That every case of recurrent paroxysmal abdominal pain, followed by vomiting and succeeded by intervals of ease, more especially if the stomach resonance be increased upwards, should be considered as presumably a case of obstruction. If the onset has been accompanied by shock the presumption is still stronger. External hernia should be at once searched for. If this be absent, then enemata should be carefully and thoroughly given and repeated and the stomach washed out, *morphine being absolutely withheld*, and hot applications used to relieve pain. If, after this treatment has been carefully carried out, relief from both pain and vomiting does not occur *and continue*, whether or not there may have been motion or flatus passed after the enemata, then operation should be arranged for without waiting for the signals of the third stage—namely, the dry tongue, quick pulse, anxious face, and, above all, the distended abdomen. For dry tongue, quick pulse, and anxious face mean that toxic absorption from an infected peritoneum has already sapped the patient's power of withstanding shock, and the distended abdomen implies either an incomplete and unsatisfactory operation or one around which nearly all the elements of shock are sure to be assembled.

A distended abdomen in those cases which survive operation usually means a long and distressing illness, too often complicated by the effects of adhesions, and frequently to be followed by a second operation for the closure of the enterostomy. As general practitioners we are all of us, I suppose, agreed that it is little less than criminal to watch and wait while a glaucomatous eye becomes blind and stony, or a cancerous breast contracts obvious adhesions and develops palpable masses in the axilla. None of us would advise postponing operation till extravasation should take place from an impassably strictured urethra, nor should we put off turning till an arm presentation had become firmly impacted. About such cases as these we have fully made up our minds, and I believe that before long we shall consider it not less criminal in cases of intestinal obstruction to wait for the distension and peritoneal infection, which—rather than the obstruction itself—are too often the true causes of unsuccessful operation and fatal results.

A METHOD OF INTESTINAL DRAINAGE.

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It is well recognized nowadays that it is a fatal mistake to return over-distended bowel into the abdomen in cases of intestinal obstruction.

The usual method for evacuating the intestinal contents and the one which is the most effective is to incise the most distended loop after protecting the rest of the coils with towels or gauze. This practice, however, has many disadvantages. To begin with, it has to be carried out by an assistant. Secondly, it is practically impossible, one way or another, to prevent infection being conveyed into the peritoneal cavity. Furthermore, it entails a great deal of trouble for the surgeon and his assistants, as it necessitates frequent change of gloves and cleansing of hands.

To obviate all these drawbacks I have thought of a simple method which has been used with success in this hospital, and which consists in utilizing the well-known Murphy button with a piece of soft rubber tubing (about a yard or more long) as follows: A purse-string suture of silk is passed round one of the ends of the rubber tube, the male or female half of the button is introduced into the lumen and the thread tightened so as to grip the neck of the button. Next, a segment of the distended bowel is clamped and a linear purse-string suture inserted. The gut is incised, the other half of the button placed in position, and, finally the two sections of the instrument united in the usual way. The anastomosis between bowel and rubber tube is complete, and on removing the clamp there is no leakage and the faecal contents pass out of the tube into a jar containing some kind of deodorant well away from the area of operation. The purse-string on the bowel need only be secured by a temporary knot so that the suture may be tightened and the incision instantaneously

closed after the withdrawal of the button, the bowel being reclamped before the button is removed. If one opening does not give satisfactory drainage, the process can be repeated with as many coils as the surgeon desires, or a piece of drainage tubing can be passed up the soft tube through the button into the bowel and the intestines "milked" without the hands coming into contact with faecal matter.

This method is perhaps more serviceable in cases which require immediate colotomy. The use of the Murphy button would be found to be in every way superior to Paul's tubes, as it involves no danger of detachment or leakage. The soft tube with half the button in position being ready the operation can be completed in a few minutes. The button, as a rule, remains *in situ*, affording good drainage for at least four days, during which time there is no necessity to even inspect the wound. When the button comes away the peritoneal cavity is completely shut off and the wound partially healed. The artificial anus thus made leaves nothing to be desired.

With the kind permission of Dr. Thomas Clifford, Surgeon to this hospital, I am able to cite the following case which illustrates the twofold use of the method:

Mrs. D., admitted on October 10th, suffered from intestinal obstruction. Immediate laparotomy. There was great distension of bowels rendering palpation difficult. The most distended coil (upper sigmoid) was secured and emptied by Murphy button and tubing. There was good drainage. At this stage the hand could easily be introduced into the abdomen and the nature and extent of the obstruction ascertained, which turned out to be a carcinoma of the lower part of the sigmoid flexure. As the patient was very collapsed by this time, the small loop of bowel to which the button was attached was fixed to the lower angle of the incision and the rest of the wound rapidly closed. The dressings remained dry till October 15th when the button became detached, leaving a perfect artificial anus. The wound healed by first intention. The rubber tube was also utilized for introducing large quantities of saline solution into the large intestine.

SEVERE ECLAMPSIA IN EARLY PREGNANCY: RECOVERY.

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THIS case presents some points which I venture to think may be of interest. First, it is somewhat rare for eclampsia to occur so early in pregnancy. In this case the patient was between four and a half and five months pregnant as nearly as could be judged by the menstrual history. It is also generally taught that in severe cases of eclampsia the fits usually persist till the completion of labour. Here the last fit occurred twenty-six hours before delivery.

Mrs. J. K., primipara, aged 30, married in August last year had previous to becoming pregnant enjoyed excellent health. She had never had scarlet fever. Menstruation commenced at the age of 15, was of the usual twenty-eight day type, the flow lasting five days. Menstruation occurred last on New Year's Day, 1909, but she had one day's bleeding on January 30th. I was called to her at 2.30 p.m., on June 3rd. I was told that she had been sitting in a chair when she suddenly became unconscious and began to twitch all over. She had been complaining of headache and slight swelling of the ankles for several weeks previous, but had always been able to go about. Had never been troubled with sickness.

Condition on Arrival.—The patient was lying in bed deeply comatose. The conjunctivæ were sensitive, but she could not be roused. There was slight swelling of both ankles. The fundus of the uterus lay midway between the pubis and the umbilicus. Vaginal examination showed the cervix to be tightly closed.

Treatment.—Morphine, croton oil, hot packs, and the usual remedies were applied.

Subsequent Course.—After I had been in the house twenty minutes a second fit, characteristic of the usual eclamptic seizure, occurred. A sample of urine obtained by the catheter went practically solid on boiling. After this fit the patient became partially conscious for a few minutes and was able to recognize her sister. At 3.50 p.m. she had another severe fit. The bowels opened freely and the skin reacted, but no diminution took place in the severity of the fits. Between 3 p.m. and 11 p.m. the patient had nine fits, the last four of which had to be controlled by chloroform.

At 11 p.m. Professor Kynoch saw her in consultation with me. As there was no sign of labour setting in, and as the