experience of this fever, it has occurred to me to see periostitis far oftener than "swelled leg," about which much more has been written.

COLOTOMY WITH DELAYED OPENING OF THE BOWEL.

By G. H. HUME, M.D.,

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At a recent meeting of the Clinical Society of London, (March 13th) Mr. Davies-Colley read notes of three cases of colotomy in which the operation was done in two stages. In the discussion which followed, opinions strongly favourable to this method were expressed by Mr. Bryant and Mr. Howse. Only one speaker seems to have considered that the operation was rendered more complicated by being divided into two stages, and that it was better in all cases to open the bowel at once. My experience in the two cases here recorded, induces me to add my testimony to that of Mr. Davies-Colley, and to join in recommending that the completion of the operation be postponed for a few days, in all instances in which this delay is practicable. Every surgeon who has experience of colotomy, knows how difficult or impossible it is to keep the wound in a satisfactory state when the operation is done in the usual way. The constant fouling of the wound by faecal discharge is the source of endless trouble to the surgeon; and to the patient it involves risk of peritonitis, and the certainty almost of deep suppuration and protracted healing. A modification of the operation, which secures union of at least the deep parts of the wound before it is exposed to this contamination, must be, in the truest sense, a simplification, as concerns both surgeon and patient.

The two cases in which I have adopted this method of delayed opening of the bowel were similar in character, and were identical as regards the details and results of the operation.

The first case was that of a man, aged 36, admitted into the Newcastle-on-Tyne Infirmary in the spring of 1884. He was suffering from an intrapelvic growth surrounding the upper part of the rectum, and producing almost complete obstruction. There were occasionally thin, bloody, offensive motions, but no solid faeces were passed; and the recurring attacks of abdominal distension and pain were very distressing. The first stage of colotomy was done on March 17th; by the usual oblique incision the bowel was readily found, and was stitched to the skin by two or three silk-worm gut sutures. Except at the part where the bowel was attached, the wound was brought together by deep stitches of the same material. The operation was done under carbolic spray, and a gauze-dressing applied. The dressing was not removed until March 22nd, and then the wound was found to be entirely healed, except in the area to which the bowel was fixed. At this part there was a thick coating of lymph, which was scraped aside; and the bowel, lifted up by means of a suture, which had been left long for the purpose, was freely opened. There had been no constitutional disturbance following the operation, and no further dressings were required after the opening of the intestine.

In the second case the patient was also a man, aged 36, the subject of malignant disease of the rectum. The first stage of colotomy was performed on January 29th of this year, and the bowel opened five days afterwards. No intermediate change of dressing was needed, and the wound was quite healed, when the first applied dressing was removed.

The relief to symptoms in both cases was great. In the first case an almost painless failure of strength ended in death on June 15th, when the pelvis was found filled with malignant growth, with secondary deposits in the liver. The second patient left the infirmary on March 19th, much relieved from pain, and irritating discharge from the rectum.

In both cases, the full advantage of the operation was experienced so soon as the bowel was opened, without the drawbacks of a wound healing slowly under unfavourable conditions. The postponed opening of the bowel permitted the use of antiseptic precautions and dressings; and experience shows that, as a rule, deep wounds in the loins, such as are necessary in colotomy and in exploratory operations about the kidney, heal readily when kept aseptic, and when healing is aided by the pressure of careful bandaging. In neither case did the stitches, passed through the wall of the intestine, cause any irritation, or show any tendency to ulcerate out. The skin and coat of the bowel, on the other hand, were found firmly attached when the cavity of the latter was opened; and the sutures could evidently have been safely left for an indefinite time. So far, therefore, as the experience of these two cases goes, special devices for securing the protruding bowel, in

place of stitches, such as the clamp used by Mr. Davies-Colley, or the protected torsion-forceps recommended by Mr. Howse, would appear to be unnecessary.

OBSTETRIC MEMORANDA.

LABOUR MISTAKEN FOR A "BILIOUS ATTACK."

I wish to bring under notice the following case. A few days ago I got an urgent message to go and visit Mrs. G., a young woman, married about eleven months. On arrival at the house, I was informed by the husband that his wife was suffering from a bilious attack, "Just exactly the same as the one you attended me for." On going upstairs, I found her mother and mother-in-law there, both confident that it was "only a bad bilious attack," and another woman who asserted that it was a case of labour. I was asked by the patient herself to "give her something to relieve her quickly of this awful pain."

On making inquiries, I was told that she had menstruated quite regularly. On placing my hand on the abdomen, I felt what appeared to me to be an enlarged uterus. Her mother asserted most positively that the young woman had menstruated only the week before. On making a vaginal examination, I found a foetal head presenting low down, almost pressing on the perineum. Her friends were greatly surprised when I told them what was the matter, and had to send to a married sister for some clothes to put on the child. In about half an hour after my arrival, she was delivered of a female infant, which appeared to me to be about a seven months' fetus. The child is now alive and well. R. E. BURGESS, M.D., Kettering.

HOW TO PREVENT SEPTICÆMIA IN CASES OF MORBIDLY ADHERENT PLACENTA.

WITH reference to Dr. K. N. Macdonald's interesting case, I wish to say a few words. When the placenta is removed, its site in the uterus is thrown into an elevated surface, projecting into the interior of that organ; and, on examination with the finger, gives the feeling of adherent placenta. I am aware that on various occasions, when it was thought that the placenta was not entirely removed, on account of feeling the elevations, it was really removed. I would, therefore, say that the great likelihood is, that Dr. Macdonald did actually, at the various times he mentions, remove the whole placenta; and this is still more likely, because there is every indication that the placenta itself was small, and when, after the lapse of some hours, the blood was expressed from it, it would appear still smaller.

J. STUART NAIRNE, F.F.P.S.G.

SURGICAL MEMORANDA.

SURGICAL TREATMENT OF ANEURYSM OF THE AORTA BY THE INSERTION OF WIRE INTO THE SAC.

IN the article descriptive of Professor Loreta's case of abdominal aneurysm cured by the introduction of wire into the sac, in the JOURNAL of April 11th, reference is made to the late Mr. C. H. Moore's case, treated in the same bold manner in the Middlesex Hospital. By the kindness of that justly styled "excellent surgeon and excellent man," I had an opportunity of seeing not only the sac of the aneurysm with the wire coiled in it, but also most of the organs, immediately after the *post mortem* examination. The immediate cause of death was inflammation of the sac and pericardium. In case surgeons should be tempted to deal with aneurysm of the aorta after this fashion, I venture to invite their attention to the following fact. In the fresh preparation, as I saw it, innumerable clots of varying consistence were hanging from the wires, ready to drop into the blood; and emboli, exactly like them, were visible in the arteries of the organs, carefully dissected to show them. Here is a danger with which, it strikes me, enterprising surgeons inclined to repeat Moore and Loreta's operation must have to reckon.

W. C. MACLEAN, M.D.

CLINICAL MEMORANDA.

VARICOSITY OF THE LINGUAL VEIN AS A DIAGNOSTIC SIGN.

THE cases related by Dr. Dickson in the JOURNAL of May 2nd are very similar to one under my care at the present time. A lady sent