A case of carcinomatous stricture of the rectum, in which the descending colon was opened in the loin / by Alfred Jukes.

A CASE

OF

CARCINOMATOUS STRICTURE

OF THE RECTUM,

IN WHICH THE DESCENDING COLON WAS OPENED IN THE LOIN.

BY

ALFRED JUKES,

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With Plates.

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TO

MONSIEUR AMUSSAT.

Dear Sir,

I dedicate these few pages to you, as being the first European Surgeon who has had the boldness to re-introduce an operation of Callisen's for opening the Lumbar Colons; and by a modification of the same, founded upon accurate anatomical investigations and proofs, established its success in several cases, to the manifest relief of the individuals under your care.

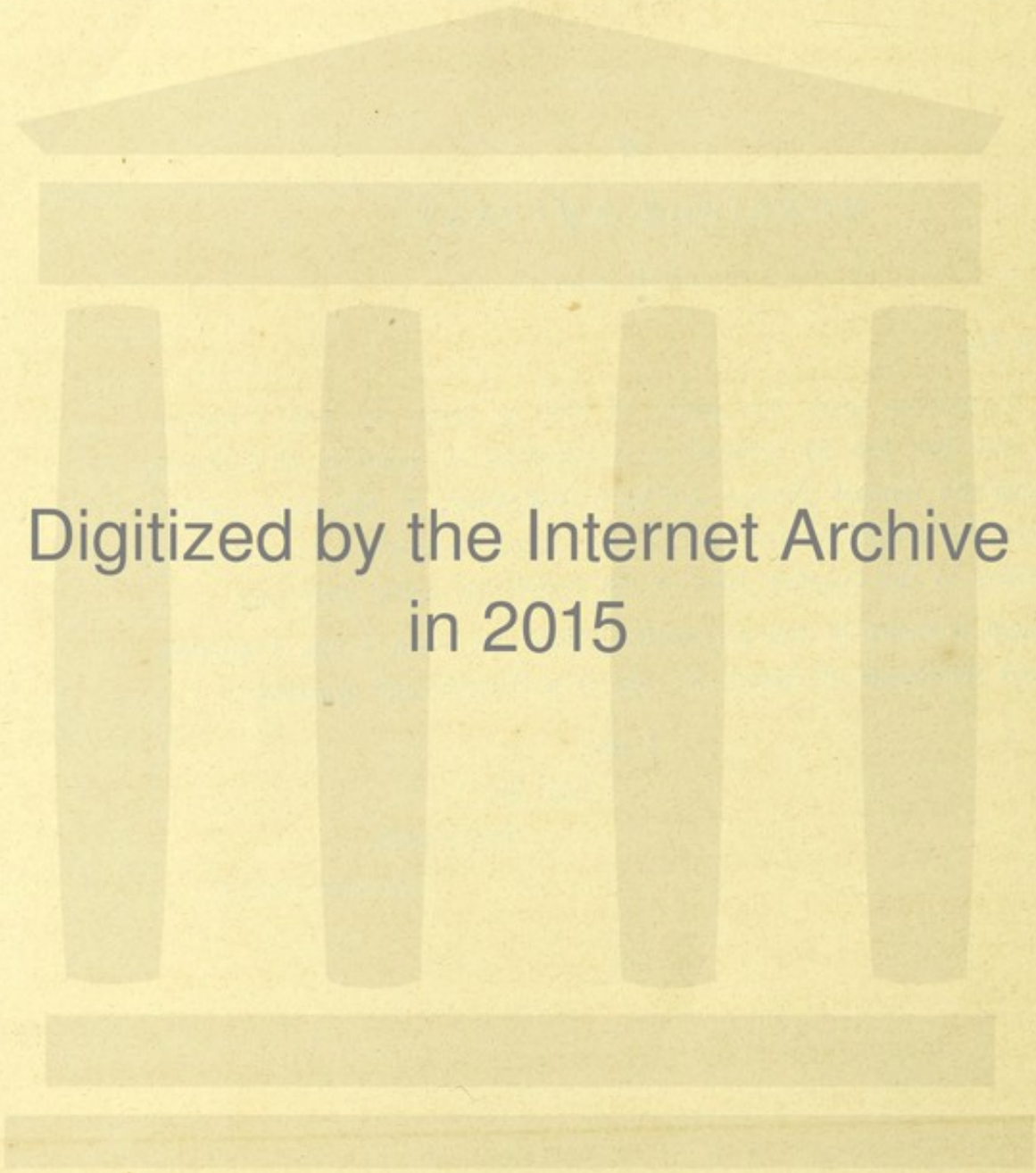
Though unknown to you personally, believe me, when I say, I entertain the highest sentiments of respect for you as a Surgeon and Anatomist.

I am,

Dear Sir,

Your's truly,

Alfred Jukes.



PREFACE.

SOME apology may perhaps appear necessary, for publishing in a separate form, a solitary case of operation for opening the Iliac Colon. As however, it is a novel proceeding in this country, Mr. Clements, of Shrewsbury, being the first and only English practitioner, besides myself, who has performed it, I have deemed it more advisable to record my case singly, appending some drawings by way of illustration, and thus to attract to it an attentive perusal and deliberate reflection, than to introduce it to the notice of the Profession through one of the periodical Medical Journals, where, in the mass of interesting intelligence which marks the advance of our professional literature, it might perhaps have been passed over without due consideration.

It is the second instance of the successful application of Amussat's operation, by British Surgeons, for the removal of intestinal obstructions, at a period when this would otherwise have proved speedily fatal. I say successful, because, although my patient lived only sixteen days after its performance, yet, during that time, the bowels acted freely, and were relieved from every sign of obstruction by the artificial aperture; indeed, during the last three days of her existence, the greater part of her stool was voided by the anus. Thus then the operation, so far as it was concerned, had effected its object, and the woman's death, as will be seen in the report of the case, was attributable to chronic inflammation of the peritonæum, which, from the appearances found upon dissection, would seem to have existed in a latent form, for some time previous to her admission into the Hospital. This fact induces me to believe, that had the operation been resorted to earlier, the probability of its prolonging her life to a distant period would have been greater

I am fully sensible that it is an operation which must not be hastily recommended or practised. On the contrary, it will not be required, unless urgent and undoubted symptoms of obstruction in the large intestines be present; and even under these circumstances it should never be proposed, until every other rational and justifiable expedient for the removal of the disease, has been employed without avail. Nevertheless, when a patient is placed in the position which I have described, the formation of an artificial anus offers the only rational and feasible mode of relief; and since it is now clearly established, that the Lumbar Colon, on either side, may be opened with safety and comparative facility, I have felt myself called upon to place the particulars of this interesting case before the Medical Profession, in order to excite the attention of its members to the important and not infrequent class of diseases for which M. Amussat has proposed a mode of treatment so simple, ingenious, and practicable. I trust also, that the accompanying sketches of the parts involved in the disease and operation, will contribute in some measure to elucidate the descriptions, as well as to confirm the views in question.

Since the publication of this Pamphlet, I have discovered that a case in which this operation was performed by Mr. TEALE, of the Leeds General Infirmary, in March last, has been reported in the Twenty-fifth number of the Provincial Medical and Surgical Journal. The case terminated fatally on the seventh day after the operation, by perforation of the cæcum.

I have attached this note to express my regret that the report to which I refer, had previously escaped my observation. The fact however shews how liable we are to overlook such cases, when published in the Journals singly.

A. J.

July 6, 1842.

CASE.

SARAH PASS, aged 30, a married woman, residing at Bromsgrove, Worcestershire, was admitted into the Birmingham General Hospital, May 6, 1842, under the care of Dr. Blakiston, suffering from symptoms of intestinal obstruction. Her frame is emaciated. She has an anxious, troubled expression, and her complexion is somewhat sallowed, though the cheeks retain freshness of colour. She reports herself to be the mother of four children, the youngest of whom is fifteen months old. All her labours were quick and natural. During her second pregnancy, she received a kick upon the belly from her husband, when intoxicated, but no bad consequences followed it. Her bowels were tolerably regular until eight months ago, when she became the subject of obstinate constipation, succeeded by vomiting. These symptoms continued for a month (during a fortnight of which time, she had no alvine evacuation whatever,) and then subsided. She does not appear to have passed her evacuations with regularity since the attack,—her bowels not acting, at various periods, more than once in three or four days. About a month ago she had a return of urgent symptoms. Her motions became sparing and infrequent, and for the last three weeks entirely suppressed, with the exception of a scanty evacuation, described as slimy, which was passed five days ago. She has during this period experienced urgent desire to empty the bowels, but her attempts have been ineffectual. For the last week or more, she has suffered greatly from distension of the belly and vomiting, which latter symptom has been progressively increasing, and has caused her to refuse all food for the last three days, excepting a little tea and broth.

