looked like motions"; but this had not been kept for inspection.

Oct. 21st. He was no better. He complained of being much weaker. He had been losing flesh the last few days, evidently. Pulse 120, without much power. The abdomen was swollen and tender. The urine was high coloured; not so much had been passed the last two days. The sickness was just the same; large quantities of fluid, with stinking flatus, gurgled up into the mouth. Flatus was passed *per anum* in the night; and this morning, while I was in the house, he discharged, while passing urine, about an ounce or a little more of "semifluid, healthy, brownish fæcal matter, normal in smell and appearance, tinging linen with the usual stain". He complained very much of pain; said he could not wear it out many days more. The morphia injection was continued.

Oct. 22nd. There was no change; he was perhaps not in such constant pain. Pulse 120; face very anxious. The question of gastrotomy was carefully considered, and ultimately deferred for another day or two.

Oct. 23rd. He had not a good night; sick as usual; face not so anxious. Pulse 120, feeble. At 9 A.M., he had the sensation (so he said) of some rush of fluid in the intestine, and presently passed *per anum*, six or eight ounces of yellowish fæcal matter. The abdomen was more easy.

Oct. 24th. The bowels acted once again on the 23rd; then two or three times this morning. The pain was almost gone, except on movement.

Oct. 25th. He was going on well. The bowels acted three or four times.

Oct. 26th. The bowels acted; the motions were natural.

The convalescence was tedious; and interrupted by dyspepsia and irregular action of bowels.

Dec. 9th. He to-day resumed his usual work.

REMARKS. I think there can be not much doubt that the seat of distension was in the small intestine; more than this, even, that an extramural band was very probably the efficient cause. I would base my opinion on these reasons:—

1. The frequent repetition of large injections until no tinge of colour from fæcal matter was present when they were retained *per anum*.

2. Resonance on percussion in the whole course of the large intestine.

3. Diminished secretion of urine.

4. Distension just evident on the left side of the abdomen, about the umbilicus; pain present at this spot also in the first place, and radiating thence over the abdomen; dulness and increase of resistance (the latter slight also in this situation).

5. The existence of prior disease (seven or eight years previously) competent to the production of a constricting band.

In almost every particular, this case answers to the description given by Mr. Gay, in his paper on Intestinal Obstruction by Bands, noticed in the JOURNAL of April 13, 1861; and the question of abdominal section seriously canvassed on more than one occasion, was, therefore, I believe, thoroughly legitimate; the relief by nature's action might have been hoped for, but could not be expected.

This difficulty at once presents itself, however. Supposing the obstruction to have existed in the small intestine, whence the fœtid odour and the fæcal appearance of the ejecta? A somewhat similar case to the above is reported by Dr. Copeman in the BRITISH MEDICAL JOURNAL, Dec. 1, 1860. Three *post mortem* examinations showed strangulation of the ileum by a fibrous band; and fœtid eructations and vomiting of fæcal matters had been noted for several days.

Is it too much to suppose that in a state of disease and abnormal irritation, the small intestine may, by its solitary or other glands, eliminate the fæcal elements; an office discharged under normal conditions by the lower portion of the bowels?

A few words with regard to the bearing of a case of the kind on the *questio vexata* of the source of the colouring matter of the fæces.

There can be, I think, no question that the small quantities of fæcal matter discharged *per anum* on the eighth and ninth days were simply from the colon; *i. e.*, the normal secretion of the mucous membrane of this part, induced by, and partially mixed with, the unabsorbed portions of the nutritious injections. Note, too, that no flatus was passed *per anum* until the day after these frequent injections were commenced; and that the expulsion of flatus, and of these small quantities of dark brown fæcal matter, did not bring with it any relief to the patient's sufferings. Again, when the bowels commenced to act freely (on the eleventh day), the motions were as opposite as possible to the brown and scanty discharge on the two preceding days—yellowish in colour, and not possessing so intensely an offensive fæcal odour.

