

from the joint if it continues active, and after a brief time the symptoms subside once more.

Allow me once more to name these types of the disease:

(a) *Destructive Hip-Disease*, due to a florid tuberculosis of bone or to an acute infectious osteomyelitis.

(b) *Painful Hip-Disease*, due to the ordinary form of focal bone tuberculosis, where irritation surrounds the foci and the tendency is to purulent degeneration.

(c) *Painless or Quiet Hip-Disease*, due to the fibroid form of focal bone tuberculosis, where there is little irritation surrounding the foci and a tendency to the deposit of fibrous tissue.

(d) *Transient or Ephemeral Hip-Disease*, due probably to a focus of tuberculosis, which is rapidly absorbed or is so far removed from the joint that it causes little or no synovial irritation.

Whether or not these types will meet with your acceptance, I have no means of knowing. Any classification in our present state of knowledge must be to a certain extent a preliminary one and subject to change when our knowledge of pathology becomes more extensive. I present it purely as a clinical classification, moreover, although I have tried to give it a pathological foundation. The types are not always well-marked, and border line cases are common, but that is the case in any scheme of classification, pathological or clinical. I offer it in the hope that it may serve some of us in a more accurate study of the disease.

A CASE OF INTESTINAL OBSTRUCTION RELIEVED BY LAPAROTOMY AND SEPARATION OF ADHESIONS BETWEEN THE SIGMOID FLEXURE AND THE UTERUS.¹

BY MAURICE H. RICHARDSON, M.D.

ON February 5, 1891, I was called to Chelsea, by Dr. W. R. Chipman, to see Mrs. J. L. The diagnosis in this case was so obscure that I was obliged to rely almost entirely on the history. For this reason I give in some detail the description of the onset and course of her symptoms, in her own words.

Mrs. L., aged sixty. "Two years ago I was taken with a terrible pain in my left leg. One Saturday night I was taken deathly sick. Monday morning I was worse. The trouble in the knee resulted in water in the joint, and I was treated for that trouble and for gastric disturbances by different physicians. The leg was terribly bad. It grew worse, and had to be extended. I was under treatment till Christmas for the knee and stomach. I had terrible pains in the back and in the left side. I was in bed all the time. I couldn't straighten up on account of the pain in the back. I was in perfect distress. Early in June my legs began to swell badly, and then my stomach began to swell. I have been doctored for dropsy ever since. My breath was very short, and I was doctored for heart-disease. I have been growing larger and larger and getting worse ever since. Now the leg is comparatively well, and the feet are not especially swollen. Before this I was never sick, though I used to have pain across the kidneys and pain in the bowels. The bowels would get tired. Family history good. No consumption in the family, nor cancer. I have been in bed five weeks to-day. My mouth and tongue

are terribly sore. I passed the turn of life at forty-five, and had no special trouble. In the last few years I have noticed no enlargement of the bowels till the present trouble came on. I couldn't straighten up — I would give way across the kidneys. The bowels have been regular. I have had an operation every day. There is no pain in the back passage, but after an operation there is some pain in the bowels. The stools are thin. If I do not have an operation every day I bloat right up, and for this reason I take medicine every day. I have terrible distress, and get as tight as a drum. I can't get my breath. I have gained weight. Never had dysentery or typhoid fever. No trouble in the rectum or the womb. The pain I have starts under the ribs on the left side, and goes down and ends just over the bladder — in the middle, low down. There has been no fever at any time. I pass no wind to speak of. The operations are small and thin."

Examination.—A very large woman. The abdomen was enormously distended with gas and everywhere tympanitic. No masses could be felt at all. There was nothing suggesting the tense and resistant coils of distended intestine sometimes found in acute obstruction. Nothing could be detected by rectal or vaginal exploration. She indicated the left lumbar region as the seat of the pain, from which it extended downwards towards the pubes, ending just above that bone. Tongue was clean. Pulse 84, of good quality. Heart and lungs normal.

The essential features of this case were a large and strong woman with gradually increasing difficulty in having movements of the bowels; enormous distension of the abdomen, with occasional passage of flatus, and a daily discharge of a certain small amount of thin fluid. General appearance of patient good; family and previous history good. The increase in weight, instead of the emaciation of malignant disease, I thought was due to the enormous collection of fecal matter in the loaded bowels. It is difficult to give an adequate idea of the excessive distension and size of the abdomen.

In ten or twelve cases of chronic intestinal obstruction I have operated upon, I have found an annular stricture in the region of the sigmoid flexure. In no material point as to history or physical examination did this case differ from the others. It was not possible to locate the seat of the stricture by large injections, this procedure throwing no light upon the diagnosis or point of obstruction. It seemed probable that this patient was suffering from an annular stricture somewhere in the region of the sigmoid flexure. The only evidence pointing towards the seat of the lesion was in the locality, direction and stopping-point of the pain. I have been able a good many times to make a correct diagnosis of the seat of the obstruction, and its cause, in this way.

I had the patient transferred to a private hospital, where the case was studied with great care, and where she was examined by several of the physicians of the Massachusetts General Hospital. We all agreed in the advisability of exploratory operation with the chances in favor of a malignant stricture which would require the formation of a permanent artificial anus. On February 16, 1891, with the assistance of Dr. Mumford, and with Drs. Homans and Fitz present, I made an incision in the median line, between the umbilicus and the pubes, long enough to admit my hand and arm.

