the sheet-anchor in violent cases. Do not add digitalis. Calabar bean is indicated in the early stages of general paralysis. Iodide of potassium and mercury often allay excitement, when the mental symptoms are due to some syphilitic taint.

Hydrocyanic acid, with or without the bromides, is useful in robust cases of mania.

Henbane, in my hands, has proved a disappointing remedy. It is feeble as a sedative, and only valuable as such in large doses, such as half an ounce of the tincture; and even in small doses it often produces headache.

Combinations of drugs are invaluable, such as chloral with bromide of potassium, chloral with the liquor morphine bimeconatis, bromide with cannabis Indica, in acute mania; bromide with ergot, in recurrent insanity; morphia with assafoetida, in hysteria.

Conium is useful where there is much motility; quinine in intermittent insanity; and sumbul or chloral in the status epilepticus.

Aperients are almost always required in the early stages. The milder purges are, as a rule, indicated. These are: Æsculap and Hunyadi János waters; granular effervescent citrate of magnesia; stewed prunes, oranges, and similar domestic remedies. In extreme cases, enemata are necessary, which must sometimes be administered daily, and, if there be no obstruction, croton-oil. Avoid pills, as the patient, if suicidal, will hoard them up, and then take a poisonous quantity.

Should medicine be refused, a subcutaneous injection is occasionally useful, but I prefer disguising my remedies. Chloral in beer or portwine, tincture of opium in coffee, antimony in any liquid (as it is tasteless); and, as regards aperients, calomel between thin slices of bread and butter; syrup of senna in a cup of tea, in lieu of sugar; and other similar harmless modes of deception are now allowable.

3. The *moral treatment* must consist of a mixture of kindness and firmness; and, above all things, we must remember that each case requires different treatment.

4. The *hygienic treatment* is obvious. Let the patient walk out daily till he nearly drops from fatigue, and soon all complaints of loss of sleep and want of appetite will cease; and, although the disease may yet have to run its course, the symptoms will be milder, and the outlook more hopeful, than would have been the case if the patient had been allowed to have his own way.

I must apologise for the concentrated form in which I have been obliged to put these remarks. Let us not think that, by treating the premonitory symptoms of insanity, medical men will want for work. As long as human nature, sexual intercourse, and alcohol exist, so long will there be excess; and, in consequence, plenty of work for our profession—whether we endeavour to sound a note of warning to the foolish, or to alleviate the distress of those who now undeservedly suffer for the sins of their forefathers.

STRICTURE OF THE SIGMOID FLEXURE OF THE COLON: DEATH.

Read at a Meeting of the Sheffield Medico-Chirurgical Society.

By M. MARTIN DE BARTOLOME, M.D.,

Physician to the Sheffield General Infirmary, and Lecturer upon Clinical Medicine and the Practice of Physic at the Sheffield School of Medicine.

I WAS first called to Miss A. S., aged 51, on Tuesday, September 29th, 1885. I found her in bed suffering from slight abdominal pains, and looking as well as usual. She informed me that her bowels had not acted since the preceding Wednesday, September 23rd, but that she felt no particular inconvenience, neither was she alarmed, because she had been in the same predicament several times before, particularly upon two or three occasions when the bowels had not acted for above a fortnight; and checking herself, she added, with great emphasis, "certainly beyond a week," and then "had always become all right by themselves." She assured me that, with these exceptions, she had always been healthy; indeed, although I have frequently attended in the family for several years past, I have never heard her complain.

When I first saw her—and, indeed, throughout her illness, with the exception of a few hours which I shall presently mention—her temperature was 98° as a maximum, her pulse 90, also as a maximum, regular, and of good strength, and the respirations 18, and quite tranquil; the abdomen was distended and tympanitic; the only alteration from her usual appearance which struck me at the time, and which continued to the end, was her complexion, which had a decided mahogany tint, very different from her natural healthy bloom.

From the temperature being so normal, and the pulse only 90 as the

maximum, from the absence of any constitutional disturbance, or anything like acute suffering, and from the positive account she gave of her previous attacks, I concluded that the obstruction was caused either by some congenital malformation, or by some chronic disease of the intestines, probably of a malignant character, but of its situation I could form no idea in the absence of any local pain or other symptom, and the abdomen being firmly unyielding and equally resonant all over, rendered percussion useless as a diagnostic.

I requested the patient to take nothing into the stomach which she could avoid taking, and, above all, to turn a deaf ear to the importunities of officious friends, whose proffered nostrums I have found in more than one such case most efficient in making bad worse, and in thus destroying what little chance the patient originally had.

