Owing to the immediate urgency of such cases, it was considered advisable to operate at once. The delay of an hour or two materially lessens the chances of recovery. The hernia of the caecum and appendix was probably of three years' duration. The finding of the appendix in the femoral canal adherent to the sac and the subacute exacerbations of pain at different intervals, point to attacks of appendicitis. The supervening acute strangulation was caused by a portion of small intestine finding its way into the sac and overriding the original hernia.

The patient states that she was bending down at the time when she was seized with pain, and it was probably at that moment that the small gut was forced into the sac beyond the appendix, and there tightly constricted.

ACUTE FAECAL IMPACTION IN THE RECTUM.

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THE term "acute" has been chosen in order to avoid confusion with those cases of faecal impaction which occur in individuals afflicted with chronic constipation, and which give rise to total or partial obstruction. The subject is perhaps worthy of comment, because all the cases here referred to have occurred in persons normally free from irregularity of the bowels, but in whom a temporary alteration in conditions—more especially in diet—has taken place. In their description of faecal impaction the textbooks confine attention almost entirely to those cases in which it occurs either in the caecum or colon, that is, above the rectum. The reason is, that they refer solely to those cases which are here excluded, namely, the sufferers from chronic constipation. On looking up the *Lancet* for the last twenty years, and the *BRITISH MEDICAL JOURNAL* for ten years, I can find only one recorded case of acute faecal impaction in the rectum. This is chronicled by Mr. E. C. Ibbotson,¹ and refers to a healthy boy, always regular in his bowels, who suddenly became unable to pass anything by the rectum. He was discovered to have a mass impacted in the rectum consisting of undigested tiger nuts, which he had eaten a day or two previously. The condition was relieved by glycerin enemata.

The cause of this condition has, in my experience, always been due to a diet leaving a glutinous residue, associated either with too great a loss of fluid from the tissues or too small an intake. In order to save more detailed explanation, I will describe one or two cases.

CASE I.—A male, aged 44, had severe haemorrhage from a duodenal ulcer. He was fed by the rectum for five days. This feeding consisted of three 9-oz. nutrient enemata and 1½ pints of saline in the twenty-four hours. For the next three days he was given 5 oz. of peptonized milk every two hours, and subsequently ordinary milk, jelly, custard, and soup, on successive days. During the first four days of mouth feeding the bowels acted with enemata. On the sixth day he complained of great discomfort. On attempting to defaecate there was great tenesmus, and nothing passed except a small amount of faeculent fluid. On examination the rectum was found to contain a large faecal accumulation of the consistence of putty. After being broken up by the finger this was easily evacuated by the aid of a soap enema. In this patient the body fluids were deficient, owing, in the first place, to the original haemorrhage, and subsequently to the too small amount of fluid given.

CASE II.—A male, aged 60, had an acute attack of diarrhoea and vomiting. He was kept in bed, and given milk diet and a bismuth mixture. Two days after the diarrhoea stopped, but during the continuance of the slop diet the patient complained of tenesmus accompanied by the frequent passage of small fluid motions. This continued for a week, at the end of which his doctor asked me to see the patient. He was then much depressed, complained that everything he took ran straight through him, and that the pain was almost unbearable when he passed those frequent fluid motions. There was fullness of the ischio-rectal fossae and redness around the anus. On rectal examination a huge mass of putty-like faeces was felt, quite as big as a fetal head. This had to be extracted piecemeal by means of the finger, after which he made an uninterrupted recovery.

CASE III.—A female, aged 40, had an acute attack of diarrhoea with pyrexia. When seen the condition had been present for three days. She was given milk diet and a mixture containing tr. opil. and deco. haematoxyli, etc. After two days the diarrhoea stopped, but remembering former cases of rectal impaction, I ordered a dose of the liquid extract of

casarea sagrada. It was then, however, too late, and the same evening the patient had acute pain in the rectum with violent tenesmus. Examination again disclosed a mass of putty-like consistence, but not of very great size, and this was easily evacuated after being broken up by the finger.

During the past two years I have seen the same condition in three women under treatment for haematemesis. In each case a description would be practically identical with the first case described, and will therefore be omitted. In the last two described cases there was a loss of fluid from the body, due to diarrhoea or vomiting, or both. In all of the cases the most prominent feature was tenesmus, whilst in four of them there was spurious diarrhoea, due to catarrh set up in the rectal mucous membrane by the presence of the faecal mass; the stools therefore consist of mucus discoloured by some small amount of faecal material. The tenesmus is due partly to mechanical stimulation by the impacted faeces and partly to the catarrhal inflammation of the mucous membrane, the one tending to aggravate the other so long as the condition remains unrelieved. The character of the impacted mass was just the same in all the six cases. Globular in shape and pale yellow in colour, it is made up of finely divided particles, with just enough moisture to give a doughy consistence. The formation of such a mass is easily explained when the conditions are considered. In the first place the residue which passes into the large intestine after the digestion or partial digestion of milk, custard, soup, and gelatinous substances, although small in quantity is made up of very finely divided particles. These have a greater tendency to cohesion than have more granular residues, and the small bulk of the substance fails to give a sufficient stimulus to the motive power of the gut.

