belladonna extract was given every hour; and, after nine grains had been taken, copious alvine evacuation ensued. In two attacks since, the latest being last month, eight grains and nine grains respectively were effectual.

No alcohol was prescribed in any of the above cases, but patient No. 1 took about two ounces of port wine before the belladonna treatment was begun. In the after-treatment, and as a preventive of obstruction, the most effectual remedy I have found has been pulvis glycyrrhizæ composita. The belladonna treatment was suggested to me by the perusal of a paper by Mr. Macrae of Gateshead-on-Tyne in January 1873.

ON LATENCY OF SYMPTOMS IN ACUTE ABDOMINAL AFFECTIONS.*

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IN a discussion on the diagnosis and treatment of the causes of intestinal obstruction, it has occurred to me that a paper will not be out of place which gives the results of an experience that perhaps has been somewhat exceptional: an experience in which it has been the rule in acute abdominal affections for the symptoms to be more or less obscure and latent, so that the condition present has not been marked by those features which are usually described as its characteristics. And, as in several of the most striking instances the chief clinical fact has been obstinate constipation, the importance of such cases has been impressed upon me as influencing the diagnosis, and therefore the treatment, of cases of intestinal obstruction.

A brief outline of several instances will best support my statement.

A woman aged 47 was admitted into the Bristol General Hospital, with a history of ten days' complete obstruction of the bowels. There had been three similar attacks during the preceding five years. There was a total absence of all acute symptoms, both local and general. There was no anxiety or pain; the pulse was good; the temperature normal; the skin warm and moist; the tongue perfectly clean; the abdomen was much distended, but entirely free from pain and tenderness; there was no vomiting. Two days later, without any previous change, symptoms of perforation set in suddenly, and the patient died. On *post mortem* examination, there was no mechanical obstruction; but intense peritonitis existed; over the caecum and adjacent part of the colon, the peritoneum was mottled with dark ecchymoses and greyish-black gangrenous patches; and inside this portion of the gut were deep gangrenous ulcers with sloughy and blackly ecchymosed bases and edges.

In this case, the cause of the obstruction was thought to be probably fecal accumulation; it proved to be cessation of peristaltic action from intense enteritis. And yet there had been an entire absence of all acute symptoms up to the occurrence of perforation.

Again: last May, a young man aged 19 was admitted into the Bristol General Hospital. A week before, there had been vomiting and diarrhoea for two days, without any febrile symptoms; vomiting had continued, but diarrhoea had given place to complete constipation. The pulse was 80, large and soft; the temperature subnormal; the tongue almost clean; the abdomen moderately distended, almost free from pain, and but very slightly tender at the lower part on firm deep pressure. There was frequent bilious vomiting. Two days later, without the development of any further special symptoms, the patient sank rather rapidly and died. On *post mortem* examination, there were ulceration and perforation of the vermiform appendix, peritonitis, enteritis throughout the whole small intestine, and, from three inches above the valve, the ileum was plugged for four inches with a solid fibrinous cast. Here the only positive clinical evidence was the presence of constipation with persistent bilious vomiting. As the onset was acute, the absence of the causes of chronic obstruction was indicated; and, in the decision between those of acute obstruction, there was one point to which great importance was attached: the two days' diarrhoea which preceded the constipation; this was looked upon as strong evidence in favour of enteritis apart from any suddenly produced mechanical obstruction. This conclusion was adhered to in spite of the almost entire absence of those symptoms and signs usually described as characteristic of intense enteritis, for the reason that, in my experience, it had been the exception for such acute abdominal affections to resemble the descriptions ordinarily given of them.

Again, a patient was lately admitted suffering from a severe attack of acute dysentery. Up to the time of his death, there was but little pain, and the abdomen was soft and flaccid, and almost free from tenderness. And yet the *post mortem* examination showed that peritonitis existed; that perforation had taken place; and that the whole of the large intestine had been transformed into a mass of ragged sloughs, and was so rotten that, in removal from the body, it fell to pieces and became quite unrecognisable.

With regard to acute peritonitis, I cannot say that I have never seen a case typical according to the usual description of this condition; but I must say that such a case has been the exception; and that, in the majority of instances I have met with, there has been an absence, to a greater or less degree, of the so-called typical symptoms. In fact, my experience has compelled me to teach that, although the presence of the symptoms usually described as characteristic of acute peritonitis is most valuable, yet their absence, local or even general, does not by any means negative the existence of that disease.

The bearing of what I have said upon the question of diagnosis in intestinal obstruction is obvious, inasmuch as more or less complete cessation of the action of the bowels accompanies acute peritoneal inflammations and the graver forms of enteritis; and, if these conditions are not marked by their distinctive symptoms, there is great chance that the true nature of the condition may be overlooked, and the constipation put down to some one of the causes of chronic obstruction of the bowels.

And yet I think that this latency of symptoms is not without its positive value in diagnosis; for I believe that, where the obstruction is due to some suddenly induced mechanical cause relievable by timely operation, the acute symptoms are far more commonly pronounced; that in such a condition their absence is the exception; and that, therefore, an absence of urgent symptoms is so far evidence against the utility of surgical interference.

My experience has, therefore, led me to the following conclusions.

1. An entire absence of acute symptoms may coexist with an intense local inflammation; and therefore it is prudent, in all cases of intestinal obstruction, to adopt treatment consistent with this knowledge.

2. If, in a case of intestinal obstruction, urgent symptoms are in abeyance, this is so far in favour of the view that the obstruction is either non-acute, or, if acute, is not to be relieved by operation.

I have been induced to bring this paper before you, in order that I may learn how far my experience in acute abdominal affections has been consistent with that of members present who are far better qualified than myself to speak authoritatively upon this subject.

RESPIRATION OF ASCENDING AND DESCENDING RHYTHM.

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IN its typical form, this remarkable phenomenon consists of a respiratory cycle in which respiration, at first light and unfrequent, becomes, by an ascending scale, fuller, more forcible, frequent, and exaggerated, until marked dyspnoea is attained; and which gradually subsides, by a descending scale, to a condition of complete apnoea, that persists for a considerable period and completes the cycle; after which a fresh cycle begins by light and almost imperceptible respirations. Each cycle is naturally divided into the period of apnoea and the period of respiration or dyspnoea. First described by Cheyne, and nearly thirty years later by Stokes, it is often named after them; and to the Irish school we are indebted for much that is known on the subject. Yet it is possible, as believed by the late Dr. Warburton Begbie, that Hippocrates observed and recorded an instance of it in the case of "Philiscus, who dwelt near the wall", and died on the sixth day of the duration of an acute illness, in the course of which were marked nervous symptoms, and whose respiration throughout was "large and rare, like that of a person who required to be reminded to breathe".

The three recorded in this paper are the only cases in which I have detected typical respiration of ascending and descending rhythm (Cheyne-Stokes) among the insane. In the first, the general extreme atheroma of the arteries was the most striking feature observed at the necropsy; the atheromatous change, with the resulting rigidity, inelasticity, and tendency to dilatation, being most marked in the thoracic aorta, the left subclavian, and the coronary and cerebral arteries; whilst the principal cardiac alterations were dilatation and hypertrophy of the left ventricle. Associated with these changes was the chronic renal disease, and the Cheyne-Stokes respiration was not developed until

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