an uncontrollable desire to go to stool and much tenesmus. She had been under medical treatment for years, and all the recognized forms had been tried. On examining the bowel with the sigmoidoscope I found the mucosa quite normal in appearance. In the middle of the sigmoid, however, the bowel was found to be firmly fixed and angulated, apparently by adhesions. The uterus was also found to be markedly retroflexed. It seemed probable that the tenesmus from which she suffered was due to the condition of the uterus, and a gynaecologist who saw her with me confirmed this view.

I opened the abdomen and found a number of firm adhesions binding down and kinking the middle of the sigmoid flexure; these were divided and the wound left in the peritoneum sewn up. The uterus was also drawn forward and anchored to the abdominal wall so as to correct the position.

The patient made a good recovery, and all her symptoms have now completely disappeared. When I last saw her some months after the operation she had put on weight, her complexion was good, she no longer had any mucus in the stools, and she told me that she never remembered feeling so well and fit.

Though most of the cases of true colitis (that is to say, when a chronic inflammation of the mucosa of the colon is found) get well as the result of medical treatment and lavage, there are nevertheless a certain number which either fail to get entirely well or suffer from frequent relapses. These cases are, I believe, best treated by appendicostomy, which enables the patient to keep the colon efficiently washed out daily with the minimum of inconvenience, and the symptoms quickly clear up.

The most difficult cases to treat are perhaps those in which there is a general atony of the bowel combined with ptosis of the colon. Stitching up the colon is quite useless, as it is unreasonable to expect any stitches to hold up the stomach and transverse colon permanently when the natural supports have not been sufficient to do so. It is impossible to deal directly with the condition, but I have had very satisfactory results in such cases from appendicostomy, and the fitting of a belt to support the abdomen. The object of the operation in such cases is to prevent the stagnation of the faecal contents of the colon, which is the chief cause of trouble, and at the same time by the introduction of suitable peristaltic stimulants to improve and restore the muscular tone of the bowel wall.

The following well illustrates this type of case:

Mrs. B., aged 32, a married lady, was sent to me by her doctor suffering from severe chronic colitis. There was a history dating back twelve years, though the symptoms had only been really severe for the last four years. She always felt ill, and had a chronic aching pain in the left side of the abdomen. She was always very constipated, and had to take large doses of aperients, and this often without success. The stools contained mucus, and often large casts over a foot in length. She had been treated for long periods by the usual remedies, and had on different occasions consulted several well known physicians, but without obtaining any relief from her symptoms.

Examination showed an atonic condition of the bowel, and chronic inflammatory changes of the mucosa. There was also well-marked ptosis of the transverse colon.

I operated, and on opening the abdomen found the colon much dilated and thin. There was also considerable enteroptosis. Appendicostomy was performed, as the only alternative seemed to be removal of the colon.

The colon was subsequently irrigated daily with warm water (at first in small quantities) to which a teaspoonful of ox bile was added. She rapidly improved in health, and learnt to wash out the bowel for herself. The mucus entirely disappeared from the stools, her health improved, and the bowels acted without any aperient being used. During the next six months she put on 2 st. in weight, and when I last heard from her, about nine months after the operation, she was quite well, and although on my advice still washing out the bowel, was quite free from any of her old symptoms.

Appendicostomy is an operation followed by excellent results in many of these cases, but it is not a panacea for all cases of so-called chronic colitis any more than is lavage. It should only be performed in suitable cases, and that can only be done if we first ascertain the cause of the symptoms. I have seen cases in which appendicostomy has failed even to relieve the symptoms because there was some obstruction or other lesion which had not been detected.

I do not wish it to be thought that I am advocating operation in all cases in which there are symptoms of chronic colitis. I think operation should only be resorted to after a careful trial has been given to medical treatment. But the important thing is to ascertain the cause of the symptoms by a careful examination aided whenever possible by the use of the sigmoidoscope, as it is useless treating a case by medical measures where there is an obstructive lesion in the colon, or a chronically inflamed

and thickened appendix. And, in any case, it is not satisfactory to institute treatment without knowing the cause of the symptoms.

