Seeing that the calibre of the bowel is narrowed, often, as in the case of the woman I have narrated, to such a degree that it is not larger than an urethra, and that all the troubles arise from an accumulation of faeces behind the point of obstruction, and the secondary changes thereby induced in the bowel, the principle of treatment must be, never to allow solid faeces to form. The contents of the bowels must be kept fluid and not suffered to accumulate, but must not be hurried on to such a degree as to interfere with absorption. The saline purgative I usually employ is Carlsbad salts, which, from their uniform constitution and portability, offer the greatest advantages. The waters of Friedrichshall, Pullna, or Hunyadi János are extremely efficient for the purpose. For poorer patients, I use Glauber's salts (sulphate of soda), with almost equally satisfactory results. As regards dosage, each case requires study. Usually, a drachm or two drachms of Carlsbad or Glauber's salts given, on rising, in warm water, keeps the bowels sufficiently loose to enable the faeces to pass and to prevent accumulation. The patients must have explained to them the nature of the case and the imperative necessity of keeping the bowels loose, otherwise they will try to do without the medicine in the belief that they will gain benefit by so doing. Sometimes it is diarrhoea and not constipation which has to be treated. This is most effectually controlled by bismuth in full doses, combined with ipecacuanha and opium in small doses, which soothe the inflamed and often ulcerated condition of the bowel on which it depends. Patients must be advised to live on easily assimilable food which makes but little faeces, and cautioned to avoid food which tends to produce flatulence; and especially enjoined against the use of drastic and hydragogue cathartics. When these injunctions are scrupulously followed out, it is surprising with what little disturbance to the general health, and with what little discomfort, life may be sustained. To what length it may be prolonged, I am not in a position to say; but, seeing the slow rate of progress of the growth, the little hindrance it offers to digestion and absorption, and the degree of contraction which may exist whilst the patient is going about and performing his or her daily duties, I think I am not going beyond reasonable probabilities when I say that, I expect the patient may be spared some years of life. How this would be terminated in cases in which the diagnosis was made, and appropriate treatment carefully pursued, I cannot affirm, as the diagnosis in those cases is usually made *after death*. Death might occur eventually from complete stenosis (unless an artificial anus was made), from the cachexy or infection of the system, or precipitated by some intercurrent disease. These are mere speculations. My purpose has been to point out how the disease may be recognised, and its usual and fatal effects warded off.

TWO CASES OF INTESTINAL OBSTRUCTION TREATED BY ABDOMINAL SECTION.

Communicated by T. CLIFFORD ALLBUTT, M.D.,
Physician to the Infirmary, Leeds.

THE discussion on Obstruction of the Bowels and its Treatment in the Medical Section of the Association last year has been provocative of much useful discussion. I venture to communicate two cases of obstruction of the bowels in which abdominal section was performed. The cases were related to me by Mr. Ockley, assistant to Mr. Dowse, of Skelmanthorpe, under whose care the cases were, and who operated successfully in one of them. The narratives are as follows.

CASE 1.—John E., aged 60, a tailor, came under my (Mr. Dowse's) care on April 21st, 1877, at 4.30 P.M. On arrival, I found the patient suffering excruciating pain in the left side, and, upon inquiry, was informed he was suddenly attacked with the pain two days previously, about 2 P.M., after having eaten a hearty dinner. He described it as if something had fallen in his inside; it was accompanied with faintness and vomiting, but passed off after a short time. To-day, the pain and sickness were more severe and continued. Temperature 100; pulse 82. The bowels were evacuated on the evening of the 19th; he had no motion since, although he had taken opening medicine (castor-oil, etc.), which had all been vomited back. On examination, there was a hard knotty tumour on the left side, high up close to the short ribs, which I thought might be either intussusception of the bowel, or perhaps some undigested food which had lodged there. I ordered ice, soda-water, and milk, bismuth mixture with henbane, extract of belladonna, and powdered opium (of each half a grain); and a large linseed-meal poultice in which was belladonna liniment with plenty of lard, to be changed every three hours.

April 22nd. He was rather better, and had not so much pain. The tumour had shifted rather lower, and, as the bowels had not been relieved, I ordered an enema of warm water and soap. The other treatment was continued.

