tumour, I have noted a frequent occurrence of dropsy of the corresponding side of the trunk.

That in empyema the pressure signs should be so marked we may suppose is due to the more acute pleural inflammation producing at the same time a greater amount of paralysis of the underlying intercostal muscles and a greater intrapleural tension.[1] The œdema of the side of the trunk may of course be caused by direct pressure on veins, etc., but, apart from this, it may, I think, be due to the fact that the interference with the proper performance of the respiratory movements caused by empyema or lung tumour will impair to a greater or less extent the absorption of lymph. The influence of the respiratory movements on lymph absorption is well known, and Dybkowsky[2] has shown that fluid artificially introduced into the intercostal tissues finds its way into the pleural cavity as the result of the respiratory acts. This latter experiment is specially interesting in connexion with empyema, for here we have, in addition to interference with the respiratory acts, high intrathoracic tension and an altered condition of the pleural walls.

ARTICLE V.—*Notes of a Case of Abscess in Abdominal Cavity.*

By JOSEPH BELL.

ON the evening of the 13th of April 1880 I was asked by Dr Playfair to see with him in consultation Mr M., West Coates, whose case he regarded as one of great danger.

I found the patient a spare, somewhat delicate-looking man, complaining of great pain in the lower anterior portion of abdomen. The abdomen was generally tense and wooden in feel, especially so in pubic and iliac regions. If anything, the tension was more marked in left iliac fossa; through the thin walls I fancied I could feel coils of intestines matted and rough. He was vomiting frequently and was obstinately constipated. Dr Playfair communicated the following history:—

Patient's illness began early on the morning of April the 2d, with severe abdominal pain, vomiting, and fever. He had been visiting a friend the night before, with whom he had had supper, and had eaten some new bread. Other than this there was no discoverable cause for his illness. For the pain and vomiting of which he now complained he was ordered poultices to the abdomen, and bismuth and opium internally with ice and milk. For four or five days he greatly improved. He was almost quite free of pain, the sickness had ceased, and

[1] See "Transudations and Exudations."—*Med. Times and Gazette*, January 1880.

[2] *Ludwig's Arbeiten*, 1866: "Ueber Aufsangung und Absonderung der Pleurawand."

the bowels had been freely moved with enemata and castor-oil. On the 12th April, however, the pain and vomiting suddenly returned and constipation set in.

As to patient's previous history, it may be mentioned that he had never been robust, and had twice been attacked by pleurisy.

Per Anum.—An examination by the anus revealed the following:—The anal aperture gaped and was funnel-shaped, and a little bloody serum stained the examining finger. From previous experience this prepared me to expect evidence of an intussusception which I have frequently felt per anum, and at first I thought it was so, for at the extreme reach of my forefinger a softish, rounded tumour, as large as a small orange, was easily felt. Tracing the boundaries of this, however, it was not an intussusception, as the finger could be pushed past it easily, and healthy bowel was felt beyond it; nor was the pressure of this tumour on the rectum the cause of the obstruction, as the bowel above it was flaccid and empty.

I now tried to make out what this tumour was and what it contained. It was *not* bladder, for the catheter proved it to be empty, or nearly so, and it (the bladder) was obviously compressed and irritated; the patient's micturition, previously healthy, being frequent and scanty.

The tumour gave to the finger the impression that it contained a thick fluid which could be displaced, and I thought I also felt a coil of intestine, or something of a more solid character, behind and above the fluid portion.

The diagnosis was of an abscess or suppuration in the rectovesical *cul-de-sac* of the peritoneum, probably limited by adhesive inflammation gluing together the intestinal coils, but with at least one loop or coil hanging in the fluid and deprived of peristalsis, hence the obstruction.

What, then, was to be done? A free incision from the rectum into the tumour was very tempting, but from this we were restrained by the fear of (*a*) hæmorrhage, which if present could not be checked, and (*b*) of hernia of this coil into the rectum, which also would have been a serious if not hopeless result.

We ordered hot fomentations to the abdomen; nothing by mouth except very small quantities of iced milk. Gave a full hypodermic injection of morphia.

Next day we met again; vomiting still continued, but with less urgency, there being less to vomit. Patient had slept after the injection, but his aspect was worse; decubitus dorsal; pulse small and shabby; temp. 101°; and the breath had a characteristic and horrible odour. I had brought with me Dieulafoy's large aspirator, and introduced the largest needle, guarded by my finger, into the tumour by the rectum. By this means I drew off about thirty ounces of pus of the consistence of thick cream, and with a mingled odour of fæces and gangrene so horrible that, though the day was cold,

we had to cover the patient with clothes and throw open door and windows. After obtaining all the pus that would come I then reversed the action of the instrument without moving the needle, and washed out the abscess cavity, freely and frequently. His relatives, who had both seen and smelt what we drew off, formed a most unfavourable prognosis, in which we could hardly help sharing. Next day, however, the whole aspect of affairs had much improved for the better; vomiting had ceased, two healthy evacuations were obtained by injection, and the patient was able to eat. Temp., 99°; pulse 90; gaining in strength.

I did not see him again till the 20th April, a week from my first visit. When Dr Playfair wished my opinion as to the condition of the tumour before mentioned, which had not entirely disappeared, I was told that three days ago he had begun to pass by the bowel, mixed with the fæces, a yellowish fluid like what had been drawn off by the aspirator, and smelling as horribly. From this I concluded that the abscess had burst into the rectum. I found it still there, though lessened in size, and containing now no fluid, but the coil of intestine could still be made out, and now it was obviously packed with fæces. I ordered a good dose of castor-oil, which was retained and acted freely, since which the patient has gradually but slowly recovered.

I have ventured to lay this brief account of this case before the Society on account—1. Of its rarity, as I have never seen nor even read of a similar one. 2. From its fortunate issue after the very simple and yet decided treatment, for the critical, almost hopeless state of the patient could hardly be exaggerated. 3. With the hope of eliciting some observations from my fellows as to their own experience of such cases.

ARTICLE VI.—*Notes on Two Cases of Spina Bifida in the Cervical Region.* By JOHN M'WATT, M.B., C.M., Resident Medical Assistant, Glasgow Royal Infirmary.

SPINA BIFIDA is a malformation difficult to cure, and, when left alone, generally terminates fatally by rupture of the tumour and draining of cerebro-spinal fluid. Different methods of cure have been tried; but considering the nature of this abnormality, the most sanguine can never expect that any treatment will produce the same satisfactory results as are obtained in other forms of congenital malformation. The method of treatment brought into notice by Dr Morton seems to be looked upon by the profession with favour, and from various cases reported, promises to go far in the way of curing cases suitable for treatment.

The following cases came under my care while acting as house-surgeon in the Edinburgh Royal Infirmary, and I have thought them worthy of being noted:—