of the wound; and at the upper and lower end of the wound the intestine is fixed in the same way, taking care not to pierce the mucous coat. When the projecting bowel is cut away in the second stage of the operation, it sometimes bleeds freely at a few points, but they are easily seen, picked up, and tied.

In comparing inguinal or, as I prefer to call it, anterior, with lumbar colotomy, let me take the two operations as they affect the surgeon, and as they affect the patient. Who that has performed lumbar colotomy can forget the long transverse incision, the deep dissection, the anxious outlook for landmarks, the groping about amongst connective tissue, the blowing up of the colon to aid the search and make the operator more certain that he has picked up the right thing; then the doubt and uncertainty attending it? Will the colon be found uncovered with peritoneum at the spot, or will it have a meso-colon, involving a prolonged search, and perhaps the opening of the peritoneal cavity? Again, look at the limited choice of position. The surgeon is limited to a small portion of the descending or ascending colon, according as he takes the left or right side. Lastly, consider the results. First, in regard to life: about 10 per cent. is believed to be the mortality as the immediate result of the operation, from erysipelas, shock, septicæmia, and other causes; and, in regard to the fulfilment of the object of the operation, every surgeon knows how often he is disappointed, owing to fæces still passing down over the raw and painful surface, and not all passing out of the wound. Contrast with these points in lumbar colotomy the small incision of anterior colotomy, about two inches being amply sufficient; the readiness with which the colon is reached—often, indeed, it bulges out into the wound; the certainty with which it is recognised, owing to the fibrous band and appendices; and the wide range of choice, extending, in fact, over the whole length of the colon. In most cases a small incision just inside the anterior superior spine will be the surgeon's choice. But, in my second case, I opened about two inches above that, so as to keep well clear of the disease; and, in the first, I opened in the linea alba. Lastly, compare the results. In regard to the immediate effect on life, Mr. Allingham, in his paper, records six cases, all recovering. He may be said to have acquired special skill, and to employ special care; but here we have seven cases, under four different surgeons, and all recovering, although the first was done under circumstances which Mr. Allingham himself regards as highly unfavourable.

In regard to the fulfilment of the object of the operation, that is most complete in every case. When the bowel below the wound gets emptied nothing more passes, and the patient is ever afterwards freed from the pain and annoyance of fæces passing over the raw, cancerous surface.

In conclusion, to make the contrast complete, compare the two operations as they affect the patient's comfort. In lumbar colotomy, the artificial anus is in a place which he can reach only with difficulty, and cannot see at all, and must in consequence be beholden to others for his cleanliness and comfort. In anterior colotomy there is an opening which he can see and easily reach, which in time acquires a kind of sphincter action, and which can be kept blocked by a proper truss. He is, therefore, beholden neither to man nor woman in the discharge of a function in which every decent human being wishes to be independent of extraneous help.

A CASE OF INVERSION OR "PROLAPSE" OF THE URETHRAL MUCOUS MEMBRANE.

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Miss N., aged 9, from her early childhood had had difficulty in holding her water any length of time, but had otherwise been well. On February 3rd, 1888, after the child had suffered for two or three days from a severe cough, which all domestic remedies failed to relieve, her mother was alarmed by finding a sanguineous discharge from the vulva.

On February 6th, Mr. S. Welch, of Victoria Park Road, was sent for. He found a dark red, cherry-like tumour in the situation of the meatus urinarius.

On February 8th, I saw the patient in consultation with Mr. Welch. The tumour consisted of a sort of thick frill, deep red in colour, projecting for rather more than half-an-inch from the

lower part and sides of the meatus. At the upper part of it was an opening, which the catheter entered. The tumour was not exceedingly tender, and the patient complained of no pain or difficulty in micturition.

On February 14th, the patient was anaesthetised. The state of things was the same, except that there were some small sloughy spots on the most prominent part of the protrusion. A wooden staff was put in the urethra, and upon this the prolapsed mucous membrane was cut off all round with the platinum knife of the Paquelin cautery. The child recovered well. There was much pain in passing water for some days after the operation, which was relieved by the patient's passing water in a warm bath.

The morbid condition in this case (prolapse, or inversion of the urethral mucous membrane) is a rare one. The literature relating to it is scanty, and much of it unsatisfactory, because in reading many of the reported cases, one cannot help thinking, as to some that they were cases of vesical tumours, projecting through the urethra; as to others, that they were simply urethral caruncles. Judging from the few cases that are well described, it seems to occur chiefly in children, and in the later years of childhood. It does not cause much trouble in micturition, but the protrusion is tender, although the tenderness is nothing like that of a urethral caruncle. The protruded mucous membrane often bleeds.

The treatment advised in the textbooks is various, and in some is, I venture to think, unnecessarily difficult and complicated. Thus the writer of one manual, following the lead of Dr. Emmett, of New York, recommends his "button-hole" operation, that is, making a "button-hole" in the urethra from the vagina, pulling out the mucous membrane at this button-hole (so as to pull back the protruded part), and cutting it off, then sewing up the "button-hole." It seems to me more rational to cut off the protruded and congested mucous membrane rather than some healthy mucous membrane higher up, to say nothing of its being a simpler and easier operation. There is a case reported by Guersant¹ in which, fourteen days after the protruded mucous membrane had been cut off, the patient, aged 10, died from tubercular disease, and a necropsy was made. It was found that the urethra was only covered with mucous membrane over its posterior third. The anterior two-thirds were bare of mucous membrane, and the cellular tissue exposed. This shows that, after cutting off the protruded part, the mucous membrane above, which had been dragged down by the protrusion, may be spontaneously retracted into its normal position.

In another textbook, Dr. Gaillard Thomas, of New York, is honoured by being quoted *verbatim*. He recommends cutting off the protruded part, and then leaving a catheter in for some days. Why the catheter should be left in the author does not say. It will cause pain, and may set up cystitis, and I cannot see what useful purpose it serves. The best treatment seems to me very simple, to return the protruded part if possible, and, if not, to cut it off. This is quite enough without tormenting the patient by fastening in a catheter.

OBSTETRIC MEMORANDA.

A WOMAN TREATED SUCCESSFULLY TWICE IN THREE YEARS FOR COMPLETE PLACENTA PRÆVIA.

THE following short account may be of interest as showing the extraordinary power of recuperation possessed by women after the most exhausting hæmorrhage and total loss of strength, and also grounds for a supposition that there is not only in some women a tendency to recurrence of ordinary adherent placenta, but a tendency on the part of the placenta to become adherent over the same abnormal site—namely, the os uteri.

In June, 1886, I was called to Mrs. W., and found her fainting, blanched, and almost pulseless, with abundant indications of the most violent hæmorrhage. After administering ether, etc., I found on examination a presenting placenta, and, warned by the recurrence of the bleeding, and with no time to send for my assistant, I very quickly detached a portion of the adherent placenta, introduced my hand into the fundus, turned, and brought down a foot, and, using gentle traction, I only paused when the thigh of the fetus completely blocked the os. After readministering stimulants I brought away a large full-grown child, and immediately removed carefully the entire placenta, which was attached completely over the os. Kneading and the action of a large dose of ergot, given

¹ *Rev. Méd. Chir. de Paris*, Dec., 1852, p. 357.