I ordered her a copious injection of gruel with yolk of egg, castor-oil, and turpentine every twelve hours, and a pill containing one grain of calomel, and half a grain of opium, three or four times daily, or oftener if the pain increased. I also directed belladonna ointment to be applied over the abdomen, and a warm linseed poultice to be constantly kept upon the ointment.

She continued in this condition, with occasional bilious vomiting, up till October 8th, when she had a copious and very offensive stercoaceous vomiting, which I may here observe never returned, though the patient continued occasionally to vomit the contents of the stomach and unmistakable bile.

My attention was now called to a prolapsus ani, which, the patient informed me, had existed for many years, and had caused her great inconvenience, because she could but seldom entirely reduce it, and she had been compelled, in consequence, to wear a bandage in order to support and protect it.

I found, upon examination, a protrusion of the rectum about the size of the fist, and covered with skin; the anus was patulous and lax, and would, I think, if the patient had been put under the influence of chloroform, have readily allowed the whole hand to pass. On introducing the finger into the rectum, I fancied I could feel, with the extreme point, a small and rigid stricture; and, while pressing against it, I felt, heard, and smelt, two distinct and separate most offensive "retrograde sighs," which induced me to think that there might be an opening in the obstruction, and that, although I had been forbidden to speak again of any surgical interference, it was my duty to ascertain, if possible, whether surgical dexterity could not do something to save the patient's life. It was then late in the evening, and, as I did not wish to waste time in useless discussion, I hastened home and returned immediately with an O'Beirne's tube, which I tried to introduce into the bowel; but, although I passed it eighteen inches through the anus, I found that the tube had only coiled itself in the rectum; the point of the tube, however, must have pressed against the stricture, because it was slightly besmeared with blood just as my finger had been.

I then desisted from further interference, and again most earnestly pressed upon the patient the possibility of relieving her by an operation, but all to no purpose, for it only distressed and irritated her;

and she most peremptorily desired that the subject should not be mentioned again.

The temperature that night rose to 100° Fahr., and the pulse to 98, which I attributed to excitement, for both subsided to their former rates before the next morning.

From this moment the injections, which had done nothing but wash the rectum, were discontinued, and the patient very gradually and almost imperceptibly sank, until her death, which took place on Sunday, October 11th, 1885, at 11 o'clock P.M., nineteen and a half days after the last natural action of the bowels.

Post mortem examination thirty-four hours after death.—The body was well nourished, not to say fat. The intestines were distended pretty equally throughout their whole length by above a gallon of well-digested fæces, of about the consistency of thick hasty pudding, and very offensive. The right ovary was of a dark purple colour, and about the size of a large orange; it was multilocular, and contained thick dark grumous fluid. The intestines presented here and there insignificant streaks of florid congestion. The rectum, at about six or seven inches from the anus, was almost entirely closed by a firm and most remarkable puckering, caused by a firm membranous band nearly surrounding the bowel, which I can compare only to a wire passed round the intestine with its ends firmly twisted, as you will perceive by the specimen before you much better than I can describe it; this band, which in its centre is round like a whipcord, was firmly attached at both ends to the promontory of the sacrum, thus firmly enclosing the bowel against the spinal column. It is represented by the black band in the diagram.

The membranous band and the puckering of the bowel appear so devoid of any morbid deposit, except organised lymph, that the only explanation which offers itself to me is the following. I think the patient must at some former period have suffered from limited peritonitis, just about where the peritoneum is reflected from the spinal column over the bowel; this inflammation must have led to the effusion of lymph, which, becoming attached by its ends to the sacrum, formed a bridge over the rectum; and this, again contracting in all directions towards its centre, while becoming organised, gradually shortened its length between its extremities, and drew inwards its thin edges, thus slowly and imperceptibly forming the hard and firm stricture, and giving it its remarkable shape.

The opening through the stricture was very small, but it has unfortunately been dilated by handling. The remarkable features of the case throughout were the normal state of the temperature, of the pulse, and respiration, and the absence of anything like constitutional disturbance and of acute suffering, except for the last twenty-four or thirty hours of the patient's life.

PREVENTION OF LACERATION OF THE PERINÆUM IN PRIMIPARÆ.

By J. ALGERNON TEMPLE, M.D., M.R.C.S.Eng.,

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THE issue of the BRITISH MEDICAL JOURNAL for November 21st, 1885, contains an article on the above subject by Dr. David Gaussen, which deserves more than a mere passing notice. Practically, it is of great value.

For many years, I have been greatly disappointed with the means recommended for prevention of laceration of the perinæum; and, after most careful study of the subject, I came to the conclusion that the only method of any value was to prevent extension of the head from occurring, and to compel it to be born in a state of forced flexion.

