A CLINICAL LECTURE
ON
COMMON DISEASES OF THE RECTUM.

Delivered in University College Hospital.

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We are constantly having in the wards cases of severe disease of the rectum—I mean cases of piles which require operation, cases of fistula, and cases of cancer. I propose to-day to speak rather of the commoner cases of disease of the rectum, such as you will meet with among out-patients and in your own practice later on. Ordinarily the rectum performs its function without any disagreeables, and when one has a healthy evacuation of the bowels there is a feeling of relief which is somewhat remarkable. That evacuation, of course, should be perfectly painless, and in the great majority of instances it is so; but you will find, when you get into practice, that patients will complain to you in the first place that they cannot get the bowels open, and then perhaps they will say that when they have had them opened they suffer such pain that they dread every operation.

With regard to the question whether a daily action of the bowels is essential to good health, I may say that no doubt, with the great majority of persons, a daily action is a necessity, but still you may meet with people who are a little different in that respect, and will go two, or even three or four, days without evacuation and without any discomfort. I mention that because it is well to consider the idiosyncrasy of each individual. It is of no use, where you have torpid bowels and a weak condition of the muscular fibre generally, such as you meet with for instance in elderly females and anæmic persons, to try and force them by violent purgation into the ordinary daily habits of healthy people. Of course, if you take a healthy person, you have there a standard, but you may find variations from it for which you must be prepared. As to the time at which the bowels should be opened, that of course, in many cases, is a matter of simple convenience. The busy man, going off to catch a train immediately after breakfast, had better perhaps have his bowels opened at night, but a person who has a little leisure, and, moreover, is able to enjoy that matutinal pipe which, I am told, is so extremely useful in producing an alvine action, may well repair to the water-closet after breakfast; but take my word for it, that patients who have anything the matter with the rectum, who suffer in any way upon the discharge of fæces, should, as a rule, have their bowels opened at night; and the reason is obvious. The action of the bowels takes place more conveniently after they have undressed: that is an important point in connection with women who wear tight stays—when they are in their dressing-gowns or nightgowns they have much more power to empty the bowel than at any other time, and immediately after they have done so they can repair to bed, where they can lie in a horizontal position for eight or ten hours, so that any little inconvenience, any disarrangement of the vascular supply of the bowel passes off, and in the morning they are quite well.

If there is any difficulty about the action of the bowels patients are only too ready to fly to purgative medicine. You have only to read the advertisement columns of the newspapers to see what fortunes are made by purgative pills. The great secret of those pills is that they are extremely mild, so that it takes half-a-dozen to produce any action, and the patient will very soon get through a box of twenty or twenty-five, and then will have to buy another box. There is a sort of popular idea that anything like aloes is very apt to do harm to the lower bowel. I believe that is a pure delusion. Patients who have trouble about the rectum can use aloes without any particular disadvantage; indeed, I think it is rather a good drug to prescribe, because it has a stimulating effect upon the lower bowel.

Then, besides purgatives which are not to be had recourse to unnecessarily, we have ordinary laxatives, and the fashionable laxative of the present day is some form of mineral water. You find large quantities of mineral waters advertised, which are more or less artificial in their manufacture, and which can be drunk in quantities, say, of a wineglass in a tumblerful of warm water before breakfast, producing an alvine evacuation soon after breakfast. That is an example of the kind of thing people are now in the habit of taking. But there are very much older remedies; for example, there is sulphur, a teaspoonful or two of which may be conveniently taken in milk. The old-fashioned confection of senna has been superseded now pretty much by the nicer preparation of compound liquorice powder, a teaspoonful or two in a little water early in the morning or over-night producing an easy evacuation in the morning.

