CASE OF LONG-STANDING DIARRHŒA CURED BY THE SURGICAL TREATMENT OF AN ULCER OF THE RECTUM.

By THOMAS ANNANDALE, F.R.S.E.,

Surgeon to the Edinburgh Infirmary, and Lecturer on Clinical Surgery.

DR. —, aged 50, applied to me on the 28th of March, 1872, on account of persistent dysenteric diarrhœa. He had recently returned from India, where he had resided continuously since May 1847. For the last three years he had suffered from constant diarrhœa, which had resisted many remedies carefully tried. He also suffered from much irritation of the rectum, which was supposed to be due to piles. It was an usual thing for Dr. — to have four, five, or six motions daily, and he had had no "formed" motion for three years. Having made an examination of the rectum, I ascertained the presence of an ulcer, which was situated about one inch above the anal orifice. This ulcer was on the posterior wall of the rectum, was of the size of a fourpenny-piece, and had a depressed surface, with hard edges. It was only slightly painful when touched.

On April 22nd, I made a free incision through the sphincter and base of the ulcer, and this was followed by a decided improvement in the symptoms. On the 21st May, finding that the sore, although much smaller, still presented an irritable appearance, I again divided its base freely. Some inflammation and suppuration of the lymphatics passing up towards the groin followed this second operation; but on the 29th, eight days after its performance, a most marked improvement in the dysenteric symptoms took place. On June 1st, the patient had no motion at all; and on June 2nd, one "formed" motion, the first for three years. Since then, the patient's progress has been perfect towards recovery, and he writes me that he has gained one stone four and a half pounds in weight since the end of March, and is quite well. On examining the rectum a few days ago, I found that the ulcer had quite disappeared, and in its place was a small puckered cicatrix.

During the progress of the case, milk diet only was allowed, but the patient can now take animal food with benefit.

REMARKS.—This case is an illustrative example of a class of cases which are by no means uncommon, but the true nature of which is not always determined, for it is not the first one of the kind which has come under my surgical care after medicine has failed to afford relief. It is important to note that in such cases the operation is not always followed by immediate relief to the diarrhœa, but that some weeks may elapse before improvement occurs. In another case of the kind under my care, it was several months before an improvement in the symptoms was observed. I have also noticed that the first effect of the operation in these cases may be to cause a temporary cessation of the diarrhœa; but this result is not permanent, the final relief only taking place after some weeks or months.

It will not, I think, be doubted that the ulcer of the rectum in the case just reported was the cause of the dysenteric symptoms, for its removal gave the relief which careful medical treatment had failed to afford. The patient, a gentleman of high standing in the Indian medical service, has himself no doubt in regard to this point, and will, I feel sure, bear testimony as to the value of surgical treatment in cases such as his own.

ON MECHANICAL AND FORCIBLE DILATATION OF THE CERVIX UTERI.

By HENRY BENNET, M.D.,

Late Obstetric Physician to the Royal Free Hospital, etc.

I HAVE read with interest the articles of Dr. Matthews Duncan on the mechanical dilatation of the cervix uteri, as also the subsequent remarks of Dr. Atthill and of Dr. Aveling. I quite agree with the latter writers, that Dr. Matthews Duncan has made a valuable contribution to the mechanics of the subject, and has added to our knowledge of what is actually done when *force* is used to introduce a sound or bougie into the cavity of the uterus, either for mere uterine examination or for dilatation of the os internum. I am surprised, however, that none of these gynecologists have noticed or discussed the doctrinal points which I brought before the British Medical Association in a paper read at Birmingham last August, which was published in this JOURNAL in October; yet these doctrinal points are at the base of the entire question of cervical dilatation. In this paper I merely reproduced the views brought before the profession in 1848, in the second edition of my work on uterine inflammation, and which I have repeated, with the autho-

riety of increasing experience, in each subsequent edition. I maintain, founding myself on anatomy and physiology, that the os uteri internum is normally closed during life, by a vital contraction of the circular fibres, which prevents, in healthy women, the easy entrance of the uterine sound *at all*, except in some women, not in all, a day or two before, during, and a day or two after, menstruation. In these healthy women force has to be used to pass it; and this force, Dr. Matthews Duncan tells us, is, in his experienced hands, equivalent to four pounds, an amount of force that would bend a metal sound if exercised at the handle.