These factors alone, however, are not enough to cause a faecal impaction, but must be supplemented by the over-extraction of water from the residue. All the cases here recorded were suffering from shortage of fluid arising either from too small an intake or too great an output, and therefore whatever fluid could be extracted from the residue in the large bowel would be taken up by the blood vessels and leave a cohesive mass.

The accumulation does not remain in the colon, as so commonly occurs in cases arising from chronic constipation, but passes on until checked at the anal sphincter, where further addition may be made to its bulk. This onward movement is accounted for by the muscular efficiency of the gut in these cases, as compared with its sluggishness in chronic constipation. The impaction at the sphincter and is purely mechanical. The diameter of the mass is too great to pass through a physiologically dilated sphincter. That the muscular power of the rectum is brought fully into play is emphasized by the painful tenesmus.

In order to avoid the occurrence of faecal impaction during the treatment of conditions requiring a milk diet, or a diet leaving a cohesive residue, it is of prime importance to give a sufficiency of water. A patient fed by the rectum probably does not retain and absorb enough fluid to meet his requirements. I always order 9-oz. feeds and half a pint of saline alternately every four hours, which are well retained. This represents a total of 57 oz. of fluid. The amount, however, is probably not enough, because the conditions which make rectal feeding necessary—for example, severe haematemesis or vomiting—also deplete the tissues of their requisite quantity of fluid. The demand of the tissues for more water is carried through the period of rectal feeding into the initial stages of feeding by the mouth, and it is during this period of slop diet that impaction takes place. The milk should, therefore, be diluted with water or lime water, or, better still, the rectal saline injections continued during the first three days of feeding by the mouth.

In cases of diarrhoea extra fluid should be given by the mouth, and is well taken in the form of lemonade. A safeguard is to give a small quantity of some saline aperient, which tends to prevent the absorption of too much fluid from the bowel. In such cases, whenever there is tenesmus associated with the passage of small quantities of faecal-stained mucus and pain on attempting to defaecate, it is imperative that an examination of the rectum be made.

In one of the above cases days of pain and anxiety would have been avoided had the rectum been examined as soon as the tenesmus arose. Breaking up the mass is a comparatively painless operation, and the immediate relief

after the passage of the fragments well compensates for any unpleasantness experienced by patient or physician.

REFERENCE.
1 *Lancet*, 1907.

A CASE OF TUBERCULAR LEPROSY.

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LEPROSY is a disease which is comparatively rare in this country and the cases that one occasionally meets with are, as a rule, patients who are natives of districts in which the disease is prevalent or have resided in such area for a number of years. The latter are rare, and even in the tropics where the disease exists with most frequency, its occurrence now is extraordinarily diminished, and in Norway, Russia and Greece, where the disease used to be very common, the percentage of cases that occur annually is much on the decline.

There are two kinds of leprosy—tubercular and nerve leprosy, though occasionally mixed forms also occur. The case which I am about to relate is a typical example of the former with as yet no indication whatever of the nerve type.

The patient, L. W., was admitted into the Seamen's Hospital about the middle of May with the appearance shown so well in the photograph. The face and feet were covered with a hard crusty exudate. The skin of the forehead was wrinkled, indurated, and nodular; the eyebrows fell over the eyes, lips thick and hard, and covered with crusts; the cheeks were hard and massive with large nodules; the whole producing a picture of the so-called

native of Barbados, 29 years old, and left his native home ten years ago, and has only been twice home during that period. He admits having seen cases of leprosy, but never came in contact with any. He first noticed one or two enlarged glands below the angle of the jaw on either side; they were hard and painless at first, but in the course of a few weeks got rather tender. Gradually small nodules formed on his forehead and cheeks, and soon after the wrist-joints became swollen and tender, and the ankles thickened and nodules formed here and there along his thigh and up the forearm. The nodules increased in size and number, and the patient felt that he was getting weaker. In the course of about twelve months the nodules on his face began to exude a glairy exudate, which, on drying, formed hard crusty masses all over his face. His lips

got extremely thick and crusty, and his teeth covered with sordes, with the result that his mouth and throat got very septic. He visited several hospitals, and on each occasion was told he was suffering from an intractable form of syphilis, and as such was ordered admission to this hospital. On admission the temperature was 99° F., but it gradually got higher, and in the course of a week it was up to 103° F., kept between 100° and 102° for seven days, and then came down to normal. For the next seven days it varied from normal to 100° F., and the following week again rose to 104° F., and for the following seven days varied from 100° to 103° F., and then dropped to normal, remaining fairly stationary for another week, and then rising again.

This high rise of temperature occurred fairly regularly about every other week, and during the high fever the patient had very severe pains all over him, not particularly confined to the joints. In the course of a few weeks several more nodules were discovered along his forearm and thighs, varying in size from a pea to a walnut. This variation of temperature was in all probability due to the septic condition of his mouth and

throat, and, although regularly gargled and syringed with antiseptics, his temperature remained very unsettled.

Fig. 1.—Section from a nodule, showing clumping arrangement of bacilli.

“facies leontina” which is described as characteristic of this disease.

The disease commenced four years ago, nine months after the patient came back from a trip to Barbados. Patient is a

Fig. 2.—Swab from the throat, showing clusters of leprosy bacilli with a few epithelial cells.

The diagnosis of leprosy was come to—first, by the general appearance of the patient; secondly, by the marked wasting of the thenar and hypothenar eminences