than multiparæ; this however is simply due to the fact that being in many cases connected with parturition and abortion, those who are susceptible to this inflammatory disturbance evince it when those causes which tend to induce this disorder are for the first time called into existence.

If the disease be due to the rupture of any sac containing pus, or to the escape of any irritant fluid into the sac of the peritoneum the patient may never rally, but die within a few hours, it may be in a state of collapse. In a few rare cases it happens that adhesions already formed may prevent the extensive or free escape of such fluids, and recovery more or less complete is thereby rendered possible.

In the more acute cases the disease may be ushered in by a distinct "chill" or rigor, a feeling of intense indisposition being thereafter experienced. In the majority of cases there is no chill, and the patient is wholly unable to fix a time when the inflammatory process may have originated. Usually the onset is insidious. Often I have seen patients the victims of pelvic peritonitis who were wholly ignorant of the possible existence of anything like a grave disorder. The disease may, as in a patient recently under my care, develop in the peritoneum covering the rectum, without giving rise to any symptom other than a feeling of discomfort and pressure in the "back passage." In this case the uterus was closely applied through the medium of a small amount of plastic exudation to the upper part of the rectum. In many other cases which have come under my care, the insidious character of the disorder has been noteworthy and astonishing. In the majority of cases pain is the symptom most frequently complained of. This is as a rule referred (although not constantly) to the side which is the seat of inflammatory change. I have occasionally, as in the case of the pleura, noted its reference to the opposite, and as far as examination goes healthy, side. Sometimes the pains are ill-defined, and are felt more or less extensively in the lower abdomen. They may recur in paroxysms, and continuing severe for two or even five hours, leave the patient afterwards so very tender that she is wholly unable to bear even the slightest pressure on the lower abdomen. Such paroxysmal pains may, like those complained of at the onset of the disease, be accompanied with nausea and vomiting. The pains vary; sometimes they are slight, sometimes severe, and occasionally, especially when the peritoneum covering the uterus is involved, they are likened to those of labour.

Menorrhagia is a most common association of pelvic peritonitis, and in many cases it is this alone which leads the patient to seek advice. There is as a rule no pain so long as the hæmorrhagic discharge is free, a fact explicable on the ground of depletion. Pain may, however, develop and continue whilst the patient is losing, the loss apparently being insufficient to relieve the state of consequent increased vascular tension. This is especially apt to be the case if the inflammatory attack develop during menstruation, and there results no augmentation in the amount of discharge.

Pelvic peritonitis may develop in a woman who has either recently miscarried or been delivered of a full time child. Under such circumstances the symptoms are especially prone to be insidious. Slight pains may have been experienced since the abortion or confinement, or a hæmorrhagic discharge more profuse than usual may appear without the patient experiencing any other discomfort. The discharge, once established, continues as a rule free, and more or less constant for weeks or even months. Occasionally clots are expelled. In such cases no pain whatever may be complained of till the hæmorrhagic discharge ceases. The pain may be of the "bearing down character." This bearing down pain differs from that associated with initial prolapse in that it continues when the patient is recumbent. This symptom in pelvic peritonitis is the result of structural change, although it may sometimes be associated with structural enfeeblement as well. In prolapse it is a direct result of gravitation, and ceases to be experienced when the influence of this factor is withdrawn.

Pain may be referred to the hip, the thigh, or vagina, according to the distribution of those nerves implicated, whether directly or in a reflex manner. As a result of pressure, I have occasionally noted a distension of the superficial veins of the thigh.

Bladder Symptoms.—If the disorder be free from complication, there is, as a rule, no frequent desire to pass water. In the early days pain during micturition is seldom complained of. When, however, adhesions have formed, pain is experienced, either when the bladder is over-distended or over-contracted, and the pain will continue so long as either of these states of this viscus exists.

If the patient, therefore, does not answer immediately the call to pass urine, pain more or less severe is complained of. Under such circumstances pain is specially noted in the early morning after sleep. In the majority of cases pain is experienced for a greater or less length of time after the bladder rids itself of its contents.

Rectal Symptoms.—Plastic deposit may insidiously encircle the sigmoid and upper part of the rectum, and induce symptoms of pressure, with or without pains of a shooting character referred to the "back passage." The gut may even, in some rare cases, become completely constricted, and serious symptoms in consequence ensue.

In the majority of cases of pelvic peritonitis the temperature of the body is but slightly elevated, except when the inflammation is severe and extensive, or when the effusion is from the first purulent or has become so. In chronic cases the pain is, as a rule, aggravated just before, but is relieved by the appearance of the recurring hæmorrhagic discharge. Suppuration and abscess formation is not at all an uncommon result of pelvic peritonitis. Purulent exudation sometimes takes place (commonly in association with metrorrhagia and little pain), and usually ends fatally when the inflammation is severe and extensive. As a rule, adhesions are formed before the granulation tissue generates pus, and the pus so confined and accumulating produces one variety of pelvic abscess. The peritoneum itself, as well as the inflammatory adhesions confining the purulent exudation, become adaptatively thickened, and thereby the risk of extravasation into the general sac of the peritoneum is minimised. Fortunately rupture takes place rather towards the bowel, vagina, or some other pelvic structure, or occasionally towards the abdominal wall. The most frequent and by far the most advantageous location for discharge of the contents of a pelvic abscess is at some part of the bowel. I have seen pelvic abscesses in which the walls of the sac had become so thickened, and the fluid therein contained caused so much tension, that the differential diagnosis from that of uterine fibroid was rendered most difficult.