Present state. Her features are pinched, she has no headache, and her intellect is clear. Her breathing is quick, her pulse soft and tranquil, her skin cool, and her tongue whitish and moist. She has vomiting after food, the rejected fluid being mixed with ropy mucus, tinged with bile, and free from stercoraceous smell. Her abdomen is as large as though it contained a gravid uterus at the full period of gestation. This distension is evidently owing to the dilated intestines, which from the thinness of

the abdominal parietes can be seen convoluted beneath, and ploughing the surface of the belly with projections and furrows. The integument of the abdomen is corrugated, and marked by the silvery blue lines produced by distension in her pregnancies. Both large and small bowels appear to be equally dilated, for both iliac regions as well as the lumbar spaces above the crest of the ilium are bulged out, whilst the convolutions of the small intestines in the middle and front may not only be seen, but moved, and even altered somewhat in shape by a little manipulation. Percussion yields tympanitic resonance throughout, and no solid tumour can be felt above the pelvic brim, in consequence of the hand being buoyed off the deeper parts, by the distended bowels. On examining the vagina and rectum, a firm, dense tumour is felt some three inches from the anus, on the left side of the recto vaginal septum, extending upwards towards the left sacro iliac symphisis. This growth seems to be intimately connected with the uterus and rectum, and to have rendered the position of the uterus preternaturally oblique, by pushing its fundus forward, and inclining its cervix backwards, into the hollow of the sacrum. The lower end of this tumour is thinned off though rounded, whilst above it expands both in breadth and thickness, forming a convex surface in the rectum. It moves with the uterus, as is proved by inserting the tip of one finger within the os uteri, and drawing it forward, at the same time having a finger of the other hand in the rectum, when the upper portion of the mass is thrown more backwards, and encroaches upon the cavity of the rectum to a greater degree. The size of the portion within reach is equal to that of a small pear, but its upper terminus cannot be felt. Pressure upon it by the finger, produces slight pain. It does not constrict the canal, so far as we can reach, to a sufficient degree to produce the symptoms of obstruction under which she labours. A tube was passed into the rectum for about ten inches without encountering any obstacle, and a syringe attached with the intention of giving her an enema of cold water. The two or three first syringeful were retained, amounting perhaps to six ounces, but at each succeeding stroke of the piston, a quantity of water equal to that injected, returned unmixed with fæces. The attempt was therefore for the time abandoned, and she was ordered to take beef tea in small quantities, and no medicine.

She vomited the same kind of bilious watery fluid until ten o'clock at night, when her sickness ceased. She also made several efforts to empty the bowels, but discharged only a few ounces of a muddy water, corresponding pretty much with the quantity of injection retained. From this a scanty brownish sediment of faintly stercoraceous odour, was deposited on standing. At midnight she was free from pain, had a pulse soft, rather small, and 78, and complained much of borborygmi and flatulence. An enema tube was again introduced, and passed readily to the distance of fourteen inches, but no flatus escaped through it, and the attempt to inject liquid into the canal was less successful than before, since the first syringeful returned immediately.

7th, Meridie. Had a restless night, occasional pain in the abdomen, and a sense of choking from flatus which she was unable to expel. The aerial rumblings have also been loud and troublesome. Her tongue is moist, and thinly coated with ash-coloured fur; she is very thirsty, and has not vomited for fourteen hours.—Has had frequent desire to pass stool, and to make water, but the excretions are scanty and mainly urinous, a very thin sediment of whitish-yellow colour, and fœcal smell, being the only indication of alvine discharge. The abdomen is more distended, and the convolutions of the small intestines are marked upon its walls with curious distinctness.

10*th, Vespere.* Another attempt to inject the canal by the rectum was made this morning, but proved a complete failure. Since then her vomiting has recurred, and she has twice ineffectually essayed to expel something from the bowels. She has become extremely anxious and irritable, and complains of occasional severe pain in the abdomen. There is, however, no tenderness, nor does the system generally participate in her excitement. She was ordered to take 30 minims of liqr. opii. sedativus.

8*th.* Has vomited profusely during the whole night, the rejected matter having the same characters as that which has preceded it. Has passed nothing from the bowels, although the tenesmus and attempts at defecation have been frequent. The paroxysms of abdominal pain have been more severe, and the intervals between them of shorter duration. She is desponding, and her face is more pinched and anxious. She complains of soreness in the rectum from the introduction of the tube. Her pulse is 80, soft, and the respiratory and cutaneous systems are free from exalted action.

The increasing urgency of the symptoms, and the return of the injections having established the insurmountable nature of the obstacle, Dr. Blakiston requested me, as Surgeon of the week, to see the case, since it appeared to him, to be one requiring operative interference, and peculiarly adapted for the formation of an artificial anus in the loin. After examining the patient, and concurring in his opinion, I invited my surgical colleagues to meet me in consultation at eight o'clock in the evening, when it was determined to open the descending colon in the left lumbar region, as recommended by Calisen, and more lately practised by Amussat.

When the woman was laid upon her belly, the seat of this portion of the colon was distinctly marked by the great lateral distension of the loin, and the tympanitic resonance upon percussion. A transverse incision was made over it, extending from a point about two inches distant from the spine, directly outwards. This incision was four inches long, and was situated about one inch above the crest of the ilium. The latissimus dorsi and quadratus lumborum

muscles being divided, a mass of fat started out through the wound, and below this the bowel might be felt greatly distended. A sufficient proof that the peritonæal cavity had not been opened, was deduced at this stage of the operation, from the unbroken cellular connections of the gut with the adjacent parts, and the inability to pass the finger around it, from the wound. The projecting adipose tissue being next separated from the intestine with the handle of the scalpel, two strong ligatures were passed through the coats of the colon at a short distance from each other, and fastened to the lips of the external wound. An aperture, an inch long, was next made into the bowel, by a vertical incision between the two sutures, when a sudden rush of fœtid air took place, followed by the rapid expulsion of at least three pints of dark green semi-fluid and highly offensive fæces. The distension of the belly was soon relieved, but slight pressure of the hand upon it, caused the excrementitious liquid to pump out through the lumbar wound, like water from a fountain. The relief of the patient was immediate, but the suddenness and amount of the discharge produced faintness. She was placed in bed, and had a little brandy and gruel; warm wetted cloths were applied to the wound, and she was ordered to take directly thirty minims of liqr. opii. sedativus.

9*th*. Had a tolerable night, with short but refreshing sleeps. Her face is more cheerful, her tongue clean and moist. She has not vomited since the operation, nor has she felt any nausea. Her appetite, on the contrary, is rather inordinate, and she asks frequently for brandy to relieve her lowness. Her skin is warm, and her pulse 96, and compressible. She has had one copious evacuation from the loin, which contained hard fœcal masses, and was extremely offensive, besides several smaller and more liquid discharges. She has made water three or four times. Her abdomen is lessened in size, and from the flaccid state of the muscles, the intestines fall from side to side, with each motion of the body, constituting a source of discomfort. Some tenderness, on firm pressure, was felt in the left iliac region, but it was slight, and was not perceived in any other part. No matter of any kind has been voided by the rectum, nor has any inclination for this been felt. Her abdomen was lightly compressed by a bandage, in order to give support to the intestines, and prevent the irritation excited by their unrestrained motion.

10*th*. The evacuations from the artificial anus have been more numerous and recent. Their consistence is thinner, their colour yellowish green, and their smell less offensive. Her abdomen is to day, full and tympanitic, and very slight

tenderness is yet felt on the left side, just in front of the wound. The irritability of bladder continues, and the urine is scanty and high-coloured. Her breathing is easy, her skin warm and soft, and her tongue whitish and moist, but her pulse has been throughout the day very excitable: at 8. a.m. it was 98, at 11, a.m. 130, whilst this evening it is 100, sharp and small; she feels great lowness, and craves for wine. In consequence of the disposition to diarrhœa, she has been ordered arrow-root, beef tea thickened with isinglass, rice-milk, etc. and since morning has taken the following draught every fourth hour. Take of sesquicarbonate of ammonia five grains, of aromatic confection ten grains, of mint water an ounce:—mix.

11*th*. Was, at my morning's visit, going on most favourably. She said that she felt soreness of the belly, but no pain was complained of upon pressure. The support afforded by the bandage has been beneficial.—Six stools have been voided by the lumbar opening, in the course of last night and to day, all recent, bilious, and soft, though solid. Upon straining, in order to empty the bowels, she declares that flatus escaped by the anus. About eight o'Clock this evening she was attacked with shivering, which lasted for a few minutes only, and has been succeeded by perspiration. She felt no pain, but immediately after the rigor, some hard scybalœ were discharged through the wound. She feels nausea, but has not vomited. Her pulse is now, (10, P. M.) 132, and sharp, and her body is bathed in sweat.

