if it can be seen on the face of the stump, if it has not been tied before the removal of the *écraseur*.

I have now removed the tongue, wholly or in part, thirty-six times, and in all but three by the method here described. Of the thirty-five patients (one of whom was operated on twice, at an interval of four years and a half, thus making the thirty-six operations), thirty recovered, and five died. Of the deaths, one was from diphtheria, beginning about ten days after the operation; two from septicæmia; and one from general debility, arising chiefly from other causes than the cancer of the tongue; and one died six weeks after the operation from subacute pneumonia, the symptoms of which began about a week after the operation, with cough and slightly raised pulse and temperature, and consolidation of the base of the left lung. All the symptoms proceeded quietly to the last, the patient having recovered quickly from the immediate effects of the operation, and being able to take carriage-exercise for some weeks to within a day or two of his death. The sputa were offensive, and I have no doubt that the inflamed lung-tissue had in part broken down.—*British Med. Journ.*, Oct. 20, 1883.

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Colotomy in Syphilitic Ulceration of the Rectum.

In a paper on this subject Dr. EUGENE HAHN says that it has not yet been determined whether the so-called syphilitic ulceration of the rectum, which is exclusively confined to females, and can often be observed in syphilitic women, is certainly of syphilitic origin or not; whether they must be attributed to the secondary or tertiary period; or arise from mucous patches, condylomata, or gummous nodules; or whether they are not of a syphilitic nature, and arise from infection with gonorrhœal secretion, or are the product of infection from a soft ulcer, is still unsettled.

Hahn has seen fifty cases and made about thirty autopsies, and is confident that he has seen some cases of the so-called syphilitic ulceration of the rectum which could not have been attributed to a syphilitic origin.

The views of different authors on this question differ widely. Some, as von Bärensprung and Fournier, hold to the syphilitic nature of this ulceration, and assign it in different periods to mucous patches or to gummata. Fournier ascribes it to the tertiary period, and distinguishes between these ulcerative or gummatous forms, and those called by him the ano-rectal syphiloma, which begin in the submucous tissue. Pathological anatomy has not yet determined this question; as Virchow says that he has had no opportunity to observe the first stage of the process, and must, therefore, leave it doubtful whether the ulceration ordinarily has a condylomatous or gummous beginning, or whether it is chiefly of a secondary nature. Its almost exclusive appearance in women favours the primary nature of the disease. As far as the customary local and general treatment is concerned the results are usually very poor.

Antiseptics, astringents, and cauterants, in powder and ointments, slitting of the stricture, the sharp spoon, and the actual cautery, bougies, iodide of potassium, inunctions and injections, all alike seem to be equally inefficacious in many of these cases. The purulent discharge continues, and the patient goes on from bad to worse. Some die from the great drain on the system, with amyloid degeneration of the different organs, others of pyæmia or septicæmia. It occurred to Hahn that if the fecal matter could be kept from the surface of the ulcers of non-syphilitic nature, they could be cured by judicious treatment; and by anti-syphilitic remedies; if they were of specific origin, they could be cured. He, therefore, proposes colotomy, and reports the following case:—

A woman, æt. 25 years, prostitute, with a severe rectal affection, came under

his care. The purulent discharge, in spite of the most assiduous treatment, continued to be enormous, amounting to about a litre per diem. Different antiseptics, astringents, and cauterants were tried in vain, as was general treatment with iodide of potassium and mercury. The same treatment had been tried in other hospitals without success. The patient was losing strength and flesh daily, until finally she was reduced in weight to 68 pounds. Examination showed a complete rupture of the perineum, with a large cloaca between the vagina and intestine. The sphincter ani was torn and powerless. He performed left anterior colotomy with the most excellent results. The purulent discharge ceased within fourteen days of the operation, and the patient began rapidly to gain in strength and weight. Other cases in which this treatment was successful are reported. One, a patient operated upon a year ago, had had, for some time, an enormous purulent discharge, which rapidly diminished after operation. In this case local treatment really did harm, for the introduction of bougies always caused a greater or less degree of peritonitis. There was a recto-vaginal fistula in Douglas's pouch, which he cured by the following operation: The mucous membrane of the vagina was freshened to a considerable extent around the fistula; the cervix was slit bilaterally, the posterior flap freshened, brought into contact with the freshened mucous membrane, and the two sutured together. The purulent discharge from the rectum continued, and colotomy had to be performed about a year after the first operation. On account of using a bad pessary there was a prolapse of the colon. This can be avoided, he says, by the use of a good rubber pessary. Three of his patients died within from eight months to two years and a half of intercurrent disease. In all three there was a marked bettering of the condition, both in regard to the lessening of the discharge, and general health. In none were there any good results from anti-syphilitic treatment. The local treatment was so directed that several injections of salicylic acid, thymol, permanganate of potash or alum were used daily, directed through the peripheral end of the colon by means of an irrigator. For this purpose the patients were placed upon a kind of injection bath, and the fluid injected through the peripheral end of the colon until it ran from the anus in a clear stream. After the first injections had been made and the fecal matter removed, there was a decided bettering of the purulent secretion. Two patients died several days after the operation, one of inanition because the operation was undertaken too late, the other of peritonitis.

