time, a suprapubic fistula. I believed that by thus diverting the urine I should not only succeed in abating the cystitis, but that the burrowed condition of the perineum would improve, and that probably the large opening there which had resulted from the original operation would tend to close. If it did not altogether close I determined again to vivify the edges, and to apply deep sutures. The immediate effect of the operation was very satisfactory. The cystitis and pain disappeared. The pus still continued to flow in great quantities, but the general constitutional disturbance which preceded the operation entirely subsided. The patient had quiet nights, and he put up flesh. I watched the perineal wound with great interest, and it was gratifying to observe that it gradually contracted, and finally became as small as a pinhole. During four weeks a catheter was almost permanently retained through the suprapubic opening; but the patient, who was of a very irascible disposition, removed it on some occasions without leave, and allowed the urine to escape as it might. The catheter was passed two or three times a day, but as this irritated him very much, he finally begged that it might not be used any more. At this time the perineal fistula was about the size of a pinhole, and when the patient desired to pass water, he was able to keep the part dry by simply applying his finger to the opening. The suprapubic fistula slowly contracted, and finally closed altogether.

The condition of the patient at the end of three months was that his perineal fistula had been reduced to the size of a pinhole; that the suprapubic fistula was slowly closing; that his pain had become tolerable; that the urgency to micturate was diminished, so that he could retain urine for three hours.

This was so far satisfactory; but he now began to complain of abdominal pains, with irritability of stomach, and an examination showed that some enlargement of the liver existed. This gradually increased, and finally the patient died of exhaustion. The liver was enormously enlarged and lardaceous, and the left kidney was riddled with abscesses. The opening in the bladder had completely closed, and the perineal fistula, and the tracks leading to it, were almost obliterated.

Suprapubic cystotomy, for the purpose of "retrograde catheterisation," was performed by Sédillot; and Sir H. Thompson has practised suprapubic puncture in cases of irritability dependent upon enlarged prostate. I am not, however, aware that the operation which I have here briefly sketched has been deliberately done for the cure of obstinate perineal fistula. The effect in such an unpromising case as the one I refer to was certainly such as to justify a fair trial in other cases. The patient was very unmanageable, and he insisted upon having the india-rubber catheter withdrawn before perfect closure had taken place in the perineum. Yet the union, so far as it went, was firm; it showed no tendency to break down; the bladder-irritability was greatly reduced, the pain was almost removed, and the bladder could retain urine for several hours.

In a case of long-standing fistula, with considerable riddling of the perineal strictures, I would recommend, in the first place, thorough slitting and scraping or clipping out of all the fistulous tracts; the retention of a catheter through the perineum for several days, so as to prevent the passage of urine along the old paths; and then the opening of the bladder above the pubes by a small incision, so as to divert the urine in that direction. The suprapubic opening should be maintained until there is firm closure of all perineal fistulae. There need be no fear of the superior opening into the bladder remaining permanent, once we are in a position to permit urination by the urethra. The tendency of such tracts is to become obliterated when they are kept at rest and are relieved from the passage of urine through them. If, however, the closing should be delayed, the edges could be pared and the lips be brought together with a pin or two and a twisted suture. I hope that the procedure suggested in the foregoing paper will receive a fair trial, because I believe that in this way we may cure cases which we now regard as hopeless, and rescue many persons from a condition of misery.

ITALIAN HOSPITAL.—At the recent annual meeting of this charity it was stated that the present premises were no longer adequate, and steps were being taken to build an additional ward at a cost of £500.

BRIGHTON THROAT DISPENSARY.—Two wards for the reception of in-patients will be opened in March next at the Brighton, Hove, and Sussex Throat and Ear Dispensary.

REMARKS ON COLOTOMY.

By W. C. ARNISON, M.D.,

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THE readers of the JOURNAL will remember a paper by Mr. H. W. Allingham, in October, 1887, advocating inguinal or anterior colotomy, as being, in most instances, preferable to lumbar colotomy, and proposing an important modification of the old operation, namely, bringing the whole calibre of the bowel through the wound, and fixing it by means of sutures passed into the meso-colon, in such a manner that the deep part of the bowel, with the meso-colon, formed a projecting spur which effectually prevented faeces passing down the rectum, and secured their discharge entirely through the artificial anus.

At the time this paper appeared I had a patient under my care in the infirmary with malignant disease of the rectum, on whom I intended performing the operation of lumbar colotomy; but, after reading the paper, it appeared to me just the case for the new operation. There were no urgent symptoms, the finger could be passed through the constricted part, and I was waiting a convenient time to perform the first part of the operation, that of fixing the gut to the abdominal wall, when suddenly symptoms of acute obstruction set in, and rendered immediate operation necessary. In the concluding paragraph of his paper Mr. Allingham says: "In those cases in which the patient has been left too long, namely, when the abdomen is tremendously distended, necessitating immediate opening of the intestine, I certainly consider the lumbar operation the safer." My case was clearly one in which immediate opening of the intestine was necessary; and, bearing in mind Mr. Allingham's dictum, I had resolved upon lumbar colotomy, but in consultation with my colleagues—Messrs. Page and Dodd—considerable doubt was felt as to the obstruction being really caused by the disease in the rectum, for the finger could still be passed through the constriction; it was, therefore, deemed advisable to open the belly in the linea alba, so as to examine the whole length of the bowel, and let the result be the guide to further proceedings in the operation. This was done; the bowel was found distended down to the sigmoid flexure, showing that the obstruction was due to the cancer in the rectum. The colon was then caught about the junction of transverse and descending colon; and, having a good meso-colon, it was readily drawn out at the opening, and fixed in the manner described by Mr. Allingham; skin and parietal peritoneum were sutured together, and then visceral and parietal peritoneum carefully sutured together, both at the meso-colon and at the covering of the bowel at the upper and lower part of the wound. The patient was then turned on his side, and the gut freely opened under an antiseptic stream, which quickly washed away the faeces as they poured out of the bowel; pressure was applied and irrigation employed to empty the bowel more thoroughly. The wound was then well packed with tenax, and the patient removed to bed.

Recovery took place without interruption or drawback; the patient was restored to comfort and freedom from pain; he gained flesh and strength, and in a few weeks left the hospital able to attend to himself as regards cleanliness, with full power of expulsion, and considerable control over the faeces. He returned as an out-patient from time to time, but, in about six months after the operation, died from extension of the cancer in the rectum.

Of the seven cases of anterior colotomy (I do not use the term inguinal) which have now been performed in this hospital, this, the first case, seems to be the only one calling for any detailed statement, for it was not an inguinal colotomy, it was done under urgency, and the bowel was immediately opened.

Of the seven cases, two were under myself, two under Dr. Hume, two under Mr. Page, and one under Mr. Dodd. All were for cancer in the rectum; all excepting the first were done in two stages, first fixing the bowel in the wound, and after a few days opening it, and all were successful, the patient recovering from the operation, and the object of it being fully attained. In my first case I followed Mr. Allingham's plan of first suturing skin and parietal peritoneum together. At the time it seemed to me to make the operation more difficult and complicated, and I did not do it in my second operation. My colleagues have not done it at all. After drawing the bowel well out of the wound, we pass the needle through the peritoneum covering the meso-colon, then through the abdominal wall, taking care to include the parietal peritoneum, and tie in such a way as to fix the parietal and visceral peritoneal surfaces in contact. This is done on both sides

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.

By G. ERNEST HERMAN, M.B.LOND., F.R.C.P.,
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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 anæsthetised. 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.