13*th*. Has been going on well, without any recurrence of shivering. During the night of the 11*th*, two hard costive stools were voided, and pain in the wound was experienced, during their transit, which extended upwards to the left side of the chest. Since that time, her motions passed through the newly formed anus have been free, soft and yellow. She has had frequent inclination to void the excretion by the natural channel, and has expelled flatus twice, during her attempts to effect this. She has to day a happier expression of countenance. Her skin is cool, and moist, her tongue clean, her appetite good, and her pulse soft, 98; but she complains of lowness and sinking, with occasional shooting pain in the left side, and catching of her breath.—A careful physical examination of the chest, detects no morbid sign. Her abdomen remains tumid and resonant from aeriform distension. I this evening examined the rectum.—The tumour in the septum remained undiminished, and the lower part of the gut contained soft fœces: I accordingly introduced the colon tube for some eight inches, and injected a pint of tepid water, which after a few minutes, was rejected with a

moderate accumulation of soft, yellow, recently formed fœces, like that discharged from the upper aperture. None of the injection escaped through the wound, nor were the succeeding evacuations from this part more liquid. The edges of the wound gape widely, and display an ash-coloured surface, from patches of which the slough has been cast off, and a pale, feebly granulating portion exposed: there is scarcely any secretion from it. To have fresh meat daily.

16*th*. Her progress has hitherto been favourable. She has improved in appearance, since the 13*th*, her appetite has been good, and her tongue clean. She has passed regular and healthy stools by the aperture in the colon, and has been clystered daily, with the effect of bringing away small fæcal accumulations from the rectum. Her pulse has varied from 90 to 96, but her abdomen has continued tumid, the convolutions of the small intestines being perceptible through its walls. She has had constant, though slight moisture upon the skin, and the "catching" of her breath has been felt occasionally. Last night, she was seized with cough, and expectoration of thin frothy mucus, which disturbed her rest, and caused pain in the wound. She is this morning flushed, has a hot skin, and a frequent sharp pulse; her tongue is moist, and inclined to redness, and she is thirsty. Percussion of the chest yields equally sonorous responses on both sides; but, the vesicular respiration, though distinctly audible, differs in quality on the two sides, being rather loud on the right, distinct and feeble on the left. No rattles are audible. The cardiac region, as marked by percussion, is of natural extent, and the impulse and sounds of the heart are of a healthy standard. She was ordered the following draught every four hours:—Take of oxymel of squills, syrup of poppies, each half a drachm, of saline mixture an ounce:—mix.

In the evening, it was found that she had voided no stool throughout the day, and that some pain in the belly had come on, with urgent disposition, but inability to pass stool by the natural orifice; these efforts however, have been attended with several expulsions of air. Upon examining the wound, which has cleaned and is granulating, the aperture into the intestine was found closed by a small mass of granulations, projecting from the vertebral side, and forming a sort of valve to the orifice. It was moved from its position by the slightest traction upon the wound. A tube was passed from the loin downwards, towards the rectum, for ten or twelve inches, without the use of pressure, and about eight ounces of milk and water injected, when it began to return along the sides of the tube. Fæces being detected in the rectum, it was next passed up for ten inches towards the colon, and the same fluid again injected, but the

quantity retained was small, as it caused a painful feeling of distension, attended with expulsive efforts.

19*th*. Had a rigor on the morning of the 17*th*, unpreceded and unaccompanied by pain in any part of the body. It continued for an hour, and was succeeded by profuse sweating. The frequency of the pulse was then increased, and it has since remained above 100. The disposition to hectic is also shewn by the moist state of the tongue, the constant though limited diaphoresis, and the total absence of delirium. Her stools have been voided through the upper aperture, and daily injections have emptied the rectum of small quantities which had gradually collected in it. Her cough has been improving. She is, however, still feverish, her pulse is 120, and sharp, her skin hot and moist, and her cheeks flushed; her tongue remains red, her thirst continues, and her appetite, which has been somewhat impaired, is improving.—Her abdomen has been lessened in bulk, but is to day full and doughy, without tension, or tenderness. She has passed only one stool from the wound in the night, and that a very scanty one. A tube was again introduced through the wound, and carried downwards for fourteen inches, without meeting any obstacle, whilst an examination of the vagina and rectum was made at the same time. The tube could not be felt through either canal; but when slight pressure was made with it, the uterus and morbid growth were simultaneously depressed, and approached the external parts, as though pushed before it. A coloured injection was thrown in from above, but none passed into the rectum.

She was ordered to take a table spoonful of castor oil, and after this had operated, two table spoonsful of infusion of roses every four hours.

21*st*. The castor oil operated freely yesterday, and the bowels being thus unloaded, again rendered the belly pendulous, requiring support by external compression. Her cough has been troublesome, and coarse mucous with sibilant rattles have been audible over the whole chest, with the expectoration of a frothy watery, and non-adhesive mucus. She was better this morning, and conversed with some spirit: her pulse was 100, and her skin was cooler and dryer. Her bowels had been scantily moved in the night, and felt full, in consequence of which another dose of castor oil was given. At my night visit, I found her highly delighted, having *passed two copious, soft, healthy stools per anum*, without the use of the lavement, besides several free, liquid evacuations from the wound. There seems, however, to be a deficiency of reparative action, since the surfaces of the incision, though clean, are pallid and feeble, and the granulations large and flat; its extent too, is scarcely, if at all, diminished.

23*rd.* She yesterday voided three scanty, but healthy and recent stools, by the natural outlet, and only one by the wound. Her cough was less troublesome, and the bronchial rattles had disappeared. This morning the bowels were again relieved by a scanty stool from the anus, and at about 11, a. m. she was got up to the night chair, was seized with shivering which lasted for a few minutes when she complained of faintness, and vomited some fluid like coffee, mixed with a little bilious mucus. During her faintness, a large collection of fæces escaped from the wound, and a smaller quantity from the anus. I was immediately summoned, and found her pale and exhausted, with a pulse feeble, irregular and flickering, and a cold clammy skin. After the application of warmth to the surface, and the exhibition of a little hot wine and water, she rallied, and has since complained of pain in the epigastrium, which is tender on pressure, and sickness. She has vomited once, the fluid being dark coloured. Her pulse has risen to 132, and is sharp and small. Her skin is cool and dry, and her tongue moist. She still complains of lowness. The abdomen generally is full and soft, quite free from tenderness. The distension seems to be more uniform, and the furrows caused by the subjacent intestines less distinct. Has voided a thin watery stool, per anum, since morning, but none has escaped through the artificial opening. To have warm brandy and water, a dry fomentation to the belly, and one grain of solid opium directly.

24*th.* Had a good night, but is evidently sinking. Her face is pale, pinched, and hippocratic; her respiration frequent, cough almost suppressed, and her pulse small, 150. Her skin is now cool and dry, but the nurse informs me, that she perspired profusely in the night. Her tongue is moist and white, and she has nausea without vomiting. She still complains of epigastric pain and tenderness, whilst her abdomen, though full and tumid, is quite free from pain, and bears pressure well. Has passed no evacuation since the preceding report, from either aperture. The wound has a peculiar aspect; its surface has become smooth and glassy, and its colour presents a strange combination of pallor with lividity, whilst the perforation of the colon is marked by a prolapse of the mucous lining of the gut, of deep purple colour, forming two pouting lips. About eight ounces of water were injected by the colon tube from the rectum, part of which escaped through the wound. This lavement returned shortly afterwards, unattended with fæces. Her prostration increased, and despite the administration of diffusible stimulants, she died about three o'clock in the afternoon.

SECTIO CADAVERIS, TWENTY HOURS AFTER DEATH.

The head was not examined.

Chest. The pleural cavities presented no deviation from health, excepting an intimate adhesion between the investing and reflected portions, at the base of the left lung, by ancient, short membranous bands. The lungs were slightly congested behind, from post mortem gravitation, but their parenchyma was healthy, and entirely free from adventitious deposit. The bronchial mucous membrane was slightly injected, and puffy in some parts, and the tubes contained some frothy mucus. The pericardium and heart presented no trace of disease.

