On Sept. 17th, after an ounce of brandy had been given, the patient was put under chloroform and the abdomen was opened by a four-inch incision in the middle line below the umbilicus, the bladder having been previously emptied by a catheter. The intestines were found to be very much distended with gas and fæces. A loop of small intestine was brought out of the wound and punctured and a large quantity of gas and fluid fæces were removed. After the distension had been relieved in this way the puncture was closed by two fine silk sutures and the gut returned. On exploring the abdominal cavity with the hand a tight obstruction was found in the upper part of the rectum on a level with the pelvic brim. The nature of the contents of the gut and the character of the stricture could not be made out with certainty as the gut could not be brought into the wound on account of the short mesocolon. The obstruction could not be moved either upwards or downwards; it had an irregular feel and gave one the impression that some firm substance with irregularities on its surface simulating large seeds had become impacted in the lumen of the bowel. As it was found to be impossible to remove the obstruction without seriously injuring the walls of the bowel the peritoneal cavity was washed out with boric acid solution and a loop of the large bowel above the obstruction was brought into the wound and united to the peritoneum by five fine silk sutures. Two thick silk sutures were passed on either side through the peritoneal and muscular coats of the bowel and the whole thickness of the abdominal wall in order to keep the gut in firm contact with the edges of the wound. The peritoneum was then closed by a fine continuous silk suture and the abdominal wound was closed by silk sutures except the part opposite the attached gut. The intestine was then opened and a very large quantity of fluid fæces and gas made their escape. No hard masses were passed and the fæcal fluid was of a dark colour. A large pad of tow was then placed over the opening and an abdominal band was applied to keep it in position. A morphia suppository (half a grain) was put into the rectum and the patient was replaced in bed. He was rather weak after the operation and hot bottles were placed on each side and he was wrapped in blankets. At 5 P.M. the temperature was 100° F. About three ounces of fæcal fluid had passed through the opening and also a great deal of gas. There was no pain. The pulse was fairly strong (80). Lime-water and hot milk were given by the mouth. On the 18th the morning temperature was 101°. The patient slept well during the night. He had no pain but slight soreness in the vicinity of the wound. Fæcal matter escaped through the opening in small quantities. The patient was cheerful and looked bright. He took nourishment well. The evening temperature was 100·6°. On the 19th he slept fairly well. He complained during the night of acidity. This was relieved by one dose of bicarbonate of soda. There was no pain but slight soreness. The patient was comfortable and took nourishment eagerly. The morning temperature was 99·8° and the evening temperature was 98·4°. On the 20th the morning temperature was 98·4°. He had passed no fæces since the evening of the 19th. The abdomen was slightly distended. The patient passed a good deal of wind. He did not sleep well. The evening temperature was 98·4°. He was given a Seidlitz powder. On the 21st the morning temperature was 99°. The patient slept well. The distension was relieved. There was no pain. He passed a good deal of wind. No fæces were passed. The wound was looking well. The evening temperature was 99°. From the day of the operation the bowel had been washed out both upwards and downwards by a douche of weak warm boric acid lotion, and the rectum also below the obstruction was kept clean in the same way. On the 22nd the morning temperature was 98·4°. A small quantity of fæces was discharged, also a good deal of wind. All the visible stitches were removed. There was slight suppuration around the stitches owing to tension. During the whole period since the operation tension had been relieved as much as possible by two broad pieces of strapping applied across the abdomen above and below the wound. The evening temperature was 98·4°. On the 23rd the morning temperature was 99°. He slept well on the previous night. He had three large actions yesterday and two very large ones during the night through the abdominal opening. There was no pain. The evening temperature was 99°. During the afternoon there came on a copious bloody discharge from the wound. There was a large bloody slough blocking the opening and the edges of the wound were inflamed. He passed fæces twice during the day through the wound. On the morning of the 24th the wound looked better. The morning temperature was 98·4°. The patient slept at intervals during the night. The evening temperature was 99°. On the 25th the morning temperature was 98·4° and the evening temperature was 98·4°. The wound was looking well. A small amount of fæces was passed. From Sept. 26th until Oct. 7th the patient continued to improve, the temperature never rising above normal, and the fæces passing through the abdominal wound. The bowel was regularly washed out by a warm douche of weak boric acid lotion upwards and downwards every morning and the rectum was washed out every second day. There was a considerable amount of granulation tissue around the wound which was touched with caustic every morning and gradually decreased. On Oct. 7th, on administering the rectal douche, a considerable amount of fluid fæces came away. This evidently showed that some fæcal matter must have passed the obstruction. The patient's condition was very good. On the 8th he passed five formed stools per rectum yesterday; the stools were dark brown and minute gritty particles were noticed in them. On the 9th he passed one formed stool yesterday of the same character as those on the 7th. On the 10th he passed another stool. On the 12th he passed a large natural stool. On the 15th he passed a large natural stool about three-quarters of an inch in diameter. From this time until his discharge on Oct. 30th the patient continued to pass his stools by the anus in the natural manner. The abdominal wound was kept open for 17 days after the first stool passed per vias naturales and then it was allowed to close gradually. On the day he left the hospital the abdominal wound had almost completely closed, a small sinus at the lower end scarcely large enough to admit a slate pencil only remaining.

