the true pelvis, the first part of the rectum. Exploring towards the middle line, the last three lumbar vertebræ and the aorta can be easily distinguished. In all the subjects I have operated upon, at least twenty, I found no difficulty in finding the sigmoid by tracing it down from the colon or up from the rectum, even if it had a wide mesocolon, and am sure that the sigmoid flexure is more easily found in this position than the colon is in the loin.

I have seen lumbar colotomy performed when the fat and cellular tissue have been pulled and pushed about for some time before the gut could be found; this difficulty in finding it is increased when the colon has a long mesentery, and frequently ends in the peritoneum being opened, which is supposed not to be desirable in lumbar colotomy. In a case of right lumbar colotomy, in which I assisted, great trouble was experienced in finding the gut, and it was only found after the incision had been enlarged and the peritoneum opened sufficiently to admit the hand into the abdomen, amongst the intestines; the ascending colon was then discovered right over on the left side with the descending gut; it was pulled into the wound, to which it was stitched and opened. The patient did well. Since that case, when performing lumbar colotomy, after a fair trial has been made to find the gut, which fails, I always purposely make a small opening in the peritoneum, introduce my finger and feel for the gut; if this does not succeed I enlarge the opening and introduce my hand into the belly; by one of these means one cannot fail to find the large intestine.

Another objection raised to inguinal colotomy is, that the fæces pass below the artificial anus more frequently than they do in lumbar colotomy. This is not so if only care be taken to obtain a good spur.

It is said that in inguinal colotomy the opening in the gut is not high enough or far enough, from the disease. This depends on the operator, for I have over and over again tested this by first performing inguinal colotomy, and, before fixing the sigmoid colon, passed it through my fingers, so as to reach the highest point that could be drawn into the wound and opened. I next turned the subject on to its right side, and performed left lumbar colotomy, and stitched the gut to the loin; then opened the abdomen and measured the piece of gut between the two fixed points, with this result, that in the majority of cases there was only four inches of intestine between the two openings. It is rare for malignant disease to attack the sigmoid flexure; for, on looking through the *post-mortem* records of St. George's Hospital from 1848 to 1878, in all the cases the rectum was the part diseased. In those rare cases in which the sigmoid is involved, it is only at the lower part, at its junction with the rectum.

After inguinal colotomy, I have noticed there is less constitutional disturbance, for in only one of my cases was the temperature high after the second day. There is little or no suppuration, the wound healing rapidly, whereas in lumbar colotomy suppuration is not infrequent about the muscles and cellular tissue of the back. So often is this so that it is deemed advisable by some to put a drainage tube through the skin from behind into the wound.

The tendency for the opening to contract after inguinal colotomy is not greater, if the bowel is well stitched up and the opening attended to by the occasional passage of the finger, which can be more easily done by the patient when the opening is in front than in the loin.

I do not place much reliance on statistics which show that mortality is greater after inguinal than lumbar colotomy; for I think that if the method I suggest of performing inguinal colotomy is more frequently adopted, and all the details carefully attended to, the statistics of this operation will be much improved, and other parts of the intestinal tract less frequently opened by mistake.

I need hardly say that I have not arrived at the above conclusions without making many experiments, and giving the subject most careful study and thought; but my readers must not imagine that I think this operation will entirely supersede lumbar colotomy, for in those cases in which the patient has been left too long, namely, when the abdomen is tremendously distended, necessitating immediate opening of the intestine, I certainly consider the lumbar operation the safer.

OVERPRESSURE AND UNDERFEEDING.—The startling statement recently made in the Vienna press that there are in the Vienna schools 4,000 starving children, who remain without food from morning till evening, having perhaps but one miserable meal a day, appears to be only too true. A fund has been promptly started for the purpose of providing dinners, and on October 19th the first meal, consisting of lentil soup, vegetables, and bread, was given to 2,300 poor schoolchildren.

HYSTERECTOMY FOR FIBRO-CYSTIC TUMOUR.

