with the urinary constituents. I do not presume to determine whether this condition is precisely that known under the designation uræmia. In ordinary uræmia the process of secretion in the kidney is interfered with, and the products which ought to be removed accumulate. In rupture of the bladder the products have been secreted, and may have undergone considerable chemical change in the process. The absorption of these altered products may well produce a different complex of symptoms from that of a typical uræmia. Perhaps it would be more convenient to speak of urinary poisoning as the condition in these cases.

In considering the cause of death the condition of the peritoneum is not to be ignored altogether. The presence of a fluid of a different constitution from that of the normal peritoneal fluid may well have an influence on the membrane, and may affect its nervous and vascular arrangements. The symptoms of the patient indicate this in many cases, so that the diagnosis of peritonitis may be made, as in our second case. This must, however, be a subsidiary element, as the experiments of Wegner seem to prove that large quantities of urine may be infused into the abdomen without producing any pronounced symptoms.

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A NOTE ON CHLOROSIS IN THE MALE.

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CHLOROSIS is almost universally regarded as a disease which, if not peculiar to women, is at least of importance merely as it concerns the female sex—an idea which is likewise borne out by the name so often applied to it, morbus virgineus. Many authors, indeed, deny utterly its existence in members of the male sex, while others, though recognising its rare occurrence in men, have regarded it as a condition present only in connection with other feminine attributes, and existing thus only in men whose general characteristics and constitution render them effeminate. Thus Eichhorst, while denying that chlorosis is exclusively confined to women, and insisting on its occasional occurrence in men, considers that male chlorotics are always slender individuals, of feminine build, and frequently engaged in effeminate occupations, such as tailoring, etc.

In a recent article in the *BRITISH MEDICAL JOURNAL* Dr. Lloyd Jones states that in a research covering more than eight years he has been unable to discover a single case of chlorosis in the male. From the article mentioned it is inferred that these observations were founded merely on estimations of the specific gravity of the blood as a basis for testing the chlorotic condition. While doubtless there may be a definite relation between these two features, nevertheless the distinct relative decrease in the hæmoglobin has, during these last years, been considered as the crucial test for chlorosis, and on this altered relationship—first, I believe, insisted upon by Gruber—Dr. Osler lays special stress.

Regarding then chlorosis as an essential anæmia whose main characteristics are a greenish sallow tint of the skin, accompanied by a definite relative diminution of the hæmoglobin in the blood, we may say that such statements as those of the authors above mentioned fail to coincide with observations made by us during the past few months in Montreal, and hence the mention of a few cases which have led to the conclusion that, whether or not a true chlorosis be at times present in males, it may at least be said that occasionally in men a condition is found very closely approximating the chlorotic condition.

In estimating the hæmoglobin, a Fleischl hæmometer was employed, the instrument having been previously thoroughly tested on normal subjects, and due allowance made for the slight inaccuracies found.

CASE I.—J. S., a doctor of medicine aged 24, had observed that for several months a gradually increasing pallor and sallowness had deve-

loped, accompanied by gastro-intestinal symptoms, of which the most prominent were prolonged and obstinate constipation, anorexia, and fulness after eating. In addition he suffered greatly from headaches and severe intercostal neuralgia. The patient was of a decidedly neurotic temperament, had a personal history of hard work and prolonged studying at night. The family history was good. On physical examination there was found no evidence of organic disease. Estimation of the blood however revealed on an average 5,300,000 red corpuscles, white cells 1 to 400, and hæmoglobin 68 per cent. Treatment by arsenic was recommended and carried out. The patient was greatly improved thereby. Inasmuch as he left town soon after, there was no possibility of making further investigations, though letters received indicate a complete restoration of health.

