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Medical Memoranda

Paraffin-wax in the Male Bladder

The following case of a foreign body in the bladder, and the method of evacuating it, may be of interest.

CASE REPORT

One evening a young man, acting under an obsessive compulsive urge, fashioned a bougie, about $2\frac{1}{2}$ in. (6.25 cm.) long by about $\frac{1}{4}$ in. (0.6 cm.) in diameter, out of candle droppings and passed it up his urethra, from whence it slipped into his bladder. The next morning he came to hospital complaining of pain and frequency and giving the above history. Cystoscopy showed the bougie, broken into three fragments, as three white rods floating in the water used for distending the bladder. A Braasch direct cystoscope was passed and efforts were made to grasp the fragments with a Bumpus specimen-taker. These efforts were unsuccessful, because the paraffin rods, floating at the top of the bladder, eluded capture by bobbing away. As the paraffin-wax from which this candle was made was capable of solution by liquid paraffin of medicinal quality of a specific gravity of 850 at a temperature of 120° F. (48.88° C.), it was decided to try dissolving the bougie. A piece of candle $\frac{3}{4}$ in. (1.9 cm.) long could be dissolved in 20 minutes, and it was hoped that solution of the bougie would be effected by washing out the bladder for an hour with the liquid paraffin at a temperature of 120° F. The bladder was accordingly filled with the specified liquid paraffin and emptied at two-minute intervals, 2 oz. (57 ml.) of the oil at 120° F. being used for each filling. The washings from the bladder undoubtedly contained fine particles of wax, but cystoscopy immediately afterwards showed no appreciable difference in the size of the rods. The possibility of melting them by using short-wave diathermy was inquired into, but as the elevation of temperature would not exceed 5° F. (2.8° C.) above blood heat the idea was abandoned.

In 1924 Wardill, of Newcastle, described a technique for cystoscopy using liquid paraffin as a medium instead of water. The wax from which the bougie was made sank in liquid paraffin of a specific gravity of 850, and by using liquid paraffin instead of water and thus having the fragments of the bougie lying on the trigone instead of floating near the fundus it was hoped that the Braasch cystoscope and Bumpus specimen-taker, so useful in the extraction of foreign bodies heavier than water—stones, etc.—might do the trick. However, we met with failure again, because air bubbles, which the bubble extractor

of the Braasch cystoscope could not expel, prevented visualization and the bougies were not even glimpsed.

As a last resort, 4–5 oz. (114–132 ml.) of liquid paraffin of a specific gravity of 850 was instilled into the bladder and the patient was asked to void. It was hoped that this manoeuvre, by bringing the fragments of the bougie more on a level with the internal urinary orifice, might effect their evacuation. At the first filling one fragment of the bougie came away, and at a subsequent filling, a couple of days later, the remaining fragments were voided. Doubtless the lubricating effect of the liquid paraffin played some small part in helping their expulsion. The above operations were carried out under penicillin-sulphonamide cover.

It is quite possible that the use of liquid paraffin of low specific gravity, as described above, may prove helpful in securing the evacuation of other lighter-than-water foreign bodies not too large to be voided. The method seems so innocuous that it is worth a trial, and information regarding such trials would be very welcome.

It is obvious that it would be simplicity itself to remove these fragments by cystotomy, but it seemed a pity to do this if it could be effected otherwise.

It is a pleasure to acknowledge help from Dr. R. Collis, Dr. Norman Moore, Mr. Albert le Brocq, of the Greenmount Oil Co., Dublin, Dr. Dacre Hamilton, of Dublin University Medical School, and Mr. Morris, of the Irish Electro-Medical Co.

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Histamine Desensitization in Ménière's Disease

The following case of moderately severe Ménière's disease responded so well to treatment by histamine desensitization that it is considered worth recording. This form of treatment in histamine-sensitive patients is most strongly recommended, as there is little doubt that it achieved success in this case. The result also supports the findings and experience of Miles Atkinson and others who have obtained success in the great majority of their cases.

CASE REPORT

The patient, a high-ranking officer in the Royal Air Force, was posted abroad in November, 1946, to take command of a very important air-training project. Shortly after his arrival I was called one night to see him, as he was suffering from a sudden attack of intense vertigo, with nausea and vomiting, tinnitus, and deafness.

I arrived to find him quite prostrate, with extreme pallor, and covered with clammy sweat. He was vomiting repeatedly and complained of pronounced giddiness except in the prone position. His pulse was very rapid and barely palpable. There appeared to be a momentary loss of consciousness. I could not detect nystagmus, though this sign was evident in subsequent attacks. The cardiovascular, respiratory, and central nervous systems were clinically normal and I could find no evidence of focal sepsis. Little doubt remained that this was a case of Ménière's disease—a diagnosis supported by his previous history.

His wife informed me that he had suffered two previous attacks in England, the first some months previously and the second shortly before he left the United Kingdom. He had been seen then by two specialists, both of whom had confirmed a diagnosis of Ménière's disease. He had been taking 2 gr. (0.13 g.) of phenobarbitone twice daily for several months and had been given the usual instructions regarding reduced salt and fluid intake. I prescribed bromides and hyoscine, which gave some relief, but his attack continued practically throughout the night. He had completely recovered in 48 hours, but stated that his hearing was still somewhat impaired and that tinnitus was troublesome. It was known that he had

been suffering from a high-tone deafness for many years, and the impairment of hearing was therefore not altogether related to Ménière's disease. Exactly a fortnight later I was again called out in the early hours and found him in a precisely similar attack, from which complete recovery occurred again within two days. The attacks continued at roughly two-weekly intervals, a total of six being recorded.

