dealt with. Considering the marked manner in which Sir Henry Thompson calls attention to the cases of small calculi removed by me, and the importance he seems to give to his having no calculi below 20 grains in his list, it might be reasonably anticipated that he is in the habit of dealing with larger stones than I am; and that the average weight of his calculi would show a large excess over that of mine. But what are the facts of the case? I refer the reader to the very able monograph on Lithotrity, in Heath's *Dictionary of Surgery*, written by Mr. Cadge, of Norwich, in which, in a kindly notice of my work, he points out that the average weight of stone in my first 108 cases of litholapaxy was 317 grains (nearly ⅔ of an ounce), whereas the average weight in Sir Henry Thompson's 75 cases done by Bigelow's method was 130 grains (a little over ¼ of an ounce). That is to say the average weight of my calculi was nearly two and a half times larger than Sir Henry Thompson's. These facts dispose of the erroneous impression I have referred to.

A CASE OF SUPRAPUBIC LITHOTOMY.

By ERNEST HUMPHRY, M.R.C.S., L.R.C.P.,
Mackay, Queensland.

A. W., aged 65, for the last three years has suffered from frequent and painful micturition, much aggravated by exercise. He had to give up riding on account of the pain it caused, and because of the quantity of blood passed with the urine afterwards.

On December 16th, 1887, I sounded him, and at once came down on a stone that seemed to be of considerable size. He was anxious for its removal, saying he would sooner die than suffer as he had been doing lately.

On January 4th, 1888, Dr. McBurney administered chloroform and Dr. Clarkson assisted me with the operation. A Barnes's india-rubber bag was first put into the rectum and distended with air. A silver catheter was then passed into the bladder and tied in, and about 8 ounces of water injected through it and retained. There was now dulness on percussion to about three inches above the pubes. An incision was made about four inches long, in the middle line, extending to the pubes, and the integuments, fat, etc., divided down to the bladder, which was easily made out by pressing up the catheter. The bladder was now seized laterally with two pairs of artery forceps near the pubes, and an opening made between them. The contained water immediately rushed out and the stone was easily felt. The catheter was now removed, and the incision in the bladder enlarged upwards and downwards, great care being taken to avoid wounding the peritoneum. The stone was then easily removed. The edges of the bladder were sutured with catgut, the mucous membrane not being included; the skin and deep structures were brought together with silk sutures, a drainage-tube being inserted at the lower end of the wound, which was dressed with carbolic oiled lint. A soft catheter was tied in the bladder *per urethram*. The operation lasted about an hour; the patient bore it well and was left in good condition. 10 P.M. Very comfortable; pulse 72; temperature 99.2° F.; blood-stained urine escaping freely through the catheter; a quarter of a grain of morphine hypodermically administered.

January 5th. 7 A.M. Passed a good night; pulse 72; temperature 99.2°; urine clear; some redness and œdema at lower end of wound and on dorsum of penis. 11 A.M. Vomited; much pain in wound; pulse 84; temperature 101.2°; redness on penis increasing; the three lowest sutures removed and the wound opened slightly; a quarter of a grain of morphine used hypodermically. 11 P.M. General condition much improved; feels quite comfortable; pulse 78; temperature 99°.

January 6th. Good night; pulse 78; temperature 99°; wound healthy, redness less; urine offensive; catheter changed and bladder washed out with a solution (one drachm to a pint) of boracic acid.

January 7th. Suffered in the night from flatulence; an enema administered; while straining during action of the bowels some urine escaped through the wound.

January 14th. Has been going on well; upper part of wound healed; urine passing freely through its lower part, very little escaping through the catheter, which is frequently getting blocked with discharge.

January 18th. Much improved; the catheter has been taken out, and, although the urine escapes freely through the wound, he has passed some twice naturally *per urethram*. A thick pad of lint was firmly strapped over the wound, and he was allowed to get up.

January 14th. Wound healed; has been walking out, and is quite well; expresses himself as feeling better than he has done for years; no trouble with micturition; can hold his water comfortably for six hours; urine clear and free from albumen.

The stone was oval in shape, weighed just over 5 ounces, and was eight inches and a half in its largest circumference. I have not had an opportunity of cutting it, but its outer crust is evidently phosphate of lime. The evident size of the stone gave me no option but to adopt the suprapubic operation. The only anxiety the case gave me afterwards was the redness that appeared about the wound and penis, probably the result of some very small extravasation of urine.

TWO CASES OF SUPRAPUBIC CYSTOTOMY FOR VESICAL TUMOUR.

By GILBERT BARLING, B.S., F.R.C.S.,
Assistant-Surgeon to the General Hospital, Birmingham.

