...and, for the benefit of the profession, I will briefly state the condition of the patient from that date till the present time. Colopuncture was performed on October 30th, 1879. He remained quite well till the month of September 1880. At that time, he took a rather long walk over a hill. The day following, I heard the click-clicking sound which was often heard in his previous illness. All the symptoms previously described began to show themselves. I did not allow the restriction to become so great as it was at the time of the operation. I passed the long tube per anum at the end of eight days, and let off a large quantity of gas. From that date till the present, I have been under the necessity of letting off the gas every eight days, either by passing the long tube or performing colopuncture. I have punctured three times since the month of November, 1880. At the beginning of the year 1881, I began to pass a rectum-bougie every second day. I had to use the smallest size (about the size of the ordinary stomach-pump tube). I had an idea that the cause of obstruction might be at the upper part of the rectum. It was almost impossible to get the finger introduced into the rectum, on account of the violent contraction of the sphincter ani. I introduced the rectal-speculum, and distended the sphincter ani as much as I could. I inserted my finger as far as I could, and thought I found something like a fleshy mass at the upper part of the rectum. I diagnosed the case as one of intussusception. I now adopted a somewhat novel plan to cure my patient, and the result was most successful. I got the ileo-caecal portion of the bowel of a sheep. To a portion of it six inches long, I inserted a small ivory tube three inches long; to the one end I tied the intestine of the sheep; to the other I tied an elastic tube one foot long; to the end of the elastic tube I tied a small stopcock. I introduced the long tube, and let off the gas. I now put in the intestine of the sheep through the speculum. As soon as it was completely within the cavity of the rectum, I blew it full of air, and turned the stopcock. This at once pushed the prolapsed bowel up, and I could feel the distended bowel taking the direction of the descending colon. I allowed the distended bag to remain in for half an hour; then opened the stopcock, and cautiously withdrew the bag from the rectum. Next morning, all the distension was gone, and the click-clicking sound was heard no more. The following day, the patient had a very natural motion of the bowels, the first of the kind since the month of September last. He is now quite well. It is now easy to understand what took place at the time of the first operation of colopuncture. The violent peristaltic action of the bowel produced the intussusception portion, and consequently got rid of the obstruction.

DUPUYTREN'S CONTRACTION OF THE FINGERS IN WOMEN.

By William Adams, F.R.C.S., Surgeon to the Great Northern Hospital, and Consulting Surgeon to the National Orthopaedic Hospital.

DUPUYTREN'S contraction of the fingers is, according to the testimony of all surgeons, an extremely rare occurrence in the female; and the communication of Dr. Carter of Leamington, published in the BRITISH MEDICAL JOURNAL of December 24th, 1881, is therefore of great interest, as he records two cases of this affection occurring in the female; one, now under his own observation, in a lady aged 88; and the other a sister of this lady, said to have been similarly affected, who died at the age of 70.

From Dr. Carter's description of the cases now under his observation, more especially from his remark that "there is much puckering of the skin of the palm", I have no doubt that the case he records is a genuine example of Dupuytren's contraction; i.e., a contraction described by Dupuytren as a "contracture of the palmar fascia and its digital prolongation, by which the fingers are drawn towards the palm of the hand, and contracted independently of the flexor tendons."

In all probability, the second case referred to by Dr. Carter may...
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also be accepted as a genuine case of Dupuytren's contraction; but the first case referred to is a valuable contribution to our knowledge.