In January, 1947, some two months after his arrival overseas, when I had attended him in five attacks, I was faced with the problem of deciding whether this valuable officer could remain abroad or whether I should have to invalid him. He had been specially selected for this post because of his wide experience, and he was naturally most anxious to fulfil his mission. I discussed his case with several colleagues, including an E.N.T. consultant. As a result of these discussions and information obtained from current literature—e.g., Atkinson, M., *Proc. R. Soc. Med.*, 1946, **39**, 807—a skin test was carried out in order to determine whether he was histamine-positive or histamine-negative. The test is fully described in the "Any Questions?" section of the *British Medical Journal* of May 10, 1947 (p. 666), and is of course an essential preliminary to treatment if histamine desensitization is contemplated. The patient proved to be a well-marked example of the histamine-sensitive group, and I decided that he might well benefit from a desensitizing course of histamine. This treatment is also described in the section of the *B.M.J.* quoted above.

The sixth attack since his arrival developed in the early stages of treatment, which was begun in January, 1947, but was notably less severe than those from which he had previously suffered. The course was completed in April, 1947, since when (apart from mild tinnitus), he has been in excellent health and completely free from further attacks. There has also been subjective improvement in his hearing. It should be mentioned here that he has had no phenobarbitone or other medication for the past 12 months.

As more than two years has elapsed since this treatment was first given, it is reasonable to assume that a cure has probably been effected; in any case, a remarkable response has been demonstrated to histamine desensitization. Several skin tests carried out since this time have shown a consistently negative reaction.

A point of interest is that the patient's flying category, which was reduced in 1946 to non-combatant flying (passenger only), has been restored to that of an active pilot category, and he has been able to carry on with an arduous and intricate task at a highly responsible level with the utmost confidence and efficiency.

I wish to thank the Director-General of R.A.F. Medical Services and the patient for permission to publish this case.

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Congenital Cyst of the Cystic Duct Containing Calculi

I have been unable to find a report of a cyst of the cystic duct; it may be of interest, therefore, to record a case that has been under my care recently.

CASE HISTORY

A married woman aged 56 was referred to me on account of attacks of upper abdominal pain and vomiting for two years. During the attacks some tenderness had been elicited over the gall-bladder region. There had been no previous illness, but during this period she had had discomfort after eating, with flatulence, and had gained considerably in weight. There had never been any jaundice. The attacks of colic and vomiting had coincided, and the vomit was either green or brown. She had never been pregnant, and the menopause occurred at age 50.

The patient was very obese and thick-set, but otherwise quite healthy-looking. The tongue was clean, the pulse regular 108 a minute, and the blood pressure 110/65 mm. Hg. No physical signs were detected except some haemorrhoids. During chemical and radiographic investigations (during which the only

abnormality noted was a group of five ring shadows medial to and a little below the shadow of a gall-bladder which emptied normally) the patient had two further attacks of colic, and after one of these I detected a definite tenderness below the right costal margin. In view of the severity of the attacks an exploration of the biliary passages was carried out.

Operation.—A general anaesthetic consisting of hexobarbitone, gas, oxygen, and ether by intubation was administered by Dr. E. S. M. Merry. A transverse incision was employed, but owing to the patient's obesity, the flatulence, and the high gall-bladder the incision had to be extended upwards through the rectus sheath to get the necessary exposure. The gall-bladder was partially enclosed in a tunnel of liver substance. Its fundus protruded through the anterior surface of the liver. The organ was distended with bile but did not look unhealthy; but medial to its neck a hard mass could be felt deeply buried in fat which also contained the common bile duct. On dissection of the mass the common bile duct was seen to be of normal size and free of calculi.

The hard mass was in the situation of the cystic duct and consisted of a thin-walled cyst packed tightly with calculi and biliary mud. On traction on the neck of the gall-bladder it was seen to be in continuity with the cyst (see Fig.). In an attempt to bring the parts

nearer to the surface the gall-bladder was dissected from the liver, but immediately it was pulled on gently it tore away from the cyst, with which it communicated by a small aperture. This was enlarged and the contents of the cyst evacuated—the mud by suction and five black pigment calculi the size of small peas by forceps. The walls of the cyst, which was the size of a hen's egg, were extremely thin and translucent. In view of the difficulty anticipated in removing it a tube was passed into the common duct through the cyst cavity and the size of the cyst reduced by plicating sutures. The gall-bladder bed was then peritonized and the wound closed.

Examination of the gall-bladder after its removal revealed cholesterosis and three calculi similar to those in the cyst itself. As the wall of the gall-bladder was at least of normal thickness and that of the cyst was thin, translucent, and devoid of fibrous tissue and muscle, I consider that the cyst was of congenital origin and not part of an hour-glass gall-bladder. There was no inflammation, and the symptoms seemed to have arisen mechanically when its fluid contents had been replaced by the mud and calculi. These appeared to fill its cavity, but the cholecystogram showed that a passage for bile still existed between the common duct and the gall-bladder through the cyst itself. No trace of a cystic duct was seen, and the opening from the cyst into the common duct was large enough to take a No. 10 catheter easily.

COMMENT

I believe that the absence of biliary mud from the gall-bladder and common duct and its presence in the cyst was due to the flow of bile carrying into the duodenum any that escaped into the common duct during attacks of colic, and that the weight of the cyst caused valve-like actions at its junctions with the common duct and gall-bladder.

I am indebted to Professor Paterson Ross for his helpful comments in presenting this case for publication.

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The *Manchester Guardian* (June 30) has reported that the Bath Education Committee has had to close the city's school dental service because of lack of professional staff. The result of this will be that 8,000 school-children will be deprived of regular dental inspection.