It is a matter for regret that the first stools passed per rectum and which had been passed during the night were by an oversight not kept for examination but were thrown away before I paid my usual visit to the hospital. All opportunity of ascertaining the exact nature of their contents was thereby lost. I saw the patient some days after he left the hospital. He was then doing well and the abdominal sinus had nearly closed. He would not remain in the hospital until the wound had quite closed as he was anxious to get home and was feeling quite well and comfortable. On July 1st, 1899, the patient was alive and had had no recurrence of the obstruction since the operation 10 months ago. In conclusion, I desire to thank Dr. C. M. Phillips for his assistance.

Lucca, Jamaica.

PULMONARY EMBOLISM FOLLOWING ABDOMINAL OPERATION; RECOVERY.

BY EDWARD JOSEPH BLACKETT, M.R.C.S. ENG., L.R.C.P. LOND.

PULMONARY embolism is, as far as I know, a very rare and uncommon complication in abdominal operations, and cases of recovery after pulmonary embolism are also rather the exception than the rule. Therefore the following notes of a case illustrating these points may be of some degree of interest.

The patient was a woman, aged 35 years, who for seven years had suffered from repeated attacks of appendicitis. I first saw her in September, 1898, during one of these attacks. Her general health was otherwise good, though there was a family history of tubercle and gout, and the patient had herself suffered from gout and on several occasions had passed "gravel" in her urine. On Feb. 2nd, 1899, Mr. Frederick Treves removed the appendix, and as there were no adhesions between the appendix and the surrounding parts the previous attacks could not have been of a very severe character, and beyond the fact that the patient was rather stout no difficulty was met with at the operation. The appendix was as thick as a little finger and about six inches in length. A small cyst in the right ovary was found and dealt with, and there was also a fibroid in the uterus making that organ about equal in size to a pregnancy of four months. The patient did not take the anæsthetic (gas and ether)

particularly well and artificial respiration had to be employed for about 20 minutes after she had been put back into bed; she also had a good deal of after-sickness.

As regards the progress of the case so far as the operation was concerned everything went on well and the wound healed by first intention and no pain was complained of, but on the 11th, nine days after the operation, the patient began to spit blood, not in very large quantities but frothy and bright red in colour. The expectoration was very viscid and tenacious but not rusty. There was no rise of temperature and she did not complain of feeling ill though she was naturally a good deal alarmed at seeing the blood. On the 13th she complained of vague pains in the right shoulder and side. On auscultation nothing abnormal could be detected and as the pains were not constantly in one place but shifted about, being alternately worse in one situation and then in another and not always being limited to the right side, I put them down to either muscular rheumatism or else intercostal neuralgia. This condition of things continued till the 27th, the hæmoptysis being constant, though the blood varied at times in colour from a bright red to a very dark purple—almost black. On the 28th I discovered well-marked signs of pleurisy on the right side and there were pain on breathing and coarse crepitations showing that the pleurisy was of the moist variety. The pain was relieved by a linseed-and-mustard poultice. Leeches were suggested, but the patient absolutely refused to allow the nurse to put them on. Night sweats now supervened and continued till March 7th, on which date they were so severe that the nurse had to change the patient's clothing three times during the night. The pulse was very rapid (about 120) and remained at this rate for about 10 days; the temperature rose to 102° F. on the night of the 7th. On the 8th there was effusion of fluid into the right pleural cavity, the fluid reaching almost to the level of the spine of the scapula and the physical signs were well marked. This was the only day on which the patient was distressed to an alarming extent and 18 ounces of perfectly clear fluid were withdrawn by aspiration, after which she was much relieved. Directly after the removal of the fluid there was marked tubular breathing to be heard at the inferior angle of the scapula. The temperature dropped to nearly normal and only once again rose above 100°, in fact it was after this date nearly always subnormal. Sir R. Douglas Powell and Dr. Whipham very kindly saw the patient on two or three occasions both before and after the tapping and came to the conclusion that it was a case of pulmonary embolism. On the 13th there were vague pains behind the left scapula similar to those experienced on the right side, but fortunately they disappeared and nothing developed. About the 20th a fresh feature manifested itself—severe pain in the region of the bladder after micturition The urine was examined and was found to be very faintly acid with a distinct trace of albumin and a little mucus. The pain was relieved by hot fomentations. A small fissure at the anus was also discovered at this time. The hæmoptysis gradually subsided and the right lung slowly returned to its normal condition. Breath sounds were audible at the extreme base, though there was still dulness present. On April 15th the patient went to Bournemouth and the last I heard of her was that she was practically well and able to take walking exercise, which she had not been able to indulge in with any degree of comfort for some time previous to the operation.