If, then, the view of the small intestine being the seat of the obstruction be correct, this case proves, so far as a single case can (for no one swallow makes a summer), that: The dark brown colour of the fæces is furnished by the colon; the stimulus of the bile is not necessary to the production of this colouring matter from the mucous membrane of the colon; the morphia treatment cannot but be considered as satisfactory.

RARE CASES IN MIDWIFERY.

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

[*Continued from p. 35.*]

CASE VIII. *Labour Connected with Supposed Rupture of the Vagina into the Rectum.* Mrs. D., aged 22, in labour with her first child, summoned me on March 3rd, 1860. Her pains commenced on Wednesday, Feb. 29th, and her surgeon was in attendance several times on Thursday and Friday; on the latter day the liquor amnii escaped, and the head came down almost to the perineum; in the afternoon, however, her pains almost ceased, and Mr. —— left her for a little while under the firm impression that he should soon be again summoned, and that the labour would be quickly over; but, to his astonishment, no message came during the night, the pains having been very slight, although frequent. On visiting her on Saturday morning, the 3rd, he found her very feeble and exhausted, with the child's head in the same position as on the evening before, down close upon the perineum; and, when he made the examination, a large quantity of liquid fæces (?) escaped from the vagina, of a greenish brown colour and strong fæcal smell. He could not discover any opening within reach of the finger, but thought that a communication must have been formed between the vagina and rectum by the long continued pressure of the head. He also felt the importance of immediate delivery, and requested my assistance. I found the head occupying the outlet of the pelvis, ready to be born, but her pains had ceased; and during my examination, a quantity of the same kind of fluid escaped from the vagina by the side of my fingers, of the exact colour and smell of healthy liquid fæces. I could detect no opening within reach of the finger, and soon delivered her with the vectis, without any rupture of the perineum. The child was living and healthy; its head, but not its body, being covered with the same kind of matter as that which escaped before birth. I then again carefully examined the vagina and rectum, but could nowhere detect any communication between them; neither did any blood get into the rectum, although the

vagina was full of clots and liquid-blood, some of which must have escaped into the rectum, one would think, during the time I was examining the septum with a finger in each passage, if there had been an opening between them. No more of the suspicious fluid escaped after the child was born, but the placenta was adherent to the fundus uteri, requiring artificial removal; and on examining it afterwards, the fœtal surface of the amnion was thickened, hardened, and deeply stained of the same greenish brown colour as the fluid before described. But the liquor amnii, which escaped when the membranes broke, was said to have been of a natural colour and consistence; and the circumstances above narrated involved a mystery to be unfolded only by the future observation of the case. We left the mother quite comfortable, with a good pulse and firmly contracted uterus, although she lost a good deal before the placenta was extracted. I called two or three days afterwards, and found all going on perfectly well: there was no communication between the vagina and rectum, the bowels had been well relieved, and it was clear that the peculiar fluid which had excited so much apprehension lest the rectum should have been its source, proceeded from disease of the placenta itself, secreted by that portion of the amnion which was found altered in structure and discoloured, and perhaps deriving its fæcal odour from some fæcal matter escaping from the bowel during labour-pains. The appearances were certainly very deceptive, and could scarcely fail to excite the apprehension that some untoward lesion had occurred. The patient made a very good recovery.