CASE II.—H. G., a merchant, aged 27, having a history of prolonged dyspeptic disorders, was observed to have a markedly anæmic appearance; he had epigastric pain and fulness after meals, flatulence and marked constipation. Mental depression, almost approaching true neurasthenia, was superadded. Neither the personal nor family history could afford any light on his condition. Physical examination showed a normal state of all the organs, while the estimation of the blood gave the following result: Red cells 5,300,000, white cells about 1 to 350, hæmoglobin 72 per cent., this being the average of several examinations. Under treatment with arsenic and iron rapid improvement resulted, and when examined about two months later the patient's general condition was practically normal, and the blood examination showed the hæmoglobin to be 96 per cent.

CASE III.—E. H., a medical student, aged about 25, was likewise examined, inasmuch as a distinct greenish sallow complexion gave some indication of abnormal blood condition. The patient was of a nervous disposition, but had no complaint other than constipation. Physical examination of the organs was negative. During the examination of the blood the patient became very faint, almost losing consciousness. Red corpuscles numbered 6,030,000, hæmoglobin 77 per cent.

CASE IV.—M. S. This case resembled in nearly all its features Case No. II. An average of several blood examinations revealed 4,800,000 red cells, hæmoglobin 77 per cent. A soft systolic murmur was held at the base.

In these various cases presented, a blood condition has been obtained indicating a disease identical with the chlorosis described by many authors, and inasmuch as no other cause can be discovered with which to associate that anæmia, there seems good reason to believe that in them we have found an ordinary chlorosis. Although in no case there has been an extreme diminution of the hæmoglobin, yet it may be presumed that, as in these, so in many men, from some cause as yet not fully ascertained, an anæmia may be found whose main characteristic is a diminution of the hæmoglobin.

While being unable to contribute in any way to the subject of its etiology, yet that the condition described does sometimes exist in a mild form in males is at least worthy of mention, and that it may be perhaps more frequent than is generally supposed seems borne out by the experiences we have here met with during the past few months.

A REMARKABLE CASE OF INTUSSUSCEPTION.

By E. M. H. O'CONNOR, L.R.C.P.I., ETC.,

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On May 1st, 1893, I was called in to see a lad, aged 13 years. I found him to present all the symptoms of acute peritonitis. He had had two or three well-marked rigors. He complained of vomiting, retching, and intense shooting pain in the abdomen. He lay on his back, legs drawn up; the face looked anxious; tongue small, red, and dry; intense thirst; respirations 50 per minute; temperature 104°; pulse 138, hard and wiry. The abdomen was distended to a marked degree. He could not bear the slightest touch without calling out in agony.

I got the following history of the attack: Eight days previous to my visit the patient had had a severe wetting, and was put to bed when he got home, a warm drink being administered. He got up next morning apparently none the worse, and went about as usual for four days. His bowels, however, had not been moved since the wetting. A dose of castor oil was then administered, but, having no effect, the friends, after waiting two days longer, gave him half an ounce of mag. sulph. This caused him a great deal of pain, so that several times "he cried out," but there was no evacuation.

On the evening before I was called in two "strong" purgative pills had been given, and I was informed that he had been much worse since he had taken them, and that the bowels had not moved.

I ordered turpentine stupes to be applied to the abdomen. The only food was to consist of milk in small quantities,

given frequently. I prescribed tinct. opii, m xv . every three hours until I saw the patient again. Late in the evening I paid another visit. I was then informed that he had had a large passage from the bowels. On examining the evacuation it was not hard to discover that the greater part of it consisted of intestine. Having washed it I was astonished to find the specimen of which I send a photograph.

The patient was now suffering much less pain. He had taken half a pint of milk during the five hours which had elapsed, and had only vomited once.

On May 2nd there was slight improvement. He could take milk in small quantities without ill effects. The temperature was 103° , the pulse 120, and the respirations 45. He was not in so much pain. There was a slimy discharge from the bowels, and small masses of faeces were passed. From this date the patient made steady progress. The slimy discharge, which had been constant, ceased on May 10th. He sat up for an hour on May 14th, and came downstairs a week later. Diarrhoea still continued, the bowels being moved sometimes six times in twenty-four hours.

It is now twelve months since the attack. The boy looks strong and healthy. He has not had any pain in the abdomen for ten months. His bowels have been slightly relaxed ever since the attack.

