myself justified in again trying a purgative, and gave ol. ricini ℥i and ol. tiglii ♏j; this produced a scanty evacuation, but there was a slight increase in the pain and no amelioration of any of the other symptoms. Examination of the abdomen gave the same negative result as before, but he still suffered the same dull dragging pain of which he had complained all along. Opium and general treatment by rest continued.

October 26th. He seemed so well, with the exception of the comparatively slight pain, that I gave him a calomel and jalap purgative the evening before, followed by a saline in the morning, and a slight action of the bowels resulted; the pain diminished, and I hoped that the obstruction had been overcome. Opium discontinued.

October 27th. Allowed to get up a little; but that seemed to cause a return of the pain, and he still was unable to straighten himself properly.

October 28th. Pain much worse; face distinctly anxious; recourse again had to opium and confinement to the bunk.

October 29th. Vomited for the first time; pain was not so much relieved by opium as formerly.

October 31st. Slight vomiting again; there had been no passage of flatus during the last few days.

November 3rd. Slight vomiting recurred; patient was wandering the previous night; the abdominal symptoms were unchanged; the pain still persisted but was never violent, and was controlled by opium; the face, however, was beginning to look haggard and drawn.

November 5th. Some vomiting again; patient wandered a good deal at night but was calm and placid during the day.

November 6th. As he was obviously losing ground, I explained the case fully to him, and placed before him the reasons for and against immediate operation, leaving the final choice to him entirely. Without hesitation he elected to undergo operation at once. As the weather was calm and favourable, I determined not to delay a day, and at 2 P.M., with the aid of two lay assistants, I put the patient under chloroform in my own cabin, and opened the abdomen through the linea alba by a three-inch incision below the umbilicus. Examining first the cæcum, I found nothing wrong there; but on turning to the sigmoid flexure and descending colon, the latter portion of bowel seemed to be unduly fixed in its upper part, and, making slight traction upon it, I experienced a sensation as of something suddenly giving way, releasing that portion of bowel, which was then readily drawn forward into view. It was then seen that the transverse colon was occupied by a dense mass of fæcal accumulation, the formation of which had evidently been caused by an obstruction in the region of the splenic flexure. Immediately below the fæcal mass the bowel was deeply furrowed transversely, an appearance caused, as it seemed to me, by the bowel having been acutely flexed at this spot; there were no other markings sufficiently well-defined to throw any further light on the cause of the stoppage. The lower part of the descending colon, together with the sigmoid flexure and rectum contained small scattered fragments of fæcal matter. Having endeavoured unsuccessfully to ascertain more as to the mode of production of the lesion by insertion of my hand, but, having satisfied myself that, whatever the cause of the obstruction had been, the bowel was now free, I closed the wound in the usual manner and dressed it with lint dipped in iodised water. The patient was then carried back to his bunk in the forecastle. Pain severe after operation. Morphine one-third of a grain hypodermically.

November 7th. Bilious vomiting severe; catheter passed at 4 and 10 A.M.; the pain from which he suffered constantly before the operation had gone completely; troublesome thirst; sipped cold water occasionally, but took nothing else.

November 8th. Sickness gradually passed off, and he began to take a little food, and on November 9th he had a mutton chop for dinner.

November 11th. Five days after the operation, he complained of pain exactly similar to that from which he suffered before the operation, and during the morning he had a sensation as though a hard mass had moved down towards the rectum, upon which the pain disappeared: a simple enema brought away a large quantity of fæces.

November 12th. Return of pain in the morning, followed by another copious motion; castor oil ℥ss given in the evening, causing two good actions.

From this time forward, progress was uninterrupted. All the stitches were removed on the tenth day, by which time the wound was soundly healed. There was no sign of febrile disturbance throughout. On the 17th he appeared on deck in a reclining chair, and on November 24th, as soon as the ship was at anchor in Hobson's Bay, he was allowed to get up and walk about with a broad piece of strapping as an abdominal support. He subsequently, at my suggestion, obtained his discharge from the ship, and exchanged sea-life for a less arduous one on shore.

REMARKS.—The case presents many features of clinical interest. A case of genuine intestinal obstruction, distinguished by a marked absence of the symptoms usually associated with that condition, with the exception of obstinate constipation and some not very severe pain, must under any circumstances be a matter of interest; the fact that it should have followed immediately upon, and presumably have been caused by, a violent injury, makes it yet more remarkable. For many days I was uncertain whether I really had to deal with a case of mechanical obstruction at all. I regret that at the operation I failed to ascertain the exact anatomy of the obstruction; my belief is that the great bowel must have slipped through a rent in the mesentery, and that the obstruction was caused by kinking of the bowel rather than by its constriction. This would seem to explain the passage of flatus and the occasional production of a scanty motion by purgatives in the earlier days, which occurrences would become more difficult later as the fæces became massed up behind the obstruction. I must say I failed to find any rent or opening through which the bowel could have slipped, but such might easily escape a mere exploration with the hand; while this hypothesis seems best to fit in with the clinical features of the case, and also the extreme facility with which the bowel was released at the operation.

