tolerance of the rectum to nutrient enemata, that a fatal issue seemed constantly imminent. During this time she existed upon an average of less than 3 ounces of milk a day. Eventually food was taken slightly better, and strength began to return.

Actual size of gall stone.

On the night of April 22nd (eleven weeks after the onset of the first symptoms) I was hastily summoned, and found my patient in great pain, straining, and collapsed; and on examination detected a hard mass blocking the lower fourth of the rectum. By gentle pressure through the posterior vaginal wall the foreign body was extruded, and found to be a gall stone about the size of a pigeon's egg, faceted, and weighing in the fresh condition 3 v gr. xliiss. The patient slowly gained strength, and was ultimately sent to the south coast to convalesce. When I last heard of her she was "perfectly well and active."

REMARKS.

This case supports very well, I think, the contention of my friend and former teacher, Mr. Mayo Robson, that if we can be reasonably sure that obstruction is due to gall stone a palliative line of treatment will probably end in the passage of the foreign body, though many may contend that the risk is greater than that of operative treatment. The stone evidently ulcerated its way into the duodenum and became blocked somewhere in the small intestine.

CHYLOUS CYST OF MESENTERY: OPERATION: RECOVERY.

By J. O'CONOR, M.D. DUBL.,

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MR. E. M. M., aged 41, manager of a mercantile company, consulted me on September 2nd, 1896, complaining of a tumour in the abdomen. The history was as follows: For the past two years he had an inclination every morning to vomit, with a constant foul mouth and a bad smell from the breath. He frequently had severe lancinating pains in the lower part of the abdomen. In June, after riding ten miles, the pain was so bad that he had to remain in bed for three days. In July he made a sea voyage, and suffered intensely from pain all the time, but he was not quite certain how much sea sickness had to do with it. During August he had much business to transact in Buenos Ayres, which necessitated walking about, and he suffered continually from pain, the morning tendency to vomit and foul breath continuing as before. At the end of August, after jumping from a tram, he experienced the most excruciating agony; on the following morning he was unable to get out of bed, and for the first time noticed a "lump" below and to the right of navel.

A doctor was called in, and later that same day a consultation was held, and he was told he had a tumour, and was placed on low diet, kept in bed, and had free purgation. On the following day his doctor told him he had a "hydatid tumour," which would require operation.

On examination, on September 2nd, a distinct swelling was visible in median line between the umbilicus and pubes. A well-defined, tense, fluctuating tumour was felt, even in contour, movable, and about the size of an ordinary coker nut.

Palpation caused severe pain, so much so that I had to desist from finding the actual range of movement. There was absolute dullness on percussion; no thrill was obtained. The tongue was furred, breath foul, the temperature and urine normal; other organs were healthy. There was nothing to record in his past history excepting habitual constipation and an occasional attack of "asthma." The family history was excellent.

I informed him that he undoubtedly had a tumour, the exact nature of which I could not state, but that I felt pretty certain it contained liquid. I advised him to enter hospital in order that I might make an exploratory incision. This he did on September 7th.

On the following morning, the bladder having been emptied, chloroform was administered, and when the dressings were removed we found that the tumour moved freely in all directions. Assisted by my colleague, Dr. Shadbolt, an incision 3 inches long was made in the median line, directly over the tumour, and the abdominal cavity opened. It was immediately seen that the cyst wall differed from that of a hydatid in that it had a dirty grey appearance, and many large veins ramified over its surface. It looked like a sarcoma. The tumour was lifted out of the peritoneal cavity along with the mesentery in which it grew, and some 4 inches of adherent small intestine. A careful examination was made to see if it was feasible to enucleate it, but as it was so very adherent between the layers of the mesentery, and as so many vessels would require ligation, it was decided to drain it. A medium sized trocar was inserted, and half a pint of milky fluid withdrawn. The opening made by the trocar was enlarged, and the anterior half of the circumference clipped away with scissors, many large veins having been tied, the whole mass was returned into the abdominal cavity, and the cut edges of the cyst united to the parietal wound by a continuous silk suture. The remainder of the superficial wound was closed by two continuous silk sutures, and the cavity of the cyst stuffed with iodoform gauze.

