turned out to be what she knew it was, the handle of a crochet-needle, and by holding it with a forceps I was enabled to thrust the point into the vagina, and after cutting down upon it to bring it through. She recovered without any further difficulty. The instrument was the ivory handle of a needle, four inches in length, tapering to a sharp point.

REMARKS. I have but few observations to make upon the operations for the removal of stone from the bladder. It is not likely that I shall ever perform the lateral operation again, except upon the dead subject, as a demonstration to the students, for I cannot imagine any circumstances that could induce me to return to it. My own few lateral operations have been much more speedily performed, and have looked much better than the others, and I met with an average share of success in them; but the real question to be considered is the patient's safety, and this is undoubtedly best observed by the median cut. A surgeon would naturally say, at first, that the new operation would do well for small stones, but not for large ones; but now there is ample experience to show that large ones may be removed by this method without injuring the tissues, and with such experience before them, it is surprising that surgical professors should still be found to teach that it is more dangerous to stretch than to cut the prostate.

It is always considered advisable that the patient should have a certain quantity of water in the bladder at the time of the operation, and the simplest plan is to direct them to pass water at a certain time, say one hour, before the time fixed for the operation, and in this way a sufficient quantity is secured.

Now that a short lithotrite is made, and the instruments are more effective, the operation of cutting in the female must become very rarely, if ever, necessary. With a large, short, and dilatable urethra, the circumstances are those which are best adapted for lithotripsy.

In these latter operations in the male subject, I have been surprised to find how much better the patients feel from the date of the operation, although but little has escaped; this is because the weight of a broken stone is diffused over a larger surface than the same weight in one piece.

I think that the *scoop* to draw off the water, and stones, and *débris*, after an operation, is of no real use; and, according to my experience, it is better to break the stone, and let nature expel the pieces. In the case of an accidental dilemma such as that in which I was placed in one of these operations, viz., with a large piece of stone impacted in the blades of the scoop, it might be detached by the following simple method; which, however, did not strike me until I had dragged a large and rough fragment through the urethra of my patient; but he, fortunately, was not very sensitive in those parts. The plan would be to open the blades as widely as possible, turn the instrument round so that the stone could drop out, and give it a smart tap near the part entering the urethra; and the shock of this blow would inevitably shake off the fragment.

Of the lithotrites in ordinary use, the English ones, as, for example, those made by Weiss, are the strongest and best in many respects; but there is one contrivance connected with the French instruments which is of great value: namely, that when the stone is seized by the French lithotrite, the screwing and crushing may be commenced immediately, by an ingenious mechanism at the handle of the instrument; but, with the English instrument, the surgeon must turn the screw until it travels down to the upper blade of the lithotrite, before the pressure will tell upon the stone. This involves, possibly, an inch of screwing; and I have many times seen a stone slip away in this interval, the surgeon paying more attention to turning the screw than to holding the stone. An Anglo-French lithotrite, combining the advantages of both, would be the best.

I have had some bandages made, which I call my *lithotomy straps*, intended to supersede the red webbing bandages by which the hands and feet are bound together in these operations. These straps consist of padded leather bracelets fitting to the wrists, and buckling firmly round them; and some firm leather anklets, of the shape of the elastic bandages for the ankles, which can be buckled on over the ankles. The bracelets have a strong hook on the middle of their palmar aspect, and opposite each outer malleolus is an iron ring. The bracelets and anklets being put on when the patient is in bed, as soon as he is under chloroform, or the staff is introduced, the hooks are passed through the rings, and all is done. He is in like manner relieved from the irksome posture in an equally short time.

REMARKS ON OBSTRUCTION OF THE BOWELS: WITH CASES.

By EDWARD COPEMAN, M.D., M.R.C.P., F.R.C.S., Physician to the Norfolk and Norwich Hospital.

