tight stricture of the intestine, so low down as the junction of the sigmoid flexure and the rectum, is compatible with the occasional passage of faecal masses of normal size and shape. Dr. Stephen Mackenzie, in his essay on Annular Stricture of the Intestine, published in the JOURNAL, May 31st, makes the following observation: "The fact that full-sized, properly formed faeces are occasionally passed, of course shows there can be no organic stricture (of the colon)." This statement is directly contrary to my experience. About twelve months ago, I saw an elderly man with Mr. Herbert Bracey of this town. He was suffering from intestinal obstruction. A solid motion which he had recently passed was shown to me; it was of normal shape and size. I was able to reach an annular stricture at the lower extremity of the sigmoid flexure. I sent the man into the Queen's Hospital at once. My colleague, Mr. Furneaux Jordan, performed left lumbar colotomy, if I remember rightly, the day after the patient's admission. The man died in a day or two, and an annular stricture of the intestine was found, at the necropsy, in the position I have indicated. It seems to me that the shape of the faeces, in cases of stricture of the colon or rectum, depends more upon their consistence than upon the size of the stricture. The consistence of the faeces may be such that, although solid, they may be slowly driven through the narrowed gut and subsequently become moulded into a faecal mass of normal circumference in the portion of bowel below the stricture. A case reported by Dr. Walters in the JOURNAL for May 31st illustrates my point. A woman, aged 62, had "annular scirrhus stricture at the junction of the sigmoid flexure and rectum". "Sometimes, the evacuations were not larger than the little finger; at others, large bulky motions would be passed". While the passage of flattened or pipe-stem-like motions is suggestive of stricture near the lower outlet of the bowel, their absence and the passage of faecal masses of normal calibre does not prove the absence of such constriction. I notice that two recent authorities avoid making an unequivocal statement as to invariable narrowing of the faeces in these cases of intestinal stricture. Dr. Bristowe (Reynolds's *System of Medicine*, vol. iii, page 75) writes: "If, however, the obstruction be in the vicinity of the rectum, solid motions generally soon assume a narrow tape-like or pipe-like form." Niemeyer (*Practical Medicine*, American translation, 1873, vol. i, page 568) observed: "In the ordinary forms of constipation, sausage-shaped faeces, of extraordinary size, are often passed; in stricture of the intestine, on the contrary, particularly when seated in the lower part of the intestine, they often have a very small calibre." I see that Dr. Leichtenstern, in his elaborate essay on intestinal obstructions (Ziemssen's *Cyclopaedia*, vol. vii, page 517), is careful to say that flattening, lead-pencil-like shape, etc., of the faeces only occurs in many, he does not say in all, "cases of constriction of the rectum and colon". My proposition is, that stricture in these situations may exist without this alteration in the shape of the alvine evacuations. The converse, that this alteration in shape may occur without stricture, is pointed out by Dr. Leichtenstern and other writers. He says that this change of faecal form may appear in cases of "starvation-intestine", and also in some instances of "violent rectal tenesmus"; but he does not state, as I do, that the passage of a motion of healthy bulk may occur even when there exists serious constriction of the lower part of the bowel, if a sufficient space remain above the anus for the evacuation to become moulded into a normal shape.

TREATMENT OF INTESTINAL OBSTRUCTION BY EXPLORATION OF THE ABDOMEN.

By T. PRIDGIN TEALE, M.A., F.R.C.S.,
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I HAVE read with interest in the JOURNAL of May 31st Mr. Messenger Bradley's address on the "Treatment of Intestinal Obstruction".

From his criticisms I feel convinced that he has not read my original paper in the BRITISH MEDICAL JOURNAL of January 11th, 1879. Had he done so, he would not have said "though six cases are alluded to, the only record which I have of his paper details, and that imperfectly, but one"; whereas I gave four cases at least with details as complete as I deemed necessary for my purpose. In using the word "obstruction" I meant not merely constipation, which may exist for many weeks with impunity, but obstruction to the passage of flatus, which immediately imparts danger to such a case. This was present in all my cases.

