CASES OF IMPERFORATE BOWEL.

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DURING a period of twelve years, five cases of abnormal states of the colon and rectum have been brought under my notice, and these cases illustrate three varieties of imperforate bowel. In two instances, the external opening was closed; in two, the bowel ended in a *cul de-sac* an inch or more above the anus; and in the remaining case the bowel was not discovered.

The affection in any of its forms is rare, and it is a curious fact that all these cases occurred in my own practice out of about 3,000 births, whilst Dr. Collins observed only one instance in 16,654 children born in the Dublin Lying-in Hospital, and Dr. Zohrer of Vienna records two cases out of 50,000 new-born children. It may, however, be true, as suggested by Dr. West, that many instances of simple closure of the anus may have passed unrecorded, whilst all the instances of more serious malformation have been described.

In two cases, where the obstruction was situated at the orifice of the anus, the conditions were pointed out to me by the nurses, who noticed the defect when the children were first washed. In both those cases I waited till the collection of meconium caused the parts to be distended, and I then made a crucial incision, snipping off the angles afterwards. These cases gave no further trouble. I directed the round end of an ordinary "dip" candle to be passed into the bowel night and morning, and the children recovered without any other treatment.

The following case, though more interesting, is less satisfactory in its results.

A lady residing near my house, was attended by the late Mr. W. of Birmingham. The child, a male, was healthy and well nourished. I was called in on the third day after its birth. The friends became anxious, as the infant had not voided any stool, whilst the stomach rejected both food and castor oil, which had been administered according to instructions given by Mr. W. I visited the child in the forenoon; it appeared to be in a state of constant discomfort; vomited frequently, and made continued violent straining efforts to defæcate. I passed a soap suppository into the rectum, which was immediately returned with a little mucus tinged with blood; then, having oiled my finger, I passed it into the rectum and found that the bowel terminated in a pouch. I communicated the fact to the friends, and Mr. W. met me in consultation in the evening of the same day. He recommended an opiate mixture to be administered and the operation delayed till the pouch should become distended, and then for a trocar and cannula to be passed through the projecting part. Of course the symptoms of strangulated bowel continued, and with increased severity. The stomach and bowels were distended, and the child made a continual moaning cry, except when interrupted by vomiting and retching. The following day, Mr. W. again saw the little sufferer, and again postponed any operative proceeding, alleging that such cases usually terminated fatally, and the lower the bowel descended, the greater hope there would be of success. On the fifth day, I passed a trocar into the projecting bowel; some thick meconium passed, and water was injected through the cannula to favour the discharge; very little relief was given by this operation. The symptoms continued as before, the child getting perceptibly weaker. After the cannula was withdrawn no more meconium passed, and the child lingered on for forty-eight hours, when death happily removed it from further suffering. An examination was allowed after death. The rectum was perfect and the colon ended in a blind pouch. The trocar had passed through the centre of the membrane, but the collection of the meconium above pre-

vented any escape through so small an aperture. With all respect to Mrs. W.'s great experience and sound judgment, there can be no doubt but that we fall into two errors in the treatment of this case. In the first, blinded by the belief that the lower the bowel was protruded the greater hope there would be, the child was permitted to sink into that feeble state, that had the operation been successful, I am convinced the child would not have rallied; indeed, the bowel from distention, had become so paralysed, that very feeble expulsive efforts were made at the time of the operation, though previously very violent strainings had tended very much to exhaust the little patient. In the second place, the opening by means of the trocar, was a useless operation. Even the water injected through the cannula did not return, and though Mr. W. tried to coax down the meconium by passing a long probe into the bowel, very little indeed escaped. The pressure of such a quantity of thick fluid would, of course, prevent any escape, and a bottle filled with any thick fluid having a narrow neck, will clearly demonstrate how useless was that operation.

