following manner:—Two needles, one of which was provided with a cutting edge, were introduced into points of the margin of the cornea opposite to each other in the transverse line, and so manipulated as to divide the circumferential attachment of the film. In withdrawing the cutting needle, the outer of the two openings into the anterior chamber was enlarged sufficiently to permit of the introduction of a delicately-formed canula forceps, by means of which the unbroken circular film, which was of extreme toughness and quite opaque, was readily withdrawn. It was anticipated that by this means useful vision would be restored to the patient's remaining eye.

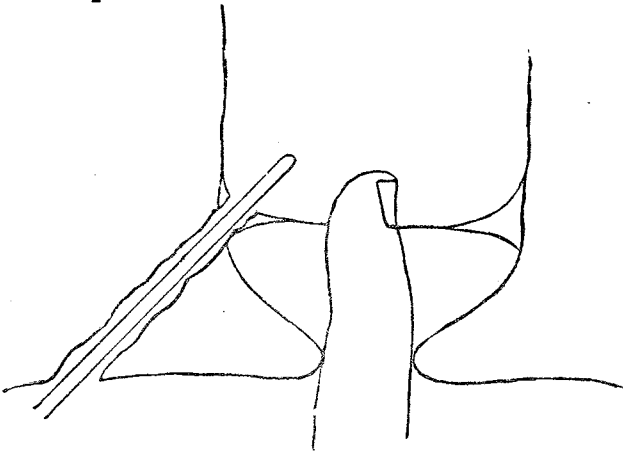
## PROVINCIAL HOSPITAL REPORTS.

### QUEEN'S HOSPITAL, BIRMINGHAM.

STRICTURE OF RECTUM WITH FISTULA IN ANO; THE STRICTURE AND THE SPHINCTER ANI DIVIDED BY ONE OPERATION.

(Cases under the care of Mr. FURNEAUX JORDAN.)

Emma C—, twenty-nine years old, a married woman, had suffered from rectal symptoms for twelve years. Examination disclosed an annular simple stricture, with an anal fistula, having two openings externally. Four limited incisions were made, bougies having failed to secure any benefit. Then a director was passed along the fistula, and entered the rectum above the stricture. All the parts between the rectum and the director were divided. The recovery was complete. Large solid stools were passed before she left the hospital.



*Remarks.*—In referring to this case, Mr. Jordan remarked that most rectal diseases, excluding cancer, could as a rule be cured with certainty. The treatment of simple stricture, however, was often unsatisfactory, and sometimes dangerous. The bougie and limited incisions in careful hands had been occasionally fatal. Very probably the extension of inflammatory action from the rectum to the peritoneum was due to the incessant unrest in the sphincter. Simple stricture mostly lies within an inch and a half of the anus. In such cases he should, in future, after making a few very limited radiating incisions, divide the stricture and the sphincter ani, even if no fistula was present. The advantages would be: complete rest, complete division of the stricture at a point most remote from the peritoneum, and ready escape of all inflammatory products.

#### A CASE OF RETRO-PHARYNGEAL ABSCESS DUE TO CARIES OF THE TEMPORAL BONE.

Mr. Furneaux Jordan remarked that this case was one of great interest, because the common cause of this abscess was caries of the cervical vertebrae.

Sarah P—, aged thirty-four, had been a patient two years before with purulent discharge from the left ear, tenderness over the left mastoid region, and facial paralysis. She rapidly recovered under the influence of a seton at the back of the neck. She now came with slight facial paralysis, decided impairment of the mental faculties, and a retro-pharyngeal abscess. There were none of the well-

known indications of atlo-axoidean or other vertebral disease. She was again deriving striking benefit from the nuchal seton. How long the improvement would continue could not be foretold. Nature kept the temporal bone at rest; hence, probably, when carious, it often did well.

## Medical Societies.

### PATHOLOGICAL SOCIETY OF LONDON.

TUESDAY, APRIL 18TH, 1871.

MR. J. COOPER FORSTER, VICE-PRESIDENT, IN THE CHAIR.

Mr. ARNOTT exhibited a specimen of Soft Cancer of the Breast. The patient, from whom the breast had been removed by Mr. Nunn in the Middlesex Hospital, had noticed the tumour for ten months, and latterly it had been growing rapidly. The whole of the breast was occupied by a large smoothly lobulated tumour, with a fluctuating prominence in the centre. The skin was cedematous, the nipple slightly retracted, and there was a moderately enlarged gland in the axilla. But as, in addition to these characters, there was hardly any pain, and as the woman's health remained perfectly unimpaired, it was thought by nearly all to be cystic sarcoma, rather than true cancer. Even after the removal of the mass, this impression was at first confirmed by the naked-eye appearances. A subsequent microscopic examination, however, convinced Mr. Arnott that it was really an example of so-called "firm medullary cancer." Such parts of the tumour as were not spoiled by degenerative changes and blood extravasation were made up of closely crowded, large, irregular cells of varied shape, containing one or more large oval nuclei with bright nucleoli. These cells were contained in the wide meshes of a fine fibroid stroma which pervaded the mass and mapped it out into irregular loculi—as shown in a drawing sent round with the specimen. Apart from the interest attaching to the diagnostic difficulties of the case, Mr. Arnott was anxious to draw attention to the fact that it was one of those examples of cancer which, occupying a mid-position between scirrhus and medullary, serve to prove the real identity of these two forms of the disease. He thought that English pathologists generally laid too great stress upon the distinctive characters of these varieties, even where they were careful to separate the medullary sarcomata from the latter class. Seeing that occasionally, in the hardest scirrhus cancers, nodules of very soft structure were met with, and that the secondary growths of both scirrhus and medullary were apparently quite identical, it seemed more fit that, in using the terms scirrhus and medullary, nothing more should be understood than a difference in consistence, the only real distinction between the histological structure of the two tumours consisting in the proportion of fibrous stroma present. This was in the hardest cancers abundant, and was proportionately less as the firmness of the tumour diminished, this distinction being probably mainly dependent upon rapidity of growth.

Dr. MURCHISON brought forward a specimen showing a fistulous communication between the gall-bladder and the colon, and taken from a woman who died in Middlesex Hospital from epithelial cancer. In this case no doubt gall-stones had passed by a short cut into the gut without passing along the ordinary route, so as to produce jaundice. Generally speaking, when communication existed between the gall-bladder and the gut, it was the small intestine which was concerned. There were symptoms of old disease in the gall-bladder.

Dr. FAGGE referred to a similar case in Guy's museum.

Dr. DUCKWORTH exhibited a Gall-stone which had passed through the umbilicus of a patient who had never exhibited signs of jaundice. The stone had probably made its way through the fundus of the gall-bladder.

Dr. MURCHISON showed a specimen of Acute Atrophy of the Liver, in association with gall-stones, taken from a case of great clinical interest. The patient was a man aged sixty-six, admitted into hospital last October, and who died in a month afterwards. On admission, the man was jaundiced, caused by the passage of a gall-stone, as was evidenced by the antecedent symptoms. In a few days the man