CASE I. *Fimbriated Papilloma: Recovery.*—M., a stout man, aged 67, was admitted to hospital, September 22nd, 1887. He stated that for the last five years he had frequently noticed blood in his urine, and that it appeared without cause and disappeared in like manner. Eighteen days before admission an unusually severe hæmorrhage commenced, and continued without intermission until operation, twenty-one days after it started. The urine, always deeply tinted with blood, and specially so towards the end of micturition, was acid in reaction and free from pus; micturition was frequent, nearly every hour in fact, but without actual pain, although at times there was discomfort from the passage of clot. Careful and repeated examination of the urine failed to detect fragments of growth. Palpation failed to detect any enlargement of the kidneys. Rectal examination revealed general enlargement of the prostate, but bimanually no tumour or thickening could be felt in any part of the bladder. The diagnosis made was vesical papilloma, and the high operation was determined on. When the bladder was opened the finger detected a soft sessile tumour the size of a rather small strawberry, situated at the posterior part of the floor. The growth was easily removed with a scoop, leaving the coats of the bladder apparently healthy. The incision in the bladder was treated in the ordinary way, no attempt being made to suture it. The patient made a slow recovery, and remains well at the present time. Microscopic examination of the tumour showed it to be a papilloma.

CASE II. *Scirrhous Carcinoma: Death: Partial Post-mortem Examination.*—Mr. —, a thin, nervous man, aged 61, the subject of chronic bronchitis and asthma, was seen by me in consultation with Dr. Edginton. There was a history of intermittent hæmaturia for two years, the attacks varying both in frequency and severity, but, on the whole, becoming decidedly worse during the latter part of the time. Examination *per rectum* detected some enlargement of the prostate, but bimanually no tumour or thickening could be felt in any part of the bladder, nor could anything be made out by that method when the patient was anæsthetised for operation. The sound was introduced with some difficulty, but detected nothing abnormal in the bladder, nor did it excite hæmaturia. Palpation failed to detect any enlargement of the kidneys. The urine was examined several times for the presence of tumour fragments, but none were found, nor was there any pus present. During the attacks of hæmaturia micturition was frequent, and pain was produced by the passage of clot, but in the intervals there was neither pain nor increased frequency. The diagnosis made was vesical tumour, probably papilloma. The patient's sight failing him, he was seen by Mr. Priestley Smith, who found him suffering from "incipient atrophy of both optic nerves, probably due to the frequent and profuse losses of blood by the urethra." On March 7th, assisted by Dr. Edginton, I performed suprapubic cystotomy, and, on passing my finger into the bladder, detected a flat sessile growth about the diameter of a crown piece, situated on the left side of the posterior wall, and encroaching on the vertex; the centre of this patch was soft, and bore short papillæ; the margin was slightly raised and indurated. The papillary surface was scraped away with a scoop and the finger-nail, a drain was placed in the bladder, and the incision in the latter left unsutured. During the whole proceeding we had the utmost anxiety from the depressing effect of the chloroform on the patient's heart

(ether being inadmissible); and Mr. Elliott, who very skilfully managed the anæsthetic, found that when it was pushed to the extent of producing muscular relaxation, the heart almost flickered out. The following day, March 8th, the pulse was 120, feeble, and intermittent; the wound looked well; there was no tenderness or sickness.

March 9th. Wound looking well, no tenderness, no sickness; troubled with flatulence. Temperature 101°, pulse 106. Had an attack of dyspnœa, which depressed him greatly.

The two following days the record was much the same, a failing pulse with repeated attacks of dyspnœa of great severity. The wound all the time was satisfactory, and although there was flatulence there was neither tenderness nor sickness. Death took place on the fourth day after operation. Examination of the parts after death showed complete absence of urine infiltration. The peritoneal reflection lay at the upper part of the incision and was quite intact; a coil of small intestine was slightly adherent here, but there was no general peritonitis. The growth occupied the extent and situation described at the operation; its central part was excavated and rather sloughy; about a quarter of an inch of tissue intervened between its base and the peritoneum, the latter being firmly adherent here, so that it could not be stripped off. The lower margin of the growth was situated one inch and a half from the orifice of the left ureter. The ureters were not dilated. The prostate weighed nearly one ounce and three-quarters. No enlarged lymphatic glands could be detected in the abdomen or pelvis. Microscopic examination showed the growth to be a scirrhous carcinoma.

REMARKS.—The diagnosis of papilloma was made in each of these cases from the recurrent hæmaturia, and the absence of pain and increased frequency in the intervals. That these two symptoms were wanting in the malignant growth is no doubt explained by the very unusual position of the tumour at the vertex. Bimanual palpation might have been expected to give some assistance in the diagnosis, yet under anæsthesia not even a suspicious thickening could be recognised in Case II. At the time of the operation the possibility of excision of the carcinomatous tumour was in my mind, as the conditions seemed eminently suitable for Antal's extra-peritoneal method. The *post-mortem* examination showed, however, that it was impossible to separate the peritoneum from the base of the growth, and the patient's condition on the table quite prohibited me from making the attempt.

OBSTETRIC MEMORANDA.

LABOUR COMPLICATED BY PROLAPSUS AND HYPERTROPHY OF THE CERVIX UTERI; ITS PROGRESS AND TREATMENT.

