of memory, and confusion, and in a very emaciated condition; the external symptoms of disease remaining very much as before. After some preparative treatment, the full doses of iodide were given; and all special symptoms were removed, and his general health re-established, on February 10th—the necrosed bone remaining in the same state as before. He continues an out-patient, in good health.

With this case I close my list of syphilitic cachexiæ treated by this method. I have nothing so decisive to adduce in regard to rheumatic cachexia. In fact, I can only state in general terms that, where I have employed large doses, great amendment of general symptoms has usually followed, and sometimes much local relief. But there is undoubtedly more tendency to the recurrence of the disease: in fact, the local symptoms are never entirely overcome. In sciatica, I have succeeded by this method in two very obstinate and protracted cases, which had long resisted treatment.

CASE X. Henry Robinson, aged 27, after for many weeks suffering from acute pains in the sciatic and its branches, and being much reduced by loss of appetite and sleeplessness, began the large doses of iodide on March 13th, rapidly increasing them to twenty grains three times a day; and on the 18th of April he left the hospital free from the complaints. And Stephen Sprag, aged 30 (both farm labourers), had been suffering similarly, and almost to the same degree, for three months. He commenced the twenty-grain doses on the 21st of March, and on the 9th of April left the house in his usual health. In both these cases, and, to the best of my belief, in all here narrated, the iodide had previously been given for some weeks in five-grain doses without effect; and the change followed so directly on the large doses as to justify its being attributed to their influence. In neither case has there been recurrence.

In the treatment of these cachexiæ, I do not exclude regimen and dietetic adjuvants, though I admit I have made the treatment in the above cases as pure as possible, to avoid the risk of fallacy. But I do not doubt that the old methods of skin-elimination, by external or internal means, or by a combination of the two, as in the "Zitman method", would greatly assist. At all times, the vehicle of the iodide may with advantage be the decoction of sarsa or of the "woods".

I would add a few remarks on the action of the iodide on the mucous surfaces. In a certain proportion of cases, the salt, in ordinary medicinal doses (say gr. iii to gr. v), will produce irritation of the Schneiderian membrane and coryza; but, as I have already said, this is not the case where a large dose is used. This, I think, points out that the small doses are more likely to affect the mucous tracts generally than the large, and should lead us to employ them when we have this object in view. My observations have chiefly had reference to the pulmonary membrane; but there is good reason to believe that the other tracts, and perhaps more notably the genito-urinary of the female, are amenable to its influence. I will cite two cases of very severe capillary bronchitis, in which I believe relief was afforded more rapidly by the use of the iodide, combined with a very small dose of tartarised antimony, than would have resulted from the use of either remedy alone—certainly, than if the tartarised antimony only had been used.

CASE XI. J. Skerat, aged 48, a town labourer, subject to chronic bronchitis, was seized with a very violent attack of dyspnoea and lividity in the early days of March, and was admitted into the hospital in a very alarming state. There were physical signs of minute bronchitis over both lungs; and his general symptoms corresponded with this local condition. He had stupes and expectorants, with one-eighth of a grain of tartarised antimony, for several days, with partial relief; and on the 25th he began to take three grains of iodide of potassium, with one-twelfth of a grain of tartarised antimony, every three hours. From his commencing this treatment, his improvement was very marked, and he was convalescent on April 18th.

CASE XII. W. Hudson, a traveller, aged 48, exhibited on admission (Feb. 21st) a very similar condition. His respiration was 40; his cough incessant; and he expectorated half a pint of muco-purulent fluid in twenty-four hours. Small moist rhonchus was heard throughout. On March 2nd, he began the same doses as in the former case; and his improvement was equally immediate and satisfactory, as he was quite convalescent on the 20th.

I have notes of other cases in which some advantage seemed to result from the treatment, but none so decided as these; but the cases in which no benefit seemed to result were very few.

