ally difficult owing to peculiarity in the development of the tumour.

My feeling is very distinct, in that in future I shall always commence the operation of hysterectomy with the intention of completing it in the way I have described, and I feel that I can safely recommend it to others as an operation well worthy of attention.

DILATATION OF THE STOMACH, WITH ENTEROPTOSIS.

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A LABOURING man from the west of Ireland, aged 35, was admitted to hospital under my care, suffering from stomach trouble of many years' duration. Examination disclosed enormous dilatation, with chronic gastric catarrh and paresis of the muscular coat. After about a week he died of exhaustion, and his death was preceded by several convulsive seizures. On opening the abdomen the stomach was seen to occupy the entire superficial space, the fundus reaching to the sixth intercostal space. The greater curvature occupied both iliac fossæ, and extended almost to the pubes. Nothing else could be seen save a wedge-shaped portion of the left lobe of the liver, which was inserted into a sort of sulcus corresponding to the lesser curvature. The capacity of the stomach was found to be 160 ounces. On raising the stomach the transverse colon was found immediately behind it, and in close apposition to it, forming a long curve with sharp angles at the hepatic and splenic flexures, and its lowest portion about two inches above the pubes. The ascending and descending portions of the colon occupied their normal positions. There was scarcely a trace of omentum, and the transverse colon was packed with hardened fæces.

It was evident that the dilatation had been caused in the first place by a diet consisting largely of potatoes, which by mechanical pressure weighed down the organ, causing stagnation of the stomach contents, and subsequent gastric catarrh and atony of the muscular coat. The dilatation¹ was further aided by the fact of the pylorus being dragged down, and thus causing traction on the first portion of the duodenum, which possesses tolerable freedom of motion, as it passes backwards and to the right before it turns sharply down to form the second portion which is firmly fixed, thus of necessity causing a stenosis by increasing the sharp bend between the movable and the fixed portion of the duodenum. The position of the transverse colon represented, though in an exaggerated degree, a condition described by Glénard² under the name of enteroptosis.

Glénard based his observations on the fact that the alimentary canal, from the stomach to the rectum, is suspended by ligamentary attachments at certain points; that at several of these fixed points sharp angles are formed, and that if any of the ligaments become relaxed or give way, it is attended with two results—first, a falling (ptosis) of that portion of the alimentary tract; secondly, in certain cases—for example, in the transverse colon—increased traction on the next fixation point, causing obstruction of the passage of ingesta, and even partial stenosis of the intestine itself.

Glénard believed that the condition is most likely to arise in the right portion of the transverse colon; that, owing to a relaxation of the colico-hepatic ligament, the ascending and transverse colon run obliquely from below upward across the abdomen to the splenic flexure, where the intestine is held firmly in its place by the phrenico-colic ligament, and that the acute angle produced at this point by the falling down of the other end of the transverse colon causes a narrowing of the lumen of the gut and consequent stoppage of its contents.

He details several physical signs as diagnostic of this condition, for example, splashing, pulsation of the abdominal aorta, movable kidney on the right side, all of which may be

met with under other conditions; but the physical sign on which he lays most stress is "corde colique transverse," by which he means the sensation imparted to the hand on palpation as of a ribbon-like band, one centimetre in width, which he believes to be the displaced transverse colon, lying over the aorta above the umbilicus. His reason for believing this is that pressure in the right iliac fossa on the ascending colon produced rumbling sounds in the "corde transverse." In speaking of patients suffering from this affection, Glénard alludes to them as "nervous dyspeptics," and Ewald,³ in writing of the disease, classifies it among neuroses of the stomach.

The case now described, although a true ptosis of the transverse colon, differs from Glénard's disease in the following particulars:

1. The patient could not be pronounced in any sense a neurotic subject.
2. The hepatic flexure of the colon was in its normal position, nor were any of the attachments of the bowel relaxed with the exception of the transverse mesocolon.
3. In Glénard's disease the transverse colon is the first part affected; then follows relaxation of the mesentery, and the small intestine descends into the pelvis. The stomach is then drawn down (gastroptosis), and subsequently there may be a falling of all the viscera, which he termed splanchnoptosis. In the case now described, however, the enteroptosis was distinctly secondary to the dilatation of the stomach, or, at least, coincident with it.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

CURE OF INTUSSUSCEPTION BY RECTAL INJECTION.

ON March 15th, 1893, M. A. G., aged 6 months, was brought to me by her mother, who stated that the bowels had not acted for three days, and that the previous day the infant became very ill, vomiting incessantly matter described as being like "what passed from its bowels" before it was taken ill.

The face was pinched and drawn, the eyes sunken, and the abdomen rather tense. A large sausage-shaped tumour could be easily discerned in the right ileo-colic region. The temperature was 97.8° F., and the surface of the body quite cold; the pulse was 110 and very weak; respirations 56. The child occasionally threw its arms about, screaming loudly, as if in pain, and twice vomited stercoraceous matter. It passed urine normally, but there was a great deal of bloody mucus upon the diaper, although rectal examination revealed nothing.

Having diagnosed intussusception, I proceeded to inject about half a pint of warm water, using steady pressure. After about twenty minutes I could no longer make out the tumour, and desisted with the enema. I administered a little weak warm brandy and water, and prescribed 2 minims of tincture of opium and the same quantity of tincture of belladonna in a teaspoonful of syrup and water every four hours and after six hours had elapsed from the time of the enema two ounces of milk and water every three hours. The child was then put to bed, and hot water bottles applied to it.

Next day I saw the child at 10 A.M., and the mother told me it had remained in about the same condition until 1 A.M., when it became much worse, being icy cold, refusing milk, retching incessantly, and passing much blood and slime after severe straining. The child was in a state of collapse, and, upon abdominal palpation, the tumour could be distinctly felt, and appeared to be much larger than before. The pulse was 120, the temperature 97° F., and the respirations 60.

I now determined at all hazards to forcibly inject warm water, as two previous cases I had attended both died. In

¹ Since the above was written, I notice that attention has been drawn to an almost identical condition as a cause of gastric dilatation by Sir Wm. H. Broadbent in his lecture published in the BRITISH MEDICAL JOURNAL, December 2nd, 1893.

² *Lyon Médical*, Mars, 1885, t. xlviii, p. 450.

³ *Berlin. klin. Woch.*, 1890, No. 12, etc. An interesting paper on the same subject by Einhorn will be found in the *New York Post Graduate*, vol. viii, No. 2, 1893.