intestinal derangements. The average age of the 18 cases was 38 years, that of the males being 36 and that of the females 38 years. The eldest male was 60, the youngest 14; the oldest female 62, the youngest 13 years.

Cause of Death.—In no instance was the presence of the Meckel's diverticulum in any way connected with the cause of death. In one case at least it was so placed as to have readily allowed of the occurrence of an internal hernia.

Position.—The distance of the diverticulum above the ileo-cæcal valve averaged $34\frac{1}{2}$ inches; the greatest was $50\frac{1}{2}$, the smallest 15 inches.

Length.—The average length of our 18 specimens was nearly 24 inches; the longest $6\frac{1}{2}$ inches, the shortest half an inch.

Size.—This varied considerably. The diameter in 12 averaged an inch and a half. A photograph of the largest specimen is reproduced on p. 459. It was discovered in a male subject, aged 42, dying from acute pneumonia. The diverticulum was connected with the ileum by a narrow mouth three-quarters of an inch wide, and then extending to a diameter of an inch, rapidly widened into a large pouch almost as big as the cæcum. It had a diameter of $3\frac{1}{4}$ inches, and a circumference of $10\frac{1}{2}$ inches. It lay quite free in the abdomen. Possibly its large size may have been due to distension by the intestinal contents.

Connection with Intestine.—In all the cases the diverticulum freely communicated with the intestine. In only a few instances was the mouth distinctly smaller than the lumen of what might be called the body of the diverticulum. Occasionally the origin from the gut proved to be distinctly funnel-shaped. No valve was present in any case.

Relation to Mesentery.—The diverticulum always arose on the far side from the mesentery, although not always immediately opposite to it. In one instance it was adherent to an adjoining fold of mesentery. Generally the diverticulum came off at right angles to the gut, but in some subjects it was placed a little obliquely to the intestinal canal.

Contents.—In no instance did the diverticulum contain any foreign body. Often there was nothing but air, but in some a little faecal matter was present.

Special Characters.—Two specimens had a cord-like structure coming off from their termination. In one the cord was fixed to the abdominal wall, forming a loop. One had a bifid extremity. Several had bulbous or club-shaped terminations, with secondary lateral dilatations. Many were mere nipple-shaped projections.

In no instance was the lumen of the diverticulum continued to the umbilicus or abdominal wall.

I am indebted to my brother, Mr. W. S. Kelynack, for the preparation of the accompanying photograph.

REFERENCES.

¹ *Journal of Anatomy and Physiology*, 1892, vol. xxvi, pp. 91-93. ² Some of the cases met with I have already described elsewhere; see *Transactions of the Pathological Society of Manchester*, 1892, vol. i, p. 140; *Journal of Anatomy and Physiology*, 1892; *Manchester Medical Chronicle*, 1896 vol. v, No. 5, pp. 338-43. Many of the specimens I have added to the Pathological Museum of Owens College. ³ It must be remembered that in the pathological department of the Manchester Royal Infirmary, as in most general hospitals, considerably more male subjects are examined than female.

REMARKS ON COLITIS IN THE ADULT.

By ARTHUR JAMES CAMPBELL, B.A., M.D.,
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COLITIS is, I think, more frequently met with in the south-west than elsewhere in our island, and probably yet more frequently in tropical countries, where it merges into dysentery and is treated as such. It is generally developed in delicate persons, more particularly women; pregnant women are particularly liable to be attacked, while young girls may not only have this complaint, but sometimes on account of it develop a wretched carriage owing to "pot belly" and bowed back. Occasionally a patient may attribute the illness to some indiscretion in diet, but the majority fail to give any satisfactory cause. I believe the catarrhal condition is engendered by repeated slight irritations, possibly increased by a "chill" rather than by an error of diet.

The colon alone is the usual seat of disease, although the smaller intestine may be invaded in the later stages. The descending colon is the part most often attacked, and in

those severe cases in which death occurs, the mucous membrane of the gut is swollen with more or less ulceration, and the colour resembles prune juice, or even dark chocolate, the presence or absence of bismuth not appreciably affecting the hue. The severe catarrhal condition is very intractable and prone to become chronic. It may last from months to years. One severe case under my care is now entering on her tenth year of suffering.

