R Pulveris rhei,
Balsami copaibæ, aa 3 ss.

Misce; et divide in pilulas xij, quarum capiat duas hora somni pro re natâ.

Turpentine and the secale cornutum have also been found efficacious in restraining menorrhagic discharge.

The best local remedy is the sulphate of alum hip-bath, which may be made in the proportions of twelve ounces of alum to two gallons of water. It may be used daily for about twenty minutes, first tepid, thence gradually reducing it to the normal temperature.

Should the discharge continue unabated, notwithstanding the use of the above remedies, a polypous growth or some morbid condition of the uterus is to be suspected; and the uterus must then be examined.

CASE. An unmarried lady, aged 33, became greatly debilitated and blanched by a profuse flow of the catamenia, which continued every month for about eight days. Various remedies were tried for a considerable time to moderate the discharge; but in vain. As her debility became alarming, the condition of the os uteri was examined; when a small polypus of the size of a nutmeg was found attached by its stem to the internal part of the cervix. This growth was at once removed by ligature, and the menorrhagia ceased.

When profuse red discharge takes place at that period of life when menstruation usually subsides, it is often attributed by unprofessional persons to what is vulgarly termed "a change of life", whilst in truth it is more frequently caused by some organic lesion of the uterus. There is seldom any difficulty in diagnosing such a disease as the cause of uterine discharge. In this case the hæmorrhage is sudden, profuse, clotty and irregular; and when it subsides it is followed by a watery, foul, and offensive discharge. There is almost constant and distressing pain around the pelvic region, extending through the external spermatic nerves half way down the anterior part of the thighs. Sitting upon a hard seat will occasion severe pain of the uterus through the perinæum, as also the passage of the contents of the rectum. Besides all this, the mere aspect of the patient, without a vaginal examination, will at once show the wear and tear of carcinomatous disease. Here nothing can be attempted beyond alleviation; and this will best be afforded by opiates, styptics, and rest in the horizontal posture.

Southampton, April 25th, 1853.

CASE OF SCIRRHOUS CONTRACTION OF THE RECTUM; ARTIFICIAL ANUS: DEATH.

By GEORGE MAY, Esq., Surgeon.

CASE. A widow lady, aged 63 years, of peculiarly active habits, enjoying good general health, performing the animal functions naturally without difficulty, and being totally unaware and unsuspecting of local disease, on March 10th, 1853, felt slight irritation of the lower bowel, with desire for relief, but without result. This induced her to take a dose of pills, to which she had been accustomed to resort occasionally. As these pills did not act, she consulted me March 13th, expressing a desire to have a more active aperient. I prescribed ʒiiss of compound senna mixture, to be repeated after six hours, if needful. As these medicines also did not act, and some sickness resulted, a more extended investigation of her symptoms was made. I examined the abdomen with reference to the existence of hernia, but did not discover any. She was now ordered pills with calomel and colocynth, which also occasioned sickness, and failed to act on the bowels. I made another examination of the abdomen, and detected a small tumour in the situation of a right femoral hernia, but without tenderness or pain; the umbilicus also felt slightly full. Not being confident of the existence of hernia, we determined on an immediate operative exploration of these parts. I divided the integuments on the inner side of the femoral

tumour, with a view to reduce the hernia, if present, without opening the sac. The femoral ring was exposed, without discovering hernia, and the tumour lay above it. I now exposed the external abdominal ring by an incision at right angles to the first, and found the tumour to be adipose, and attached by a narrow peduncle to the inguinal canal; but hernia did not exist. The umbilicus was now explored in a similar way, without discovering hernia. Another small swelling was discovered at the outer edge of the right rectus muscle; but we were satisfied, without incision, that it was also adipose. An examination of the lower bowel was made with the œsophageal tube, which passed twenty inches without obstruction, but was slightly grasped as it was withdrawn. She stated that its introduction did not cause pain. About half a pint of water was injected through the tube, and returned unstained by fæces. The sickness which, for the first three or four days, was frequent, and on one occasion of a dark coffee colour (but not at any time fecal), now subsided. The abdomen was generally full, and moderately tympanitic, without special prominence of either portion of the intestinal tube. She suffered occasional pain, with flatulent distension, chiefly in the centre, mid-way between the umbilicus and pubes; but there was no tenderness on pressure. Flatus passed *per anum* occasionally, but no fecal matter. She had a frequent desire for relief by stool, and felt throughout a strong conviction that she should eventually succeed in obtaining it. From the third day of my attendance until her death, the treatment consisted chiefly of calomel and opium, also a dose (gtts. xxv) of Battley's sedative solution occasionally, when she was distressed by painful flatulency. This always gave considerable relief. Various injections, as warm water, gruel, linseed oil, aloes, etc., were also employed. She experienced comfort from the use of warm water, which was exhibited whenever she desired. Her pulse was frequent, ranging from 120 to 140; her countenance was without marked anxiety. She took and retained small quantities of liquid nourishment.

