efficiently by a dose of castor oil. The wound was healed by August 10th, and on that day the first spontaneous evacuation of the bowels took place. He was discharged on August 31st cured.

Cahier¹ in his monograph on acute intestinal obstruction ignores completely the existence of such a condition, and Treves, in his work² on *Intestinal Obstruction*, refers to tumours produced by the accumulation of faecal matters, and observes that when they are situated in the descending colon or in the sigmoid flexure they are formed generally of scybala, a proof that even in his vast experience he has not met with a similar case. This author indicates a sign of much importance in the differential diagnosis of these tumours, that they give to the fingers the sensation of a mass of putty. In the second case this sign placed beyond all doubt the diagnosis, but could not be applied to the first case, as there was no tumour to be discovered on palpation. It is worthy of note that in both cases the site of the tumours was identical, in the last portion of the sigmoid flexure, a position very little subjected to external pressure. In the second case the diagnosis was made of a "pedunculated" dilatation of the intestine, because on several occasions it could be demonstrated bimanually that the lesser cavity of the pelvis was completely free, and at such times that the tumour could be detected above the pubes. The second case also illustrates a disadvantage in the method of Schleich in those laparotomies where it is of the first importance that the functions of the bowels be not retarded. The meteorism produced by the morphine in the injection caused the keenest suffering to the patient.

At the present date, March 1st, 1899, both patients are enjoying good health, having overcome their obstinate constipation.

REFERENCES.

¹ *Les Occlusions Aigües de l'Intestin*, par le Dr. Cahier. Paris: 1896. ² *Intestinal Obstruction*, by F. Treves. London: 1890.

FIBROUS STRICTURE OF THE RECTUM.

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FIBROUS stricture of the rectum, unaccompanied by ulceration, is not a common affection, and it is difficult to treat it satisfactorily. It occurs more commonly in women than in men. The situation of the stricture especially considered is from 1 to 2 inches from the anal margin, where the levator ani slings the rectum. The stricture is usually a narrow one, but in some cases the strictured part is an inch or more in depth. Such strictures have been attributed to the fibrous thickening in the sheath of the levator ani, caused by long-continued reflex spasm of that muscle. The originating irritation is usually some piles or an ulcer about the anus. Dr. Reider attributes it to syphilitic infection of the pudendum, which sets up endophlebitis and periphlebitis of the rectal veins, which carry away the blood from the pudendum.

The usual treatment by passing bougies is very painful, and affords only temporary relief. Forcible dilatation is a dangerous and unscientific method. It is dangerous because the stricture yields at its weakest part, which may lead to laceration and infection of the peritoneum. It is unscientific, as the tear when healed leaves the patient in much the same condition as before the operation. The method here advocated is so simple, and in two cases was so satisfactory, that there seems no reason why it should not come into general use.

It consists in a vertical division at the part most removed from the peritoneum. The vertical is converted into a transverse slit, and the margins stitched together. To do this the stricture must be within reach, and it is an advantage if the mucous membrane above the strictured part is loose and healthy.

The following are notes of one of the cases so treated:

History.—M.F., a housewife, aged 55, was admitted to the Bradford Infirmary on June 9th, 1898. She had suffered from rectal trouble for more than twenty years. Fifteen years before admission bougies had been passed, the treatment being followed by some temporary relief. Her condition had become gradually worse. For six months before admission she had been in constant terror, the dread of obstruction of the bowel and distension of the abdomen alternating with the acute pains on passing a motion. Her condition had become one almost bordering on insanity, her mind being constantly directed to her rectal trouble. The patient was otherwise in fairly good health, the other organs being sound.

Condition on Admission.—There was some excoriation of the skin about the anus. A tight stricture was felt an inch from the anal margin, so narrow that it admitted the index finger with difficulty. The stricture

was about a quarter of an inch in depth, the rectum being fixed at this spot, but above the stricture the rectal mucous membrane was loose and healthy. No scars were noticed on the pudenda or above the anus.

Operation.—On June 10th, under E.C. mixture, the sphincter ani was thoroughly stretched, and the stricture brought well into view. A blunt-pointed bistoury was passed through the stricture, which was divided vertically opposite the sacrum. The length of this incision was about an inch and a half. With the fingers the stricture was now stretched until the vertical cut became transverse. The two margins were stitched in this position with chromic gut sutures. After that operation the narrowed part readily admitted three fingers.

After-History.—The wound healed without trouble, but the patient could not be convinced that the stricture was not present, although the bowels were opened freely and naturally. After remaining some days in hospital she returned home, still believing there was a rectal stricture, although the bowels were moved daily. Eventually she became so insane on this point that she was transferred to the Menston Asylum.

The simplicity of this method, which is an application of the operation of pyloroplasty to rectal strictures, is a great advantage in treating suitable cases. There seems no reason to doubt the permanency of the cure. The ending of this patient in an asylum shows what a serious impression is made on the minds of those suffering from this distressing trouble.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

NASAL TREATMENT IN ASTHMA.

I was somewhat surprised, during the very interesting debate on Asthma in Relation to Disease of the Upper Air Passages, at the Laryngological Society on May 5th, to find that no speaker, with the exception of Dr. Dundas Grant, laid special stress on the very frequent presence of the gouty diathesis in the asthmatic. I venture to suggest that it is not impossible that some of the failures related may be due to neglect of that factor.

Somewhat of a sceptic as regards the value of nasal treatment in asthma, my conversion was brought about by means of what appeared to be a typical case of gouty asthma, most severe attacks frequently alternating either with eczema or articular gout. Persistent gout treatment under the guidance of several eminent physicians and at various spas had failed to give more than temporary relief; but since the fortunate discovery and thorough removal of several nasal polypi four years ago there has been no real attack of asthma.

In a letter received last week the patient says: "Although wonderfully well, I find that if I neglect my precautions regarding dietary there is at once a tendency to irritation in the nose and to slight difficulty of breathing." This case, in addition to a number of others working out on similar lines, makes me think that there is frequently a double source of irritation present.

Another circumstance which has arisen in five cases has impressed me a great deal. All were treated by skilled operators; in three cases polypi were removed; in two there was radical treatment of hyperæsthetic patches on the nasal mucous membrane; but in all recurrence of asthma took place after a very little time. They came under bath treatment for gout which was followed by the use of a carefully-planned dietary, devised with a view to aiding uric acid elimination. There was in each case more or less improvement in the asthma, but there was much left to be desired. I referred them to rhinologists, and in every case the nasal lesions were found to have recurred; removal of these was followed by relief so extraordinary as to amount to a practical cure, and although from one to three years have elapsed, all these patients have remained well except one, who from time to time takes fits of dietetic unrighteousness.

A possible explanation is that, as in almost all cases of this type, there is a marked failure to excrete the normal amount of uric acid by the kidneys (examination of the twenty-four hours' urine by the Gowland-Hopkins process always showing a decrease of from 10 to 30 per cent.) there may be an attempt at vicarious elimination by the nasal mucous membrane, or at any rate to deposit in a part whose vulnerability has become increased. A certain amount of irritation may thus be set up leading to the renewed growth of polypi, etc. Careful observation has convinced me that, as in gouty asthma, the