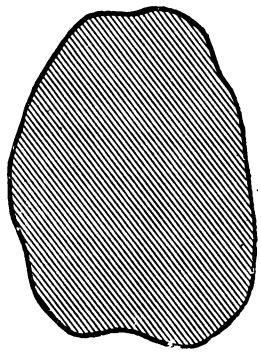
tolerance of the rectum to nutrient enemata, that a fatal issue seemed constantly imminent. During this time she existed upon an average of less than 3 ounces of milk a day. Eventually food was taken slightly better, and strength began to return.



Actual size of gall stone.

On the night of April 22nd (eleven weeks after the onset of the first symptoms) I was hastily summoned, and found my patient in great pain, straining, and collapsed; and on examination detected a hard mass blocking the lower fourth of the rectum. By gentle pressure through the posterior vaginal wall the foreign body was extruded, and found to be a gall stone about the size of a pigeon's egg, facetted, and weighing in the fresh condition ℥ v gr. xliss. The patient slowly gained strength, and was ultimately sent to the south coast to convalesce. When I last heard of her she was "perfectly well and active."

Remarks.

This case supports very well, I think, the contention of my friend and former teacher, Mr. Mayo Robson, that if we can be reasonably sure that obstruction is due to gall stone a palliative line of treatment will probably end in the passage of the foreign body, though many may contend that the risk is greater than that of operative treatment. The stone evidently ulcerated its way into the duodenum and became blocked somewhere in the small intestine.

CHYLOUS CYST OF MESENTERY: OPERATION: RECOVERY.

By J. O'CONOR, M.D.Dubl.,
Senior Medical Officer, British Hospital, Buenos Ayres.

Mr. E. M. M., aged 41, manager of a mercantile company, consulted me on September 2nd, 1896, complaining of a tumour in the abdomen. The history was as follows: For the past two years he had an inclination every morning to vomit, with a constant foul mouth and a bad smell from the breath. He frequently had severe lancinating pains in the lower part of the abdomen. In June, after riding ten miles, the pain was so bad that he had to remain in bed for three days. In July he made a sea voyage, and suffered intensely from pain all the time, but he was not quite certain how much sea sickness had to do with it. During August he had much business to transact in Buenos Ayres, which necessitated walking about, and he suffered continually from pain, the morning tendency to vomit and foul breath continuing as before. At the end of August, after jumping from a tram, he experienced the most excruciating agony; on the following morning he was unable to get out of bed, and for the first time noticed a "lump" below and to the right of navel.

A doctor was called in, and later that same day a consultation was held, and he was told he had a tumour, and was placed on low diet, kept in bed, and had free purgation. On the following day his doctor told him he had a "hydatid tumour," which would require operation.

On examination, on September 2nd, a distinct swelling was visible in median line between the umbilicus and pubes. A well-defined, tense, fluctuating tumour was felt, even in contour, movable, and about the size of an ordinary coker nut. Palpation caused severe pain, so much so that I had to desist from finding the actual range of movement. There was absolute dulness on percussion; no thrill was obtained. The tongue was furred, breath foul, the temperature and urine normal; other organs were healthy. There was nothing to record in his past history excepting habitual constipation and an occasional attack of "asthma." The family history was excellent.

I informed him that he undoubtedly had a tumour, the exact nature of which I could not state, but that I felt pretty certain it contained liquid. I advised him to enter hospital in order that I might make an exploratory incision. This he did on September 7th.

On the following morning, the bladder having been emptied, chloroform was administered, and when the dressings were removed we found that the tumour moved freely in all directions. Assisted by my colleague, Dr. Shadbolt, an incision 3 inches long was made in the median line, directly over the tumour, and the abdominal cavity opened. It was immediately seen that the cyst wall differed from that of a hydatid in that it had a dirty grey appearance, and many large veins ramified over its surface. It looked like a sarcoma. The tumour was lifted out of the peritoneal cavity along with the mesentery in which it grew, and some 4 inches of adherent small intestine. A careful examination was made to see if it was feasible to enucleate it, but as it was so very adherent between the layers of the mesentery, and as so many vessels would require ligation, it was decided to drain it. A medium sized trocar was inserted, and half a pint of milky fluid withdrawn. The opening made by the trocar was enlarged, and the anterior half of the circumference clipped away with scissors, many large veins having been tied, the whole mass was returned into the abdominal cavity, and the cut edges of the cyst united to the parietal wound by a continuous silk suture. The remainder of the superficial wound was closed by two continuous silk sutures, and the cavity of the cyst stuffed with iodoform gauze.

For the following forty-eight hours vomiting was incessant, but ceased on the third day. The highest temperature recorded after the operation was 99.5° F. The bowels were moved on the fifth day, and by the fourteenth day the cavity had contracted flush with the parietal wound. The pain, tendency to vomit, and foul breath completely disappeared, and he was discharged cured two weeks later. He said he "had not felt so well for two or three years."

Dr. Welchli kindly made a microscopic examination of the fluid, and reported that it was ordinary chyle.

On referring to Mr. Treves's treatise in his *System of Surgery*, I find that he states that there have been only 19 cases of mesenteric cysts recorded, 12 of which were cured by operation and 7 died. The situation and mobility of this tumour exactly corresponded with Mr. Treves's teaching, but he says they are usually painless. In this case pain was one of the earliest and the most distressing symptoms.

ARTIFICIAL FEEDING OF THE INSANE.

By L. HARRIS-LISTON, M.R.C.S.,
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The persistent refusal of food amongst the insane is a symptom of frequent occurrence, which, when moral suasion has failed, has to be treated by forcible feeding.

Of the last 200 patients admitted to a lunatic hospital for private patients, among whom refusal of food is said to be more common than among paupers, 27 required forcible feeding, which I performed on them nearly 3,000 times. Complete refusal of food for twenty-four hours in a strong well-nourished patient, or the missing of two meals by a feeble one, may be taken, as a general rule, to indicate the operation; freshly admitted cases with a history of starvation, who are feeble, with weak pulse, and who resist taking food, should be fed at once. Of these 200 patients 85 were males, 115 females, and of the 27 fed, 12 were males and 15 females; this 27 does not include many patients whom the attendants were able to fee with a spoon, but only those who successfully resisted thi method. Of these 27, there were 4 in a state of acute mania 4 in a stuporose condition, 13 were melancholiacs, 4 were