Then there are methods of attacking the bowel itself. By far the simplest and the best method—very little used in this country, comparatively speaking—is the ordinary enema. You will find that enemata are very seldom prescribed nowadays, but if you have cold water thrown up into the bowel with a simple Higginson's syringe, such as I hold in my hand, you will help many patients to produce an evacuation comfortably, without any distressing strain. There is no need for any complication of reservoirs or anything of that kind for the water which you throw up the bowel. In the present days of water-closets, all that the patient has to do is to empty out the pan of the water-closet, fill it up with cold water, and, having previously filled the syringe, then introduce the pipe into the bowel, and inject a pint or a pint and a half of water. After waiting a few minutes, the strain upon the sphincter becomes a little strong; the evacuation takes place, and the fæces are brought away with the enema. It is curious how little these enemata are used in this country as compared with France. In England there is a sort of modesty about these things, and you will find that people object to an enema when its use is very advisable. Many women in particular, who have a somewhat feeble lower bowel, derive great advantage from throwing up cold water into the bowel at the time of the action.

Then there is another thing that has come into fashion of late—the injection of small quantities of glycerine, which no doubt in many cases is extremely useful. The chemists sell a small syringe for the purpose, holding from one to two drachms, and patients have got into the habit of throwing up a small quantity of glycerine just within the sphincter, and in a few minutes the action is produced. In many cases—I will not say in all—it is really a very efficient remedy.

Another thing that I may mention I have known for a great many years, but I find very few people comparatively know of it. The difficulty which many persons experience in getting rid of a mass of fæces which has been lodged in the upper part of the rectum and become a little inspissated and hard, can be got over entirely by pressure with the finger just beyond the tip of the coccyx. There is plenty of room between the tip of the coccyx and the anal orifice for the finger to be pressed against the rectum, and you will find that the hard motion which has lodged in the rectum is pushed out through the sphincter, and being once through it is promptly passed, and the softer matter follows easily enough.

You must be prepared sometimes to find that a woman who is having apparently a healthy evacuation daily yet retains in the upper part of the rectum large masses of fæces in the shape of balls. It is very remarkable how fæces get retained in this way. I cannot tell you why it should happen with one patient more than another, but I have seen it over and over again; the fæces rub against one another, and become formed into distinct balls, which remain there, and which the patient cannot get rid of by any voluntary effort. I am quite sure this is much more common than is generally supposed. I have met with it many times, and always in women, not necessarily women who have borne families, but generally elderly women; they complain that they are never comfortable, that they never get that feeling of relief they should have, but are always straining and bearing down almost as if in labour, and at last matters come almost to a stoppage. It then becomes a question of clearing out these hard balls of fæces with a lithotomy scoop or the handle of a table spoon, which will do on an emergency. In that manner you can evacuate the bowel in a way that the patient cannot do for herself. It is quite worth

while, then, when a woman complains of uneasiness about the rectum, to put the finger up so as to make yourself thoroughly sure that the upper part is not blocked with these balls.

Suppose, now, that the patient complains that every time he has an evacuation he feels pain, and that the pain lasts for an hour or two afterwards, and is really so bad that he dreads every evacuation. You may at once say in such a case that the patient is suffering from fissure, though the patient very likely thinks he has piles. Now a fissure, in the great majority of cases, is, I believe, a tear; the patient has happened to have a very hard motion, which has been forced through the sphincter, and has distended the part, and torn the mucous membrane. That is, no doubt, the explanation of the formation of a fissure in most cases. In addition to that there may be, if it is a long-standing case, a little ulcer above the sphincter which communicates with the fissure. But, presuming that it is a comparatively recent case, and simply a fissure, if you look at the anus you will see a little crack running up through the mucous membrane: and if you put in your finger, which should of course be greased, the sphincter spasmodically contracts, but if you gently insinuate it with a twisting movement you will at last pass through, giving the patient considerable pain, but you will ascertain that you have there the crack running up the anus through the mucous membrane only, but going down to the fibres of the sphincter. Of course there is nothing so good as a finger for ascertaining this, but if you have any doubt you can use a small bivalve speculum, which is introduced closed, and is then opened so as bring the aperture opposite where you think the crack is, and you can then see the fissure running up through the anus. There is also another variety of speculum—the small Fergusson's speculum—with an opening at the end, or with the opening running the whole length.

