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

nature of the swelling, and treat it as far as was possible. The patient was anæsthetised by Civil Surgeon Scott, and an incision made, one and a half inch long, situated one and a half inch from the anterior superior spine of the ilium, at right angles to a line drawn from the spine of the ilium towards the umbilicus. On examining the interior of the abdominal cavity with a finger, I could feel a hard mass in the left iliac fossa encircled by shotty glands. The incision was then lengthened one inch in a downward and forward direction, and the sigmoid flexure and the lower part of the descending colon brought on to the surface of the abdominal wall. At first sight the swelling appeared to be caused by a chronic intussusception of the descending colon with the sigmoid flexure, as the encircling band of glands, which were bound down by adhesions, formed a ridge under which the sigmoid seemed to be invaginated. The lower part of the colon was very œdematous and thickened, the peritoneum covering it being very rough and red, but on the inner side, at the junction of the colon with the meso-colon, the gut showed a small patch of gangrene, which gave way as I was trying to define the true edge of what I took to be an intussusception. I then inserted my finger into the lumen of the gut, through the part that had given way, and felt a hard, irregular growth, encircling the entire interior surface for about three inches, and was about to ulcerate through at the gangrenous portion of the bowel. The intestine was then clamped digitally, well above and below the growth, and the lower part of the descending colon and a considerable amount of sigmoid flexure removed—six inches of intestine being removed, also a few glands in the meso-colon. There was a great deal of hæmorrhage, especially from the œdematous portion of the colon; this having been controlled, the cut surfaces of the meso-colon were sutured together and the intestine joined together by Maunsell's method, the upper part of the intestine being drawn through an incision made on the remaining anterior surface of the sigmoid, this position being chosen on account of the œdema of the upper part. Three rows of fine silk sutures were put in—a great many being required on account of the distended condition of the upper segment. The exposed intestine was then well washed over with hot saline and returned to the abdominal cavity. The peritoneum and abdominal wound were then partially closed and two drainage tubes inserted, one passing down towards the pelvis, the other between the outer surface of the sutured bowel and abdominal wall. Throughout the operation the patient took the anæsthetic very well, ether and chloroform being used. The patient showed only a very slight amount of shock after the operation, was able to read the paper next day, and stated that he had no pain. After twelve hours he was given ʒi. of albumen water with a little brandy every half hour, which was gradually increased, as he had no vomiting or abdominal distension. Three days after the operation there was a small amount of fæculent discharge from the second drainage tube, there also being a rise of

temperature to 101·4° F., with pulse rate 100. The wound was therefore opened up and the pelvic drainage tube removed, the second one being left in position opposite a small fæcal fistula, which had formed where the incision was made in the sigmoid flexure, the gut having given way where it was sutured up with some silk of doubtful antiseptic properties, as all the prepared silk had been used up during the operation. Under this treatment patient's temperature soon became normal, and the fistula rapidly becoming closed with granulations, the wound also healing by second intention. The patient passed a well-formed motion six days after the operation, and is now able to take solid food. He has rapidly put on weight, and has always been in the best of spirits.

The growth was sent to the Army Pathological Department in London, from whence the following report was received :—

"Examinations of sections of this growth point to its being of a sarcomatous nature, the cells being chiefly of the spindle shape. Sections of one of the neighbouring glands showed one or two areas in which a similar sarcomatous infiltration appeared to be commencing. The bulk of the glands was healthy."

I should like to add that much of the success of the operation was due to the kind assistance I received from Captain Challis, R.A.M.C., and Captain McCullum, R.A.M.C., to whom I feel much indebted.

SHORT NOTES OF SOME UNUSUAL CASES.

By Lieutenant-Colonel G. F. GUBBIN.
Royal Army Medical Corps.

Malingering.

"*Conjunctivitis*" *Caused by the Use of Nitrate of Silver.*—A soldier was under treatment for what appeared to be simple conjunctivitis; various remedies were used for its cure, but no improvement followed. On a certain Sunday morning I everted one of the lower eyelids, and saw on its inner surface an appearance which I thought was caused by lunar caustic. I caused the man's bedside table to be searched and a piece of lunar caustic was found in it. The man was tried by court martial for malingering and was rather severely punished.

"*Jaundice*" *Caused by the Local Application of Tincture of Iodine.*—At the time when his unit was under orders to proceed to another station in the colonies, a non-commissioned officer reported sick one morning, stating that he was suffering from jaundice; he exposed the front of his chest, the skin of which was of a yellow colour. On further examination I found that his conjunctiva was normal in appearance, and that the yellow discolouration of the skin was limited to the front of the chest; further, it was, to a certain extent, removable by washing, and, in fact, he had simply painted his chest with tincture of iodine. I had then to decide