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CASE X. *Fatal Obstruction from Stricture of the Rectum.* On May 16th, 1855, I was requested to visit a single lady, aged 33, on account of hæmorrhage from the bowels, for which she had for some time been treated by a practitioner in London without benefit. I believe he was not a regular physician, and had directed her to avoid aperient medicine, and to put up as long as possible with the inconvenience which she suffered from constipation. I found her general health giving way; but she was neither anæmic nor emaciated. Her history was one of long continued constipation; but under the advice she had received, she avoided aperient medicine, and endeavoured to meet the difficulty by limiting the supplies of food, until, in fact, her health had been very much reduced by starvation. I found the rectum completely full of lumpy fecal matter, very capacious, and its mucous membrane loose, and embracing in its folds the scybala which the rectum contained. I hoped that intestinal impaction might be the cause of all her pain and ill health; and prescribed colocynth and henbane in small repeated doses, with the compound gentian mixture, and an enema as often as might be required. The result of this treatment was the evacuation of large quantities of feces, emptying the rectum of its contents; but although these measures and an improved state of diet were greatly restorative to her general health, I found on subsequent examination that, at the distance of about a finger's length from the anus, the rectum was contracted to a very small size, and that the opening along the bowel was through a small mamillary projection, surrounded by structure firmer than natural, leading me to fear the existence of scirrhus stricture of the rectum. The calibre of the bowel at the seat of stricture was not much larger than a goose-quill. Still her health improved, and her complexion was not unhealthy or of a colour to indicate the existence of cancerous disease; and, for a length of time, attempts were made by her surgeon in Norwich to dilate the stricture, hoping that it might not be malignant. On one occasion, she consulted Mr. Fergusson in London, who thought the disease was not malignant, and encouraged further attempts at dilatation. These were attentively and carefully persevered in for a length of time by her surgeon, with varying degrees of success. Sometimes the bowels would be sufficiently relieved, and then she was better; at other times there would be obstruction and great distension of the bowels, accompanied with distressing colicky pains. In order to facilitate the dilatation of the stricture, the sphincter ani was divided, and the diseased part brought more within the reach of manipulation. At last, the distension of the bowels became more constant and painful; her strength failed; emaciation became rapidly progressive; and although even yet, by means of the introduction of a small tube (No. 12 catheter) and injections, the bowels were sufficiently relieved to prevent death from obstruction alone, it became painfully evident that the vital powers were ebbing fast, under the joint influence of mechanical obstruction, pain, and malignant disease. In the middle of July 1856, she died; and on the 17th, a *post mortem* examination was made, which disclosed the following morbid appearances.

The body was extremely emaciated. The abdomen very prominent. The intestines were universally distended. The colon was of an immense size, with longitudinal bands of extraordinary development. The cæcum was very large; and, on tracing the course of the colon, we found that it first passed upwards to the liver, then took a sharp bend downwards to a level with the caput cæci; here it made another curve at an acute angle, and then passed upwards and towards the left side as high as the level of the mamma, whence it again passed downwards as low as the pubes, pushing the rectum to the right of the median line. After this, it took another turn upwards toward the left loin, and then again passed to the left side of the brim of the pelvis, where it became narrowed into a stricture, through which the little finger passed with difficulty. Here the rectum might be said to commence, forming a pouch capable of holding about two pints of fluid, and pushed somewhat to the right by one of the coils of the colon; this pouch terminated in a firm stricture, surrounded by a considerable mass of scirrhus structure, about three inches from the anus. The bowels above the stricture contained not only air, but

several pints of liquid fæces of healthy appearance. A small opening was discovered in the condensed structure of the lower stricture, leading apparently from the interior of the canal to a kind of abscess between the two strictures external to the bowel; but nothing had escaped into the cavity of the abdomen, neither was there the slightest appearance of peritoneal inflammation. All the other abdominal organs were healthy. The chest was not examined.

The angles at each point where the colon had doubled upon itself were so acute as to prevent the escape even of air from one portion into another; forming, as it were, so many impermeable strictures; and, although fluid could readily be injected by means of a catheter into the rectal pouch between the two strictures, none apparently passed higher through the upper stricture, nor would liquid fæces or even air pass downwards without great difficulty.

CASE XI. *Fatal Obstruction from Stricture of the Rectum.* On November 9th, 1855, I was summoned to Mrs. N., aged about 56, who had obstruction of the bowels from stricture of the rectum, with enteric pain and distension. I found a stricture about two inches and a half up the rectum, very resisting at first, but giving way to the finger on continued pressure, like a tight sphincter. I passed a stomach-pump tube through it, and it went all along the colon, so that its point or end could be felt through the abdominal parietes near the cæcum. Some flatus and liquid fæces escaped, and afforded temporary relief, and a pint of warm gruel was injected through it to dissolve still further the contents of the bowel. The pulse was 130, and small; the tongue dry. She had no vomiting, but considerable borborygmus, with occasional eructation from the stomach. She had been under the care of Mr. — about a fortnight, during which time there had been no satisfactory relief from the bowels. Leeches and purgatives had been duly employed; and we now advised a pill containing aloes and opium every four hours, and turpentine stupes to the abdomen.

November 10th. The patient had no relief from the bowels. Her general state was much the same. Pulse 130. No vomiting. The tube was passed again to-day.

November 11th. On passing the finger through the stricture this morning, some liquid fæces escaped in a jet, proving vermicular or expulsive intestinal action above the stricture. No material alteration in her general condition had taken place. She had no vomiting. Pulse 130. The countenance was perhaps a little less anxious. She had tormina every now and then, but not much abdominal tenderness. The bowels were prominent and tympanitic. We passed a rectum-bougie through the stricture, and left it in, with directions that it should not be removed for an hour or more, unless it caused pain. She had been unable to take much during the night, but had not been sick. She had low irritative fever, with remissions. She was directed to take wine and water, with small quantities of fluid nutriment.

November 12th. She was much the same. A middle sized rectum-bougie, larger than that used yesterday, was passed its whole length, and there appeared to be less resistance. A dose of morphia kept her so quiet, that the bougie remained in nearly all day; and when it was removed, she passed half a pint of liquid fecal matter. But her pulse remained 130, was more feeble, and the abdomen was tympanitic and painful.