These cases of fissure are very often of long standing, and in that case you very commonly find that there is a little mass of granulation protruding into the fissure, sometimes wrongly called a polypus. You should always look for that, because it is important to remove it. The reason why a fissure is so excruciatingly painful is that it runs down to the fibres of the sphincter, and when the fæces pass they irritate the fissure and the sphincter, and there is a spasmodic contraction of the muscle, which is exceedingly painful, so that the patient tells you that he is obliged to lie down for a couple of hours after an evacuation, and that he feels sore for some time. These cases are very readily cured. If it is a recent fissure, and if the patient is in delicate health, say a pregnant woman, you may not care to do more than apply something locally to the fissure, and if it is simply a superficial one, I know nothing better than some form of belladonna, either belladonna ointment, or, what is rather nicer, ointment made up by mixing a grain of sulphate of atropine and half an ounce of lard. That makes a good ointment, not too strong for use, and it relieves the patient very much, and seems to help the part to heal up. But it must be a very slight case for that to cure it. The same thing may be said with regard to nitrate of silver. It will cure fissure if you are very careful. If you have a sharp pointed stick, and then through a speculum draw it down just into the fissure, so as to go quite to the bottom, it may be possible to cure it. But I strongly advise, in most cases of fissure, that you should do something a little more active. The best thing is to over-dilate the sphincter. If you over-dilate the sphincter, you no doubt tear a few superficial fibres, and thereby paralyse the muscle a little, and the consequence is you cure the fissure. The simplest way is to put two fingers, or better, two thumbs, into the anus, and, grasping the buttock, then draw them apart. As it is painful, it is well worth while giving an anæsthetic; but it is not a long operation, and it does not lay the patient up. If he is kept quiet for a couple of hours he is immediately relieved of pain, and the first time there is an evacuation there is no pain at all. Another way is to notch the sphincter with a bistoury. That is a thing which in the early part of the century was made a very serious operation of by cutting through the whole sphincter, which is quite unnecessary. It is quite sufficient simply to notch and divide the superficial fibres of the sphincter. You pass a blunt-pointed bistoury with the finger into the rectum, turn the edge of the bistoury to the fissure, and withdraw the knife and finger together. Some prefer that operation, but I do not think it makes much difference which you do. It is well, however, sometimes to be able to assure a nervous patient that there need be no cutting operation.

With regard to the little ulcer which occasionally exists within the bowel in connection with a fissure, there is no doubt that in that case division is best, because the bistoury is carried through the ulcer, and it cures both it and the fissure. But if there is an ulcer the case takes longer to heal; you have to lay the patient up a week or ten days because the cut has gone through the ulcer.

Another thing of which patients complain is pruritus ani. The patient will tell you that he is worried to death by itching about the anus; that it comes on as a rule at night when he gets warm in bed; that he loses his rest, and that his health is thereby considerably interfered with. There are various causes for pruritus ani. It is well to remember that there may be some local cause which can be got rid of at once. One of the common causes of pruritus ani in children, and sometimes in adults, is the presence of ascarides in the rectum. Within the last few years the views about ascarides have a great deal altered. It used to be thought that they lodged entirely in the rectum, and that you could cure the patient by copious enemata, usually of salt and water. But it has been shown within the last few years that that is not a fact, and that these ascarides have their habitat mainly in the cæcum, and are to be found more or less throughout the whole length of the large intestine. You must bear in mind, then, that it is not sufficient simply to attack the rectum with enemata, but you must give purgative medicine also, which shall act upon the cæcum and clear away the worms themselves and the mucus in which they are lodged. You may often see them coming away in large balls as the result of purgative medicine, and until they are thoroughly cleared out you cannot hope to cure the patient.

Another thing to bear in mind is that you may occasionally have pediculi. The pediculus pubis, the ordinary crab of the pubes, if it exists, may find its way readily round to the anus. It is therefore well worth while to make an inspection both of the pubic hairs and of the anus, to see whether or not you can detect the pediculus, which, as may well be seen with a magnifying glass, bears a close resemblance to an ordinary crab. If once made out, this is readily cured. You can get rid of crabs by two or three applications of some mercurial lotion, such as the lotio hydrargyri flava, carefully soaked into the hairs, which will kill the pediculi, and hot water and soap will then put matters right.