By A. W. MAYO ROBSON, F.R.C.S.Eng.,
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MISS A., aged 37, was brought to see me by my friend Dr. K. in April, 1887, when she gave the following history: that she had been well up to six years before, when, without apparent cause, she noticed her abdomen to be increasing in size; and, although she had been regular in her menses and otherwise in good health, it had steadily increased until a few months back, when it began to enlarge more rapidly, and to interfere considerably with her digestion and with the action of her bowels, as well as from its weight to impede her locomotion. She had consulted an eminent surgeon about four years and a half previously, who diagnosed an omental tumour and advised her to wait.

On examination in my consulting-room I found the abdomen occupied by an irregular lobulated mass, giving a solid feel for the most part, but in two places, to the right and left of the umbilicus, fluctuating distinctly, as if there were two separate cysts, the wave of fluid being more distinct in the one to the right of the umbilicus. The upper boundary of the tumour was irregular and bossy, and seemed to move freely during respiration. Whilst the tumour itself was dull on percussion, the dulness extending into the hypogastric and inguinal region, chiefly the right, it was encompassed above and at the sides by parts resonant on percussion. The mass, which projected over the pubes in a pendulous manner, could be moved from side to side and slightly from above downwards, the movement giving no pain, and conveying to the hand the sense of a smooth peritoneum. The umbilicus was flattened, and the abdominal veins were only slightly enlarged. Measurements—40½ inches circumference, two inches above navel, 41 inches at navel, and 40 inches two inches below. *Per vaginam* the os uteri was felt high up anteriorly, Douglas's pouch being filled by a globular mass, which could be pushed into the abdomen, the os then descending somewhat. The sound passed the normal distance and to the left. The general symptoms, which were evidently due to pressure, were frequent so-called bilious attacks, indigestion, constipation, difficulty in relieving the bowels, and at times the bladder; fatigue from the great weight, loss of appetite from impaired digestion, and general *malaise*.

The diagnosis was somewhat uncertain, and rested between multilocular ovarian cyst, with uterine myoma, and fibro-cystic disease of the uterus. After careful consideration, Dr. K. agreed with me in recommending operation. On May 2nd ether was administered by Mr. Herbert Robson, and, assisted by Mr. Mayo, Dr. K., and Mr. H. A. Smith (Dr. G. Brown being present), I opened the abdomen by an incision two inches in length in the linea alba below the umbilicus. A cyst presented, and was aspirated of ten ounces of bloody serum; but, as the tumour was not materially diminished, the incision was prolonged upwards to three inches above the umbilicus and downwards past the peritoneal *cul-de-sac*, which was quite three inches above the pubes. The mass was now with some difficulty brought through the wound. On passing the hand down the back of the tumour it at once reached the peritoneal *cul-de-sac*, which was quite level with the wound, the ascending colon coursing up the right side of the tumour. It was now evident that the mass was sessile, and that the only way to get it out was to incise the peritoneum over its posterior and lateral aspects, and then to enucleate the tumour until a pedicle could be got sufficiently small for the application of a clamp. Since large veins coursed freely over it, and part of the enucleation had to be done by touch rather than by sight, this was both an anxious and a critical process, especially at one time, when a large vein was torn through, sending out a stream of blood as thick as my middle finger, and which, coming out of the centre of a dense mass, could not be stopped by pressure forceps, and in fact was only controlled by wedging forcibly a sponge into its open mouth. The bleeding was stopped by forcipressure as the operation progressed, until all the forceps were in use, and then ligatures were applied. The broad ligaments, with large leashes of vessels, were separately tied beyond the ovaries with strong silk, and then, as there was again free bleeding from the large vein previously mentioned, an elastic tourniquet was temporarily passed around the stump until Kœberlé's *serre-nœud* was applied. On proceeding to remove the mass the bladder was opened just above the grip of the clamp. I at once stripped it from the tumour down to the *serre-nœud*, applied another clamp above, and removed the first one. The opening was stitched with a continuous silk suture, avoiding mucous membranes; and then by small interrupted sutures, thus doubly closing the rent. The