Abdomen. The *parietal peritonæum* was universally thickened and opake. In some of the more translucent parts, the subjacent vessels were seen to be unusually large and injected. This opacity was pearly, and was not accompanied by any recent plastic effusion, excepting in the epigastric region, where thin, soft, filamentous bands, passed from it to the liver. Its cavity contained about a pint and a half of thin, serous pus, part of which was lodged in the iliac and lumbar fossæ, but mainly in the true pelvis. The *visceral peritonæum* was the seat of corresponding changes. Where investing the liver, it was thick, opaque, and thinly coated with patches of lymph, some of which were recent and rough, from having been torn in opening the belly. The splenic portion was considerably thickened, adhered intimately to the diaphragm, and, like the liver, had layers of recent lymph upon its surface. Over the stomach, and anterior layer of the great omentum, its surface was uneven from thin laminæ of lymph, of some standing, which adhered firmly. The vessels of the omentum were also congested. In that part of the serous membrane which invests the small intestines, increased vascularity and thin deposits of lymph were also seen, and a few convolutions of the ileum on the left side, presented the same deposit in a rounded granular form, whilst the opposed surface of the great omentum had undergone similar changes. When the omentum was raised from the intestines, and turned upwards over the stomach, the cæcum was found lying on the left side of the spine, towards the left lumbar region, being apparently pushed into this position, by the distension of the small bowels situated below, and to its right side. Upon replacing the omentum, a portion of the transverse arch of the colon was found to pass immediately in front of the cæcum. The small intestines and caput coli, were distended by air, whilst the large intestine beyond this point, was contracted, and contained only

a very small quantity of fæces. The descending colon at the point opened, was firmly adherent to the muscles of the loin, and required dissection for its separation. In effecting this attachment, it had become drawn backwards so as to form an angle inclining towards the loin. The peritonæum at this part was most accurately examined. Its integrity was perfect, and it exhibited no greater amount of inflammatory action, than any other portion of the membrane. The sigmoid flexure of the colon lay coiled in its natural position, but immediately below the brim of the pelvis, the rectum became lost in a hard mass, partially surrounding it, though mainly occupying its anterior aspect in the recto vaginal septum. This growth, upon a more careful examination, was found to consist of scirrhous matter deposited in the loose cellular textures of the septum. It was intermixed with condensed fat, and reached from within a short distance of the fundus, downwards in the recto vaginal septum, to at least an inch below the os uteri. The rectum, at the upper part of this mass, and about ten inches distant from the anus, was contracted in its calibre, by a carcinomatous thickening and conversion of its coats. The length of the stricture was about four inches. Its margins were formed by two smooth, thick, and elevated lines, arising from the deposit of cancerous matter, in the submucous cellular tissue. They were red, and vascular, especially the lower. The interior of the gut, in this space, presented patches of ulceration, and in two or three places, a dark brown softening had commenced, and formed small cavities, from one of which a sloughy sinus extended deeply into the interior of the recto vaginal tumour. The textures of the bowel in the scite of the contraction, were intimately incorporated with the carcinomatous tumour, whilst its connection with the uterus, though close, was yet separable by the knife. The amount of constriction of the bowel was not very great, since the middle finger could be passed through it. The structure of the rectum, above and below, was quite healthy, as was that of the intestines generally. The descending colon at the point of operation, presented an aperture nearly an inch long, of semicircular form, with rounded edges, owing to the prolapse of mucous membrane through it. Its colour was natural, excepting around the hole, where it had an uniform pink tinge. The aperture was oblique with regard to the axis of the colon, and did not occupy more than a sixth of the calibre of the tube, in its contracted state. The folds of the mucous membrane converged towards it. The interval between its upper angle and the left kidney was about three-fourths of an inch. The Liver was large, healthy in structure, but dark in colour from venous congestion. The Spleen was also dark, purple, and finer than usual in its consistence. The Genito-urinary apparatus was quite healthy.

REFLECTIONS.

THERE are some points in the history and progress of the case which appear to be worthy of remark, and which I shall now comment upon as they occur in the very faithful daily notes and observations which have been kept for me, by Mr. Alfred Baker, the Resident Surgeon of our Hospital, whose accuracy of research, diligent and untiring perseverance in the exercise of the various arduous duties of his office, entitle him to this public testimony of my friendship and esteem.

The obstructing medium was of slow growth. The early history shews that the woman had a similar attack eight months previously, and then suffered from constipation for more than three weeks, which bade defiance to medical treatment, and must have terminated fatally, had not a profuse diarrhæa come on spontaneously, by which she was relieved from symptoms of obstruction. This statement, when connected with the subsequent imperfect and irregular action of the bowels, is strongly confirmatory of the tardy progress of her malady. Whether any slow disease had been insidiously progressing before that period, could not be ascertained from the replies of the patient; but even supposing the constipation to have arisen in the first instance from acute disease, the after symptoms shewed that it had passed into the chronic form, and had never entirely disappeared. Its simple or malignant nature was a matter of some doubt, for whilst the age was favourable to the developement of those deposits termed malignant, such an idea was contra-indicated by the fresh pencilling of the cheeks. The emaciation was explained in either case by the mere check to nutrition, arising from the rejection of all aliment from the digestive tube.

The seat of obstruction was not evidenced by the report of her previous illness, and hence the diagnosis was necessarily formed upon the examination of the pa-

tient at the time of her admission. Indeed the brief notes of her state just before admission were scarcely so precise and positive as might be wished, for her memory seemed to be impaired, and she had lost the recollection of her former illness in the consciousness of severe and present affliction. From this cause, her dates on important points sometimes varied, and the account must therefore be only considered as an approximation to truth.

The length of time, three weeks, for which constipation existed without vomiting, gave me the impression that the impediment to fæcal discharges occupied a position low down in the intestinal tube. This idea was strengthened by the egesta when sickness commenced. The fluid was watery, mucous, and faintly bilious; appearances which led to the supposition that the main fœcal accumulation was at some point beyond the ileo-cœcal valve, which thus offered resistance to regurgitation during the retro-peristaltic movements, A further corroboration of this opinion was afforded by the external examination of the abdomen, through the attenuated walls of which cavity, the distension of the great as well as the small bowels was clearly shewn. The convolutions of the lesser intestines in the middle of the belly separated them pretty distinctly from the dilated colon, which projected each lumbar and iliac region considerably beyond its customary plane. This distension was more marked on the left than on the right side, proving the permeability of the tube thus far; and as the belly yielded sonorous responses on percussion, the scite of the obstruction was now limited to some point below the brim of the pelvis, and consequently within its true cavity.

The tumour felt in the recto-vaginal septum, was clearly connected with both the uterus and rectum, but its nature and point of origin were doubtful, owing to the inability to reach its upper margin. It was evident that it did not compress the rectum sufficiently to produce an obstacle to the fæces at any part within reach of the finger; and the easy and unresisted transit of the colon tube to the extent of ten or twelve inches, rather pointed to some impediment above the tumour, whilst the return of the fluid injected, located this barrier very near to the extremity of the tube.

When, therefore, the inefficiency of enemata had been fully proved,—when the symptoms increased in severity,—when Dr. Blakiston, the physician under whose care she had been received, had judiciously determined that further medical treatment was unavailing,—the operation was proposed to the patient, acceeded to, and immediately performed in the presence of my Colleagues. The woman was laid on her face, the abdomen being raised by pillows, when the

situation of the left colon became most distinctly marked by the uniform bulging of the loin. From the attenuated condition of the patient, I had a comparatively small depth of cellular and muscular tissue to divide, before a mass of fatty substance protruded, which was recognized as a portion of the adipose membrane surrounding the kidney. A careful separation of this by the finger and scalpel exposed the distended colon, which was secured and opened, as described in the report of the case.

Whilst speaking of the operation, I must not omit to notice the value and importance of making a free external incision. When the integuments, subjacent fascia, and superficial layer of muscular fibres, are thus liberally divided, the subsequent steps of the operation are greatly facilitated, and the dangers which might otherwise result from the retention of the fæculent matters, or their infiltration into the surrounding tissues, are diminished.

The subsequent notes of the case, shew how immediate was the relief which followed the formation of the artificial anus, by the disappearance of every grave symptom. The digestive organs, now competent to prepare nutrition for the body, resumed their functions with inordinate alacrity, and so urgent were the calls of hunger, that great firmness was required in restricting the supply of food within due limits. To this cause—the activity of assimilation,—in conjunction with the liquid form in which nourishment was administered, may be attributed the diarrhæa, which commenced on the second day after the operation, since the evacuations presented characters which could leave no doubt of their recent formation. The curious variability in the frequency of the pulse at this period, is worthy of notice. It arose, doubtless, from irregular nervation, produced by exhaustion from purging.

A reference to the daily reports will also illustrate the atonic condition of the muscular fibres of the intestines, which do not appear to have regained their customary contractility, during the patient's life. It is probable, that their distension may, especially in the latter stage of her disease, have arisen from altered secretion as well as from atony, since their convolutions were distinctly visible through the abdominal walls, until within two days of her death; and the resonance on percussion had, until that time, been clear and tympanitic.

It will be observed, that until the third day from the performance of the operation, every sympton was favourable. A rigor then occurred, which was supposed to have been excited by the transmission of some hard fæces through the aperture in the colon. This was, however, succeeded on the fifth day by pain

in the wound, and in the inferior part of the left side of the chest, with some catching of the breath. There was no constitutional disturbance attending these symptoms, and a careful examination failed in detecting active disease, either in the thoracic or abdominal cavities. On the eighth day, a troublesome, but mild catarrh attacked her, and was ushered in by fever, with perspiration. The following day brought with it a second attack of shivering, succeeded by profuse sweating; and although remissions of her symptoms did now and then occur, I may safely remark, that from this period, the case never wore a satisfactory appearance. It was clear, from her condition, that suppuration was going on somewhere; but it was a more difficult point to determine the exact locality of morbid action. An examination of the chest excluded it from my suspicions. The wound presented no trace of inflammation nor purulent deposit. In short, by pursuing a system of negation, as well as by reflecting upon the greater disposition that its contents would acquire to light up inflammatory action, after intestinal obstruction, my supicions were directed to the abdominal cavity; but even when thus limited, the seat of disease was still obscure, for the dilated intestines, by diffusing the contained fluid thinly over their surface, or confining it to the Pelvic cavity, prevented the discovery of any effusion; whilst the absence of pain and tenderness on pressure, until the day before her death, and its restriction then to the epigastrium, conduced to a still further concealment of the extent to which the peritonæum was involved.

