

cases that even this firm stricture was forced at each introduction of the instrument, so as to enable the bowels to be freed. Why, then, should we be deterred from employing a sufficient degree of force in other cases when the degree of resistance is infinitely less? When the difficulty of introducing the tube is great, the application of a blister over the sacrum, extending up a little on the spinous processes of the lumbar vertebrae, would be found a considerable assistance; and in order to effect this rapidly, if the case be very urgent, a sponge should be impacted into a tumbler, boiling water poured upon this, throwing it off repeatedly in order to produce the necessary degree of heat, and then the tumbler could be inverted over the part to be blistered. Having thus disposed of spasmodic stricture, he would now say, that in cases of the organic kind, every success might be obtained by the same means, with this difference—namely, the use of small tubes gradually increased in size. With respect to malignant stricture of the rectum, he was of opinion that this might be a legitimate case for the lumbar operation.

[Dr. Williams says that the great difficulty in the formation of an artificial anus in the lumbar colon consists in the difficulty of distinguishing the colon from the small intestine, for the signs mentioned by M. Amussat, whether taken separately or collectively, are not diagnostic, consequently there is always a risk of opening the peritoneum, and thus sacrificing the entire principle and chief advantage of the operation. M. Amussat has however discovered a sign which bids fair to do much towards removing the difficulty in question.]

This sign rested on the fact that the small intestines sustained a motion of alternate ascent and descent corresponding to expiration and inspiration, in which the lumbar colon did not participate; if, therefore, the exposed intestine presented this oscillation, it was the small intestine—if it did not, it might be presumed to be the colon. As M. Amussat made no mention whatever of this distinctive sign in any of his publications on the subject, it was very satisfactory that it had now been made known and recorded.

[At another meeting of the Surgical Society of Ireland, Dr. O'Beirne states that in his work on Defæcation, he thought it was satisfactorily shown that the cæcum is perhaps of all parts of the intestinal canal, that most peculiarly subject to large accumulations, while at the same time there may be no fecal matter in the sigmoid flexure of the colon.]

In the natural process of defæcation, as it is called, the difficulty of transferring the load from the cæcum to the sigmoid flexure was formerly a kind of riddle to physiologists: the fecal matter having obviously to rise, not only against gravity, but being also resisted by a quantity of flatus, which acts as powerfully as air would if admitted into a thermometer to resist the rising of the mercury. In his work he has satisfactorily shown how the transfer takes place, and how the introduction of the tube, by permitting the flatus to escape, so materially assists that transfer.

[Dr. Woodroffe then mentioned that he had been at Paris lately, and through the kindness of M. Amussat, had seen the patient on whom he had recently operated.]

She opened her dress, took off a belt she wore round her waist, and withdrew a *bouchon*, with a tape attached. While he (Dr. Woodroffe) sat near her, he could not detect the slightest offensive smell, nor was there the least redness or excoriation of the skin in the neighbourhood of the opening. While the plug was withdrawn she allowed him to pass in his finger, which he did to a considerable extent before he reached the intestine. He would observe that she appeared to have a sort of sphincter power over the opening, being able to repress the discharge by an effort of the will; she had perfect use, too, of all the muscles of the

trunk. Having arranged her dress she left the house, and he was surprised to see her trot along the street at the rate of four miles an hour.—*Dublin Medical Press*, Feb. 1845, p. 117.

CASE OF POPLITEAL ANEURISM CURED BY COMPRESSION.

In the last number of the *Provincial Journal*, Mr. Jolley surgeon to the Torbay Dispensary, relates a case of popliteal aneurism cured by pressure upon the artery above the tumour. The author of it appears to be ignorant of the successful results of the treatment of aneurism by compression in Ireland within the last few years. "Three successful cases (he observes) have been published, two by Mr. Liston, and one by Mr. Greatrex, surgeon of the Guards. I believe (he adds) we are indebted to Mr. Liston for this new era in surgery." We cannot help saying that it would be most desirable if gentlemen, in prefacing their cases by statements of this nature, would take the trouble previously to ascertain their correctness, and to inform themselves of the exact facts; instead of but three cases, twelve have been already published, eight of which were treated in Dublin, where also this method was re-introduced by Dr. Hutton, and shown to be effectual, simple, and but little painful.

We quote Mr. Jolley's case now, because if the clumsy and unscientific mode of using pressure by a tourniquet can succeed in curing an aneurism, compression, carried out in the way in which it has been employed in Dublin, is far more likely to be effectual.

"Thomas Wotton, aged 38, applied at the Torbay Dispensary in July, 1844. He stated that in April he used great exertion in walking from Teignmouth; when within a short distance of his abode, he was suddenly attacked with pain behind his right knee, and with difficulty reached home. On his arrival he found a swelling of the size of a walnut, which throbbled violently; he was unable to rest, and on the following morning attempted to walk, but failed.

July 15th. The tumour had much increased in size, and his nights were extremely restless. The hydrochlorate of morphia was prescribed.

22nd. Several professional friends saw him; all agreed that the case was one of popliteal aneurism, but, from his debilitated state, not one for operation.

23rd. It occurred to me to try the treatment adopted by Mr. Liston, and having procured a tourniquet, I placed it at the upper part of the thigh, maintaining pressure upon the vessel, and continued the morphia.

25th. The pressure of the instrument had caused considerable uneasiness, but no excoriation or sloughing. Increased the hydrochlorate of morphia to three-quarters of a grain at night.

27th. Lessened the pressure of the instrument, as the patient complained of the great uneasiness and restlessness. Repeated the morphia.

30th. The patient appeared in better spirits, and strength improved. Increased the pressure of the instrument.

August 5th. The tumour appears to have become more circumscribed; he suffers less pain in his leg than formerly. Continued the morphia.

15th. The tumour is very hard, there is a slight pulsation, and the bruit is much less distinct than formerly.

25th. The leg was bandaged by a flannel roller from the foot upwards, and a pad of lint placed over the aneurism.

September 1st. No more severe pain; the tumour has considerably decreased; the murmur is still heard, but no pulsation is felt in it or in the course of the artery between the aneurism and the seat of pressure.

10th. This day the press-artère was removed, but the leg bandaged from the toes, and the compress kept over the