For the following forty-eight hours vomiting was incessant, but ceased on the third day. The highest temperature recorded after the operation was 99.5° F. The bowels were moved on the fifth day, and by the fourteenth day the cavity had contracted flush with the parietal wound. The pain, tendency to vomit, and foul breath completely disappeared, and he was discharged cured two weeks later. He said he "had not felt so well for two or three years."

Dr. Welchli kindly made a microscopic examination of the fluid, and reported that it was ordinary chyle.

On referring to Mr. Treves's treatise in his *System of Surgery*, I find that he states that there have been only 19 cases of mesenteric cysts recorded, 12 of which were cured by operation and 7 died. The situation and mobility of this tumour exactly corresponded with Mr. Treves's teaching, but he says they are usually painless. In this case pain was one of the earliest and the most distressing symptoms.

ARTIFICIAL FEEDING OF THE INSANE.

By L. HARRIS-LISTON, M.R.C.S.,

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THE persistent refusal of food amongst the insane is a symptom of frequent occurrence, which, when moral suasion has failed, has to be treated by forcible feeding.

Of the last 200 patients admitted to a lunatic hospital for private patients, among whom refusal of food is said to be more common than among paupers, 27 required forcible feeding, which I performed on them nearly 3,000 times. Complete refusal of food for twenty-four hours in a strong well-nourished patient, or the missing of two meals by a feeble one, may be taken, as a general rule, to indicate the operation; freshly admitted cases with a history of starvation, who are feeble, with weak pulse, and who resist taking food, should be fed at once. Of these 200 patients 85 were males, 115 females, and of the 27 fed, 12 were males and 15 females; this 27 does not include many patients whom the attendants were able to feed with a spoon, but only those who successfully resisted this method. Of these 27, there were 4 in a state of acute mania, 4 in a stuporose condition, 13 were melancholiacs, 4 were

suffering from delusional insanity, and 2 were chronic dements; 12 of them were at some period actively suicidal.

The effect of feeding was soon apparent in most cases, nutrition improving, some getting fat, and no doubt the lives of many were saved by its adoption; sometimes, but rarely, the pharynx, œsophagus, or stomach became irritated by the tube, and then feeding by the bowel had to be resorted to; in one lady, a case of stupor, gastritis was set up, and curiously enough, the pyrexia was coincident with the commencement of her recovery.

Besides the improvement of nutrition, feeding has a lasting moral effect, in some cases a few feedings effecting a cure of the habit of refusal; it occasionally cures a delusion, as one case in a friend's practice exemplifies, a case in which he was "commanded" not to eat; after a few nasal feedings with a tube smeared with assafœtida he was commanded no more. A mere exhibition of the tube will cure the habit in some hysterical cases.

The method of feeding adopted was the funnel and soft rubber œsophageal tube passed to the stomach by the mouth or nose; the latter way I now almost always use as generally preferable, its only danger being the passage of the tube into the larynx, of which the evidence, stridulous breathing and loss of voice, is at once perceived, and remedied by withdrawing the tube to the pharynx, pouring a little food down tube, and as patient swallows pushing it down; the passage of the tube by the mouth is a more expeditious procedure, as a large tube can be used so that a quart or more of food may be given in a few seconds, and this is advantageous in old people and others who secrete a large amount of mucus about the throat which they cannot swallow while the tube is in the œsophagus, and which, collecting over the glottis, causes dyspnoea. The disadvantages of the passage through the mouth are the need of a gag, which is apt to injure the lips or break the teeth of patient, and the possibility of the gag slipping out, and so rendering biting and swallowing the tube, or injuring the operator's fingers, probable. The latter accident happened to me once, causing a poisoned wound of a finger, and consequent inability to use the hand for a week, but during this time I was able to pass the nasal tube with the left hand, a statement which shows how easy the operation is.

DIET GIVEN.

Breakfast at 9 A.M.—A pint and a-half of milk, two eggs, with one ounce of whisky.

Dinner at 2 P.M.—A pint and a-half of beef tea, two eggs, two ounces of port wine, and one ounce of maltine.

Supper at 7 P.M.—A pint and a-half of milk, two eggs, one ounce of whisky.

The food is given warm, and the patient kept lying down for half an hour afterwards; medicines are given with the food as required; generally a purge is needed every two days, when half an ounce of castor oil may be added; occasionally the juice of half a lemon is added to the dinner.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

TWINS FROM A SINGLE OVULE.