On March 23rd, being the tenth day after my first visit, and probably the fourteenth day since the last fecal evacuation, it became evident that no medicinal means would prove successful; and the constitutional distress having become more urgent, an operation for artificial anus in some portion of the tube above the presumed seat of stricture was proposed. After a delay of thirty-six hours longer, it was performed. Chloroform was not used, being objected to by the patient.

An opening, three inches in length, was made through the integuments, on the right side of the abdomen, over the cæcum; and the latter was opened to about an inch in extent. The edges of the bowel were attached to the integuments by several stitches, and extravasation of blood and fecal matter into the abdominal cavity carefully prevented. The operation was performed without difficulty, and she expressed herself as somewhat relieved. A small quantity of liquid fæces continued to ooze through the wound for three or four hours.

She suffered considerable pain a few hours later, which was relieved by opiates. The exhaustion, which had existed to some extent before the operation, continued to increase; and she died about twenty-eight hours after the operation.

EXAMINATION OF THE BODY, seventeen hours after death. The small intestines were generally but moderately distended. The descending colon was distended with flatus and fæces. A firm stricture from scirrhus carcinomatous deposit existed in the rectum, about six inches from the anus, scarcely permitting the point of the finger to pass within it superiorly. Its extent was about three inches; it was annular, but was chiefly situated in the anterior wall; it was stratiform, and about one inch in thickness; it closely adhered to the fundus of the uterus. The mucous membrane was ulcerated, and about four inches of the tube above the stricture had overlapped the strictured portion, considerably augmenting the obstruction. The ascending and transverse portions of the colon were less distended.

The small intestines, near the wound, were agglutinated by recent peritonitis. No secondary carcinomatous deposits were found in the abdomen, and no other part was examined. Several calculi were found in the gall bladder, and one was impacted in the cystic duct.

REMARKS. The peculiarities of this important case consisted in the absence of premonitory evidence of stricture, in the sudden supervention of symptoms of obstruction, and in the capability of passing an œsophageal tube high up in the bowel without obstruction, and without any complaint of pain, although the mucous membrane was found to be ulcerated. A correct diagnosis was therefore extremely difficult—perhaps impossible. The absence of persisting sickness, and the duration of the symptoms, seemed to justify the inference that obstruction existed in some portion of the large intestine; while the ready passage of the œsophageal tube forbade the presumption of its existence in any part of the left side.

The choice of operation for artificial anus lay between an opening into the cæcum through the loin, external to the peritoneum, or anteriorly through it. The latter was preferred, as giving the opportunity of opening into any part of the intestinal canal, should circumstances require it. The cæcum was found to be moderately distended, and also the ileum at its cæcal termination. The ascending colon was contracted above; an opening was therefore made into the cæcum.

Since the operation for artificial anus was first performed by Pillore, in 1776, forty-eight cases have been recorded; and are embodied in an interesting and valuable communication by Mr. Cæsar Hawkins, published in the *Medico-Chirurgical Transactions*, vol. xxxv. From this table, it appears that an opening into the cæcum by Littre's operation on the right side, has been performed four times before the present case; and that all these cases were fatal. The small intestine has been opened twice, both cases being fatal. A similar operation has been performed on the left side, also through the peritoneum, in eight cases, five of which recovered, and three died. I am not aware of any reason, anatomical or otherwise, which can account for these comparative results; and must presume death to have arisen from other causes than injury to the peritoneum.

