THE DISAPPEARANCE OF CARDIAC MURMURS.

Dr. M. A. Boyd, of Dublin, at a recent meeting of the Royal Academy of Medicine in Ireland, read a paper on the disappearance of cardiac murmurs which have existed sufficiently long, and have led to such changes in the cardiac walls as to be considered organic in character. Such disappearing murmurs are generally consecutive to acute rheumatic endocarditis; cases also occur of chronic endocardial changes which ultimately leave the heart free from all traces of disease. Dr. Boyd gave three instances of cases under his own observation—one the murmur of mitral regurgitation, with consecutive changes in the left ventricle and auricle, which existed for two years, and ultimately disappeared, as did the hypertrophy associated with it; and two others of aortic regurgitation existing for a considerable period, which finally got quite well also. In both these latter cases the existence of hypertrophy and dilatation of the ventricle might be taken as sufficient evidence that they were of a permanent nature, as also the length of time they continued after the primary endocarditis. A well-established constrictive murmur, in his opinion, never gets well; it may disappear or cease to be heard, owing to failure or weakness of the cardiac walls, or to excessive dilatation of either of these or the aorta, but the symptoms associated with it remain, and *post-mortem* evidence shows no cure. Plastic material deposited on or in valves, may ultimately get absorbed when it only interferes with their adaptation, but when deposited around the margin of an orifice it must ultimately, by its contraction, cause obstruction. Such absorption is most likely to take place in young subjects, owing to the rapid metabolic changes which occur in their tissues and to compensation being more easily established; and is more frequent where the valvulitis is rheumatic than where it is the result of alcoholism, gout, or contracted kidney.—*Med. Press.*

"BALLOONING" OF THE RECTUM.

Attention has been called by Mr. Thomas Bryant, in the *Lancet* for January 5, 1889, to a condition of the rectum, which he believes always to exist in conjunction with certain forms of stricture of that organ. This condition he terms "ballooning" of the rectum. When a stricture is quite low down, and within easy reach of the surgeon's finger, this symptom does not exist, although its counterpart—a patulous condition of the anus—may possibly be present. When the stricture is higher up, and beyond reach of the surgeon's touch, the ballooning of the rectum is often present, and when so becomes a symptom of great value. The rectum in its normal condition is a collapsed tube, and when the finger is introduced the walls are found in contact, and have to be separated by the finger for examination. On the other hand, when a stricture of the rectum exists, this does not hold, for often when the finger has passed the sphincters it enters a cavity, the walls of which are expanded or "ballooned." In this cavity the surgeon will be able to move his finger freely, and its walls will only be felt when searched for. The extent of ballooning will vary with every case.

When this condition is found the surgeon will be justified in more than suspecting the presence of a stricture, for he has never found this ballooning of the rectum under other conditions than those of stricture. In cases of obstruction complicated with symptoms which suggest the possibility of a stricture being their cause, ballooning of the bowel becomes, therefore, a symptom of importance, and one which should materially help toward confirming a diagnosis of stricture. Mr. Bryant believes that the described condition of the lower bowel is due, primarily, to the atrophy of its muscular coats, brought about by the arrest of all peristaltic action from above the seat of stricture; and, secondarily, to distention of the atrophied bowel by retained flatus. In stricture of its upper segments this state of the rectum is analogous to patulous anus and incontinence of fæces in stricture of the lower segments. It is not met with in all cases of stricture, and particularly in those of rapid formation, but is present, as a rule, however, in examples of chronic stricture, and should be looked upon as a characteristic symptom.

INGUINAL VERSUS LUMBAR COLOTOMY.

Mr. Harrison Cripps records thirty-seven colotomy operations which he has performed with a mortality of only slightly more than five per cent. Of these operations fifteen were performed in the lumbar regions and twenty-two in the inguinal. Fourteen of the cases of lumbar colotomy were performed for carcinoma, and all of these recovered; the fifteenth case was thus treated for fibrous occlusion, and died of exhaustion on the fifth day. During the past eighteen months he has entirely discarded the lumbar in favor of the inguinal method.

Of the twenty-two cases in which the colon was reached by the latter route, twenty-one were done for rectal cancer, and all but one recovered.

Mr. Cripps' objections to lumbar colotomy are: First, the space in which the operator has to work between the last rib and the crest of the ilium is often very limited, so that to a very great extent he is at the mercy of the anatomical accuracy of the course of the bowel, and even a slight deviation involves a difficult operation;