anæmia resulted from loss of blood before a positive diagnosis was made.

CASE I.—J. McD., aged 33, sent by Dr. Valentine, Earlestown. Blood first appeared in the urine in January, 1897. He was free from hæmorrhage until April, when clots appeared at frequent intervals until July. The urine was repeatedly examined for portions of growth, with a negative result. He lost a large quantity of blood, and became very weak. In July examination with the cystoscope revealed a growth springing from the bladder wall, half an inch above the right ureteral orifice, and a small villous fringe growing beside it. The larger growth was pedunculated, its colour was a brilliant pink, and each small sprout on its surface was translucent. On July 10th suprapubic cystostomy was performed, and the growths were readily removed through a Ferguson's speculum introduced into the bladder. Two glass drainage tubes were left in, and removed on the third day. The suprapubic wound closed slowly. A small quantity of urine escaped for a month. Microscopically, the growth proved to be a simple papilloma. On December, 1898, there were no signs of recurrence. The patient soon regained his usual health, and returned to his employment.

CASE II.—E. H., aged 42, patient of Dr. R. T. Hughes, Birkenhead. For twelve months she had noticed a brown sediment and blood in the urine and had been under medical treatment. There was seen on cystoscopic examination a little to the left of the opening of the left ureter, an oval depressed area, blackish green in colour three-quarters of an inch long by half an inch wide; this sloughy ulcer was surrounded by a fringe of sessile papillomatous nodules, bright pink in colour and not ulcerated. On September 18th, 1897, the urethra was dilated, and with the finger the fringe was felt to be suspiciously hard. It was removed by curved scissors and the base of the ulcer was scraped. After washing out the bladder with hot boracic lotion re-examination showed the area level and apparently free from growth. The patient was returned to bed wearing a pad of wool-wood tissue to catch the urine. Next morning the pad was dry, and a catheter introduced allowed 22 oz. of bloodstained urine to escape. It was necessary to use the catheter once subsequently; at other times she passed urine naturally, so that notwithstanding the extreme dilatation of the urethra it recovered its tone almost immediately. She was sent after nineteen days to a convalescent home. Microscopically the tumour exhibited marked alveolation and was probably cancer. She improved wonderfully in health, put on weight, and went actively about until September, 1898, when hæmorrhage again occurred and on examination recurrence of the tumour was noted. This was removed by suprapubic operation on October 24th, 1898. The wound quickly healed giving for the time freedom from pain and hæmorrhage.

CASE III.—W. W., aged 31, was examined on July 11th, 1898. Three years previously he began to have hæmaturia, which recurred at intervals during eighteen months, when a small piece of "jelly" was passed. Bleeding then became constant. During micturition the stream would at times suddenly stop for a moment, causing great pain in the penis and perineum. He was very anæmic and unable to follow his employment. On July 11th a branching villous growth situated above and to the left side of the orifice of the left ureter was seen, swaying about on a single stalk. On July 21st, with the assistance of Dr. Tisdall, the growth was removed through a suprapubic opening. A small artery was cut through in its base, but by seizing it with a pair of long artery forceps and withdrawing the Ferguson's speculum, the vessel was tied with chromic acid gut. Glass tubes were introduced for drainage and removed after forty-eight hours. On the fifteenth day a little urine leaked suprapubically, so a catheter introduced through the urethra was tied in the bladder and left in for three days, when sound union occurred. On the nineteenth day he left the nursing home. On January, 1899, he was found to be quite free from bladder trouble, and following his ordinary employment.

CASE IV.—Mrs. R., aged 58, sent by Dr. Fox Jackson, Ulverston, when seen in August, 1898, had had hæmaturia for two years; large clots of blood were repeatedly passed. On August 17th a large and almost sessile growth was seen by the cystoscope to be growing from the fundus of the bladder, having sloughy surface and irregular margins. The urine was highly ammoniacal and bloody; it contained also pus and fibrinous shreds. She had not lost flesh during the previous two years, so that, although its appearance suggested malignancy, we hoped it might prove to be a simple tumour. On August 23rd by suprapubic cystostomy a large mass of soft, sloughy, putrid growth was removed. The base of the tumour was somewhat indurated. Twenty-four hours afterwards the urine was highly ammoniacal, and phosphates were deposited in a thick crust on the glass drainage tube. The bladder was washed with a watery solution of chinolol—1 in 1200, every hour, and after 24 hours all decomposition had ceased. The wound rapidly healed, and the patient returned home after three weeks. In February, 1899, she had gained a stone in weight. There was, however, recurrence of the hæmaturia, and on examination a flat mass of growth was seen on the old operation area, so that the outlook is not hopeful.

The main object of this paper is to urge the importance of early examination of the bladder in all cases of hæmaturia.

TWO CASES OF EXTREME DILATATION OF THE SIGMOID FLEXURE: COLOPEXY: RECOVERY.

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THE two following cases are related as examples of what is believed to be a rare event in such an extremely common condition as constipation. The first case was under the care of Doctor Alfonso Masi, of the Military Hospital, Buenos Ayres, and the second came under my care. In no work within our reach can we find any allusion to the subject of localised sacculated

dilatation of the colon as the result of a state of chronic constipation.

Owing to such dilatation and the consequent accumulation of fecal matter, the condition of both patients was one of extreme gravity, as evidenced by the repeated attacks of intestinal obstruction and the high degree of anæmia.