No one acquainted with Pathology will be inclined to dispute, that the appearances found in the serous membrane of the abdomen after death, were the result of a slow, continued, and insidious inflammatory process; the symptoms of which, like those of similar affections of the serous membranes of the chest, are too often latent or obscure. The pearly opacity, the universal thickening, and the patches of granular deposit, found upon parts of its surface, sufficiently stamp its nature. The epigastric pain and tenderness, with the previous, and then inexplicable pain in the left side, and "catching of the breath," were amply accounted for by the recent deposits of lymph upon the surface of the liver and spleen; and the union of this latter organ with the diaphragm. With regard to the purulent fluid found within the peritonæal cavity, it was the thin serous pus, arising from chronic derangement of its secreting apparatus, and not the rich healthy matter poured out by this membrane under acute inflammation.

In the treatment of the case, it will be seen, that so soon as a small quantity of fæcal matter had passed through the obstructed portion of the rectum, which was on the fifth day, attempts to re-establish the permeability of the gut by mechanical

distension were commenced. The injections employed for this purpose removed the soft stercoral accumulations below the stricture, but were not retained in large quantity, and do not appear to have passed *through* the contracted part, since the fluid, coloured with this express object, never escaped from the lumbar aperture. The situation of the stricture, about ten inches from the anus accounts for the small quantity of injection retained, and explains the return of the enemata, even when the tube was introduced for twelve or fourteen inches, since the diseased part would be pushed upwards by the tube, and the rugæ of the mucous membrane obliterated, whilst the obstruction would remain the same. That the calibre of the diseased portion did eventually become somewhat greater, is rendered probable by the copious evacuations through the natural outlet at an advanced stage of the case; but whether this increase of capacity was attributable to the removal of the deposit by ulceration on its inner surface, or to an actual dilatation of the stricture by the use of the colon tube, cannot be positively determined. A still further doubt is thrown over this subject, by the possibility that the gradual return of contractile power in the muscular coat of the colon, when relieved of its over distension, might alone be sufficient to enable it to propel its now soft stercoraceous contents through a stricture, which does not appear from the post mortem examination to have closed the canal completely. The injections were practised from the artificial aperture as well as from the anus; and it was during one of these processes, that the tube, having been passed to a considerable depth, was found to have pushed downwards the uterus and the tumour towards the external parts, whilst it could not be felt by the finger, either in the rectum or vagina. This circumstance was not accounted for until after death, when a cavity or sinus was found penetrating the scirrhous tissue in the recto-vaginal septum, into which the point of the tube had probably been inserted without pressure, owing to the process of softening which the central parts of these tumours so often exhibit.

The displacement of the cæcum described in the dissection, may perhaps be regarded as an argument in favour of Amussat's opinion that the right colon is more subject to variation of position than the left; but, it must be remembered, that the seat of this portion was marked before the operation by unequivocal signs, and I have no doubt that it changed its situation immediately after, and as a result of the operation.—It may be thus explained. The entire length of the large intestine would be emptied rapidly of its contents, after the aperture was made, and would consequently collapse; whilst the small intestines, unable to force their contents so quickly

through the ileo-cœcal valve, would naturally come forward in front of the empty cœcum, and being yet full would stretch themselves to the right side, overlap it, and push it inwards towards the median line, where, not being afterwards subjected to inordinate distension, it would remain. I must at the same time state my belief that such a transposition of cœcum can take place only when it is nearly empty.

The examination of the parts connected with the operation was most satisfactory. The peritonæum was entire, and free from injury. The interior of the colon presented no trace of inflammatory or other morbid process. The aperture into its cavity was capacious, whilst the condensation of the cellular structure around it, and the firm adhesions which had been formed between its edges and the lumbar muscles, prevented their separation, excepting by a tedious dissection, and furnished additional evidence to that already advanced by M. Amussat, of the possibility of opening the lumbar colon without penetrating the abdominal cavity, and without injuring any important organ. His operation is one of easy performance, and free from those dangers which have hitherto surrounded the Surgeon when applying the rules of his art to cases of obstruction in the intestinal canal, or deficiency of the anus from congenital malformation.

Mr. Clements of Shrewsbury, established an artificial anus, by opening the colon of a person in his neighbourhood, in the month of October, in last year. Through his kindness I am enabled to give the following brief particulars of his case, which it is his intention to place more fully before the Public, at the next meeting of the District Branch of the Provincial Medical and Surgical Association.

His patient was a female who had laboured under constipation of the bowels for sixteen days. Her belly was greatly distended, she had hiccough and vomiting, which for four days before the operation had a fæcal character. From the inefficiency of all medical treatment, and from reasons drawn from certain local signs, Mr. C. determined to open the colon in the right loin. The relief was instantaneous, and fæcal matter and flatus escaped abundantly from the wound. The progress of the patient was most satisfactory. In six weeks after the operation, the new anus was quite established, and the woman was able to walk a considerable distance. In the seventh week, the cause of the obstruction, previously doubtful, was ascertained by the occurrence of an attack of colic, followed by the expulsion of a large number of plum-stones from the bowels.

This case is exceedingly interesting, not only on account of its success, but

also, because it combats certain doubts which have been advanced, as to the practicability of thus opening the ascending colon, without injury to the peritonæum.

In illustration of this part of my subject, I shall refer to the valuable remarks of M. Amussat, made before the Royal Academy of Medicine in Paris, who, after cursorily reviewing the anatomical relations of the parietes of the lumbar regions, proceeds to discuss the peculiarity of their connections with the corresponding portions of the colon. Speaking of the left colon he says, we find upon attentive examination, that the intestine is destitute of peritonæum in at least its posterior third, being here surrounded by a cellular coating, continuous with that which lies upon the outer surface of the serous membrane. The three bands of longitudinal fibres may, in the lumbar colons, be described as anterior, internal, and external; and by measuring the space between the two latter fasciculi, we may ascertain the dimensions of the part uncovered by peritonæum, since they point out the lines at which this membrane is reflected from the bowel upon the walls of the belly.

With regard to the right colon, he reports that he has never yet found a lumbar meso-colon, although, when the intestine was contracted, the interval between the two folds of peritonæum has been sometimes very small. At the same time he observes, that whilst the ascending colon acquires from this arrangement a greater degree of mobility than the descending, he has never yet found it possessed of a mesentery so perfect as to render it floative in the abdominal cavity. Admitting, therefore, that this objection may be urged against an attempt to perforate the right colon, when empty, it will not necessarily constitute a sound argument against such an operation when the bowel is distended.

We have all been taught the trite axiom, that the peritonæum is a large bag, containing nothing besides its own exhalations. It is, however, intimately connected with the organs behind it, and when the lumbar colon, which is thus related to it undergoes dilatation, this membrane becomes more closely applied to its anterior surface, whilst the points at which it is reflected from the sides, are more widely separated by the lateral jutting of the bowel during the act of distension.

Whilst these changes are going on from the progressive accumulation of alimentary matters within the gut, its increase of size is chiefly manifested in front, because little resistance is offered to it in this direction. Hence we might perhaps expect to find that its connection with the loin would be impaired, if not destroyed. The occurrence of this is however prevented by the elasticity of

the serous membrane stretched over it, by the uniform support given to the contained organs by the muscular parietes of this cavity, and by the resistance offered to such a disunion by the strength of the cellular adhesions existing between the colon and the lumbar fossæ. The combined effect of these agents retains the bowel in its natural position more firmly than under ordinary circumstances, and from their mode of action, I am induced to believe that the colon of either side will be fixed with greater or less firmness in its lumbar fossa, in a ratio corresponding with the amount of its distension. The greater length of serous attachment on the right side, appears to me to endow this portion of intestine with greater capacity for bearing dilatation rather than with latitude of motion when distended. Unless freedom of motion is thus prevented under these circumstances, I cannot see in what manner we are to explain the backward bulging of the loin in those patients subjected to the operation. The only instance in which this did not occur, appears amongst the cases related by Amussat, and he himself furnishes a symptom which will probably characterize all such cases. In his second operation, after describing the preliminary steps, he states, that the left loin immediately projected, but much less than in his former patient; and *more outwards.* We do not therefore feel surprised, when he goes on to tell us, that after completing his incision through the integuments, muscles, and fat, he ascertained that the projection was formed by the small intestines covered by peritonæum, whilst the colon being contracted, lay hidden beneath the outer edge of the quadratus lumborum.

