This, then, is a brief outline of a subject about which very much more might be written, and also in connexion with which very much more work remains to be done. I expect that in the near future we shall be able to distinguish different forms of catarrhal irritability of the colon, separating those of rheumatic or uric acid origin from those of influenzal origin, and both again from those due to intestinal micro-organisms.

A CASE OF INTUSSUSCEPTION ACCOMPANIED BY POLYPUS AND STRICTURE:

PERFORATION: RESECTION: RECOVERY.

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IN the following case the history, taken together with the condition found, leads me to conclude that acute ensued upon chronic intussusception.

An unhealthy, neurotic, anaemic woman, aged 37, married, with five children, and living in a two-roomed house, had complained of indefinite abdominal pain for about six months. She often allowed her bowels to remain unopened for a week; her meals were most irregular, and she was in the habit of chewing quantities of raw rice and oatmeal. When seen from time to time she refused to allow any examination to be made.

History of Present Illness.

When seen she had severe abdominal pain, referred to the umbilicus, coming on in paroxysms, and inability to retain food. The bowels had not been opened for a week; there was no vomiting when no food was given; pulse 100; temperature normal. Nothing could be made out from the abdomen, and examination by rectum or vagina was refused.

Enemata were given every six hours for thirty-six hours; a mixture was also given. The enemata produced two actions; the patient gradually felt better, and nourishment could be given by the mouth.

On the fourth day she had another similar attack, which passed off in forty-eight hours. On the seventh day, in my absence, Dr. T. H. Redwood saw her; she said she was better. On the eighth evening I found she had been vomiting for twenty hours, and that for the last ten the vomit had been faecal. She was regurgitating mouthfuls of liquid faeces at short intervals. Pulse 140. It took another four hours to persuade her to submit to operation that night.

Operation.

After being admitted, she was given an enema, with no result; saline solution and adrenalin were infused hypodermically, and a nutrient enema with brandy was given also. Her general condition considerably improved, and the vomiting ceased; there was practically no distension, and nothing could be made out on abdominal examination. On rectal examination, a lump could be made out in Douglas's pouch; a catheter was passed; the stomach was not washed out, and a general anaesthetic was decided on; the pulse was 120. The anaesthetic used was C.E., which was taken very well. The abdomen was opened in the middle line from the umbilicus to the pubes. A little fluid escaped on opening the peritoneum; the gut was fairly empty. On putting the hand into Douglas's pouch, the lump was easily found, and proved to be an intussusception of the lower end of the ileum about 18 in. long, and a hard lump could be felt at its apex. With some difficulty, owing to the size of the apex, it was reduced, the abdominal cavity having been well shut off with gauze before commencing reduction. There were practically no adhesions, but two yellow spots and a perforation appeared on the receiving layer, and from this point on it was slighly adherent, and still more so at the apex, which was reduced with difficulty. Here there were two more yellow spots and two perforations on the receiving layer. A polypus could be felt inside the gut, which was markedly dimpled and thickened at the point of attachment. There was an annular stricture beyond the polypus and a great difference in the size of the gut on either side.

The patient's condition having improved, it was decided to resect and laterally anastomose the shut ends with Murphy's button (third size). This was done 3 in. beyond the stricture and 3 in. beyond the unhealthy spot mentioned. About 2 ft. of intestine was removed. More subcutaneous saline and a hypodermic of adrenalin were now given. The halves of the button were pressed together firmly enough for good coaptation of the opposing surfaces of gut wall, but on removing the clamps there was slight leakage in one spot; they were pressed more firmly together, and reinforcing sutures put in; this may account for the button coming away on the ninth day. A little fluid was found in Douglas's pouch. The abdomen was closed, and a large Keith's tube left in above the pubes, with a gauze wick. The preparation of operation area and operation took about an hour. The patient never vomited again from the time that she was put on the table until she was well. An injection of streptococcic and *coli* vaccine was given.

