It would thus appear that a person may be the subject of extensive ulceration of the small intestines without the presence of any symptoms to attract the attention of his medical attendant; or else they may be so slight as to be totally disproportionate to the extent and severity of the disease actually existing.

Through the courtesy of Mr. Craven, I once had the opportunity of examining the body of a stout man, aged 57, who, while in the act of sexual intercourse, was seized with sudden and violent pain in the abdomen. He was seen by his surgeon two hours afterwards, and he died, with all the symptoms of perforation of the bowel, at the end of twenty-eight hours from the attack. An opening was found about the middle of the ileum nearly a quarter of an inch in diameter, and almost circular in shape. From the appearances around it, it had evidently been the seat of an ulcer, which had perhaps healed, or the intestine had become agglutinated to another part at that spot, the adhesion being broken down at the time of the attack, and permitting effusion of the contents of the bowel. There were, however, no appearances of disease at any other part of the intestinal canal. This man had felt himself perfectly well before, and was quite unconscious of the disease of his intestine, which had thus been indirectly the cause of his death.

Thirdly; the *post mortem* appearances were, *par excellence*, those of enteric fever; but the symptoms during life did not correspond with them. There were no rose spots to be seen; no diarrhœa, in fact the bowels were rather constipated than otherwise; no gurgling in the iliac fossa. The abdomen was carefully examined by the eye and hand on the 16th, and had either the spots or gurgling existed, they must have been noticed.

It may be useful to compare this case with one published in the BRITISH MEDICAL JOURNAL for September 17th, 1859 (case of Julia Watkinson, also under the care of Sir H. Cooper), in which the reverse condition of things obtained; namely, the presence of the usual symptoms of enteric fever with the absence of the characteristic morbid appearances. It would thus appear, presuming the two cases to have been examples of enteric fever—indicated in the one case by the characteristic symptoms, and in the other by the usual morbid appearances—that we must not always expect to find both the symptoms and pathological appearances present in the same case; nor, when they are so, to be always proportionate the one to the other; for we have seen that the most serious organic lesions may exist, and yet the constitutional disturbance be so slight that the disease may be entirely overlooked. Such cases as these must surely tend in some degree to shake the faith of the medical observer in the so-called pathognomonic symptoms of enteric fever.

Another point suggests itself, though not arising out of these particular cases, but from the consideration of the subject in general. Peyer's patches of glands are considered to be simply aggregations of the solitary glands which are found in the large as well as the small intestine. If such be really the case, and if the essential nature of enteric fever exist in a specific disease of the intestinal (Peyer's) glands, how is it that the aggregated glands (Peyer's patches) are alone the seat of ulceration, and not the solitary glands as well, as we should expect would be the case if the two were alike in structure and function? How is it that we do not find numerously scattered small spots of ulceration both in the large and small intestines (especially in the cæcum and appendix vermiformis, in which parts the solitary glands are said to be the most numerous), instead of isolated large ulcers, increasing in size and number as they approach the ileo cæcal valve, beyond which boundary none are ever seen? This latter fact—namely, the ulcers invariably extending as far as, but no further than, the ileo-cæcal valve, would in itself seem to indicate that the specific ulceration has its real seat in some structure which exists in the small but not in the large intestine. These cases were made the subject of clinical lectures at the time of their occurrence.

Original Communications.

DIRECT COMMUNICATION BETWEEN THE BLADDER AND RECTUM; PASSAGE OF FÆCES THROUGH THE BLADDER AND URETHRA FOR FOURTEEN WEEKS.

By WILLIAM PRICE, M.D., Margate.

THE subjoined case may be thought worthy of publication, as so few well authenticated cases are on record, of a communication existing between the bladder and rectum in the male adult without proving speedily destructive to life.

A gentleman, 54 years of age, of strongly marked strumous habit, and somewhat hypochondriacal, had for a series of years subjected himself to using the strongest purgatives, and employed large injections of water or gruel. His diet consisted solely of milk, eggs, beef-tea, and broths, to the exclusion of solids. The fæces seldom possessed much consistency. He suffered from bad prolapsus ani, aggravated with internal and external hæmorrhoids.

He first complained of pains in the left iliac fossa, with slight peritoneal tenderness over the whole abdomen. After the lapse of two or three weeks, the exacerbations of pain became much aggravated towards night; and the patient lost flesh perceptibly. I was called to him during the night, and found him in intense agony, unable to pass urine. A large suppository and the warm bath afforded, after a time, relief. He passed, in my presence, through the urethra, about three ounces of fluid, of a smell and character unmistakably fæcal. Two days afterwards, free purulent discharge was set up from the inflamed bladder; the irritability of which viscus was well nigh unbearable. The quantity of mixed fæcal and purulent discharge passed with the urine in the twenty-four hours varied from ten to fourteen ounces; it was voided every two or three hours; and the quantity passed each time seldom exceeded an ounce. In the liquid were frequently to be found grape-stones, orange-pulp, and other extraneous bodies.

Nothing passed *per anum* till eleven days from the first date of the attack, and the dejections occurred subsequently in small quantity at intervals varying from nine to fifteen days. By degrees the purulent discharge diminished, and the constitutional irritation subsided greatly. The patient continued from this date till within a few days of his decease, thirteen weeks later, comparatively free from pain, save at the time when he was emptying the bladder, immediately before and after the passage of the contents.

A *post mortem* examination revealed peritoneal inflammation of the lower half of the large intestine, with some purulent effusion into the cavity of the abdomen. There was rigid adhesion between the rectum and bladder throughout. Scirrhous deposit existed in the coats of the rectum, with stricture about the middle third. Immediately above the seat of stricture was an ulcerated opening of the size of a horse-bean, communicating with the bladder; the coats of which were much attenuated and chronically inflamed.

As some of the symptoms above detailed rarely occur in practice, I have thought the case sufficiently interesting to bring under notice.

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