The same phenomena are daily witnessed in the bladder when retention of urine occurs, for we know that this viscus not only ascends above the brim of the pelvis, carrying upwards the peritonæum, and separating it from the abdominal muscles, but also that it at the same time becomes more fixed and immoveable, distending the perinæum, and encroaching upon the cavity of the rectum, so as to form a distinct bulging which is penetrable by a trocar without danger of wounding the serous membrane.

The practicability of applying this method for the formation of an artificial anus on the right side, was proved by the published account of M. Amussat's operations, and receives further confirmation from the success which has attended the proceeding in the hands of Mr. Clements.

The merits attaching to M. Amussat's modifications of this surgical proceeding, have now been tested by eight cases; and from the success which has attended them, it may be fairly placed amongst the list of standard and established operations.

Its facility of execution, and the power which it gives to us of forming artifi-

cial outlets for the contents of the bowels, without wounding the peritonæum, and consequently without endangering the occurrence of infiltration, or peritonitis, are advantages not presented by any other operation, and which stamp it as one of the most important improvements in modern surgery, whilst its aptitude for the removal of peculiar and distressing complications in various diseases, will attract towards it the attention and approbation of the profession.

In order to describe the nature of the cases in which the surgeon may adopt it with utility, we must regard it in two points of view,—as a curative, and as a palliative proceeding. As a curative measure, if so it may be termed, when applied to remedy mal-formations, its performance may be demanded in those cases of imperforate anus, in which, from the absence of the signs usually denoting proximity of the lower end of the rectum to the surface, we are led to infer that it forms a cul de sac, high up in the pelvis, or that its sides are adherent; an aperture thus made into the descending colon will afford a more easy, more speedy, and less dangerous mode of remedying the defective developement, than the deep, difficult, and consequently tardy dissection of the perinæum. It at the same time will be so low down in the intestinal tube, as not to interfere with the perfect nutrition of the body.

As a merely palliative mode of treatment, this operation admits of a more extended application. With this view it may be performed in cases of chronic disease in the coats of the large intestine causing stricture, in some instances in which foreign bodies are impacted in the canal, and attended with urgent symptoms of obstruction, as well as in those cases wherein a barrier is created to the evacuation of the bowels, through compression made upon them by tumours or enlargements of other organs in the same cavity.

By some practitioners it may be considered that we are scarcely justified in recommending any operation in cases of malignant disease, for the mere relief of urgent symptoms; but when we reflect upon the fatal nature of these symptoms, when we remember that an alteration is thus made in the course of the excrementitious matters, by which a source of constant irritation is removed from the morbid growth, and that in consequence of this, its increase may be suspended and retarded, and life thus prolonged for an indefinite period, it can scarcely be necessary to adduce any arguments in favour of its performance.

The following short notes of two cases, illustrate the course and termination of obstruction in the colon from slow disease, commencing in, and limited to, its proper textures.

About twelve years ago, I attended Mrs. R.——, aged 45, who laboured under obstinate constipation, hiccough, distended belly, and stercoral vomiting. The abdomen was furrowed on the surface, from the ropy coils of small intestine beneath. A constant decantering of fluids (if I may use such a form of expression) was taking place between different convolutions, and the dilated cæcum projected the iliac and lumbar regions on the right side, in a marked degree. After a continuance of all these symptoms for three weeks, she died. On examining the body, I found the small intestines and cæcum enormously distended with thin fæculent, and gaseous matters, whilst the whole colon beyond was contracted. The cæcum which lay in the right iliac fossa, was eight inches in length, between four and five inches in breadth, and twelve inches in circumference. At its upper part, or rather at the commencement of the ascending colon, the gut was suddenly contracted by the deposit of some firm substance between its coats. The stricture was narrow, as though a ligature had been tied around it, and the aperture of communication between the colon and cæcum was reduced to a mere slit, about three-fourths of an inch long, and one-fourth wide. The opening of the ileum into the cæcum was larger than common, and its valves were enlarged, but healthy. An idea of the relative dimensions of these two apertures will be gained from the sketch seen on the fourth plate, which was taken from the dried bowel.

The second case occurred in the practice of my friend Mr. Russell, who has obligingly favoured me with the following report.—

Miss M———s, had been subject for a long and indefinite period to occasional obstruction of the bowels, attended with pain, which was always relieved by the discharge of more or less dark coloured blood, after which the pain ceased, and the bowels acted. In the intervals between these attacks, her health was good. On the first of September, 1832, she was confined to bed by griping pain in the belly, which was tender on pressure. She had passed one stool the day before, her pulse was quick, her skin hot, her tongue furred and white, and her thirst urgent. A mercurial bolus, followed by a saline aperient was prescribed, with fomentations to the belly. At night, vomiting came on, but the bowels had not been relieved. A cathartic enema was given, the liquid changed to a solid aperient, and an effervescing mixture ordered to relieve her thirst.

On the *2nd*, the sickness, abdominal pain and tenderness were relieved, but the bowels remained constipated; a drop of croton oil was given every hour, by the mouth, and an enema every fourth hour. In the evening, she was found to have passed a quantity of dark thick blood per anum, from which she had derived relief.

On the *3rd,* she was worse; the vomiting had ceased, but the belly was more tender and distended by flatus. She was bled largely, and retained a dose of castor oil. The cathartic injections were changed for assafætida. During the day, she again passed some thick blood from the anus, and in the evening felt better.

4th, She was seen by Dr. Darwall. The same symptoms continued, but her abdomen was more distended. Turpentine frictions were applied to the belly, and a tobacco clyster injected. This soon returned, having produced great faintness and relaxation. It was afterwards repeated with the same effect. Turpentine enemata were then substituted, with repeated doses of aloes and hyosciamus. The severity of the symptoms now increased; the constipation was insurmountable, the belly became more and more distended, the sickness recurred in the morning of the *7th,* stercoral matter was vomited, and she died at ten o'Clock at night.

On dissection, the entire intestinal tract, as far as the sigmoid flexure of the colon, was found exceedingly distended with flatus. Portions of the ileum were very dark in colour, and tore upon the slightest touch. The cæcum and colon were enormously dilated, but this dilatation ceased suddenly just above the sigmoid flexure. Here a hard circular band was found constricting the canal so as to barely allow the introduction of the finger. It was dense, and appeared to be a deposit of scirrho-cartilage. The mucous membrane was ulcerated at this point, and had doubtless furnished the blood which had been from time to time discharged. The peritonæum did not present a trace of inflammation.

In the first of these two cases it may be imagined that the situation of the stricture of the descending colon, would preclude the patient from deriving the full measure of relief, which the operation under discussion is calculated to afford. But from my remembrance of the post mortem examination, and the projection of the distended cæcum above the crest of the ileum, I am convinced that little or no difficulty would have been experienced in perforating this portion of the intestine through an incision in the loin.

In the second, which is more minutely recorded, the early symptoms and the course of the disease clearly directed attention to a chronic obstruction in some part of the intestinal canal, and the bowels showed how invincible was the obstacle. The state of the small intestines after death, displayed the effects of a slow and unremitted process of distension, which had thinned and softened their coats, at the same time that it had lessened the cohesion of their constituent particles.

Both of these persons would unquestionably have been proper subjects for the formation of artificial fæcal apertures, had such a proceeding, at the time of

their occurrence, been freed from the dangers which are acknowledged to attend wounds made into the great serous cavity of the abdomen.

I shall now relate in few words, the history of a case, in which a tumour commencing in the bladder or cellular membrane around it, produced symptoms of stercoral obstruction, by the pressure which it exerted upon the upper part of the rectum: and I have again to acknowledge the kindness of Mr. Russell in supplying its leading features.

Mr. R. says, I first saw Mr. S—— on the 23rd of September, 1840. He was an elderly man, more than 70 years of age. He had been an invalid for a long time, and had been under the care of Sir B. Brodie, Mr. Hodgson, and others. His countenance was anxious, and expressive of suffering, and he was much emaciated. He complained to me of great difficulty in passing his urine, which was voided in very small quantities, and occasionally contained blood, sometimes in a liquid, at others in a solid or coagulated form. This hœmaturia had been formerly very great in its amount. He complained of total inability to procure evacuations from the bowels, and his abdomen was amazingly distended by flatus, within the intestines. His rectum had been examined by Mr. Hodgson, who could not discover any obstruction in it; and as the examination was attended with great pain, I did not urge a repetition of it. O'Beirne's tube had been used without relief. He could not bear large injections, which produced intolerable suffering, as also did the employment of any force in the propulsion of enemata. He had, by the direction of Sir B. Brodie, taken the Infusum Diosmæ, and thought that his urinary symptoms had been somewhat relieved by it. Medicine, however, had failed in effecting any permanent improvement. He occasionally passed per anum, a small quantity of what he called mucus: this was generally followed by an escape of flatus, from which he experienced temporary relief. The constipation continued, but he had very little sickness, until within a few days of his death, when it became more urgent, and the distension of the intestines increased, so that the whole course of the colon could be distinctly traced through the parietes of the abdomen. He died, January 3rd, 1841.