ON November 8th I was called to attend Mrs. W., aged 28, in her third confinement. On examining her I found the head presenting; I ruptured the membranes, and in a short time delivered her of a well-developed male child. On placing my hand over the uterus to express the placenta, I felt a second child *in utero*, and on examination *per vaginam* found another head presenting. I immediately ruptured the membranes, and about a quarter of an hour afterwards delivered her of a second, equally well-developed, male child. On carefully examining the placenta after expression I found two placentæ in close apposition, fused into a single mass, a separate cord to each almost joining at their insertion, the vessels of the one appearing to anastomose with those of the other. The whole placental mass was surrounded by one chorion, enclosing two distinct amnions. This was evidently a case of twins developed from a single ovule containing a double germ, a condition I believe to be somewhat rare, and conformed to the rule laid down by Schroeder, that in these cases the children are always of the same sex, and generally males.

Although both fœtuses were exceptionally well developed, presented by the vertex, and were enclosed in a single chorion, there was not the slightest difficulty or delay in the birth of the first child.

On inquiring into the family history I find the patient's mother had only one child, her husband died six months after, and she did not marry again; but the grandmother gave birth to twins, both of which were females.

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THE SCHOTT TREATMENT OF CHRONIC HEART DISEASE.

EARLY in last year a patient, over 70 years of age, suffering from a greatly dilated right heart, with marked mitral insufficiency, complicated by frequent attacks of angina pectoris, whose symptoms lately had practically resisted all forms of treatment, was advised to undergo Schott's course.

During the first bath there was slowing of the pulse from 86 to 76, with increased volume, the dyspnoea and cyanosis became less marked, the lips improving in colour, and the face assuming a healthy ruddy glow. A feeling of tightness and oppression within the chest was complained of which continued for fully two minutes; after the fourth bath, however, this uncomfortable feeling altogether disappeared. On leaving the bath the patient expressed himself as feeling refreshed. On examination after the bath what was most striking was the change which had taken place in the extent of the cardiac dulness; indeed, but for the extreme care with which the dulness had been mapped out previously, one must have concluded that a mistake had been made in the tracing; on the right side, to the right of the mid-sternal line, the area of dulness had diminished $1\frac{1}{4}$ inch, while a corresponding increase in the pulse force was proved by sphygmographic tracings taken before and after the bath.

By the end of the course, five weeks, the patient had but little discomfort from his attacks of angina pectoris; he could comfortably walk a mile and ascend two flights of stairs, feats previously impossible; dyspnoea much relieved, mitral *bruit* less accentuated.

Nine months after treatment a thorough examination of this patient was made, and the excellent results accruing from the treatment were still marked.

Several cases of a similar character have come under observation since the above patient was treated, in all of which the improvement has been as marked. The deduction from those observations is that the size of a diseased dilated heart can be reduced by the judicious use of baths and exercises as recommended by Schott, and that the reduction is not only beneficial, but probably permanent. Whatever the cause of the heart shrinkings and increased tone may be physiologically, there can be no doubt about the results, and from these results we can but infer that repair does take place in the degenerated heart and vessels. The diminution in the size of a dilated heart resulting from this treatment can only be accounted for by the contractions being increased, and consequently the cavities more efficiently emptied.

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ALEXANDER MITCHELL, M.D.

TREPHINING THE FRONTAL SINUS.

THE following interesting case came under my care at the London Throat Hospital towards the end of 1895:

The patient, a woman, came complaining of inability to breathe through the right nostril, accompanied with a distressing discharge. The difficulty in breathing had come on, gradually increasing, during the last eighteen months; the discharge had lasted for quite five years. On examination, the nostril was found full of large polypi. When these were removed the discharge was found to be as bad as ever, and pus was clearly seen flowing from the infundibulum. It was determined to open the frontal sinus. This was done with a small trephine a few days later. The sinus was found full of a web-like granulation tissue, in which three small mucous polypi were embedded. The whole of this tissue was carefully scraped out. A small drainage tube was put in, with the object of keeping the wound open as long as necessary. The sinus was well syringed out through the wound with the biniodide of mercury solution (1 in 1,000) each day until the