

tends to prove that in mercury alone we possess the only real specific for eradicating the virus of this disease. In neglected cases of late secondary or tertian there is no doubt of the value of the above combination, but in these the object is to secure an absorbent effect on syphilitic neoplasms, nodes, gummata, &c., and for this purpose the exhibition of iodides is useful. They should not be considered as actual antisymphilitic remedies.

### RUPTURE OF THE LIVER.

BY CAPTAIN F. E. GUNTER.  
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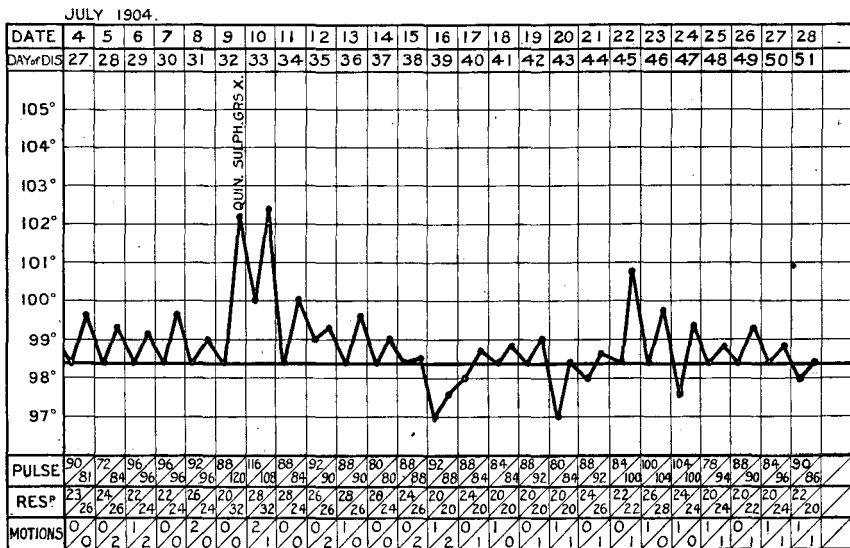
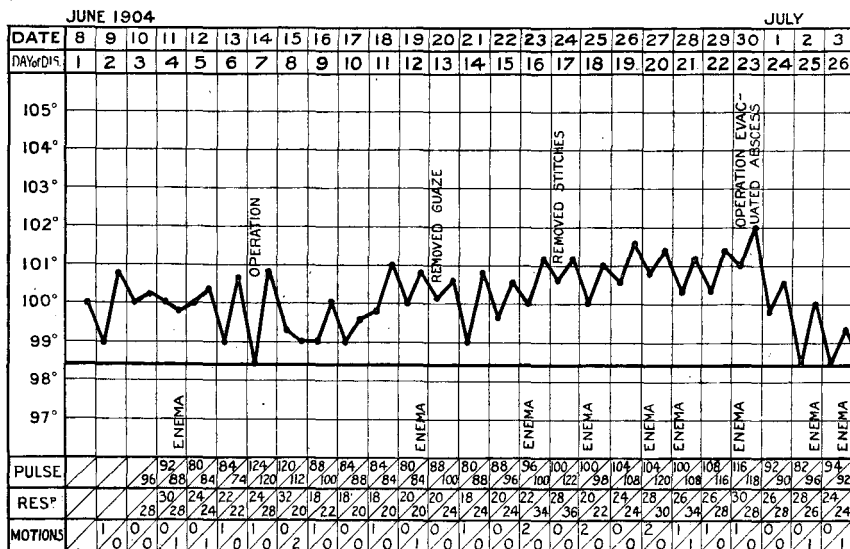
PRIVATE H. was brought into hospital, Peking, this afternoon (June 7th, 1904) in a semi-conscious condition, having received a kick in the abdomen from a horse. There seemed to be some tenderness in the right hypochondriac region, but beyond this there were no definite signs. Patient had been progressing favourably up to date (June 14th, 1904), with the exception that his temperature was a little raised, and that he had some pain and tenderness in the right hypochondriac region. Last night, however, about 1 a.m., I was sent for, and was told that the man had fallen out of bed and was in a condition of collapse. I found him with a temperature of 95° F., a very feeble pulse, and in a precarious condition. He rallied somewhat under treatment, but it was evident that he would not recover unless some active measures were adopted. Accordingly, this afternoon, assisted by Lieutenant Hansell, Assistant-Surgeon, United States Army, to whose kindness I am greatly indebted, I performed laparotomy. As it appeared probable that the liver was ruptured, I made an incision in the right hypochondriac region, parallel to the linear alba. About one quart of blackish blood escaped. There were no signs of peritonitis. There was a large tear of the anterior surface of the liver, from which blood was oozing. The gall bladder appeared to be intact. No attempt was made to stitch up the rent in the liver, but the cavity was packed with gauze and the parietal wound partially closed. He was given a saline injection and a hypodermic of strychnine.