THE patient, a woman aged 38, had been troubled with prolapse since the time of her girlhood, and a sister of hers had suffered from a similar affection. She was married at the age of 34 to a man aged 60, a printer, and gave a history of two former pregnancies, each of which had terminated in miscarriage at the fourth and fifth month respectively. During the present pregnancy the patient had worked very hard at washing, which often demanded great physical exertion.

She was first seen early on Tuesday morning, when she complained of continuous pain in the lower part of the back and abdomen, intensified at intervals of ten to twenty minutes. On bimanual examination the cervix uteri was found completely blocking up the vulvar opening, so that the finger could not be passed into the vagina, and projected externally for about two inches as a round fleshy mass three inches in diameter, tense and œdematous to the touch, with the central os sufficiently dilated to admit the forefinger. The fœtal head, covered by membranes and protruding slightly during the intensity of the pains, was felt at a distance of three inches from the external os. For several hours no further effect was produced on the fœtus, and 1 grain of opium was given. The patient soon obtained relief, and slept for some hours.

Next day the pains returned with greater frequency, and the membranes soon ruptured. The cervical mass increased in size, and now projected externally for three inches, with a diameter of about four inches; the central aperture was patulous to the same extent as on the previous day, and the fœtal head occupied the same position as then. After lasting for several hours the pains again left the patient, and next morning returned with greater severity. The fleshy cervix increased further in size, was tense, painful, and of a dull red colour, and appeared in imminent danger of sloughing. Hot fomentations were then applied continuously for four hours to this portion of the cervix, when it was found to be softer to the touch and rather smaller in diameter, with the fœtal head visible at the central aperture as a circular mass the size of a shilling. The edges of the cervical opening were still too rigid to allow of the expulsion of the fœtal head, so the fomentations were continued, and chloral in 20-grain doses was given every ten minutes. Rapid dilatation of the os followed, and at the end of half an hour the seven months' fœtus was easily expelled, and was shortly followed by the placenta. The patient immediately fell into a deep sleep, attended with insensibility of the pupils. She could not be roused by the ordinary means, but the subcutaneous injection of 5 minims of ether was followed by immediate effect; she could then be roused, and was able to drink some brandy. Next day the patient showed symptoms of collapse and exhaustion, and the cervical mass, though softer, was little smaller than on the previous day and quite irreducible. Towards evening the symptoms of collapse increased; stimulants and the tincture of strophanthus were administered, but the patient expired shortly after midnight. H. T. BARTON, M.B., C.M.

Burnley.

CLINICAL MEMORANDA.

CASE OF FATAL EPILEPSY IN AN ADULT.

ON April 13th, 1888, I was called to Albert H., aged 43, a mason. He had always been perfectly healthy, but had complained of pain in the head and giddiness for the past few weeks; he had never had a fit of any sort before, and was very intelligent. On the day named he had just had his dinner at mid-day, went out of doors to resume work, fell down insensible, was picked up, and was immediately sick. On my arrival about an hour and a half after the attack, I found him perfectly unconscious, pupils no larger than normal, but entirely unaltered by exposure to light, face pale, with a clammy perspiration over it; hands warm, but slightly clenched; arms, legs, and body quite rigid, and feet very cold. I had him carefully removed home, a distance of about half a mile; put to bed, heat to feet, and tried to administer stimulants (ammonia), but the act of doing so brought on fresh convulsions, when the breathing was stertorous, with slight foaming at the mouth. When I left he was quiet, and seemed likely to fall into a gentle sleep, but convulsions returned in rapid succession, and he died from exhaustion five hours after the onset of the attack. During a convulsion the pulse became very weak, but regained power between them, but was weaker with each attack. The respirations increased in frequency during attack, but were tranquil between them. My prognosis was guarded; if attacks ceased, he would recover, but otherwise would sink from exhaustion, and the latter proved to be the case.

Would not this be a case of death in the *status epilepticus*, which Bristowe mentions as a rare termination; and was it not strange that the patient had never before shown any symptoms of this disease? His father and several brothers and sisters had died in fits. HERBERT V. RAKE M.R.C.S.Eng., L.S.A.

Fordingbridge.

GYNÆCOLOGICAL MEMORANDA.

CASE OF INVERSIO UTERI OF FOUR MONTHS' STANDING: CURE.

C. G., aged 21, primipara, confined on Sunday, November 1st, 1884, at 3.30 P.M., after sixteen hours' labour, by a midwife. Male child, born out of bed; the patient then got into bed; the placenta came away after a short time, the mother observed "midwife take hold of cord," once or twice before the placenta came. Afterwards flooding commenced, and continued until 7 P.M., when the patient's condition gave cause for alarm. Mr. Brash was then sent for; he quickly attended, and called to his aid Mr. J. Delpratt Harris; unsuccessful efforts were made to return the uterus, and again under chloroform. She was removed to the Devon and Exeter Hospital. On November 23rd Dr. Aveling's sigmoid repositor was applied, and worn until the following Friday, then removed on account of pain and serious condition of the patient. Pelvic cellulitis appeared, frequent vomiting and diarrhœa; at the end