ENTEROSPASM: OPERATION: DEATH.

By VAUGHAN PENDRED, M.D.DURH., F.R.C.S.ENG.

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MR. C. W. DEAN'S case of enterospasm reported in the *JOURNAL* of March 13th recalls a similar case I had under my care four years ago, which ended fatally, and on which I obtained a partial autopsy:

The patient was a querulous, excitable, grey-haired little woman aged 57 when I first saw her in October, 1904. She was fat and healthy-looking. For the preceding three years she had suffered from time to time from colic with vomiting and diarrhoea. Latterly these attacks had become very frequent and severe. The tongue was coated. The urine showed a trace of albumen, and she complained of frequent micturition. During the next two months, in spite of energetic treatment, she had much colic and some emesis, and had plainly emaciated. A copious bleeding from the rectum occurred about this time.

In January, 1905, I sent her to Guy's Hospital, where some improvement took place during her month's residence. An x-ray photograph of the abdomen was negative. Movable right kidney was diagnosed and the wearing of a belt advised.

Month after month she continued to waste, and had constant vomiting attacks. Constipation alternated with diarrhoea, which latter somewhat relieved her pain.

In July, 1905—or ten months after my first notes—she was nearly bedridden with colic, coming on every few minutes, accompanied by tremendous borborygmi. Visible peristaltic waves passed across coils of intestine from left to right every few minutes, as though the intestine were endeavouring to overcome some obstruction. By the end of this month her condition was pitiable, and I had to keep her constantly under the influence of morphine. The pain was almost constant night and day. The vomit now became stercoraceous, hiccough supervened, and the bowels were confined. In short, the symptoms pointed to intestinal obstruction.

On July 29th I opened the abdomen below the umbilicus, but at first could find nothing amiss. Some feet of small intestine, distended but healthy looking, prolapsed through the wound. At one point the distension of the gut suddenly ceased, and the distal portion was flat, toneless, and of a paler colour, so that I thought that I had discovered the obstruction that I sought. Whilst I was considering what I would do next, the collapsed gut began to fill out again just as it had appeared to do through the abdominal wall. In order to return the gut it was necessary to incise a prominent coil, from which gas and foul liquid faeces escaped.

Three days later her condition was as bad as ever. The gurgling, peristalsis, pain and sickness, with occasional haematemesis, being nearly continuous. She died in the middle of September, emaciated to a skeleton, as she was unable to take food for many days. The peristaltic waves were a marked symptom up to the last moment of her life.

A *post-mortem* examination of the abdomen was all I could obtain leave to make. Every organ, though wasted, was macroscopically healthy. The intestine was partly opened up, and presented a normal appearance. Portions of the organs were sent to a London pathologist, who confirmed my opinion of them.

This case parallels Mr. Dean's in many particulars. Both patients had suffered from abdominal pains, vomiting, and bowel trouble for some years. The appearance of the ileum at the operation was similar. In Dr. Ashe's and my case the flattened gut "livened up" under observation. Anorexia and utterly uncontrollable vomiting, with occasional haematemesis and melaena, were such prominent symptoms in my case, that they point to a profound toxæmia, and not merely to a disturbance of innervation of the intestine.

FISTULAE BETWEEN THE STOMACH AND BILE PASSAGES, ETC.

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THE CASES of unusual fistulae in the *JOURNAL* of May 1st by Mr. Mayo Robson make one think that the unrecorded cases may be more numerous than would be expected, and the following three may be of some interest:

M. L., aged 32, a multipara, whom I saw with Dr. Lowson on June 17th, 1899, had the following history: From November, 1898, she had repeated attacks of biliary colic, which developed in intensity till April 5th, 1899. The vomit was at times