But unfortunately, as we know to our cost, pruritus ani does not always depend upon local causes. You find that a patient is perfectly cleanly and that no worms exist in the rectum, and yet he suffers almost agonies from pruritus. If you consult the authorities you will find that every remedy that has ever been recommended has been tried with more or less success, which shows how little successful the remedies really are. For myself I rather believe in lotions than in ointments. On the other hand I allow that sometimes ointments answer extremely well; but I think you may get most relief, in the majority of cases, in the first place by attending to the general health, keeping the bowels regular, and so on, and then applying locally some sedative. Cocaine is not a bad thing to apply. A 5 per cent. solution of cocaine painted over the anus will often give great relief. Before cocaine came in we used hydrocyanic acid, and that was extremely useful in the form of a lotion of dilute hydrocyanic acid and lead. Opium and belladonna, atropine (the essential part of belladonna) and all the various sedatives have been tried from time to time with more or less success, and, I am sorry to say, with more or less failure. It is a curious thing, but you will find that patients sometimes go on for a long time suffering with this annoying and troublesome complaint, which no remedy seems to touch, and then they get well; but it does not always appear what it is that has cured them.

Then we meet, as we do everywhere, occasionally, with syphilitic affections of the anus. Children are brought to the hospital from time to time with distinct mucous tubercles about the anus. It is a little difficult sometimes to explain this occurrence, but I believe the explanation often is the ridiculous habit that mothers and nurses have of kissing the children all over. They are not particular what part of the the child they kiss; and sometimes the unfortunate child's anus is inoculated in that way from the lips of the nurse. But

you will find cases that you cannot account for in that way. There is no doubt that from time to time we have mucous tubercles simply from vaginal discharges creeping round: I mean that a woman has mucous tubercles of the vagina, or labia, and the discharge runs back to the anus and produces mucous tubercles there. Occasionally you may also find that persons get them from their bed-fellows. I do not mean by any outrageous bestiality, but that some contact from their bed-fellows has accidentally inoculated the part. Mucous tubercles are readily recognised as flat moist patches, and the only thing I will say about them is that you must be careful in treating them to keep the adjacent parts from rubbing one against the other. If you have to treat mucous tubercles about the anus apply some mercurial dressing which shall separate the two sides of the buttocks and prevent their rubbing together. I have always found that the best plan is to take a piece of linen, spread it with white precipitate ointment, and tell the woman to fold it so that the ointment shall be outside, and then to draw it thoroughly between the buttocks, so that the mercurial ointment shall come in contact with the anus and thus become rubbed into the system. You will remember that mucous tubercles are but a symptom of secondary syphilis, and if you find them about the anus you may be sure that the individual has syphilis in his system, and their treatment will be only part of the general treatment of syphilis, into which I need not now enter.

Then we find occasionally about the anus what are termed rhagades. There is hypertrophy of the skin of the anus with ulceration in the cracks between the folds, which is undoubtedly syphilitic, and should be treated very much like mucous tubercles. But you will find occasionally that there are considerable outgrowths of moist skin about the anus which are commonly called "tabs." They are not really a disease, but are only a symptom, and wherever you see them you may be sure that the woman—for they usually occur in women—has syphilitic disease of the rectum. You should at once introduce the finger, and you will probably find ulceration of the rectum of a tertiary syphilitic character, with very likely more or less stricture. We do not happen to have had lately in my wards any case of the kind, but you will see from time to time women who have had these tertiary ulcerations of the rectum, which lead later on to very severe stricture, and occasionally require operative interference.

