

large quantities of bile tinged matter. We gave $\frac{1}{4}$ morphine hypodermically which controlled the pain.

July 26. Vomiting still frequent and urine almost suppressed. The pain was much less severe and lower in the intestines. For the next week the treatment was as follows :—

Every morning stomach was emptied by using the tube, then thorough lavage followed by a cathartic when necessary. Nutrient enemal every 4 hours. Thorough irrigation of colon daily. Pain controlled by chloretone. Catheterization as often as necessary. For first three days no food by stomach, then peptonoids in small amount.

August 1. Improvement was gradual and on this date after a free evacuation of bowels she passed a large stone, the description of which is as follows :—

Weight, $14\frac{3}{4}$ drachms; color, dark grey with yellowish spots; size, diameter $2\frac{1}{2}$ ins. by $1\frac{5}{8}$ ins. It is rough at one end as if eroded by projecting into intestine, while there is a large facet at the other end.

On section the appearances are those of the common cholesterin calculus. The nucleus is situated toward one end and the crystals of cholesterin are deposited in irregular striae about it. The stone is very white, but the lines of striation are faintly tinged yellow or greenish gray. On analysis the calculus consists almost entirely of cholesterin. There is a minute amount of bile pigment and a trace of calcium carbonate.

It is very evident from the composition of this stone and its facetting that it was formed in the gall-bladder. It is almost certain that its course into bowel was by ulcerating directly into transverse colon which lies in such close relationship to the gall-bladder. It does not seem possible that a stone of such size would pass through the small bowel so that the probability of its ulceration into the duodenum may be dismissed.

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