The efficacy of the large dose system in the cachexiæ, and notably in syphilitic cachexia, seems to be established, not by the few cases here adduced, but by their accordance with many others now on record, and to which I have seen an addition within a few days. The action of the drug upon mucous diseases I purpose still to continue to investigate; and I hope that ere long we may have arrived at that stage in the accumulation of facts which will justify an attempt to generalise with more confidence, and to extend by induction the application of the resulting laws.

ON STRICTURE OF THE RECTUM.*

By JOLLIFFE TUFNELL, Esq.,

Examiner in Surgery in the Royal College of Surgeons, Ireland; Surgeon to the City of Dublin Hospital, and Dublin District Military Prison; etc.

I DO not, upon the present occasion, purpose to do more than very briefly bring before the members of the Association a mode of dilatation which, in cases of stricture of the rectum, I have found to be most successful; and to exhibit to the members of the Association present the instruments by whose agency the advantages referred to may be brought about. The bougies in question can be employed in every case of stricture of the bowel that is accessible to the surgeon's touch, and which from its nature he may consider to be suitable for dilatation. In malignant cases, they also afford the means of giving much temporary relief.

The bougies, then, which I now exhibit, differ from those previously in use in being hollow, the extremity open, and terminating with a feather edge; the diameter of the aperture being equal to that of a No. 12 catheter or urethra bougie, and passing freely over a central guiding-rod.

The principle here adopted was, I believe, first employed by the late Mr. Hutton in the construction of his railway catheter. It at once gives to the surgeon the power of conducting the bougie safely and certainly through a stricture, no matter how contracted the orifice, how tortuous its course, or how diseased the coats of the intestine itself may be. The stricture once penetrated, the guiding-rod becomes no longer necessary, and now, upon its withdrawal, free exit is given through the central passage for mucus, pus, blood, or other secretions, gaseous or fluid, which may be occupying the pouch-like dilatation, which exists in almost every case of aggravated stricture.

Not only can all irritating and obnoxious secretions be thus got rid of, but a stream of tepid water can be gently injected up into the cavity of the bowel above the stricture, dissolving and breaking down any fecal lumps which may have lodged themselves above the obstruction. The patient is thus freed from that accumulation which produces the main source of suffering in this disease. It permits, too, the use of sedative or astringent injections being employed, and brought into direct contact with the ulcerated portions of the intestinal tube.

In using the tubular bougie, the forefinger of the left hand is to be passed up into the rectum until its tip is firmly pressed against the stricture, and the extent and density of the contraction thereby ascertained. The point of the thumb is then to be applied to the forefinger close up to the arm, and retained as the finger is withdrawn, thus taking an exact measurement of the distance of the stricture from the anus. The guiding-rod is next to be placed alongside of the finger, and an indentation made upon it into the nail of the right forefinger, at the point corresponding to the extreme length previously inserted. This done, allowance must be made for the extent of the stricture itself; and to this a further amount of at least an inch must be superadded for the passage of the guiding-rod beyond the stricture up into the bowel. In this way, an exact knowledge is gained of the length of guiding-rod required in order to secure a certain transit through the contracted portion of the intestine. A distinguishable mark is now to be placed upon the guiding-rod, by tying a piece of fine, but strong, white ligature silk tightly around it, the elasticity of the gutta percha readily permitting of this being done, without the bougie displacing the silk in its subsequent passage over it. A similar mark is next to be tied round the bougie itself at such point as the surgeon may determine, according to the degree of distension which it may be desirable to employ. These distances being once noted, the marks remain *in situ* until removed, so that the preliminary steps here detailed are required only at the first examination. When proceeding to dilate, the left forefinger is to be introduced into the bowel, up to, and if possible into, the stricture, the guiding-rod (well lubricated at its extremity), slid up by the side of the finger until it reaches the contraction, when, manipulated by the right hand, it is to be passed into and through the stricture until the requisite distance for its introduction into the bowel shall be demonstrated by the silk mark being about to disappear within the anus.