I may mention that the fortunate result was furthered in no small measure by the zeal and care with which the patient was tended by one of his brother tars.

A SUCCESSFUL CASE OF INGUINAL COLOTOMY FOR ABSENCE OF RECTUM IN A CHILD FIVE DAYS OLD.

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COMPLETE obstruction of the bowels in the newborn child is a not very rare occurrence, dependent on one or other of a variety of pathological conditions. Most commonly the cause is found in the imperfect development of the lower bowel. It is a matter of importance, whenever the bowels of a newborn child do not move naturally, to make a careful examination for any gross lesion of the anus or rectum before proceeding with purgative treatment; otherwise the only result may be to aggravate the child's suffering and precipitate the commonly fatal issue. The history of the case I now relate suggests the necessity of this precaution, and at the same time the successful result of the operative treatment adopted shows what may be hoped for from timely interference.

A male child, aged 5 days, was brought to me on the evening of April 18th, 1890, with the following history. The child was born on the evening of April 13th, when it presented every outward appearance of full and healthy development; the mother was a strong and healthy young woman of 26, and this her first child. Two days later, April 15th, as the bowels had not yet moved, castor oil was administered. The desired effect not being brought about, the castor oil was repeated several times on the three succeeding days, and on the evening of April 18th, as the bowels still remained obdurate, the nurse was ordered to give the child a soap-water enema. As this could not be satisfactorily done, the child was brought to me; it presented a most pitiable appearance, its face was pinched and emaciated, its arms and body in constant movement, its legs repeatedly drawn up in a piteous manner on to the abdomen, while it gave out a continuous moan; evidently the child was in extreme pain. On examination, the abdomen was found to be greatly distended, the walls so thinned that the intestinal coils could be seen and their movements watched.

The perineal region presented a normal appearance, but on introducing the little finger into the anus I found that the canal

was blocked by a membranous septum about half-an-inch from the skin surface. No bulging could be felt during the child's straining, from which it was evident that the lower end of the rectum was not in contact with the septum. Nevertheless, I decided to puncture the membrane. No escape of intestinal contents followed; I therefore carefully dilated the opening already made, and introduced my finger into the peritoneal cavity. This examination confirmed my opinion; the rectum was altogether wanting, the blind bulging extremity of the sigmoid flexure being felt at the pelvic brim. I decided, therefore, to perform an inguinal colotomy.

The operation, after washing the anal depression with weak sublimate solution, and introducing a strip of iodoform gauze, was done in the usual way on the left side. The abdominal wall was incised down to the peritoneum, the incision being about one inch and a half in length, parallel to the outer part of Poupart's ligament, and commencing externally a little above the anterior superior spine of the ileum. After compressing one or two bleeding points the peritoneal sac was carefully opened, when the bowel immediately presented in the wound. Two firm silk sutures were passed through the skin and parietal peritoneum of the one side of the incision (the muscular tissue being avoided) through the bowel and then through the peritoneum and skin of the other side. The bowel was then incised longitudinally for half-an-inch, the silk sutures hooked up in a loop, divided, and tied on their respective sides; additional sutures were put in, completely closing the peritoneal sac. An immense quantity of material escaped from the bowel.

For several days after the operation there was considerable redness encircling the wound, and some sloughing of cellular tissue around the adherent peritoneal surfaces. Gradually, however, this healed, while the child, fed on peptonised milk, throve well, and was discharged in an excellent state of health on the seventeenth day after operation. The mucous membrane had retracted within the bowel, and the wound had healed perfectly. The sound introduced through the false anus passes in a downward direction for little more than half-an-inch, striking there the blind extremity of the colon.

This condition, complete development of the anus with absence of the rectum, is rare. It is one that is likely to mislead the practitioner unless a very careful examination is made. Even on careful inspection the child appears to be perfectly developed, and unless the finger is passed into the anus the cause of the obstruction cannot be ascertained.

The history of this case of obstruction in the newborn child serves to emphasise the necessity of a careful digital examination of the bowel before resorting to any medicinal treatment. After the condition has been recognised the choice of operation seems to me a simple one. There are two alternatives, inguinal or lumbar colotomy, but the three facts, namely (1) the small amount of space available; (2) the frequency with which one finds a long mesocolon in the infant, and the consequent displacement of the colon; (3) the relatively large size of the kidney, and the consequent risk of injuring it, turn the balance in favour of opening the bowel in the groin.