A mother may come to you saying that her child's body comes down—that is the expression generally used among the poorer classes—and she at once assumes that it is a case of prolapsus. Now, be on your guard about that, because cases of the "body coming down" are not all cases of prolapsus. Of course many are, but you should observe the case for yourself, and take the trouble to put your finger into the bowel. In many cases you will find that there is a little pedunculated growth hanging there, which, when the child strains, comes through the sphincter or presents at the anus, and which is nothing more nor less than a polypus. These small rectal polypi are not uncommon in children, and the remarkable thing about them is that they generally cause some hæmorrhage. Every time the bowel is opened there is some little blood noticed in the stools, and yet if you come to treat them by taking hold of them with your nail and tearing through the pedicle there is no bleeding, and the case gets well directly. If the pedicle is at all thick it is wiser perhaps to put a ligature upon it, but if it is a simple polypus in a child you may, without scruple, tear through the pedicle with your nail and bring the little vascular body away, and no hæmorrhage ensues. So much for polypi, which you occasionally find in young adults in whom they become more or less indurated, and, though they are not nearly so vascular, they are thought to be piles. The patient says he has piles, and that every time he goes to the closet the pile comes down, but when you see it it is simply a pedunculated mass, which should be treated by putting a ligature round the pedicle and cutting it off.

True prolapse occurs both in children and in adults. In children it occurs most frequently, I believe, as the result of debility and also, no doubt, as the result of the bad habit which is so common, of allowing children to sit and strain their bowels after they have already evacuated, and at last they strain down the mucous membrane. These are really cases of prolapse. There may be a more severe condition, which we call procidentia, where the whole bowel comes down. That is more serious, and I will speak of it presently.

Prolapse may be a symptom of other disease. It is not very uncommon in cases of stone in the bladder to find a child straining to make water and bringing down the rectum at the same time. It is therefore well to bear in mind that you may have another disease behind and to inquire whether the child has serious trouble in making water. But ordinary cases of prolapsus are cases simply of debility, the child is of weak habit altogether, and the bowel has got into the way of coming down on very slight occasions. The great thing is to break through the habit, and if you can make the mother take a little trouble you can break through it readily enough. With a circular opening like the anus very little will bring down the mucous membrane through it, but if you can get the mother to hold the child when it is going to have an evacuation and to put the finger down the verge of the anus and draw on one side, and thus convert the circular opening into an elongated slit, then the mucous membrane is considerably puzzled to come down, and practically it does not prolapse. What I always promise mothers is that if for one week they will take the trouble to do this and so prevent the bowel from coming down the case will probably be cured. In addition to that little manœuvre it is well of course to brace up the bowel by throwing in cold water with an enema syringe, both before and after evacuation, and to give the child a tonic, particularly an iron tonic.

If the bowel comes down and is allowed to remain down for some hours, you may find it rather a difficult job to put it back. The shortest way is to give the child chloroform, then to manipulate the bowel and to return it with the piece of lint with which you have manipulated it. If you simply push the prolapse up and take your fingers away, it comes down directly; but if you take a strip of lint and then squeeze the blood out of the bowel, you can push the lint and bowel back together, and the lint remaining in the lumen of the bowel keeps it in its place. After some hours the lint will come away spontaneously, or with the next evacuation, and then the case is relieved. In order to keep up the bowel in an obstinate case it is not a bad plan to do as Mr. Ionides did in a case that he had here lately, namely, put a strip of plaster across to hold the two buttocks together, so as to prevent the bowel coming down again.

These cases of simple prolapse are readily enough treated, even in the adult; but we occasionally get cases of procidentia, where the whole bowel comes out, and they are exceedingly difficult to cure. It is curious that women who have that kind of thing sometimes seem to have a morbid liking for it. They do not want to get cured; it is a form of hysteria, no doubt; they like to be made martyrs of—to be kept in bed, to be always suffering, and to have their friends rallying round them, converting their bedroom into a sort of reception room. I shall never forget one case that I was called to see. It was that of a lady, who was a leading light amongst her religious party, and who had been confined to her bed for many months—I fancy for years—by a large prolapse of the bowel. I was asked to examine her, and I could find no reason why the bowel should not be returned. But she did not want it returned, and she resisted every effort that I made; the moment I put it back she strained and drove the bowel down again, so that I had to give it up as a bad job.