The tubular bougie (well lubricated also with an anodyne or sedative unction) is now to be placed over the projecting end of the guiding-rod, and passed along it into the rectum and through the stricture. The length of its insertion being determined, in like manner to that of the guiding-rod, by the silk mark fixed upon it.

As to the period of its retention; the nature of the injections to be employed for the clearing of the contents of the bowel, and the subsequent healing of ulceration; the attention to the state of the secretions, and the consistency of the evacuations—all these are matters which must be

* Read in the Surgical Section at the Annual Meeting of the British Medical Association in Dublin, August 1867.

familiar to those whom I have the honour of addressing. I shall not, therefore, trespass longer upon the time of the Association; but shall be happy to reply to any question, or supply any further information which it may be in my power to afford.

A STEEL RING IMPACTED FOR 13½ YEARS IN THE NASO-PHARYNGEAL FOSSA OF A CHILD: DETECTION BY THE RHINOSCOPE, AND REMOVAL.

By WILLIAM HICKMAN, M.B., F.R.C.S.,
Surgeon to the Western General Dispensary.

THE following case is interesting, in connection with that related by Mr. Lowndes in the JOURNAL of September 7th, and as showing how long a foreign body may remain undetected without a very careful examination.

Caroline M., a delicate and intelligent looking girl in her sixteenth year, was brought to me at the Western General Dispensary in the autumn of 1866, supposed to be suffering from a polypus of the nose. She could not blow through the left nostril at all, and the mucous membranes of both appeared thickened and red, but no actual polypus could be discovered. On looking into the mouth the soft palate was seen to be much swollen, especially on the right side, and a small fistulous opening was apparent just above the origin of the uvula. A rhinoscopic examination was now made, and a wide, square-outlined, black object was at once seen in the naso-pharyngeal space above the soft palate, completely imbedded in the swollen mucous membrane which projected into the space from the walls around. To the probe this was found to be quite hard; the tip of the finger could only just reach it and push it slightly away or to one side. An ineffectual effort was made to push the foreign body down into the mouth by means of an instrument introduced through the nostrils, but on this failing, guided by the history of the case and the appearance of the foreign body, I made a hook with a long probe bent into three curves, and passed it up behind the palate; and after some time and considerable trouble, and with the assistance of the forefinger of the left hand I managed to pass the hook through the ring and bring this away on the probe. The ring was a wide steel one (completely blackened and rough from its lengthy sojourn), which had belonged to one of the old-fashioned long purses; it measured nearly three-fourths of an inch in diameter, and nearly half an inch in width.

The following history was obtained from the mother. Thirteen and a half years previously, when not quite two years old, the child was seized with a choking fit whilst at play, and ran to her mother endeavouring to attract attention to her throat; the mother thrust her finger into the child's mouth and felt distinctly the circular outline of a ring, but it immediately escaped from her touch and she could not bring it out, and, as the choking symptoms subsided, she concluded it must have been swallowed. It was never detected in the motions, however; and in the course of a week or two a brownish discharge took place from the nose, so the child was taken to a medical man, and afterwards to several others, but all assured the mother there was nothing lodged. From that time the child had been always ailing, and was with difficulty reared, a delicate strumous-looking girl. The discharge from the nose diminished and became colourless, but continued; the nose became quite impervious to air, so that the mouth was noticed to be always open; she became very deaf, lost the sense of smell, and was continually having attacks of sore-throat, and at last the breath became so offensive that she was not allowed to attend school, and could get no other children to associate with her. During all this time she was constantly being taken to different medical men, and was treated for sore-throat, ulcerated throat, enlarged tonsils, fissure of the palate, polypus of the nose, etc., etc.—the mother's account of the accident with the ring being made light of, until at last, as she said, she was almost ashamed to relate it. The child remained a month in one of the provincial infirmaries and had one of her tonsils excised; the other was also to have been removed, but that she was obliged to return to London with her parents.