The ailment commences so quietly and insidiously, that it is established before much notice of it is taken by the patient. Pain in the bowels on rising, or shortly before rising, in the morning causes the sufferer to make a hurried toilet and hasten to obtain relief. The evacuation is more or less liquid, and may be repeated twice, or thrice, or oftener during the morning. About noon there is a respite, usually until next morning, unless the consumption of vegetables or fruit acts as a stimulus to the irritable bowel and prolongs the daily attack. The appearance of the motion varies from a brown pultaceous mass containing air bubbles and having a horrible odour to a pale liquid of jelly-like consistency, which may be streaked with blood. The usual stool is of a light yellow colour, offensive, and either watery, or in a thin, partially-shaped mass. At times, but especially in elderly people, there is an occasional period of comparative constipation, when several evacuations of small scybala with a little slime constitute the motion. Much exhaustion follows each stool, the appetite is capricious, "sinkings" and "longings" are commonly complained of, pain is at the worst moderate, but the distension which occurs during the stages of comparative constipation causes much distress. As the severity of a case increases, ten, twenty, or more motions may be passed daily, the quantity of each being sometimes very small, but the straining, tenesmus, and exhaustion are out of all proportion to the amount evacuated. Occasionally attacks with very watery blood-stained motions, accompanied by severe prostration and pain, may occur, or even hæmaturia may complicate the case, but this is exceptional.

The disease may be located by percussion and palpation. At certain times a sharply-defined tympanitic patch over some portion of the colon may enable the physician to judge whether local treatment is practicable, and to learn the extent of bowel affected, but there are periods when, owing possibly to the presence of fæces, the determination of the seat of disease by percussion is impracticable. Even then the increased rigidity of the abdominal muscles over the affected area may give a clue to the situation of the diseased intestine.

Temperature is, as a rule, normal or subnormal, the pulse usually quickened. Emaciation and pallor more or less quickly become noticeable. I have not found any other organ become affected; the tongue has a faint whitish coating, or is raw. Dr. George Thin has described a variety of this disease, in which sore mouth and enlarged liver are found. In none of my cases save one have these distinguishing features been present, and, I may add, I have not observed hæmorrhoids in any case.

Where "cure" has been effected, I have invariably found that with cessation of diarrhoea more or less severe attacks of colic have supervened, with some indigestion, but with suitable treatment they have passed away in the course of months.

TREATMENT.

For severe cases, milk diet and rest in bed; for the milder cases, abstention from fruits and vegetables, a considerable amount of milk daily, and the less exercise the better. Even mild excitement, such as going to church, ought to be avoided; Sunday morning I invariably find to be the worst in the week with these patients.

With regard to drugs, purgation seems unreasonable, and is certainly very unsatisfactory; even those cases in which one is led to suspect an accumulation of fæces high up do not gain much benefit from purgation, and the fact of retention ought to give rise to a serious suspicion that cancer or some narrowing of the gut exists, even if there be little pain and no sign of such a complication. The smallest purge has had bad effects in all the cases I have seen which were uncomplicated. Even a single slice of apple or a small quantity of any raw fruit generally causes most distressing diarrhoea, which is frequently prolonged.

Year.	No.	Initials.	Age.	Sex.	Cases: Duration.	Treatment.	Complications.	Result.
1879	1	A. M.	18	F.	Several years	Purgation (useless), later H ₂ SO ₄	None	Recovery.
1887	2	X.	50	M.	3 months	Arg. nit. sol.	"	"
1890	3	N.	44	F.	3 years	H ₂ SO ₄ , arg. nit. inj.	"	"
"	4	E. M.	16	F.	Some months	H ₂ SO ₄	"	Relieved, lost sight of.
"	5	P.	56	F.	Over 9 years	Various	Sore tongue occasionally, liver possibly enlarged	Chronic, little relief obtained.
1892	6	N. N.	18	F.	Some months	H ₂ SO ₄ , arg. nit.	"	Gradual relief, now fairly well.
1894	7	S.	18	F.	2 years	Various	Inordinate and unhealthy appetite indulged	Gradual recovery.
1895	"	S.	40	F.	Some months	H ₂ SO ₄ occasionally	None	"
"	9	J. E.	50?	F.	Several years	Various	"	Death.
"	10	S. S.	47	M.	"	Untreated, inquest, etc.	Scoliosis, displaced kidney	"
1896 and 1897	11	J. P.	55	M.	2 years	Various	Cancer of sigmoid; perforation	"
"	12	Lady —	—	F.	2 months	H ₂ SO ₄ , milk diet, rest	None	Recovery.
"	13	M. E.	21	F.	Several months	H ₂ SO ₄ occasionally	"	Relief.
"	14	E. G.	47	F.	8 months	Various	Hysteria	Recovery.
"	15	F. P.	32	F.	6 months	H ₂ SO ₄ , milk	Pregnancy	Almost well, under treatment.
"	16	A. P.	30	F.	5 months	"	"	Recovery.
"	17	D. D.	19	F.	10 months	"	"	Recovery, colic supervening.
"	18	P. P.	25	M.	1 year	"	"	Improving.
"	19	M. A. P.	55	F.	Several years	"	"	"

