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 feces, 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.

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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.,

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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