Within the last few years I have been very successful in curing some of these cases in the hospital with the actual cautery. If you have a great prolapsed bowel, of course it will never do to cut it off. If you did that, you would probably find that, just as with a prolapsed uterus, you would cut off a piece of the peritoneum. But when you have a prolapse forming a large sausage-like projection from the rectum, you can apply nitric acid, which some recommend, but which I do not think quite sufficient for the purpose. I prefer to use Paquelin's cautery. The method is to draw a series of vertical lines upon the prolapse, and then, under chloroform, to put the part thoroughly back, and with the cautery to cut two or three deep grooves in the anus itself, because in these cases it is enormously dilated, and, unless you thoroughly contract up the anus, no power will keep the bowel within. Then, of course, you lock up the bowels with opium, and keep the patient carefully in bed. As far as I have seen, we generally

get a cure in such cases, though sometimes the cautery has to be applied more than once.

A patient comes to you, and says that he is very uncomfortable because he has a little swelling which is very painful. You will find a little bluish mass by the side of the anus, and as far as I have seen it is more common in men than in women. It is nothing more nor less than a thrombus in one of the inferior hæmorrhoidal veins. You find, perhaps, that the patient has been dining out once or twice of late, and his bowels have become a little constipated and the liver overloaded, and the venous circulation obstructed. Every now and then patients will go on suffering this inconvenience for a few days without taking advice, and the thing gets well; that is, it gets well by absorption of the blood clot, and by leaving a loose fold of skin at the verge of the anus. That is how those loose external piles which we see so commonly are formed. But if you get the case in an early stage, by far the best thing to do is to make a little nick with a bistoury into the swelling, and to turn the clot out. It turns out very readily; you get rid of the thrombus, and you see the lining wall of the vein left behind; you put a little iodoform to it, and the thing heals up in a day or two, so that the patient has no further trouble.

One word with regard to ischio-rectal abscesses. The patient may have an abscess in the ischio-rectal fossa from various causes. It may be from internal causes such as ulceration, which is often tuberculous, or a fish bone or a pin may have passed through the bowel and then become entangled in the sphincter, producing perforation; or it may arise from external causes, such as sitting on damp grass, on the wet seat of an omnibus, or things of that kind which have a tendency to produce local irritation and inflammation about the buttocks. From whatever cause it may happen the symptoms are much the same. The patient has a phlegmonous swelling, which is hot and tender, between the ischium and the anus, and the ischio-rectal fossa is filled up with inflammatory deposit, which rapidly becomes purulent. In a case of that kind the sooner you make an opening and let the matter out the better, for if it is allowed to remain it will burrow up into the rectum. The best way is to put the patient on his hands and knees, then to pass the finger into the rectum, left or right, according to circumstances; you then introduce a bistoury by the side of the rectum and cut outwards. You have the patient completely under your control by the finger in the rectum, so that you can hold him firmly, and you can put the knife down by the side of the rectum, and just cut sufficiently to let the matter out freely. Then comes the question, Shall you do more? Shall you lay the abscess open into the rectum? That will depend upon how thin the rectum is. If the abscess has already encroached upon the rectum so that it is thin, it is better to lay it open at once into the rectum, because if you leave it it will degenerate into a fistula, and you will be doing one operation instead of two.

You will know at once by the smell whether or not the abscess communicates with the rectum. Nothing is more offensive than the smell of pus in an ischio-rectal abscess which communicates with the rectum. In these cases there is no doubt about laying the bowel open; but in other cases, where it is a superficial abscess due to external causes, there will probably be no smell, and then I advise you not to lay the rectum open unless you have reason to think that it has been encroached upon.