Case ix. *Case of Impaction with Ruptured Perineum.* Mrs. B. was taken in labour with her first child, at 3 A.M. on November the 12th, 1857. She was in good health, and at full period. Mr. —— was summoned at about 6 A.M., when he found the os uteri but little dilated, and the vagina hot and unyielding. Her pains were frequent, but not severe, and no liquor amnii had escaped. He did not think it right to leave, and in about eleven or twelve hours the head cleared the os uteri, but the perineum remained dry and unyielding; no liquor amnii had escaped; no membranes could be felt, and the head became firmly fixed in the pelvis, seeming too large for the parts through which it had to pass. This state of things continued until 11 P.M., when he requested my assistance. Shortly before sending for me, Mr. —— felt assured that instrumental aid would be required, and he attempted to apply the forceps, but the os externum offered so much difficulty to the entrance of even one blade that he found them inapplicable, and discontinued the attempt, hoping that I might succeed better with the vectis. I found her in strong labour; pains frequent but not of long duration, during each of which she inhaled chloroform. The head was in the pelvis, with every advantage which good position could afford, but quite wedged in, and her surgeon told me it was just the same as it had been for several hours. The vagina was hot, dry, and tender, the os externum small; the head appeared to be uncovered, but no quantity of liquor amnii had escaped; the perineum was thick, and the head made scarcely any pressure upon it as a whole, although a small *caput succedaneum* protruded a little way through the os externum; the pelvis was shallow—sufficiently roomy at the inlet—but narrow in the arch of the pubes. Pulse about 100. The patient was courageous and not much exhausted, but getting restless, and anxious to be delivered. Had passed no urine since nine in the morning, and about a pint was now drawn off by the catheter. I felt very unwilling to resort to instrumental aid, although I could see there was but little chance of doing without it; but the state of the parts was so unfavourable that we agreed to wait an hour for the progress of events. We were, however, summoned again before that time, and strongly urged to do something to relieve; and finding the head exactly in *statu quo*, and all other matters worse, Mr. —— urged me to apply the vectis and endeavour to advance the labour. There was scarcely room to introduce the blade through the os externum; but I applied it well to the head, determining to do no more than draw upon it gently during the pains, so as to increase their effect. By these means I succeeded in bringing the head well down upon the perineum; still there was no dilatation, or very little, of the os externum; and before long there was so much pressure upon the anal portion of the perineum during pains, that I believe, if left to itself, the head would have forced its way through the perineum, between the fourchette and the rectum, the tension upon the latter being so great that blood escaped freely from the hæmorrhoidal vessels. Indeed, it soon became apparent that nothing could save the perineum from rupture or sloughing; and, although the vectis remained *in situ*, no further traction was made with it. Presently the occiput passed out under the pubes, and at the same moment the perineum gave way as far as, though not into, the rectum, in spite of all our efforts to protect it. The rest of the labour was without difficulty, and a living male child was born at about 3.15 A.M. on the 13th. An opiate was given, and we left the patient tolerably comfortable, although not without great apprehension in our minds as to the condition of the soft parts, lest sloughing should ensue. I may mention that scarcely any liquor amnii escaped after the head was born, and there seemed to have been a very small quantity secreted. Next day, the patient was going on remarkably well, and I did not see her again; but I was informed by her surgeon that a good deal of inflammation and swelling took place afterwards, and that the lacerations of the perineum and posterior wall of the vagina occupied several weeks in healing. The catheter was required for some days after delivery, but by careful management and attention, she eventually recovered.

On June 21st, 1861, I was summoned again to this lady, now in her second labour. Her surgeon had been in attendance many hours, and the head was firmly impacted as before, not advancing at all, in spite of very strong and frequent pains. In addition to this difficulty, there were several bands in the vagina, preventing its proper dilatation; and they were so strong, that it was evident some fresh rupture must occur before the child could be born. They were the result of the lacerations which occurred at her former labour; and it was a question whether or not they ought to be divided with the knife. This, however, was not done; and as delivery became more and more urgent, I was requested to apply the vectis; and found directly that, by means of this instrument, I could act efficiently upon the child's head. At the same time, it was certain that the perineum and vaginal bands must unavoidably give way; and accordingly, at the moment of the birth of the head, the perineum was rent, not only up to, but into the rectum, although especial care was taken to prevent the accident. It occurred in a moment; it was believed beforehand to be unavoidable; and my firm belief is that no management whatever could have prevented it. I am inclined to think, however, that if the perineum had been divided to a small extent by incision on each side, the rupture into the rectum would have been saved, and that it would have been good practice to have done so. The rest of the labour went on well; and we took the precaution of sewing up the perineal rent with two interrupted sutures. A good deal of swelling occurred in the parts for some days, and it was difficult to keep the sides of the wound in level apposition; but the great care and attention paid her by her surgeon met with the reward of success; and I hear she now suffers no inconvenience from the accident, which might so easily have been followed by the most distressing and miserable consequences.

[*To be continued.*]