The portion of bowel, as will be seen from the photograph, consists of ileum with Meckel's diverticulum. The total length was $11\frac{1}{2}$ inches. The upper portion was invaginated into the lower, the entire length of the diverticulum appearing through the lower orifice.

CASE OF INTUSSUSCEPTION WITH SLOUGHING OF INTESTINE; RECOVERY.

By A. SUTCLIFFE, F.R.C.S. EDIN.,
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THE following case presents some features of interest, especially in the very rare circumstances of the passage of a sphacelus of bowel.

J. W. G., aged 17 years, on the morning of June 23rd, 1893,

began to suffer from severe abdominal pain and vomiting, which continued through the day, and under treatment (by belladonna and morphine) passed away during the following night. The next morning he felt so much better that he got up and seemed quite comfortable when I called. He began, however, to be worse later in the day, and vomited several times. In the evening I found some general tympanitic swelling of the abdomen, but as far as the finger could reach in the rectum there was nothing abnormal to be felt, and externally I could detect no tumour. From this time all nourishment swallowed was rejected, and the tympanites rapidly increased to the fullest extent, and for eight or nine days this condition continued. The patient refused food altogether, and only took ice, and vomited occasionally dark brown or greenish matter, which, however, had not a distinctly faecal odour. Several enemata of soap and water—as much as could be retained—were given by means of the long tube, which could be passed about half its length. This was repeated once a day at the boy's desire, as he said he felt much relieved by it. Some fluid faecal matter usually came away with the enema. In addition to this, nutrient enemata, every six hours, of beaten egg or Brand's essence dissolved in water were given and retained.

On July 1st, the faecal matter passed was mixed with blood. There was extreme tympanites, and in the general swelling the ascending and transverse portions of the colon stood out very clearly defined and resonant. There was very little tenderness, but at a point corresponding to the junction of the transverse and descending colon there was some dullness on percussion, and pressure was resented.

About July 5th the bowels began to act spontaneously, bringing away solid faeces, and the tympanites gradually lessened. All motions passed were examined, and on July 10th, seventeen days from the onset, a piece of intestine came away. I found this to be 13 inches long, and my first impression was that it was small intestine, its size (flattened breadth being about an inch) and general appearance decidedly giving that impression, though the physical signs pointed to obstruction beyond the transverse colon. The presence of an unmistakable appendix epiploica, however, showed it to be large intestine. Of intact bowel, with some mesentery attached, there was 7 inches, while the rest of the length consisted of a ribbon of only one half the circle of the gut, evidently the remains of one broken up fold of the volvulus.

On July 16th the patient began suddenly to have abdominal pain and vomiting; the temperature was 102° , and there was much tenderness to the left of the umbilicus. Tympanites increased, but soon subsided, and all inflammatory symptoms disappeared by July 21st. On August 6th he had frequent dysenteric stools, mucus flowing away involuntarily. On examination by the rectum the finger came in contact, just inside the anus, with a large tumefied mass, round and tense, in the centre of which the finger could be passed through a small hole into the lumen of the bowel. Round the mass was a *cul-de-sac*, the extremity of which could apparently be reached by the finger with an effort. On August 9th he passed much pus, with mucus, but was improving generally.

From this time he made good recovery. The mass in the rectum gradually disappeared, and soft folds of membrane only remained. For some time he required aperients. He has since had one severe attack of colic, with tympanitic distension, which quickly passed away. His bowels now act regularly, and he is in good health.

Among the noteworthy features of this case it may be mentioned that apparently there was never absolute occlusion, as some faecal matter could always be washed away, and the vomited matters never gave a distinctly stercoraceous odour. It is also remarkable that, considering so much of the bowel was involved, the transverse colon should be apparently intact, as was seen during extreme tympanitic distension, and at the same time nothing could be felt by the rectum. The attack of local peritonitis on July 16th was no doubt due to some defect in complete coaptation, and would be reparative in its effect. To account for the structural condition felt in the rectum later, it would seem that there had been a secondary descent of the bowel, with severe inflammation of the coats.