Lastly, one word about hæmorrhage from the bowel. A patient comes to you and says: "I lose a little blood from the bowel, but I do not think it does any harm." That is perfectly true; an occasional slight discharge from the bowel is in many cases a salutary thing. You remember how the rectum is supplied with blood from the inferior mesenteric as well as from the iliac and pudic arteries, and that all the arteries inosculate, while the veins communicate with the vena portæ as well as the pudic veins, so that a slight hæmorrhage may in that way relieve a congested liver. But it is different if the patient loses considerable quantities of blood from the rectum; and you should always be on your guard to inquire whether the blood is simply mixed with the motion or whether it is spurted out over the pan of the closet, because in the latter case it is obvious that it must be arterial blood or venous blood in considerable quantities shot out by the muscular efforts of the rectum. In either case the patient may lose more blood than is good for him. It may depend upon internal piles, and in the majority of cases it is so; but of the treatment of these I am not going to speak to-day.

There is one thing which causes hæmorrhage, and that is a vascular patch of mucous membrane in the rectum. When you expose it with the speculum you see blood pouring out from it. Those cases can be treated very readily by the application of caustic. They are the only cases of piles or rectal disease which really do well with caustic. To apply nitric acid to great masses of internal piles is really to play with them, and not to cure them. But if on passing the speculum you can distinctly see a vascular surface, which bleeds very readily, I advise you to touch it freely with a piece of stick dipped in the strongest fuming nitric acid, or, as I prefer, the acid nitrate of mercury, the effect of which will be that you will arrest the hæmorrhage immediately. You should then lock up the bowels with a little opium for a day or two to give rest, and the next time the patient has an evacuation there will be no bleeding, or, at least, much less; possibly another application may be required.

I will take another opportunity of speaking of hæmorrhoids, fistula, and so on. To-day I have merely gone through these minor matters, which, after all, are very important, both to the patient and the practitioner.

REMARKS
ON A CASE OF
PHOSPHORUS POISONING
WITH SPECIAL REFERENCE TO THE
MENTAL SYMPTOMS DURING LIFE
AND TO THE
PATHOLOGICAL APPEARANCES IN THE BRAIN CORTEX AFTER DEATH.

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Clinical Report by Dr. Elkins.

The patient, a lady, aged 34, suffered from mental depression, but otherwise was intelligent and coherent in conversation and had a good memory. She had been a voluntary patient in the asylum since December 18th, 1889, and therefore had many liberties which a certified patient would not have been allowed.

At 1.15 P.M. on February 4th, 1891, she informed the matron that she had on the previous evening sucked and chewed the phosphorous ends of two boxes of common red-headed matches. She was out driving in town on the afternoon of February 3rd, as usual, accompanied by another lady patient, and an experienced and trusted attendant. Having requested permission to enter a fruiterer's shop in order to buy some fruit, she then, on her own statement, obtained instead for the sum of one penny, three boxes, each containing about eighty matches. That same afternoon and evening, after her return to the asylum, she sucked and chewed the phosphorus contents of two of the boxes. The third box, which bore the words "Cleopatra Needle Matches, Bryant and May," she handed to the matron when telling her story. She said the taste of the phosphorus was very disagreeable. It was ascertained that, during the night, she had vomited a little, but unfortunately the vomited matter was not kept, and apparently did not attract attention by either its luminosity or its odour. Next morning she seemed slightly out of sorts, and nothing serious being suspected, she was given a dose of castor oil by her nurse. She ate a fair breakfast. At the medical visit it was noticed that she was not quite well, but she explained that she had been costive and had had a dose of castor oil. When seen after her statement to the matron she said she had a slight "indigestion feeling," a disagreeable taste in the mouth, some nausea and a very slight general feeling of *malaise*. She showed a disinclination for food, the temperature was 98.8° F., and the pulse, which was fairly normal in character, was 90 per minute. There was no tenderness on pressure of the abdomen and no phosphoric odour of the breath. Later in the day her bowels acted, and after taking a seidlitz powder she vomited a little bilious mucus, but neither then nor at any time during her short illness was there observed in either the motion or the vomit any luminosity in the dark, any smell of phosphorus, or any sign of the red heads of the matches. In the evening the temperature was 98.8° F., the pulse was 100, and the symptoms remained much the same as in the afternoon. On the morning of February 5th, the nurse stated that the patient had slept well during the night, but had appeared a little restless at times as if dream-