tumour was now cut away, two long pins being passed through the pedicle beyond the wire to prevent its slipping. All bleeding points were secured as the forceps were removed. In securing a large vessel bleeding deeply in the pelvis, the right ureter was caught in pressure forceps, but was instantly released, and did not suffer. The ureters were seen at quite a safe distance from the clamp. The sigmoid flexure of the colon and the rectum were partly stripped of peritoneum, which had been lifted from them. The pedicle was brought out of the lower part of the wound, the peritoneum cleared of clots, and the edges of the wound approximated in the usual way by twelve silk sutures, three silver sutures being applied through the abdominal walls and peritoneum immediately above the pedicle. A Keith's drainage tube was employed, and brought out near the umbilicus, it being surrounded by a sheet of india-rubber in the manner kindly shown me by Dr. Keith. The pedicle was freely treated with solid perchloride of iron.

The whole operation occupied two hours, the patient taking only 3 ounces of ether. The usual antiseptic precautions were adopted. On being placed in bed, the pulse was about 90, regular and fairly strong. There was scarcely any ether-sickness. The temperature, as shown by the chart, never reached higher than 100.6°, and was normal on the fourth day, only rising in the second week to 100.8°, on one occasion, on account of cystitis due to frequent catheterism. The catheter was used at first every three hours, and for the first three days drew off urine highly coloured with blood; but by the end of the week the hæmaturia had ceased. After the first week the urine was occasionally passed naturally, but the catheter could not be altogether dispensed with; the urine contained some mucus and a little pus, which diminished and ultimately cleared up under the use of triticum repens, after some small phosphatic concretions had passed. Flatus was passed on the third, and the bowels were moved naturally on the fifth day.

Barley-water alone was allowed for the first twenty-four hours; during the next twenty-four hours soda water and milk, with a little tea; on the fourth day, oysters and milk pudding were given, and after that a more substantial diet; but during the first four days nutrient injections were administered every four hours, each containing a little brandy, with beef-tea and milk. From the drainage tube 2 ounces of deeply blood-stained fluid were withdrawn on the second day, 1 ounce on the third, 6 drachms on the fourth, 3 drachms on the fifth, and 1 drachm on the sixth, when the tube was removed.

From the time of the operation to the date of removing the clamp, on the fifteenth day, not a particle of moisture was seen about the wound. The sutures were removed on the eighth day, when the wound was found to be healed. The clamp was tightened a little every second or third day, and when it was removed on the fifteenth, it only held a small portion of dried-up tissue, which took some days to separate.

The patient enjoyed her food, and took it freely from the first. She was up at the end of the third week, and when she left Leeds, at the end of the month, she looked far better in the face, and said she felt better than she had done for several years. She had lost her "bilious" attacks, and was in excellent health.

A curious point in the case was that, although the uterus was removed quite close to the vagina, together with the ovaries and tubes, the patient menstruated for three days, from the fourteenth to the seventeenth, after operation, the discharge being normal in quality and quantity. The mass removed proved to be a fibro-cystic tumour, weighing 20 pounds, filling up the right broad ligament, having the elongated and dilated right Fallopian tube spread over its roof, and the right ovary flattened out on its surface. It was firmly fixed to the back of the uterus, the cavity of which was only three-quarters of an inch longer than normal; the left ovary and tube were enlarged, but otherwise normal. Large leashes of vessels coursed along the broad ligaments, and those on the right side spread out over the tumour.