CASE I.—C. A., aged 28, for the last four years had suffered from constipation. At the beginning of 1897 he began to notice that his motions contained blood, and that their form was tape-like. As on rectal examination there was only found a very vague sense of fulness behind the bladder, his symptoms were considered to be due to a stercoraceous tumour, and consequently he was given daily enemata of half a litre of olive oil, abdominal massage, and appropriate dietetic treatment. He had the constancy to continue with this treatment during three months, during which period his condition became greatly improved. At the end of three months the bowels were acting daily, but on occasions the fecal matter would take the form it had previously assumed; consequently the diagnosis of constipation had to be abandoned. In spite of finding the posterior part of the bladder to be distinctly more accessible than formerly, and the complete disappearance of the sense of fulness, it was considered probable that the symptoms were due to cancerous ulceration of the large intestine.

Laparotomy was therefore performed on February 2nd. The large intestine was first explored and was found free from lesion from the cæcum to the sigmoid flexure. On introducing the hand in the pelvis, behind the bladder was found a dilated coil of intestine about the size and shape of the stomach. Pressure on this had no effect in reducing its size, but on lifting it out of the abdomen it was found that its contents were at once dislocated into the rectum, and that the tumour was the last part of the sigmoid flexure, enormously dilated. Its surface presented numerous streaks similar to the "distension cicatrices" of the abdomen of a multipara, a sign that it had been even more dilated and had contained at one time a large quantity of fecal matter. As a matter of fact, it was seen that a movement of the bowels could alone be produced when the dilated part of the gut was filled to the level of the orifice which communicated with the rectum, for the muscular coat of the dilated intestine was incapable of any contraction owing to its atrophied state. Enormously dilated veins crossed the meso-sigmoid, which indicated the obstruction to the circulation and sufficiently explained the hæmorrhages of the last few months. Colopexy was then performed, as offering no risk to the patient, in preference to excision of the sac. This was united to the abdominal wall at the level of the iliac fossa with silk sutures. His convalescence was uninterrupted. After a dose of castor oil on the second day he had daily one or two motions, normal and abundant, to his great satisfaction, as for many years he had never defecated in this manner.

CASE II.—F. S., aged 42, had suffered for the last eight or ten years from constipation, and in an aggravated form for the last twelve months. During this last period his only food had been thin soup and cocoa, due to his desire to diminish in every way the quantity of fecal matter. In the month of March, 1897, he had an attack of intestinal obstruction, unaccompanied by vomiting, severe abdominal pain, but with the tongue dry and parchment-like. These attacks subsequently became more frequent and severe, and were generally ushered in by vomiting, which never became of a stercoraceous character. On palpation of the abdomen a tumour was found in the right hypogastrium, at the level of the insertion of the right rectus muscle; it was globular, smooth, and painless, and presented a considerable resistance. By the rectum the tumour was also felt, descending as far as its second part. On making firm pressure with the finger an indentation could be made in the tumour, which persisted afterwards. It was impossible to dislocate the tumour from the pelvis. The treatment employed consisted in the administration of large enemata, cascara sagrada, Hunyadi Janos water, and enemata of olive oil, with the result that the patient obtained a period of relative comfort, which quickly disappeared on abandoning the treatment; and the tumour acquired greater mobility, abandoning at times the pelvis completely, as was proved by rectal examination, and appearing high up in the hypogastrium, with great relief to the patient. However he never had a satisfactory movement of the bowels, never passing any fecal matter, only what he termed "washings." As the symptoms of obstruction appeared, it was decided to perform laparotomy.

On July 19th laparotomy was performed. On opening the peritoneum the sigmoid flexure at once appeared, enormously dilated, and having lost all its sacculated character. The small intestine seemed to be somewhat atrophied. The pelvis was found to be completely occupied by a large tumour, which impeded the passage of the hand into the cavity. By means of traction on the dilated colon it was found possible to lift it up, when it was discovered to be an enormous dilatation of the last part of the sigmoid flexure. Its peritoneal covering was normal, although somewhat thickened, and the tumour was not adherent. Its consistency was solid, but it could be indented. An effort was now made to express its contents into the rectum, but in spite of employing a moderate pressure it was found impossible. One or two alternatives then remained, either to suture the dilated intestine in an elevated position to the abdominal wall, or to incise it, remove its contents, and return it anew to the abdominal cavity, and the former plan was chosen. The intestine was sutured in an elevated position to the centre of the abdominal wound, which was closed above and below it. After the operation the patient expressed himself as very much relieved, until 48 hours after, when vomiting supervened. The bowels had not been opened since the day of the operation, and this once effected the vomiting disappeared. On the eighth day it was found that the fecal mass had fallen, until it was within reach of the finger. By the aid of enemata, the lithotomy spoon, and the finger, it was found possible to dislodge it. Its volume would be approximately three-quarters of a litre, and it had lost its fecal smell. Up to August 10th he defecated only after an enema, the motions being semi-liquid, and in other cases badly formed, but obviously of recent formation. The tongue was now quite clean. On August 3rd the abdominal wound was closed, local anæsthesia being induced by means of Schleich's method. During the following night the patient was much inconvenienced by the retention of gas, but was relieved by the introduction of the rectal tube, and more

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