November 13th. She had been apparently sinking all night. The feet were cold; the respiration was irregular; the pulse indistinct; the face flushed; and the body covered with a clammy perspiration. She had no pain nor sickness, but was dying of exhaustion.

She died a few hours after the last report; and we were not allowed to examine the body after death.

In this case there was, as far as we could ascertain, neither ulceration nor much thickening at the seat of stricture; but the stricture was so tightened by spasmodic action as to bring on a degree of paralysis, so to speak, of the large intestines, and all the usual effects, except vomiting, of impermeable stricture. Had this patient been in a less feeble condition of health, it is probable that the treatment by dilatation would have been so far successful as to have been the means of, at least, prolonging her life for some time.

CASE XII. *Obstruction from Cancer of the Rectum, simulating Diarrhoea.* On January 3rd, 1856, I was summoned by Mr. — to visit a case of obstinate diarrhoea of six months standing, during the whole of which time nothing but liquid had passed from the bowels. The patient was an elderly woman, unmarried, a much respected old servant, and very calm under her illness, although at times suffering a good deal of pain. She was cachectic and much emaciated; and from her history,

I suspected some formidable obstruction to the passage of fecal matter. On examination, I discovered a large carcinomatous stricture of the rectum impervious to anything but fluid. The case admitted of no treatment, and she very soon died.

I quote this case, because it exemplifies what I have several times met with in practice; namely, the occurrence of diarrhoea in connexion with serious obstruction of the bowels. Whenever a patient states that *nothing but fluid motion has passed from the bowels for many weeks or months together*, I am led, by experience, to infer that nothing but fluid can pass, and that an important cause of obstruction exists in some portion of the intestinal canal.

CASE XIII. *Fatal Obstruction from Cancer of the Rectum.* On April 21st, 1856, I was summoned by Mr. N. to Mrs. D., aged 65, who had been suffering from obstruction of the bowels for several weeks, and was now labouring under peritoneal symptoms which indicated serious mischief. On examining the rectum, we could feel at the depth of the finger two rounded tumours, like the two halves of a walnut connected along one side, enclosing the rectum between their flat surfaces; the bowel appeared to pass through a small triangular space left between those surfaces, and was so compressed or closed by the tumours, that no instrument could be passed through, nor could any motion pass away. The tumours were smooth and rounded externally, and of a very firm consistence; and I do not remember to have seen any scirrhus tumour of the rectum of the same shape. The patient died of peritonitis in a few days; and I regret that a *post mortem* examination was not allowed.

[To be continued.]

A FEW WORDS ON MERCURY: ITS USE AND ABUSE.

By RICHARD HUGHES, M.R.C.S., L.R.C.P.Ed.(Exam.), Surgeon to the Brighton Orthopædic Hospital.

THERE is a tendency at present existing throughout the medical profession to depreciate or deny the beneficial effects of mercury. While Drs. Hughes Bennett, Inman, Habershon, and others, have stood in the forefront of the battle, it is well known that they only represent the feeling of the majority of thinking practitioners in the present day. It is surely, then, worth our while to inquire whether our forefathers were so utterly wrong in their high estimate of this medicine as modern writers would have us believe; and if not, what is the cause of its discredit among the present generation of practitioners?

The affections in which mercurials have been most generally used may be classified in three divisions. 1. Syphilis. 2. Affections of the liver. 3. Inflammations.

1. It is indubitable that, since the introduction of syphilis into Europe, its history as a disease has been indissolubly linked with that of mercury as its remedy. Generation after generation of practitioners have arisen, and have handed down to posterity a corroboration of their forefathers' testimony to the value of the practice. But it has been discovered recently that primary syphilis may, if not in all, at least in the great majority of cases, get well without mercury. Does this prove that mercury is less its specific cure? It is the natural tendency of most diseases to get well after running a certain course; but this does not hinder us from seeking to accelerate, or it may be, to cut short that course by appropriate remedial agents. And that mercury does greatly hasten the termination of syphilis is best shown in the treatment of the hereditary disease as it appears in infants. In these clear and uncomplicated cases, the rapidity with which the symptoms disappear under the use of small quantities of mercury, and without any of its physiological effects, is well known to all practitioners.

2. Mercury has for long been believed to have a specific influence upon the liver, and has consequently been largely used in affections of this important organ. Dr. Inman, in his late paper on this subject (BRITISH MEDICAL JOURNAL, Oct. 20th, 1860), justly satirises the indiscriminate administration of the drug in every form of hepatic derangement; but he must allow me to say that he has by no means proved his thesis, that mercurials have no specific effect upon the liver. What, for instance, do the experiments of Dr. Scott, on which he so much relies, go to prove, but that calomel, in doses short of purgative, diminishes remarkably the secretion of bile. This, though showing the incorrectness of our choice of cases