The drug I most rely on is dilute sulphuric acid; 10 minims three or four times a day, with a very little opium and a carminative, generally controls the diarrhœa quickly. When this good effect is produced the drug ought to be continued as required, a loose morning motion being followed by a dose, and should diarrhœa again come on, the mixture should be regularly taken, but never should the first dose be taken before the first motion; the distension then caused is most distressing. If sulphuric acid fails, large doses of catechu, or bismuth and salol, may be tried, and these failing, 10 grains of sodium bicarbonate, with dill water, act as a sedative if nothing else.

In certain cases, in which the descending colon is attacked, the passage of a long tube and injection of a strong solution of nitrate of silver (3ss-3i to 1 pint distilled water warmed), is an admirable remedy; it should be administered with caution, but frequently results in absolute and, I might say, immediate cure, the after-colic being but a minor evil easily combated.

Opium is merely of service during the early stages, or after diarrhœa has been checked. In some cases strychnine acts as a good tonic but the early administration requires caution.

SUCCESSFUL CÆLIOTOMIES FOR AN INTRA-PERITONEAL RUPTURE OF A TUBAL GESTATION AND TWO OTHER UNCOMMON PELVIC TUMOURS.

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THE following cases are worthy of record on account of their individual points of interest; the first one I photographed four hours after removal. It shows the full extent of the loss of tissue over the placenta in the inner third of the Fallopian tube; I skiagraphed the same, and that shows two separate dots, as if ossific centres were already formed. The second case is an undoubted true fibroma of the ovary, and from the investigations of Sir John Williams and Mr. Bland Sutton it is evidently a very rare specimen; its macroscopic appearance is well shown in the photograph. The third case is also an example of a rare condition—the impaction of a parovarian cyst in Douglas's pouch under the reflections of the rectovesical fascia.

CASE I: RUPTURED TUBAL GESTATION.

Mrs. H., aged 27, had been married only eleven weeks, and was fourteen days behind her period, when she was taken suddenly ill with severe abdominal pain as soon as she finished breakfast on May 25th, at 10 A.M. When my friend Dr. Biggs saw her a few hours later he found her in a state of

extreme collapse, with a cold, clammy surface, and obtained a history from her sister that years ago the patient had had gastric ulcer and hæmatemesis. By means of opium, rectal feeding, transfusion, and stimulants the patient was kept hovering between life and death until May 28th, when I saw her, and at that time we advised immediate operation, as she had rallied and became sensible during the last two or three hours, and hæmorrhage had also appeared from the vagina. The anterior vaginal wall was full, resisting, and depressed, more especially on the right side. She now complained of "killing, stabbing pain" on that side, was blanched, had a temperature of 102° F. Until this day the prominent symptoms were vomiting and nausea, abdominal pain, and collapse, with a running and at times imperceptible pulse. The abdomen was distended, and had signs of fluid in its peritoneal cavity; the thighs were slightly flexed. We now agreed that it was a right tubal gestation ruptured into the abdominal cavity, and gave an injection of morphine whilst the instruments were being got ready.

Fig. 1.—A, ovary; B, placenta; C, ampulla; D, fimbriae. Seventy-four hours after the first symptom Dr. Morland