Again, Mr. Bradley would not have said of Case 6, "some obstruction, the nature of which is not particularised"; whereas my words are "that about eighteen inches of the lower part of the jejunum was black from congestion", and that "I concluded that the black portion of intestine was in a state of enteritis, and on the verge of gangrene".

Again, he says "Mr. Teale resorted to a number of small incisions, through which flatus escaped"; my paper says "I made a quarter of an

inch puncture at each end of the protruded intestine, and caught in a bowl about two quarts of grumous intestinal fluid, and also let off a large quantity of flatus".

Mr. Bradley says "the patient lived for nine days, which seems to have surprised Mr. Teale very much". No doubt I was surprised, seeing that before the operation I did not think that the patient could live unrelieved twenty-four hours, and that the operation disclosed a foot of intestine almost gangrenous.

Mr. Bradley is still haunted by a fear of peritonitis, shutting his eyes to the teaching of hernia, the teaching of modern ovariectomy, and the teaching of the cases of exploration of the abdomen published by others and by myself.

The object of my paper was to reduce the dread of peritonitis to what I believe to be a more true position in the treatment of intestinal obstruction, and to maintain, that in those cases in which recovery seems hopeless, unless surgical relief can be given, we need not be deterred by the fear of peritonitis from submitting the patient to "the safer risk" of exploration.

I claim that as far as they go my cases support this object. Six are recorded. Three of the patients proved to be so exhausted as to be in a hopeless state. In one there was a burst bowel; in a second an abscess had burst amongst the intestines; in the third the intestines were obstructed by and studded with cancer. In none of these was there any question of setting up peritonitis. They form no argument, *quâ* peritoneum, either for or against exploration. A chance of recovery was neither given nor taken away.

Let us examine the three remaining cases. In all there was a healthy peritoneum. In all the nature and seat of the obstruction was unknown. One recovered completely. A second was free from peritonitis for nine days, until in a fit of coughing the abdominal wound was burst open, an accident which would in all probability not have happened had my attempt to relieve the obstruction by colotomy been successful. The third had no sign of peritonitis as a result of the operation, but died on the ninth day from bursting of the bowel and escape of faeces into the peritoneal cavity. In none of these cases did peritonitis prove the rock on which the case was wrecked.

It must needs be that, in the present state of "peritoneal surgery", exploration of the abdomen should be reserved, and rightly, for the most hopeless cases of intestinal obstruction, such as were all those which I have reported. Many will prove to have been hopeless from the beginning, some will prove to have been submitted to operation too late, a few will recover as a direct result of the operation. As we gain experience and confidence in our means of diagnosis and treatment, we shall rescue from death some of the cases now lost by delay. Is it too much to hope that we are now marching by means of failure onward to success in "peritoneal surgery"? May we not take a lesson from the position of ovariectomy of the present as compared with ovariectomy in the past?

One word more. Case No. VI in my paper, seems to point the way to dealing with distension of the intestines, one of the most formidable and dangerous factors in obstruction of the bowel. If further experience should confirm the teaching of this case, that we can effectually empty of gas and fluid distended intestines, and that intestines so emptied do not rapidly, if ever, regain their state of distension, we have therein the key to the successful treatment of an important class of fatal illnesses.

Leeds, June 1879.

CANCER OF THE RECTUM TREATED BY EXCISION.

By W. H. CRIPPS, F.R.C.S.,
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EXCISION of the diseased portion of the bowel for cancer of the rectum has, since the time Lisfranc, found much favour with foreign surgeons. The operation had, however, fallen into disfavour in this country, and has only been revived during the past few years. In cases judiciously selected, this method of treatment is of the greatest value, both as regards relief from suffering and prolongation of life. But to suppose that it is applicable as a method of treatment in every case of rectal cancer is as unreasonable as the assumption that cancer should be removed by operation wheresoever situated. The operation cannot be considered in any way to rival or supersede colotomy, for as a rule it is applicable as a method of treatment for cases in which colotomy is scarcely admissible. Colotomy is a most valuable operation when the cancer is situated higher and causes obstruction or intense pain; while, on the other hand, for excision to be successful, the disease must strictly