When I published my little work on Dupuytren's Finger Contractions in 1879, I stated that "I have never seen it in women"; and since that time only one case has fallen under my observation, and that occurred in a lady aged 66, who consulted me in October 1880, in whom both hands were similarly affected, but the right in a more severe degree than the left. The little finger of the right hand was flexed towards the palm by a prominent fascial band. Contraction of the ring-finger was only just commencing. In this hand, also, a fascial band passing to the thumb was distinctly prominent, and the thumb was slightly drawn towards the palm. In the left hand, the first phalanx of the little finger was not flexed by a prominent band; and in this finger the chief contraction was between the first and second phalanges. In both hands, the skin over the entire palm was dimpled, depressed, and puckered in folds, showing the extent to which the palmar fascia was involved, and the close adhesions between the skin and fascia. In this case, of which models have been preserved, as some improvement in the right hand followed gradual mechanical extension by an instrument, the operation has been deferred. I may add that this lady had been the subject of gout, and belonged to an extremely gouty family. Her father and brother had both suffered from contracted fingers.

Another case, of a somewhat doubtful character, which might be described as a spurious Dupuytren's contraction, occurring in a lady aged 48 (a single lady), was brought under my notice by Dr. F. M. Mackenzie in September last. The ring-finger of the right hand was drawn nearly halfway towards the palm, as a result of a wound in the palm of the hand from a broken glass bottle fourteen years previously; small fragments of glass remained impacted, and were taken away three years afterwards, since which time the contraction had been gradually increasing. A prominently contracted band of fascia played a more important part than usual in this case of traumatic origin, in which all the tissues are generally implicated; and, after its subcutaneous division, the finger was immediately straightened more than we could have anticipated.

My experience, therefore, agrees with the opinion generally expressed, that this affection very rarely occurs in women; and Dr. Myrtle's large practical experience coincides with this opinion. Dr. Myrtle's valuable paper on Dupuytren's Contraction of the Fingers, published in the British Medical Journal of December 3rd, 1881, is full of practical observations. His views as to the traumatic and idiopathic varieties, also as to the cause or causes and mode of production of the contraction, its connection with gout, etc., are of the greatest interest; but at the present time I wish to refer chiefly to the frequency or otherwise of the occurrence of this affection in women.

Mr. Reeves, in his communication to the British Medical Journal of December 31st, 1881, differs from other authorities as to the rarity of the occurrence of Dupuytren's contraction of the finger in the female, and observes: "I can clearly recall five cases, and I am sure that I have seen at least seven or eight in females...... These cases prove not only that Dupuytren's disease is not confined to males, but that it may be regarded as not very uncommon in them."

Two of these cases are mentioned as occurring in young ladies, one aged 17, the other 25, devoted to piano-playing, the strain and irritation of which Mr. Reeves regards as the starting-point of the pathological change which produces the contraction. Mr. Reeves observes: "The younger patient has the ring-fingers of both hands affected, and the little finger of the right is also contracted. The fascial bands are not strongly marked as yet, although the disease has lasted two years. The second and older patient has only the ring-finger of the left hand affected. No allusion is made to prominence of fascial bands, nor to the condition of the skin in the palm of the hand, in this case; and no description whatever is given of the other cases referred to. Hence it is not strongly marked as yet, although the disease has lasted two years."

The above symptoms, coupled with the knee-reaction (patellar tendon-reflects) and ankle-clonus being more marked on the side to which the head turns in the initial tonic stage, and with the temporary absence (in one case for 30 minutes) of the superficial reflexes (sole of the foot, etc.), on the convulsed side in unilateral fits, which I have observed, tend, I think, to show that the nervous system is temporarily reduced by violent motor discharges to the same condition which is more permanently produced in hemiplegia, viz., paralysis, excessive action of the (so-called) tendon-reflects, diminution of the superficial reflexes, and conjugate deviation of the eyes.

REMARKS ON PEMPHIGUS.

The numerous readers of the British Medical Journal must have noticed the curious case of pemphigus by arsenic, as given by Mr. Jonathan Hutchinson in an abstract of a clinical lecture recently published. At the same time, if the treatment therein advocated be invariably followed, it cannot but lead, I think, to obstinate and discouraging symptoms. The author of this case, treated in my much respected teacher Professor McCall Anderson, in the cutaneous disease wards of the Glasgow Western Infirmary, made upon