His body was examined on the following day. There were no traces of inflammation on the parietal, or visceral peritonæum. The colon was enormously distended in its whole extent, and the transverse arch lay over, and concealed the contracted stomach. On tracing the small intestine, the ileum was found adhering to a large tumour, which occupied the lower and pelvic portion of the abdomen. This tumour was situated between the bladder and rectum, and compressed the intestine just be-

neath the sigmoid flexure of the colon. The high position which it occupied had prevented its detection when the rectum was examined by the finger. When cut into, it was found to contain a substance very like congealed size. The bladder was very small, and had an ulcerated aperture in its upper part, communicating with the interior of the tumour. The kidnies were very small, but healthy in structure, and deeply imbedded in a mass of condensed suety fat.

I have recorded this case, rather as an example of that class of diseases in which symptoms of stercoral tympanites may arise from compression of the bowel by tumours on its exterior, than as an instance in which an operation for artificial anus was required. The patient, from his age, from the exhaustion produced by successive hæmorrhages, as well as from the absence of any very urgent symptoms, appears never to have presented a favourable moment for the performance of such an operation. The source of the hæmorrhage, and the pathological condition which gave rise to it, are shown by the appearances of the diseased parts after death. It is evident that the tumour was of a fungoid character, and that the blood escaped during the process of ulceration which ultimately led to a fistulous communication between the bladder and morbid growth.

Several other cases occur to me, and similar ones will be remembered by most Surgeons who have been long engaged in practice, in which the symptoms of obstruction and inverted peristaltic action in the bowels, were as urgent as those which characterised the two first of these cases; and in which the result was, as in them, fatal. We must all therefore rejoice at the fact, that an effectual and safe method has been at length proposed, for the removal of that state which is so eminently dangerous to, and incompatible with, the maintainance of life.

It must not be thought, from the foregoing remarks upon the excellencies of an operation which is yet new in this country, that incision of the intestine is to be indiscriminately resorted to in cases of stercoral obstruction. On the contrary, it should never be performed, unless a mature reflection upon the history of the patient, a careful examination of the present and individual symptoms, and ample proof of the impossibility of overcoming the impediment by medical or other surgical means, have impressed the mind of the Practitioner, with a firm conviction that such an operation offers the only terms upon which the life of the patient can be purchased.

Having, however, decided these points, the Surgeon will find that the method of Callisen, thus modified, has supplied a great hiatus in the resources of Surgery, and has enabled him to suggest a remedy, free from intrinsic danger, to a human being who must otherwise sink, unaided, to the grave.

A fair representation of the inconveniences which must arise from the formation of an artificial anus, should be always made to the adult patient, before commencing the operation, for most persons are accustomed to view such an aperture, as an infirmity in itself so loathsome and disgusting, that they would entertain insuperable objections to submit themselves to its performance.

Now although the attendant inconveniences do, and must detract, in some measure, from the sum of human happiness, by interfering with the social habits of man; yet they are not so numerous and disagreeable as may be thought. The situation of the aperture, when made according to this method, is such as enables the patient to cleanse and perform all the offices required for it, without assistance. The fæces themselves do not possess the common odour of these discharges, because they are voided before reaching that portion of the intestinal canal, in which their peculiar smell is acquired, whilst the involuntary escape of gaseous and solid matters may be prevented, by the application of a pad or truss, over the opening. When we add to this the fact that such a proceeding will be rarely required, excepting by persons whose previous illness has accustomed them to an abridgement of those gratifications which arise from social intercourse, we may, I think, fairly say, that the prolongation of life which it offers to them, is more than equivalent to the unpleasant results of the operation.

In conclusion. I believe that nothing has been stated in elucidation of its practicability, and peculiar advantages, which is not borne out by facts; and if this pamphlet should attract to it the attention of the Profession, and thus conduce to its more general adoption, I shall not regret its publication.

FINIS.

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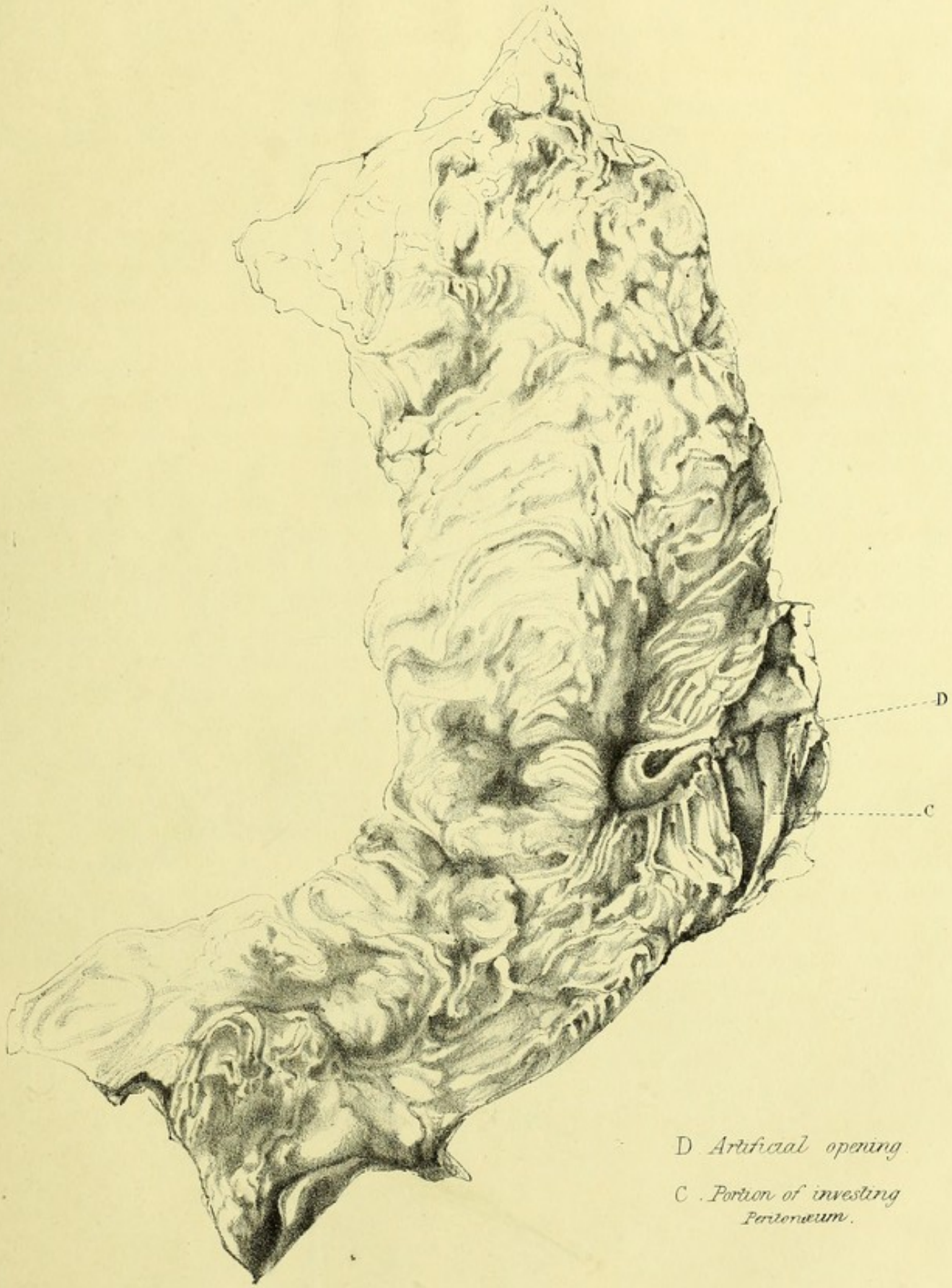
Interior of left Lumbar Colon.