In primiparæ, the vulval orifice is small and resisting, and the occiput in its descent does not reach the pubic arch (as it does in multiparæ) before extension commences; as a result of this extension, the long occipito-frontal diameter, which measures about four inches and a half, is obliged to traverse the perinæum, to be followed by the fronto-mental, which measures about three inches and a half, making in all part of a circle about eight or nine inches in length. This naturally stretches the perinæum and vulval orifice to its utmost capacity, and it is during this time that rupture is apt to occur.

To guard against this overdistension in cases where I fear laceration, after the head has reached the floor of the pelvis, and just previously to extension, I have been in the habit of applying the short forceps, and then, by carrying the handles backwards, I flex the chin on the chest, while, at the same time, gentle traction is made downwards and backwards. In this way, I deliver the occiput first, keeping the chin close to the chest; this brings the cervico-bregmatic diameter, which is but three inches and a half, through the vaginal

orifice. This plan saves the perinæum one inch or more of distension. I have had the best results from this practice, and have taught it to my class of students for the past three years.

The practice as taught by Dr. Gaussen I think somewhat difficult to carry out with the fingers, though he desires to obtain the same end as I here advocate. With the forceps, it is easy and safe.

I think this subject one of great importance, and worthy of a trial by any who may have any doubt as to its efficiency. In fact, I may say I am doubtful of the propriety of carrying the handles of the forceps forwards, as taught in the text-books, in any case.

THE DIAGNOSIS OF DISTENDED GALL-BLADDER.

By JOHN W. TAYLOR, F.R.C.S.,

Out-Patient Surgeon to the Birmingham and Midland Hospital for Women.

IN the BRITISH MEDICAL JOURNAL of December 19th, 1885, I have read with much interest the lecture of Mr. Wheelhouse on Abdominal Surgery, in which he does me the honour of quoting considerably from a paper of mine on Cholecystotomy.

In this paper, which was published in the BRITISH MEDICAL JOURNAL of January 31st, 1885, I described a diagnostic "line," which I believed would be of considerable service in the detection or elimination of a distended gall-bladder in doubtful cases. "This is to be traced from the normal position of the larger end of the gall-bladder (near the tip of the cartilage of the tenth rib on the right side) to the opposite side of the abdomen, crossing the middle line slightly below the umbilicus. In the direction of this line, a distended gall-bladder will, I believe, naturally lie."

During the past year, I have had the opportunity of testing the value of this aid to diagnosis in nine cases operated on by Mr. Tait, a tabular list of which is here given.

No.	Date.	External Signs.	Condition found on opening the Abdomen.	Operation.
1	March 26	Tumour in line	Distended gall-bladder	Cholecystotomy
2	May 7	Tumour to left of line (tending to cross middle line above umbilicus)	Hydatid tumour of liver	Hepatomomy
3	April 1	Tumour to right of line (jaundice)	Solid tumour of liver (probably cancer)	Exploratory incision
4	Aug. 17	Tumour to left of line (jaundice)	Solid tumour (probably cancer of pancreas, gall-bladder felt to right of tumour, slightly distended)	Exploratory incision
5	Oct. 14	Tumour in line	Distended gall-bladder (suppurating)	Cholecystotomy
6	Nov. 11	Tumour in line	Distended gall-bladder (adherent to abdominal wall)	"
7	Dec. 10	Tumour in line (jaundice)	Distended gall-bladder	"
8	Dec. 13	Tumour to left of line (tending to cross middle line above umbilicus)	Solid tumour (probably cancer)	Exploratory incision
9	Dec. 14	Tumour to right of line in position of right kidney	Suppurating right kidney, from which four gall-stones were removed; gall-bladder not felt; probable adhesion of gall-bladder to right kidney, and ulceration of gall-stones into pelvis of kidney	Nephrotomy

In eight of these cases (from 1 to 8) a tumour existed in the neighbourhood of where a distended gall-bladder might reasonably be expected, that is, not far from the junction of the right hypochondriac, right lumbar, epigastric, and umbilical regions; and in all, this sign was associated with symptoms of supposed biliary colic.

Of these eight cases of abdominal tumour, the four tumours which fell in the diagonal line described proved to be distended gall-bladders, while the four which varied from this line proved to be tumours of some other class.

In Nos. 2, 4, and 8 of these cases, a distended gall-bladder was confidently expected by several physicians in attendance on each case, and the general symptoms were decidedly confirmatory of this opinion; but in each of these cases, the divergence of the tumour from the diagonal line, and the result of the operation, proved the diagnosis to be mistaken. It has, therefore, appeared to me that this aid to diagnosis is almost of more value from its negative than from its positive aspect, especially in the case of all tumours lying to the left of the line, and tending to cross the middle line above the umbilicus.

I notice that Mr. Wheelhouse refers to another line which has been