Had we been able rightly to diagnose this case, an opening in the left loin, if made sufficiently early, would probably have been successful. The existence of cancer would not have barred its chance of success, as is proved by the recorded results of former cases.

I had the satisfaction to be associated in the conduct of this case with Dr. Burnie, of Guildford Street, London, a friend of the patient; and also, at the operations, with my partner Mr. Harrison, and my son.

Reading, April 1853.

CASE OF SIMULTANEOUS DISLOCATION OF BOTH HUMERI.

By C. ROBERT THOMPSON, Esq., Surgeon.

CASE. Mr. K., aged about 62, a tall, well-made, muscular man, but with a constitution much impaired by intemperance, met with the following accident on March 30th.

He had been for some time invalided, but ventured to walk out alone to visit a friend about a mile and a half from his home. He said that he felt inclined to "pitch ahead" more than once on his journey; but managed to reach within a few yards of the door, when he became suddenly giddy, and fell flat on his chest and face, on a hard uneven path. He stated that he felt an utter inability to help himself, or to make an effort to prevent the fall; at the same time, he did not lose consciousness.

Assistance was at hand; and on getting him up, he complained of loss of the use of both arms, and violent pain in

the shoulders; his face was slightly contused, and cut about the nose and brow, and he seemed very faint.

I saw him about an hour after the accident; and, on undressing him, had no difficulty in deciding that both humeri were dislocated: on the right side forwards, the head of the bone making a very perceptible prominence below the clavicle; on the left side directly downwards into the axilla, presenting all the characteristics of that displacement in a very marked manner. I reduced the left dislocation, with the heel in the axilla: the right was more obstinate, but was reduced in the same manner, after a time, by Mr. Rathill, of Westerham, who was so good as to assist me.

The patient complained much for some days of pains about the shoulders and upper part of the chest; but went on quite well, and has recovered the use of both arms.

REMARKS. In considering the cause of this unusual double dislocation, the most evident explanation appeared to be, that the patient endeavoured to save himself by throwing forwards both hands, and the whole stress of the weight of the body coming on the capsules of the joints, they gave way. But he states positively that he had no power at the time to make any effort, and that he fell flat on the chest and face. Moreover, had he fallen with his hands forwards, probably the head of the bone would have been displaced backwards on the dorsum scapulæ, certainly not forwards, as one was, into the subclavicular fossa.

The only way then in which I can attempt to explain the dislocation is, that falling as he did, heavily and suddenly on his chest, with the nervous and muscular energy paralysed for the time either by syncope or a slight apoplectic seizure, the force of the jolt, and the power of gravitation (which would act with particular impetus on the head of the humerus in a man of large prominent chest) were sufficient to dislocate both bones from their normal situation.

In looking for instances of a similar accident, I find mention of six cases in different numbers of the *Lancet* of last year.*

In one case, related by Mr. W. H. Smith, the accident may probably be attributed to the cause I have suggested in my case; the patient falling heavily forwards in a state of helpless intoxication, and both shoulders being found dislocated.

Mr. Greenwood, of Bradford, relates the case of a man, whose shoulders were both displaced by slipping on to his back when intoxicated. Here one arm had been dislocated ten times, the other once before. In this instance, I imagine the concussion of the body was sufficient to dislocate the joints.

Two cases, where this accident was caused by direct force, applied to both shoulders at once, are recorded: one by Sir A. Cooper, of a man who threw himself off a bridge into the river with the arms extended horizontally, and was found afterwards with double dislocation into the axillæ; the other by Mr. C. Webber, whose patient fell between two stacks of timber, so that both arms were struck upwards in his descent.

In the remaining two cases, the dislocations were caused by force at the hands, acting with immense leverage on the shoulder joints.

One is mentioned by Mr. Skey,† of a butcher, who was raising a calf, when it fell backwards over his head; the other by Mr. Thompson, of Brandon, also of a butcher, who was pitched out of a cart, and came head foremost with great force on his hands.

These are the only instances which I have been able to find; but I have not the means at hand of consulting many authorities on surgery.

Oxted, Surrey, April 25th, 1853.

* *Lancet*, April 10th, 17th, 24th, etc.

† *Operative Surgery*, p. 81.