The existence of an anus and rectum, although a decidedly favourable feature, does not warrant quite so hopeful a prognosis as might at first sight seem apparent; but after those cases where the anus is merely covered by integument, these must offer the second best chance of recovery. The operation usually advised in these cases is to introduce a narrow straight bistoury upon the forefinger of the left hand, or upon a director through the closing membrane, and the opening thus made enlarged with the button-ended bistoury. It seems to me, though I have never performed the operation, that, simple as it reads, it will in practice be difficult. The gut is not so resistant as to be cut easily with a bistoury, and the finger becoming covered with the slimy meconium must lose a great deal of that sensitiveness which is necessary to guide the knife; then the expanded part of the rectum may be hit upon, and the bistoury passed behind the bowel into the pelvis. The pharyngotome and trocar are also advised by some medical writers. I have already stated my reasons why I would not use the trocar.

A case similar in every respect to the one I have just recorded, occurred in my practice in the year 1859. I adopted an operation different from any I had read or heard of, and I had the satisfaction of seeing the child live till the bowel acted perfectly, and the operation proved a success. The child died some time afterwards from pneumonia, followed by abscesses in different parts of the body.

I delivered a dissenting minister's lady of her fourth child on October 4th, 1859, and the following day my attention was directed to the child's having refused food and the breast, whilst vomiting and hiccup had been noticed at times since its birth. Having found the anus perfect, I ordered a teaspoonful of castor oil to be administered. I was told the next morning that the oil was returned as soon as swallowed, and that there had been no evacuation. She still moaned as if in pain, but the face was not indicative of distress. Vomiting occurred now and then, chiefly when the child strained. Having oiled my forefinger I passed it into the rectum, and at about an inch or inch and a half, I found the bowel terminating in a pouch.

Remembering the fatal termination of a similar case which presented itself some years previously, I determined that this child should not die from exhaustion before the operation, and with the help of an assistant I performed the following operation with great ease. Seizing a slightly curved needle (armed with a double ligature) with a pair of forceps, I passed it up to the protruding bowel, and guided by the index finger of the left hand, thrust it through the centre of the pouch, withdrawing it by the forceps. My assistant then drew down the ligature, whilst I introduced a pair of sharp pointed scissors up the rectum; the pouch being put

on the stretch and steadied by the traction of the ligature. I separated the blades of the scissors and pushed them through the gut, then by closing the handles I made a good opening into the fore part of the bowel. I slipped my finger into the opening, and changing my scissors for button ended ones, I snipped through the tight edges, the ligature being gently pulled down during the whole time. By this means I opened two thirds of the closed bowel, and the posterior flap was brought through the sphincter. I passed a suture through it to the verge of the anus, and on withdrawing my finger a quantity of meconium was expelled by the straining efforts of the child. An India-rubber bottle full of warm water was injected and returned by the child's efforts, and soon afterwards the little patient fell asleep. I passed up a candle bougie twice daily for three or four days, and about the fifth day I took out the stitch from the bowel and snipped off the flap at a distance higher than the ligature, which I had left protruding through the anus. I do not know whether there would have been any risk of the bowel receding had it not been confined by the suture, but it gave no trouble after its removal. A warm water injection was given daily; the bowels acted well, and the child lived long enough to have the bowels brought into the normal condition. I should certainly adopt the same treatment in a similar state. The ligature answers several purposes; it draws down the pouch, it tightens the membrane so that the bowel does not recede before the scissors, and after the incision has been made, it makes tense the edges and permits the opening to be enlarged with ease and safety.

I have related these cases in succession, as the abnormal condition was so much alike in both, but the following case occurred about June 1856, between the two cases cited. The parents were innkeepers, and after the child had been born a few hours, the attendant noticed that no stool passed, though the child made some straining efforts. On examination, it was found that the anus was closed. I waited over two days, and as there was no protrusion or resistance when the finger was pressed against the perineum, I advised an exploratory incision. This I did with my lancet to the extent of half an inch, and passed my finger through the wound, hoping to come into contact with the globular distended bowel, but I failed to discover any fullness or anything indicating the presence of the lower bowel. I allowed the case to go on for a day or two longer, and I then advised Amussat's operation in the left loin to relieve the child's suffering. Either from absence of the descending colon, or from the incorrect performance of this operation, I did not succeed in finding the bowel, and I closed the wound without being able to give the child the relief I had hoped for. The parents would not allow a *post mortem* inspection, and I can only mention this as a case where the bowel was defective for some distance from the anus.