Since the extraction of the ring she has improved in health in every way; the discharge has ceased, the breath is no longer offensive, the hearing and sense of smell are restored, and she has gained flesh and strength;

the swelling of the throat has gone down, so that the right arch of the palate is now much contracted (from loss of substance), and the uvula pushed over to one side; the small fistulous opening has become a large smooth hole close to the margin of the palate; the tonsils are still enlarged, but only sufficiently so to fill up the gap left in the soft palate during the act of deglutition. In a further examination of the posterior nares by the rhinoscope, in which Sir Duncan Gibb very kindly assisted me, we found that the back part of the vomer, and of the turbinated bones on each side, had been quite absorbed.

For some time afterwards, the girl was much annoyed by the constant regurgitation of fluids through the nose during the act of swallowing, but this was at last relieved by cutting through the border of the aperture in the soft palate, the hole being too large to be treated by the cautery, and the outer limiting tissue being too narrow to admit of any plastic operation.

CASE OF STAB: CHEST AND ABDOMEN PENETRATED: INTESTINE WOUNDED.

By W. MICHELL CLARKE, Esq.,
Surgeon to the Bristol General Hospital.

AT about midnight, on the 7th of October of last year, a quarrel arose between two men who were leaving a public-house in Bristol, the result of which was that one of them drew his knife upon the other, whose name was James White, and stabbed him in the right side of the chest and of the abdomen. He was taken to the General Hospital, and was received and attended to by the resident medical officers.

I saw him at about mid-day, at which time he was lying on his back, but breathing with great difficulty; his face looking oppressed and blue. He was a short, stout man, of general healthy appearance, and aged 32. The wound in the chest was rather more than an inch long, and had evidently been made by a sharp instrument; I was told that there had been considerable hæmorrhage from it, so much as to have led to the supposition that an intercostal artery had been struck, but the wound had been closed with lint, and the bleeding had ceased. The whole of the right side of the chest was unnaturally resonant. The abdominal wound was situated about midway between the umbilicus and the crest of the ilium; it was small, but evidently deep, and larger internally than externally; at the time of the man's admission, a small piece of intestine and of omentum protruded from it. When I saw him, the intestine had been returned, and the wound was closed by a single stitch of silver wire, and everything about it appeared to be quite satisfactory.

I was told that immediately upon the receipt of the first wound he had fainted; that he was sick at the time of his admission, and for some time afterwards; he had taken one grain of solid opium every four hours, and also ice, and the sickness had ceased, so that, at the time of my visit, he only appeared to be suffering from the difficulty of breathing, which was considerable. I directed that he should be removed from the general ward into a warm room; that he should be supported by a bed-chair; that he should be bled if the breathing became worse; and that he should have a mixture containing nitrate of potash, tincture of digitalis, and liquor ammoniæ acetatis.

On the day after his admission (Oct. 8th), his breathing had improved; but the right side of the chest remained unnaturally resonant; he had an anxious haggard look, was thirsty, and the tongue was dry. The pulse was 120. He had continued the opium, but not regularly, and his mixture, but had not been bled. The mixture was omitted, but an occasional dose of opium continued. His food consisted chiefly of gruel and arrowroot.

On the third day (Oct. 9th), his pulse had dropped to 98; his tongue was moist and clean, he looked less anxious, and appeared altogether to be doing well; but it was noted that there was a swelling of some firmness under the abdominal wound. His sickness had almost ceased, but he felt somewhat sick when the abdomen was pressed. He had taken no opium, but continued the ice.

On the 10th (fourth day) the pulse had again dropped, and was now only 84. The tongue was moist and clean, and the expression natural. The right side of the chest still remained morbidly resonant, and there was an absence of respiratory murmur; he had also a slight cough, but, with the exception of these symptoms, his condition seemed to be altogether favourable, and everything about the abdominal wound was perfectly quiet.

On the following day (Oct. 11th, fifth day), however, his condition had altogether changed, and from a state of apparent safety he had passed into one of imminent danger. The symptoms due to the abdominal wound now, and from this time, predominated, and gave great and important interest to his case. He had an anxious expression, and