Dr. Duncan does not speak of healthy sound women; but I believe his remark applies to them, as he appears entirely to ignore the fact that in healthy women the os is vitally closed physiologically, and evidently considers this healthy vital closure a morbid state, as did Sir James Simpson, from whom he has evidently taken this view.

The os uteri internum is actually open so as to admit the uterine sound or an equally large bougie, only, as a rule (to which, however, there may be exceptions), in morbid uterine conditions. It may be thus open in chronic inflammatory disease of the mucous membrane lining the cervical canal or the cavity of the uterus, in enlargement of the body of the uterus from whatever cause, from fibroid tumours, from chronic inflammation, or from non-involution after pregnancy. In any of these states the circular fibres at the os internum *may* relax (they do not always do so), and may allow a free passage to the sound or bougie. To these states I would add that of some women of very lax fibre, with relaxed vulva, vagina, and abdomen, and with general flabbiness of tissue.

In healthy women, I repeat, as a rule, the os internum during life is closed vitally by contraction of the circular fibre. To consider this condition a morbid one is an error—anatomical, physiological, pathological. Practically, it is a most pernicious error, for it renders nearly every healthy woman who is examined liable to be considered as suffering under morbid closure. Such an erroneous idea leads to unnecessary, unjustifiable surgical interference, to cutting, to forcible dilatation with four pounds' pressure, to dilatation of all sorts and kinds, and that without real necessity.

This is the question that we ought first to discuss—What is the natural state of the os uteri internum? What is the amount of contraction that requires dilatation at all? These points I endeavoured to decide in the paper alluded to, recently published, so I shall not here revert to them, but refer to the essay itself.

I would only add that it is indeed necessary that these questions should be settled when men in the position of my friends, Dr. Matthews Duncan of Edinburgh, and Dr. Greenhalgh of London, entirely ignore the physiological condition of the os internum—do not even allude to it. At a meeting of the Obstetric Society in 1866, at which I was present, in the discussion of a paper by Dr. Tilt on "Undue Surgical Interference in Uterine Disease", Dr. Greenhalgh told us that in less than two years he had divided the os internum, with his metrotome, in more than three hundred cases in his own study. I should have liked to know what proportion these cases of division bore to the cases of uterine disease thus seen in the course of the two years in which division was not practised.

CASES ILLUSTRATING THE USE OF THE PNEUMATIC ASPIRATOR.

By T. PRIDGIN TEALE, Esq., F.R.C.S.,

Surgeon to the General Infirmary, Leeds.

As Mr. Jessop has called attention to the use of the pneumatic aspirator—an instrument highly valued by my colleagues and myself at the Leeds Infirmary—the following additional illustrations of its employment may not be without interest.

Diagnosis of Multilocular Ovarian Tumour.—In the summer of 1871, I was requested by Dr. Bealy of Harrogate to examine a case of abdominal tumour of doubtful character. A large, apparently solid tumour, of uneven surface, in which fluctuation could not be detected, filled the lower part of the abdomen, and percussion of the hollow viscera did not give very decided aid in the diagnosis. Seeing that the tumour, if ovarian and non-malignant, was probably polycystic, and that, if it were polycystic, no two cysts would be likely to contain exactly similar fluid, I introduced the needle of the aspirator—first in one prominent part, and then in a second—and drew off in the first instance an ounce of turbid viscid fluid, and in the second clear limpid fluid. Thus was proved the existence of multiple cysts varying in their contents—a condition, I believe, exhibited by no other kind of abdominal tumour than ovarian.