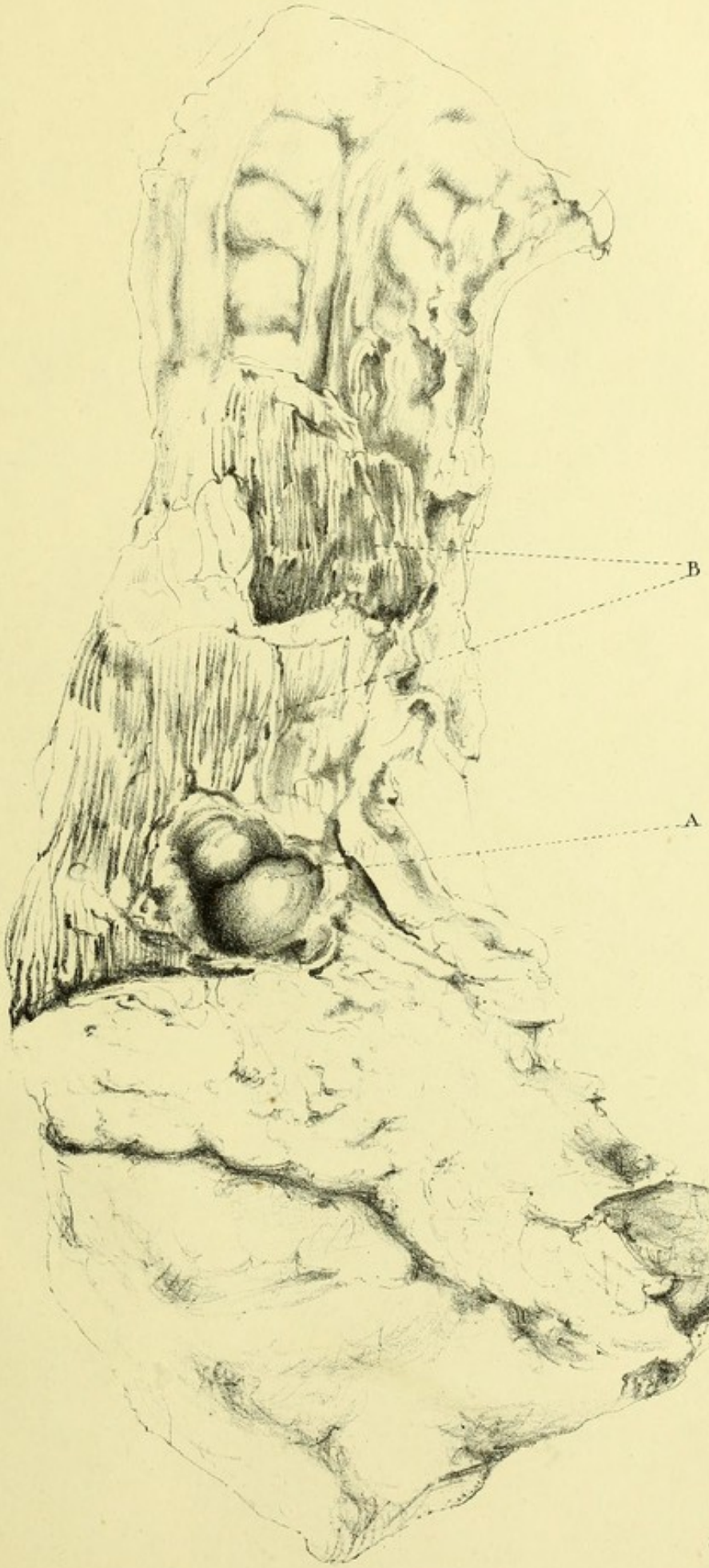
D *Artificial opening*

C *Portion of investing Peritoneum.*

A. Jukes, del.ᵗ

R. Moody, Lithog. Birm.ᵐ

Exterior of left Lumbar Colon

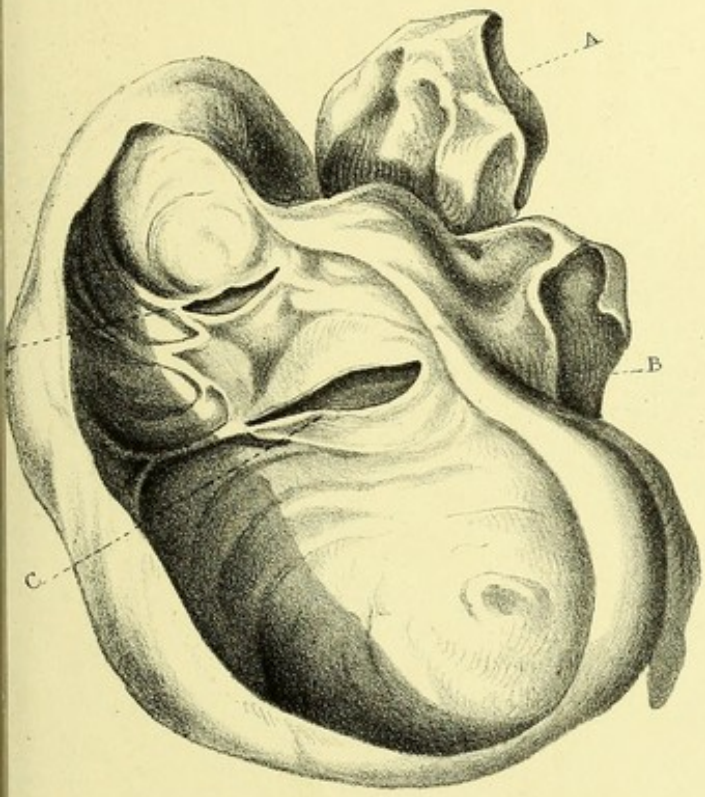


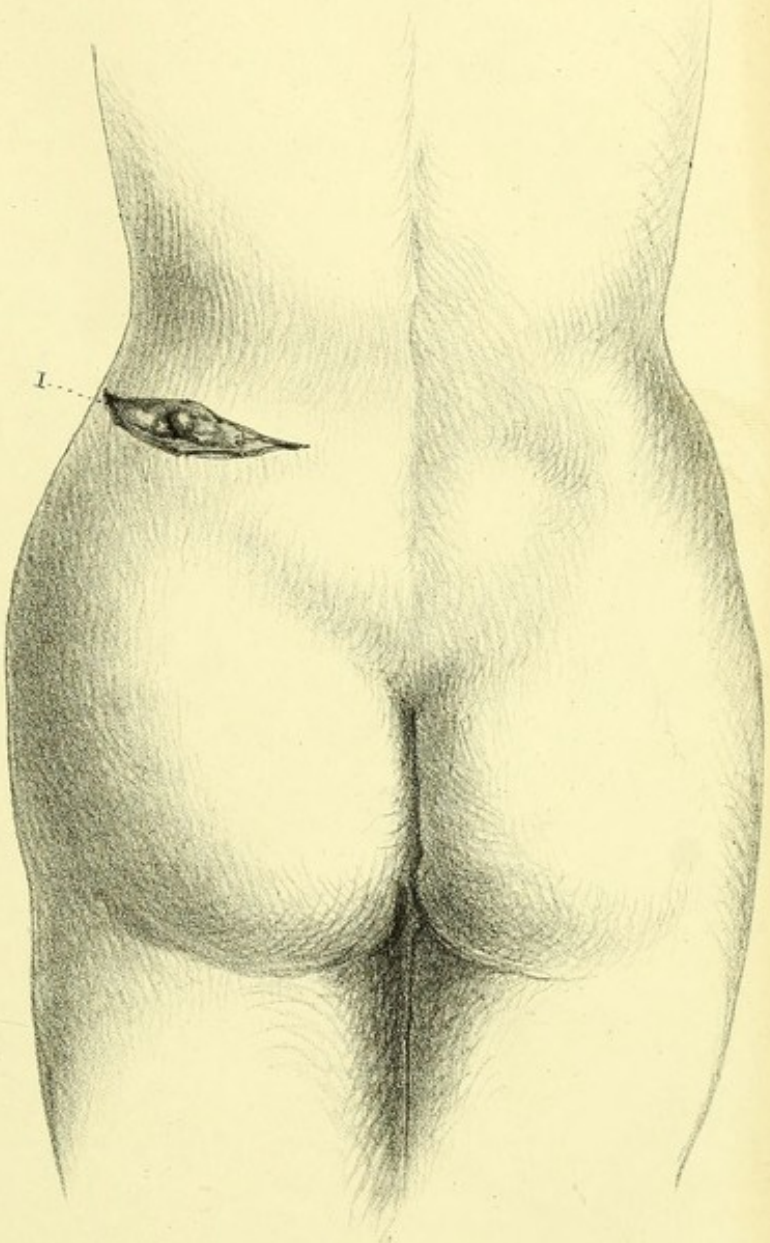
B *Muscular Fibres of Quadratus.*

A *Artificial opening with lips formed by prolapse of Mucous Membr*

A A. *Strictured portion of Rectum laid open.*
B B. *Healthy Bowel above & below Stricture.*
C. *Fundus of Uterus.*
D D. *Fallopian tubes.*
E E. *Ovaries.*
F F. *Scirrhous deposit in recto-vaginal septum intermixed with converted fat.*
G. *Orifice of sloughy sinus running into recto-vaginal tumour.*

Vide Page 20.





A *Commencement of ascending Colon*

B *Termination of Ileum*

C *Ileo-Colic Valve*

D { *Contracted aperture leading from Cæcum to ascending Colon*

I *Situation of Wound*

A. Baker delin.

R. Moody Lithog. Burn.

A. Sykes. delin.