April 23rd, 9 A.M. He was worse; his face had a very anxious fretful appearance; there were more vomiting and pain, always in the same place; pulse 110, weaker; temperature 100 deg. The tongue was rather furred for the first time. He was ordered iced brandy and soda-water, and to continue the poultices, belladonna, etc. The pupils were normal. 3 P.M. At noon, stercoraceous vomiting commenced, and continued every half-hour. I gave an enema of clean water, which came away without the least sign of faeces, and no smell whatever. I gave a hypodermic injection of morphia, and advised the friends to send for Dr. Kilner Clarke of Huddersfield in consultation. 10.30 P.M. Stercoraceous vomiting continuing and coming on every few minutes, the pulse being much weaker, Dr. Clarke proposed operation as the last chance. The abdomen was tender over the part where the pain commenced, and where the lump was felt, and was less swollen on the left side than on the right. He was passing very little urine.

The patient being well under chloroform, the obstruction was found at the commencement of the jejunum, in the form of a stony concretion about the size of a pullet's egg. As it could neither be passed forwards nor backwards, it was removed through a longitudinal incision in the bowel (this substance was unfortunately lost). The bowel was so much thinned from pressure that, although it was well stitched with carbolised catgut (the glover's suture being used), it would not hold together. The patient died about 3 A.M., or four hours after the operation.

Query.—Would this case have done better if the operation had been performed sooner?

CASE II.—George W., aged 56, a sailor, came under my care on August 21st, 1877, at 8 P.M. For about a month, he had been suffering from constipation and difficulty in passing his stools; when he did so, it was in short flat pieces like tape, and always with much straining. Sixteen or seventeen years previously, he had suffered from inflammation of the bowels; since then, he had always more or less difficulty in passing his stools. For the last fortnight, he had passed two stools. The bowels were very much distended, with clear tympanitic percussion all over, occasional paroxysmal cramping all over the abdomen, dullness over the left iliac fossa; and here the patient always pointed as the continual seat of his difficulty. I ordered belladonna, opium, nux vomica, and calomel, in pills; bismuth mixture with prussic acid; ice; soda-water and milk; and belladonna poultices frequently.

August 22nd, 10 A.M. He was much worse, stercoraceous vomiting having come on during the night; and, as the patient was evidently sinking, I advised an operation. At 3 P.M., the bladder having been emptied, in which there was only a small quantity of urine, the body was opened through the linea alba, and I passed the finger in the direction indicated by the patient, and I found two bands of lymph across the bowel close to the sigmoid flexure. On dividing these, the bowels were almost instantly relieved of a large quantity of accumulated faeces.

August 23rd, 7 A.M. The patient was much better; pulse 92, temperature 100 deg. He had two loose motions during the night. He was ordered to take a good nourishing milk-diet.

This patient made a good recovery from the operation, but died some time afterwards from rupture of a blood-vessel whilst coughing.

TREATMENT OF INTESTINAL OBSTRUCTION.*

By S. MESSENGER BRADLEY, F.R.C.S.,
Surgeon to the Manchester Royal Infirmary, and Lecturer on Practical Surgery in Owens College.

THE important question, "How to deal with doubtful cases of intestinal obstruction", suggested for debate at the last meeting of the British Medical Association, by Mr. Jonathan Hutchinson, was not seriously taken up until Mr. Pridgin Teale adopted the opposite side, at a meeting of the Yorkshire Branch held in Huddersfield last November.

Mr. Hutchinson advanced the argument that exploratory incisions, in cases of doubtful diagnosis, are unjustifiable; while Mr. Teale contends that such exploratory incisions are wise and proper measures to adopt, and even looks forward to a time when "peritonitis—traumatic, ovarian, or puerperal—will be treated by opening and washing out the abdominal cavity and emptying the intestines".†

In this present paper, besides offering a general support to Mr. Hutchinson's argument, I would desire specifically to formulate the following propositions. 1. Exploratory incisions, in cases of doubtful diagnosis, are unjustifiable; 2. Acupuncture is an inefficient and even dangerous remedy; 3. Cases of intussusception should, with rare exceptions, be left to nature.

I take it for granted that, in cases where the diagnosis is not doubt-

* The substance of an address delivered before the Manchester Medical Society.
† BRITISH MEDICAL JOURNAL, Jan. 11th, 1879.