The interesting points in the case are:

1. The difficulty in making an exact diagnosis; and in this I am not alone, for Dr. Keith, in the JOURNAL for December 8th, 1883, says, in speaking of his first hysterectomy: "It was a case of rapidly-growing fibrous cystic tumour, with much solid, and it was mistaken for an ovarian tumour. I had long expected that this mistake would some day happen to me. It had come to others, and I knew that I could not always escape, for the diagnosis is difficult."
2. The formidable nature of the operation, chiefly due to the necessity for great enucleation before a pedicle could be got small enough to be grasped by the clamp.
3. The injury to the bladder, which was due to haste in applying the clamp on account of severe hæmorrhage from the tumour, was fortunately unattended by evil results, in consequence of immediate and exact suture.
4. The fact of menstruation, normal in time, quantity, and quality, although both uterus and ovaries had been removed.
5. The complete and perfect recovery of the patient.

HYSTERIA IN THE MALE: FAITH-HEALING.

By H. HANDFORD, M.D., M.R.C.P.,
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THE following case has been under my observation at intervals since 1881. It is sufficiently remarkable to merit publication, and is probably typical of the class of cases which are suddenly cured at Lourdes and elsewhere.

A. B., aged 40, was admitted into the Nottingham General Hospital in 1881. I was at that time resident in the hospital, and had the opportunity of watching the case from day to day, and of treating it during part of his stay. He complained of a heaving, spasmodic movement of the epigastric region, which caused him much distress, and which he was unable to control. It appeared to be due to spasmodic contraction of the diaphragm, and recurred about twice every minute all day. It was unaccompanied by hiccough, and the movement was much slower and less abrupt than in that affection. He also about the same time complained of difficulty in walking. He was a fitter by trade, had been in the United States for some time, had travelled about a good deal, and was generally unsettled and nervous. He had also been accustomed to smoke heavily. The abdominal affection appeared to me to be of an hysterical nature, and I treated it by the application of a blister to the epigastrium. This resulted in the cessation of the abdominal movements for some days—in fact, as long as the pain of the blister lasted. The blister was reapplied, and the same result followed, but eventually the movements became less frequent. Meantime the condition of the legs was getting worse. There was no evident muscular wasting or loss of sensation, but great inco-ordination and muscular spasm. The superficial reflexes and the knee-jerk were exaggerated. There were no shooting pains, and no affection of the sphincters. He could at this time walk with great bodily exertion, not completely straightening the knees, but violently sweeping the legs round in a circular manner, with the ankle-joint extended, and the pointed toes scraping along the ground and catching every obstacle. He got up daily, and after two or three weeks he was one day detected in a serious breach of hospital discipline and threatened with expulsion. Next day he walked much better and was in every way improved, and a few days later he went out at his own request nearly well.

Within a week he returned as bad as before; and, though he remained in the hospital for about three months, and was treated in various ways (among others, by valerianate of zinc and cold shower-baths), he did not improve again, but left in a more helpless state than ever, though the spasmodic movements of the abdomen were more variable and a less prominent symptom than on his first admission. He was very emotional, somewhat bad-tempered, and quarrelled with the other patients. He never had any kind of fit while he remained in the hospital. Afterwards he was in two different hospitals in neighbouring counties, and in one of them he was treated by galvanism, with the result that the spasmodic movements of the abdomen ceased and have never recurred. He was otherwise unimproved. For a year or two afterwards I saw him occasionally in the streets, walking with the aid of two crutches, bearing all his weight on the crutches and swinging his legs forward together, and not attempting any independent movement with them.

About a year after leaving the hospital, he tells me, he suddenly lost the use of his right arm, and gives a graphic account of the treatment of it by mustard, friction, and warming at the fire, the result being a speedy recovery of complete use in it. About this time, his wife tells me, he began to have "fits," which came on every week or two, sometimes more frequently. They lasted several hours; and during them he was very violent, and she usually had to call in several neighbours to restrain him. He used to shout and talk a great deal of nonsense. For the last two years the fits have been as frequent, but he has been less violent, and he has not required restraint, and the wife says she could manage him herself.

He seemed somewhat proud of the interest his case excited, not only among the various medical men who have treated him, but also among the lay public, from whom he at first obtained much sympathy, and also more substantial assistance. For some time that source had failed, and he was very badly off. He worked very skilfully at fretwork and light cabinet work, and was fairly industrious.