On the day before the operation, a purgative is administered to the patient, and a few hours before the operation an enema is given. The operation is always performed in two stages. In the first the patient is chloroformed, the field of operation thoroughly disinfected, and an incision five or six cm. long is made parallel to and about half a centimeter above the outer portion of Poupart's ligament, so that one-half of the incision is above, the other half below the anterior superior spinous process of the ilium. The obliqne and transversalis muscles are now cut through, and every bleeding vessel, even the smallest, is checked. The fascia transversalis and peritoneum are now incised. The parietal layer of the peritoneum is now stitched to the outer skin, and secured by button sutures. Catgut is used for this purpose, being carried through the skin, the whole muscular layer and the peritoneum, and the sutures drawn so that the whole wound is covered by a peritoneal layer, which will prevent extravasation into the subperitoneal tissue. The threads are then cut short. The thumb and index finger are now carried into the abdominal cavity, so as to get at the colon or the upper portion of the sigmoid flexure. The colon is easily recognized by the colic and epiploic ligaments. When the colon has been found it must be stitched with the parietal layer of the peritoneum, which has already been secured to the wound. This is done by means of a thin, slightly curved needle, carried in about one-fifth of an

inch between the visceral layer and the muscular structure of the intestine; then the needle is brought through the parietal layer about one-fifth of an inch from the edge of the wound, and out through the skin, and then the threads of carbolized silk are tied. In this manner surfaces of peritoneal tissue about one-fifth of an inch wide are brought together; after five or six days they become so closely adherent that there is no fear of their separation. Eight or ten sutures are put in place, and the threads left hanging out; this he considers as important, because after six days the colon and the whole wound become covered with granulations, and the colon cannot be certainly recognized. In one case, through the neglect of this precaution, the peritoneal cavity was opened during manipulation of the wound, and fatal peritonitis ensued.

By leaving the threads the situation of the colon can be easily determined when the time comes for opening the gut. This constitutes the second stage of the operation, and is generally performed six days after the first. This procedure being generally painless, the patient is not anæsthetized. The threads are pulled apart and cut in the middle until the mucous membrane of the gut is seen, or the colon is seized with two fine, sharp tenacula, and cut through between them. Tenacula are better than pincers, because when the intestinal wall is seized with sharp pincers a slight bleeding will ensue, which obscures the field of operation. If it is necessary to enlarge the wound into the gut, scissors may be used. After a few days the use of injections may be begun.

An accident which very often happens when the patient gets up is prolapse of the intestine. On this account it is of great importance not to make too large a wound, and, as soon as the patient gets up, to fit in a proper pessary. The air-filled rubber ring will be found very advantageous for this purpose.

As to the relative danger of anterior and posterior colotomy, Hahn gives the following reasons for preferring the anterior operation: 1. After anterior colotomy the patient can clean herself and make the injections without assistance. 2. The operation can be more easily and nicely performed. 3. Up to the second stage of the operation, or the formation of granulations in the wound, complete antisepsis can be more completely carried out.—*Langenbeck's Archiv*, Bd. xxix. Heft 2.

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Piece of Bone passed through the Bladder.

Mr. REGINALD HARRISON, at a late meeting of the Medical Society of London, described a case in which the lower epiphysis of a rabbit's femur passed from the bowel into the bladder, and thence per urethram. The gentleman, the subject of this condition, at first presented a tumour in the region of the fundus of the bladder, associated with vesical irritation and severe pain at the lower part of the abdomen. The urine contained pus. He was sounded, but nothing was detected in the bladder, and soothing treatment was adopted. A later examination of the urine showed the elements of feces, and air now escaped on micturition. One day he passed the piece of bone referred to, and subsequently the symptoms gradually subsided. For a long time his chief trouble was that, when the bowels were loose, fecal matter would block the urethra; but by the use of small doses of opium, regularly emptying the bladder with a soft catheter, and daily washing out, the fecal fistula gradually closed, and the patient was now in perfect health. If the above means had not succeeded, Mr. Harrison would have performed cystotomy in order to obtain perfect rest of the bladder. He had reason to believe, from abdominal examination, that the piece of bone was impacted in the transverse colon, which had then contracted adhesions with the bladder and opened into it, thus providing an exit for the foreign body, so unusual an occurrence that he could find only two similar cases on record.—*Lancet*, Nov. 17, 1883.