RARE CASES IN MIDWIFERY.

By EDWARD COPEMAN, M.D., Physician to the Norfolk and Norwich Hospital.

[Continued from page 684 of last volume.]

CASE XXII. *Cerebral Affection after Labour.* I was summoned in the middle of the night on September 16th, a distance of eighteen miles, to Mrs.— (who had been confined about ten days) in consequence of a severe attack of illness after labour, with a threatening of puerperal convulsions. She was of middle age, and the mother of several children, one, if not more, born in China, where she had once suffered from cerebral disturbance, subdued at length by large doses of opium; of which drug she was said to be at the time so tolerant that not less than five or six grains produced any effect. The night before I saw her, she had been suddenly seized with pain in the

head, intolerance of light and noise, and confusion of mind, so that she scarcely knew where she was, and believed herself to be dying. She was very faint, and when her surgeon arrived, he ordered turpentine in drachm doses, several of which had been taken before I got there, and from which she expressed the greatest comfort, saying she felt at once that it would save her life. Before taking it, her pulse was 140. I found it a little under 100; and hearing she had been unable to sleep for several nights, I advised a full opiate enema. The lochia had not stopped, neither were there any decided uterine symptoms; but I considered that her brain, naturally susceptible, had become irritable and exhausted from want of sleep.

The enema produced a very good effect, being followed by seven hours' sleep; and a few days afterwards I was informed that all was going on perfectly well.

Her husband told me she made a very good recovery.

CASE XXIII. *Puerperal Disease.* I was summoned to a distance, late on the evening of Saturday, October 4th, to visit a delicate lady, about 35 years of age, and mother of a large family, coming in rapid succession. She had been confined ten or twelve days, and there was some difficulty with the placenta. There was no distinct history of a chill, but the nurse said the lochial discharge had been offensive for a day or two, and paler than it ought to have been, but this was only mentioned after putting the question to her. I found her very much depressed, with rapid pulse, confused sensorium, and great loss of power, both nervous and muscular; and yet there were no decided uterine or abdominal symptoms. However, we applied turpentine stupes to the abdomen as a precaution, washed out the vagina, gave a strong opiate enema to quiet the nervous system and procure sleep; and prescribed frequent small doses of quinine and chloric ether, with wine and good nourishment to support her strength.

I did not see the patient again, but have since been informed by her surgeon, that after a rather severe struggle, she ultimately recovered. She could not take the quinine, but continued the chloric ether, and turpentine stupes. After my visit, she exhibited more decided puerperal symptoms; her body becoming prominent, her mind more disturbed; she had no sleep but what was produced by medicine, and thirty or forty minim doses of chlorodyne answered the purpose well. The turpentine greatly relieved the tympanitic condition of the abdomen; but after this had subsided, she was attacked with phlegmasia dolens. In spite of this complication, however, the result was favourable, and the patient is now downstairs and resuming her family duties.

CASE XXIV. *Puerperal Disease: Fatal.* Mrs.—, aged 28 years, a delicate lady and very deaf, had been confined about a fortnight, when I was called to see her on October 1st. The history given me was as follows. Before her confinement she had an attack of bronchitis, which much reduced her strength; her labour soon followed, and the placenta required artificial removal on account of hæmorrhage, which for the moment was severe, and made her very faint. She went on pretty well for a day or two, and then had an attack of pleuro-pneumonia of the left side, accompanied by very acute pain, and relieved by antimony, blistering, calomel and opium etc. When this gave way to treatment, she complained of slight abdominal pain, the abdomen was found to be tumid, and there was commencing phlegmasia dolens in the right leg. The secretion of milk had ceased, and the lochia had changed colour. These latter symptoms made their appearance two days before I saw her; and I found her in a very serious condition, suffering from most threatening puerperal mischief, which had been masked by the more acute disease in the chest, and for a day or two escaped observation. Her pulse was 140 or more, and her respiration hurried and whistling. The sensorium was not much disturbed, but on dozing she