June 15th, 1904.—Rather a bad night, with a good deal of pain. Some blood on the dressing this morning. Pulse a little stronger. Vomits all food, so was ordered a nutrient enemata of eggs and peptonised milk, also saline injections per rectum.

June 18th, 1904.—Has been progressing well. This morning his temperature is a little raised, and he says the dressings are uncomfortable, so they were changed. Wound healthy.

June 20th, 1904.—Has been complaining of pain in the wound, so the plug of gauze was removed under an anæsthetic.

June 30th, 1904.—He has remained in much the same condition; still complaining of pain in the right hypochondriac region, and with high emperature, so after consultation with Monsieur Onimus, of the French



International Hospital, and with Mr. Hansell, who again kindly assisted me, I reopened the abdominal wound. About two pints of pus escaped. The abscess was quite shut off from the peritoneum. I made a counter-opening in the flank and inserted a couple of large drainage tubes.

July 10th, 1904.—Tube removed from anterior wound. Temperature a little raised last night, probably due to some bronchitis.

July 12th, 1904.—Anterior wound closing up. No discharge.

July 21st, 1904.—Posterior tube removed.

July 22nd, 1904.—Both wounds practically healed and the patient convalescent.

July 28th, 1904.—Discharged to attend.

#### A CASE OF SARCOMA OF THE SIGMOID FLEXURE.

BY LIEUTENANT F. C. LAMBERT.

*Royal Army Medical Corps.*

PRIVATE X., 2nd Norfolk Regiment, was admitted to the Station Hospital, Colchester, on February 19th, 1904, with syphilis. On March 25th, 1904, he complained of pain in the left iliac fossa, where a hard, freely movable tumour, the size of a walnut, could be felt. He was treated with local applications and a purge was ordered, which relieved his pain. A week later blood was noticed in his stools, but his motions were well formed and he had no pain on defæcation. He continued to pass blood irregularly for about a fortnight. The swelling at times seems to have slightly diminished after enemata were given, but still remained tender. The swelling, after a few weeks, was thought to be slowly increasing in size, in spite of all treatment, and the patient was losing flesh and getting very anæmic. On July 20th he had an acute attack of pain in the left iliac fossa, and vomited frequently; the lower part of the abdomen becoming distended, but moving on respiration. The rectum was full of hard impacted fæces. The next day he was transferred from a syphilis ward to a surgical one, as the vomiting continued, and the patient's general condition had not improved. I am indebted to Captain Challis, R.A.M.C., for the above notes. All food by the mouth was stopped and a large olive oil enema (one pint) ordered. This helped to remove a considerable amount of the fæculent material; but further enemas were required before the bowels were well relieved. The following day patient's temperature rose to 101·6°F., the pulse going up from 78 to 100. The abdominal distension was greatly diminished by the free action of the bowels, and small amounts of fluid nourishment were given by the mouth, as all vomiting had ceased. In the evening the patient had a very sharp attack of pain in the left inguinal region, the pain shooting up to the left costal margin. The swelling was very tender, but there were no signs of peritonitis. No growth could be felt *per rectum*, but the rectum was much enlarged. On the morning of the 23rd, as the swelling was extremely tender and there was some abdominal distension, together with increased pulse rate, but without rise of temperature, I thought an operation advisable to determine the correct