ON THE DIAGNOSIS AND TREATMENT OF METRORRHAGIA.

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Everyone engaged in the daily routine of practice must frequently have met with cases of severe uterine hæmorrhage which puzzled him not a little, both as to their diagnosis and treatment, caused him much anxiety and worry at the time, and possibly led to much unpleasantness. With the hope of throwing some light upon the nature of these difficult cases, I offer the following remarks, trusting they may prove of service to some.

Of all the organs of the body, the uterus alone is subject to periodical hæmorrhages as a natural physiological process, during some thirty years of the individual's existence. This function is influenced by many and various conditions, both general and local, often exceedingly difficult to understand.

Menorrhagia must not be regarded as a disease or entity *per se*, for which one method of treatment is universally applicable, nor is it necessarily an invariable evidence of disease, for it may be merely an expression of constitutional or general vascular tension, the uterine mucous membrane acting, so to speak, as a safety valve, the hæmorrhage being positively beneficial, and affording us a useful hint as to treatment.

In attempting to deal with these cases, our first object should be to arrive at a correct diagnosis of the predisposing and exciting causes, for, until this be determined, any treatment must be empirical, and we are just as likely to be doing harm as good in attempting to repress the hæmorrhage by ordinary routine treatment.

The principle of diagnosis by exclusion is one which approves itself to many, and for general purposes is to be commended, determining, in fact, to what cause the loss is not due. This, of course, can only be done by knowing beforehand what are the most likely causes of severe uterine hæmorrhage—the possibilities, so to speak—and then eliminating one after the other, until we have left only two or more probabilities. It is more especially in attempting to deal with a symptom like this that we see the importance of the gynæcologist being a good all-round general practitioner, with special experience in uterine disorders, not a mere specialist, who can see nothing amiss in a patient except through a vaginal speculum.

Before even attempting to make a local investigation of the pelvic organs, we should be careful to exclude any general constitutional conditions, such as are not infrequently met with from impairment of the function of the heart, liver, or kidneys, aggravated, it may be, by the injudicious employment of alcohol, which had been prescribed with a view of relieving the more distressing symptoms.

Some of the most difficult cases, as regards diagnosis, occur at or about the so-called climacteric period. Terminal floodings are by no means infrequent. A patient becomes irregular, passes over an interval of several months without seeing anything, and then has profuse uterine hæmorrhage. This may merely imply the lessening of arterial tension at the surface of least resistance—Nature's method of affording relief—or it may be evidence of hepatic congestion due to the abuse of alcohol, a miscarriage, or the first indication of commencing malignant degeneration of the cervix uteri.

We should always endeavour to get as clear and concise a history as possible, but be careful to elicit facts and not be misled by theories. Having satisfied ourselves, so far as possible, that the hæmorrhage is due to some local and not constitutional condition, we must then endeavour to determine the exact nature of this lesion.

Speaking generally, the most frequent local causes of metrorrhagia will be found to be threatening miscarriage; retained products of conception from incomplete abortion, or retention of a small portion of placenta; subinvolution with granular erosion or laceration of the cervix uteri; villous endometritis; hæmatocele; new growths in the form of polypi, fibroids, or malignant disease of the fundus or cervix uteri; retroflexion of the uterus, with or without prolapse of one or both ovaries.

Exceptionally we must not overlook the possibility of extra-uterine gestation, cystic degeneration of the villi of the chorion, and inversion of the uterus. The mere fact of a patient going even a few weeks beyond the ordinary time at which the menstrual period should have recurred, and then coming on profusely unwell, should put us on our guard as to the possibility of a miscarriage.

If pain of a colicky nature on either side of the abdomen has preceded the loss, ectopic or extrauterine gestation should be suspected, and the symptoms carefully inquired into. The presence of some enlargement behind or to one side of the uterus would still further point to such a condition being present.

In case of hæmatocele the attack occurs, more or less suddenly, at or about a menstrual epoch, producing well marked symptoms of shock, fainting, and pelvic discomfort. There is generally a history of chill, as from sitting on damp grass or getting wet, undue or prolonged fatigue or other likely cause of that nature.

Any one of the causes mentioned being sufficient to cause excessive loss, it follows that a coincidence of two or more of these conditions will be still more likely to keep it up; and herein lies an important hint for treatment.

A patient may be the subject of intramural fibroid of the uterus for years without necessarily suffering from excessive loss, but if