¹ Read before the Boston Society for Medical Improvement, April 25, 1892.

The distended coils of intestine immediately presented on opening the peritoneum. They were normal in appearance, except that the walls were very much thickened from the hypertrophy of the muscular coats that accompanies chronic obstruction. With the fingers of the right hand in the pelvis, I was able to explore the ascending colon and the sigmoid flexure as far as the recto-uterine fold. Between the rectum and the uterus, deep in the pelvis, were numerous adhesions which I was able easily to separate with my fingers. The exact extent and direction of these adhesions I could not make out, but I was able, with some difficulty to relieve the apparent cause of the obstruction. Not feeling certain that the obstruction had been relieved, I thought best to open the sigmoid flexure and to sew it to the abdominal wound in the usual manner, in order to provide for the exit of faecal matter and gas in case the separation of adhesions should prove to be of no avail. During my manipulations inside the abdomen, I was unable to feel any hard matter, or any evidence whatever of a new growth, malignant or otherwise. On opening the sigmoid flexure, after it had been fastened securely and tightly into the wound, enormous quantities of gas and faecal matter escaped. As in all my previous cases of chronic obstruction, the faeces were churned into a yeasty fluid. An instrument was passed down through the wound in the caecum towards the point of obstruction, but I could not pass it into the rectum.

The patient made a good recovery from the ether, and was greatly relieved by the enormous discharges of gas and liquid faecal matter. In the course of a few days, she began to pass faecal matter and gas freely by rectum, and from that time to the present she has had no difficulty whatever in having daily and abundant discharges in the natural manner. The fistula closed spontaneously in a few weeks after the re-establishment of the natural passages, and Mrs. L. has enjoyed the best of health up to present time. There has been some inconvenience from a hernia in the scar. This could not have been helped, because it was necessary to leave quite a large space between the recti for the suture of the bowel. Through this space the hernia gradually developed, and is now kept in position without much inconvenience by a truss.

This case is another illustration of the necessity of exploration in obscure abdominal diseases. In my opinion, it is at times impossible for the physician to make a diagnosis sufficiently accurate to justify non-interference. It is better that a hundred useless explorations should be made than that one life should be lost for want of a helping hand where help is possible. This case is a most gratifying example of the advantage of exploration. Even if we had found a malignant stricture of the sigmoid flexure, I still believe that the operation was not only justifiable but urgent and necessary. Those who have seen the great suffering under which patients succumb in chronic intestinal obstruction, the unbearable pain and distension, and that symptom which is frightful even to see or imagine — faecal vomiting — all these seem to me more than to justify an operation for relief, especially an operation so simple and so safe as to open the bowel in the groin. It is said, in opposition to this procedure, that the patient's life is unbearable, but in my experience of quite a number of cases of inguinal colotomy such is not the case, and the discomfort is very much exaggerated. The opening is very easily kept clean. One may have

regular movements of the bowels, and between them there is no difficulty, with a suitable pad, in preventing the escape of faecal discharges.

Even if nothing is accomplished by a thorough exploration beyond the demonstration of the truth that there is no hope of cure, or even of relief, I, for one, feel that the knowledge thereby gained justifies the slight, or, if necessary, the great risk of the procedure. Until we can say that we never err in diagnosis we have no right to refuse the patient the possible benefits of exploration.

Clinical Department.

AN UNUSUAL GUN-SHOT INJURY.¹

BY JAMES G. MUMFORD, M.D.

THIS almost unique case came to me through the kindness of Dr. H. A. Beach. I saw the patient in consultation with Dr. S. M. Greene and Dr. F. W. Leach of Newmarket, N. H., on the 23d of April last.

The patient was a lad, sixteen years of age, robust and vigorous from constant open-air exercise. He met with his injury three days before I saw him. While gunning with a friend they had occasion to enter a small boat; the patient, W. L., placed his gun on the thwarts of the skiff and, still standing on the bank, stooped to cast off the painter from a stake; his companion hastily jumped on board and stumbled against L's gun, both hammers of which were at full cock; both barrels were discharged, the shot entering L's body from behind. He fell, became collapsed, and an hour later, when brought home was still in a state of profound shock. Dr. Greene was summoned; and from his report the following conclusions were drawn: One barrel of the gun was charged with number six shot; these entered the right thigh, at short range, from behind just below the great trochanter, and passed entirely through the limb. No important structures were injured; so that this wound was disregarded. The charge from the other barrel, shot number four, entered the right buttock just below the tuber ischii. If it is remembered that the lad was stooping, when struck, it will be seen that the direction of the charge, on entering the body, would have been as though from below upwards, had he been standing erect. Investigation showed that the shot were lost in the cavity of the pelvis; their course could be judged by the symptoms. A glance at the skeleton will show that the charge entering below the great ischial tuberosity must have passed through the great sciatic foramen.

Though the immediate effect of the injury was shock the patient quickly rallied. Hemorrhage from the wound was not very great, showing that the large pelvic vessels were uninjured; but shortly after being brought home the patient passed a small amount of very bloody urine; the bowels were constipated; the temperature was 102.6° F., the pulse 120. The natural inference of perforating wound of the bladder, with serious peritoneal injuries, was drawn. Owing to the great number of shot and necessarily extensive lacerations of the pelvic contents operative interference was not considered. The patient was made comfortable with opiates and dressings. Strangely enough for the next three days improvement was steady and uninter-

¹ Read at the June meeting of the Warren Club, Boston.