The wick was changed every six hours, and a good deal of fluid came away with no smell. More saline and adrenalin were given, and she was kept up in Fowler's position. At the end of forty-eight hours there was some distension and pain, but no vomiting. Pulse 120; no flatus passed. A turpentine enema was given and not returned. A long tube was passed, and part of the enema came away, but no flatus, and distension was not relieved. Sodium sulphate ʒvi in ℥x iced water was given slowly, and liq. strych. hyd. (q.q.h.) hypodermically. Liquid faeces were passed, and from that time the patient made a good recovery, having about four actions daily, the discharge from the tube ceasing about the ninth day, on which day the button came away. The patient for the first eight days in her own house had been on a hard kitchen armchair, with her legs up day and night; she had refused to move out of it. She developed a large sore in consequence over her sacrum, which is now rapidly filling up.

On opening the gut removed, the polypus, as big as a large prune, was found to be gangrenous; a section through the base of it, cut and stained here by Dr. Scudamore, seemed to be a columnar-celled carcinoma. The only gland seen when removing a V-shaped piece of mesentery looked healthy.

The point that strikes me about the case is that this woman is about the last in the district I should have expected to stand an illness of this sort—unless her previous state in some degree could have hardened her to the condition of things found at the operation.

IMPACTION OF GALL STONE IN SMALL INTESTINE: LAPAROTOMY: RECOVERY.

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THE following case is of interest, not only on account of its rarity, but because the symptoms were so slight and insidious, and there was an entire absence of any previous history of hepatic colic or pain. The recovery after so long a period of complete obstruction before relief was given is noteworthy. The septic middle-ear abscesses were presumably caused by the faecal vomiting.

I was summoned to Mrs. L. B. on the evening of November 23rd, 1908, who was said to be suffering from colic. She was a very stout woman and was sitting by the kitchen fire and not showing any marked symptoms of distress. She complained of intermittent pain about the umbilical region with nausea and vomiting.

History.

She stated she was aged 65, and married, but with no children. She had always enjoyed good health, and till early that morning was in her usual health, taking food well; the bowels acted regularly as a rule, but had only moved slightly on the evening of November 21st. Soon afterwards slight intermittent griping pain set in, but did not become severe until the early morning of November 23rd; this, however, was not so acute as to prevent her attending to her household duties until I saw her in the evening.

The patient being fully dressed, I had not an opportunity of examining the abdomen, nor did I think the symptoms urgent enough to require it. I treated the case on the usual lines, prescribing calomel, 5 grains, and bismuth and soda for the sickness.

Next morning I found her in bed and the symptoms much the same, tongue clean, temperature and pulse normal, but no action of the bowels had taken place. There was nothing to indicate the cause, and, regarding it as possibly faecal obstruction, I ordered copious enemata, but with scarcely any result.

As the symptoms did not assume great urgency, that evening I gave her more calomel, to be followed by a brine enema in the morning, but by that time the abdominal pain became more violent and the vomiting distinctly faecal. I asked my colleague, Dr. Box, to see her with me, and we agreed that some form of intestinal obstruction, needing surgical interference, was present, and she was admitted into the hospital.

She absolutely refused to have anything done in the way of operation. The symptoms got more and more urgent, till the patient was *in extremis*. By the seventh day of the obstruction the distress became so great that she voluntarily asked me to try and do something to relieve her.

On the afternoon of November 28th, I opened the abdomen in the middle line, and on passing my hand over the intestines found the cause of the obstruction in the small intestine about 18 in. above the ileo-caecal valve. After withdrawing the bowel and clamping it above and below, I surrounded it and the wound with sterilized swabs, turned the intestine back over the end of the stone, and incised the bowel enough to push the stone through the opening endwise. I sewed up the wound with a double row of silk sutures, first continuous, second interrupted (Lembert). After washing the parts with weak izal solution and then saline, the bowel was returned and the abdominal wound sutured in the usual way.

Her recovery was slow, owing partly to the delay in operating. An abscess formed in the wound, and subsequently she had double ear abscess.

The stone was cone-shaped, and represented a cast of the gall bladder, measuring in its long axis 2¼ in., and in the transverse diameter $1\frac{3}{16}$ in.

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