firmly April 18th, 1889, under Dr. Churton's care, and transferred to Mr. Mayo Robson for surgical treatment May 29th. The patient had been married twenty years. No history of any venereal disease, or of swallowing any hot or caustic fluid. Five months before admission he began to have difficulty in taking solid food, which frequently regurgitated, and was at times returned by vomiting. This lasted for several weeks, when he was somewhat better for a short time; the vomiting, however, returned, and regularly persisted after every meal. For some little time before admission liquids as well as solids were rejected. He had lost flesh considerably.

Fig. 2.

On admission the patient was very thin and wasted. He vomited immediately after taking any kind of food or liquid, but had no pain before, during, or after vomiting. The abdomen was flaccid, and he had no pain in the epigastrium. On attempting to pass œsophageal bougies they were always arrested at a point $12\frac{1}{2}$ inches from the teeth, and not even the smallest could be passed through the stricture. When transferred to the surgical ward no food had entered the stomach for several days, and he was being fed by nutrient enemata.

Operation May 30th.—The usual antiseptic precautions were adopted, the abdomen having been purified by a carbolic dressing worn during the previous twelve hours. The patient was anaesthetised with the A.C.E. mixture. A vertical incision of 3 inches, starting from just below the costal margin, was made along the outer border of the left rectus. After the parietal peritoneum had been incised to the full extent of the wound, it was sutured to the skin margin; the stomach was then fixed to the abdominal wall in the manner described at the beginning of the paper. The wound was dressed with a layer of sal alembroth gauze, over which was placed a large pad of salufer wool.

May 31st. The patient passed a fair night, the nutrient suppositories and enemata having been given every four hours alternately. Temperature normal.

June 1st. No pain or sickness, pulse fair, temperature normal; enemata continued.

June 2nd. Patient rather weaker, and complaining seriously of thirst, which was relieved by the injection of a pint of tepid water into the bowel.

June 3rd. Enemata not retained; temperature normal; patient feeling weaker. A small opening was made into the stomach by means of a tenotomy knife. A No. 4 catheter was passed through the opening, and the following fluid introduced into the stomach at 11 A.M. by means of a funnel and india-rubber tubing attached to the end of the catheter: beef-tea, 3 ounces; condensed peptonised milk, 3 drachms; brandy, 3 drachms; water to 6 ounces. 3.30 P.M. Beef-tea, 5 ounces; peptonised milk, 5 drachms; Brand's essence, $\frac{1}{2}$ ounce; brandy, 4 drachms; water to 11 ounces. 9 P.M. Beef-tea, 4 ounces; peptonised milk, 5 drachms; yolk of one egg; Brand's essence, $\frac{1}{2}$ ounce; brandy, 1 ounce; water to 12 ounces. 11 P.M. Patient felt very comfortable since being fed.

June 4th. Had a good night, and expressed himself as feeling very well. Fed by the funnel and tube with: milk, 8 ounces; beef-tea, 5 ounces; Brand's essence, 1 ounce; yolk of one egg; brandy, 4 drachms, at 9.15 A.M. Milk, 8 ounces; brandy, $\frac{1}{2}$ ounce; beef-tea, 4 ounces; yolk of one egg, at 1.30 P.M. Brandy, $\frac{1}{2}$ ounce; milk, 6 ounces; beef-tea, $5\frac{1}{2}$ ounces, at 5.30 P.M. Milk, 8 ounces; brandy, $\frac{1}{2}$ ounce; yolk of one egg; Brand's essence, $\frac{1}{2}$ ounce; beef-tea, 3 ounces, at 9.30 P.M.

June 5th. Had a good night, was fed through the tube every four hours with the same kind of food; 12 ounces at 9 A.M.,

13 ounces at 1 P.M., 14 ounces at 5 P.M., and 13 ounces at 9 P.M. The patient had improved steadily ever since the stomach had been opened. He usually complained of a sense of fullness just at the time of the fluid being introduced.

June 8th. Sutures removed; slight discharge of gastric juice from stomach, hence a larger catheter was employed.

June 14th. Patient was allowed to sit up, and was fed every four hours through the tube.

June 24th. A short celluloid tube with a stopper was fitted into the wound, and the patient could take it out and reintroduce it for himself, and by taking out the stopper he could easily feed himself through the opening. He was made an out-patient, having gained half a stone in weight, and looking and feeling comfortable.

When seen in August, he had gained over a stone in weight, and seemed very happy and comfortable, which condition continued up to February, 1890, when his general health again began to fail, and he died at his own home from exhaustion, due to the gradual progress of the original malignant disease of the œsophagus on April 11th.

CHRONIC INTESTINAL OBSTRUCTION FOLLOWING INJURY: LAPAROTOMY.

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THE following case came under my care on board Messrs. Green and Co.'s ship, *Carlisle Castle*, during a recent voyage from London to Melbourne.

The patient, A. L., was an ordinary seaman, aged 17. On October 10th, 1889, while working on the forecabin head in heavy weather, a big sea came over, carried him off his legs, and narrowly missed washing him overboard. In the effort of saving himself he was severely strained and hurt, the right leg seeming to be the part most injured. He turned into his bunk, and three or four hours later pain came on in the abdomen and back. This pain became steadily worse, and was of a dull aching character, felt chiefly in the hypogastrium. No vomiting or nausea; micturition normal.

On October 12th I first saw him, and he gave the above history. He complained of abdominal and lumbar pain; the pain in the leg was gone.

On examining the abdomen, the appearance was quite natural; some tenderness on pressure all over, most marked, however, about the umbilical and hypogastric regions; no distension, no rigidity, no tumour; palpation and percussion revealed nothing abnormal; face not expressive of marked distress or pain; tongue clean and moist; pulse remarkably slow, 60. On standing up he was unable to straighten the trunk completely, but walked in a slightly bent attitude, and the attempt to walk greatly aggravated the pain. He had previously always enjoyed excellent health; never had typhoid or any other fever, nor had he ever had any abdominal trouble before. Bowels always regular, and had been so up to the date of the accident.

October 13th. Black draught $\mathfrak{z}\text{ij}$ given in the morning; effect apparently nil; the appetite was fair, but thirst was rather troublesome; urine somewhat scanty and high-coloured; general condition unchanged.

October 14th. Ol. ricini $\mathfrak{z}\text{j}$ before breakfast had no effect, but a drop of croton oil given during the afternoon caused a marked aggravation of the pain, and the face began to assume a somewhat distressed look; no action of the bowels took place, however; given one-sixth of a grain of opium every hour; diet, arrowroot and milk in small quantities. Until this day I had not seriously suspected the presence of intestinal obstruction.

October 15th. Fair night; pain much relieved; volunteered that the medicine had caused him to pass more water; told me he had passed small quantities of flatus at times during the last few days. On examining the rectum, well-marked "ballooning" was discovered, the finger seeming to enter a larger cavity; copious enema administered with long tube without effect.

October 19th. Patient had been taking opium and resting in his bunk since last note; the general condition was unchanged; pain and tenderness was diminished; he slept fairly; no nausea or vomiting; facial expression placid, and he lay and read during the day; he had occasionally passed a little flatus. I thought

myself justified in again trying a purgative, and gave ol. ricini $\frac{3}{4}$ i and ol. tigllii $\frac{1}{2}$ 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 faecal accumulation, the formation of which had evidently been caused by an obstruction in the region of the splenic flexure. Immediately below the faecal 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 faecal 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 fore-castle. 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 faeces.

November 12th. Return of pain in the morning, followed by another copious motion; castor oil $\frac{3}{4}$ 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 faeces 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