There are a few points of interest connected with this case to which I may perhaps be allowed to refer. In the first place as to the diagnosis: the hæmoptysis, night sweats, rapid pulse, and the family history, led me, I must own, to regard the case at first as one of tuberculosis, though it must be acknowledged that there was no rise of temperature before the pleurisy manifested itself, neither could any signs be detected in the lungs, nor any tubercle bacilli in the sputum, which was carefully examined on three separate occasions. Another view was to make the ether the scapegoat, for it was thought that this might possibly have set up congestion at the bases of the lungs, but taking into account that there was no hæmoptysis till nine days after its administration, and the fact that when there was hæmoptysis the blood was bright-red in colour and not dark as might have been expected if it had been poured out at the time or soon after the operation, this view was put out of court. The only cause left was pulmonary embolism due to a clot being washed up from the seat of the operation as there was no evidence of morbus cordis present. A curious circumstance was that at no time were there any very urgent symptoms such as one usually meets with in cases of this nature. There was no sudden onset and the only time that the breathing was at all embarrassed was when there was a collection of fluid in the pleural cavity, and it was at once relieved by the removal of the fluid. Another point not in any way connected with the lung trouble was the severe bladder pain, and I must own that no very satisfactory explanation of this seems to be apparent. The urine was very faintly acid, so it could not have been due to the presence of an excess of uric acid.

As regards the treatment adopted there is nothing special to note, it being that usually employed in these cases and the symptoms were treated as they arose. There was a good deal of pain complained of when the lung began to expand and this was relieved by the application of blisters. Hyoscyamus with Vichy and Contrexéville waters were used for the bladder trouble. I should be very glad of any suggestions as to the cause of this bladder pain, as it may arise again, and unless a cause can be found which either could be removed or could give some indications as to the line of treatment the ultimate result may be unsatisfactory not only to the patient but also to the medical attendant.

Seymour-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF SUDDEN EXTRUSION OF UTERINE FIBROID SIMULATING INVERSION OF UTERUS.

BY EDWARD MALINS, M.D. EDIN.,
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ON June 21st, 1899, at 1.30 A.M., a woman was admitted into the General Hospital, Birmingham, with a note from a medical man stating the case to be one of inversion of the uterus. The patient was in a collapsed condition; she was very pale, her face was pinched, her lips were exsanguine, and the body surface was cold. There was vomiting. The pulse was very rapid and small with severe pain in the lower abdomen. On examination a large mass was seen between the thighs protruding from the vagina. She stated that in straining to pass urine this had suddenly appeared with intense pain, loss of blood, and fainting. A medical man was sent for who advised her removal to the hospital at once. The mass was large, oblong shaped, from some seven to eight inches long, about four inches in diameter at the widest part, narrower at the distal end, and about two inches in diameter at its attachment just within the vagina. It was congested-looking in appearance, dark red, with bluish patches; it was smooth and moist to the touch; the consistence was firm and unyielding. The finger of one hand pushed well up the rectum and the fingers of the opposite hand over the pubes could be approximated. The point of a sound introduced into the bladder could also be felt through the rectum. Posteriorly to the attachment within the vagina low down a small aperture was found after some search; into this a sound was directed to the extent of two and a half inches, sliding behind and above the attachment of the pedicle. The conclusion drawn was that the mass was a large fibroid derived from, and obliterating, the anterior lip of the cervix and dragging the uterus tightly down into the lower part of the vagina. Immediate removal was decided upon. The patient was placed under ether and a transverse incision was made across the base below the bladder and a similar one posteriorly; bleeding which was free was arrested by pressure forceps and tying vessels on progress; the base was dissected away and the mass was removed; the edges of the respective incisions were brought together by silk sutures; the vagina was washed out with a 1 in 2000 perchloride of mercury solution and packed with iodoform gauze. The growth weighed 2 lb. 6 oz. It had the characters of an œdematous fibro-myoma, with some extravasations of blood in places and here and there in the interior some small cysts filled with colloid-looking material.