REPORT OF A CASE WHERE, FROM CON- GENITAL DEFORMITY, A MAN AGED FIFTY-FOUR YEARS HAS PASSED HIS FÆCES AND URINE BY THE URETHRA ALL HIS LIFE.

By FREDERICK PAGE,

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A. B., aged 54, a small-built man of a peculiar dark complexion, not unlike that of a person suffering from Addison's disease, was admitted into the Royal Infirmary, Newcastle-upon-Tyne, May 21st, 1888, and gave the following history. Immediately after birth it was discovered that fæces and urine were passed from the meatus urinarius, and that the anus was imperforate. An attempt was made by a surgeon to establish an anus in the natural situation, but the operation was not successful; fæces and urine still passed by the urethra, though fluid has from time to time escaped from the anus. At the age of 10 years the urethra became blocked by hardened fæces. Relief was obtained from an incision into the urethra immediately in front of the scrotum, and through the fistula thus formed the patient has continued with great difficulty and discomfort to pass his fæces and urine. He says he is in the habit of taking aperient medicine daily, and has to squeeze his fæces through the fistula with his fingers, the proceeding generally occupying from an hour to an hour and a half. From time to time the fistula has become blocked, and then the patient has passed his fæces and urine from the meatus. Sometimes, too, the urethra became blocked, and then the patient has passed his fæces through the fistula and his urine by the fistula and from the anus, till he has succeeded in displacing the obstruction. His urine is generally clear and natural in appearance, but sometimes there is a brown deposit from it, and it has a faecal smell. He has been married twenty-four years, and is the father of one child.

Latterly, the fistula has contracted, and thus his difficulty has been increased. Three days before admission the urethra became

blocked, and, being unable to remove the obstruction, he found himself, to use his own expression, fast, and was compelled to seek assistance. Upon examination, a fistulous opening into the urethra was found immediately in front of the scrotum, along which a probe passed readily towards the bladder. On attempting to pass the probe in the opposite direction, its progress was arrested by a hard substance firmly impacted in the urethra; the anal aperture would just admit a probe into the gut.

On May 25th, the urethra was slit up through the fistula for an inch and a half, and the substance blocking the canal, which was again a piece of hardened faeces, removed. The mucous membrane was then secured to the skin with sutures, and the fistula thus converted into a good-sized opening, through which he has continued to pass his faeces and urine so satisfactorily, that he is unwilling to submit to any other operation.

October 3rd. The patient reported himself to-day. He has to a considerable extent lost his dark, unhealthy complexion. His bowels act regularly without medicine, and he says he is more comfortable than he has ever been in his life.

In Mr. Harrison Cripps's recently published pamphlet on the passage of air and faeces from the urethra, sixty-three cases are quoted, but among them there is no example of the condition being due to congenital deformity. I think this case sufficiently unusual to be worth recording.

SURGICAL MEMORANDA.

ACCIDENTAL CURE OF HYDROCELE.

MR. SINCLAIR'S case of rupture of a large hydrocele (in last week's "Surgical Memoranda") is interesting, but I do not think a week is sufficient time to have elapsed to prove that the case is cured. My friend Mr. Nelson Foster, of Bicester, some years ago published a case of permanent cure after spontaneous rupture, but usually the accident does not excite sufficient inflammatory action to result in radical cure. If this were otherwise we might intentionally subcutaneously rupture hydrocele sacs, hoping to bring about an easy and safe radical cure.

For ten years I had regularly tapped W. H. M., aged 76, for a seventeen-ounce hydrocele. On April 25th, 1885, the hydrocele was very large, and he thought of coming to see me, but instead went to a Turkish bath, where rupture took place. The following September the hydrocele had returned to its usual size, and I drew off seventeen ounces.

I had three times in two years tapped H. W., aged 50, for a sixteen-ounce hydrocele. He went to the last Derby, and while there burst his hydrocele. The next morning I found the penis and scrotum full of fluid. He made a perfect recovery, but the sac is gradually filling, and will require tapping about the end of the year.

In both cases the extravasated hydrocele fluid was left entirely to the absorptive powers of Nature.

Wimpole Street, W.

G. BUCKSTON BROWNE

COMPARATIVE VALUE OF RIVAL METHODS OF REDUCING SUBCORACOID DISLOCATIONS.

On September 30th, 1888, I was called to see Mr. W. S., a stout, heavy man, aged 65. I found him suffering from a subcoracoid dislocation of the humerus, the result of a blow. Not caring to give an anæsthetic (having no assistance) I had him laid on the floor and endeavoured to reduce the dislocation by the method described by Dr. Neil Macleod in the JOURNAL for January 30th, 1886. I followed out his instructions, but could not succeed in accomplishing reduction; moreover, contrary to Dr. Macleod's experience, the right-angular traction method caused my patient intense pain. I then tried the old method with my heel still in the axilla, but this time bringing the arm down to the side, almost instantly the head of the bone went in with a loud snap, and (at least so the patient said) with very little pain.

Oulton.

J. R. PURDY, M.B.

GYNÆCOLOGICAL MEMORANDA.

AMENORRHOEA FROM IMPERFORATE HYMEN.

A TALL, well-developed young girl, aged 16, factory worker, complained of severe and continuous pain over the hypogastrium,

with frequent and painful micturition. She had never menstruated, but for five months previously, at intervals of about three weeks, she suffered from attacks of abdominal pain, accompanied by nausea and dysuria, lasting for several days, and compelling her to remain in bed. She felt well and was able to attend her employment during the intervals of the attacks. Her mother had noticed lately an increase in the dimensions of the abdomen. Upon examination the abdomen was found to be considerably enlarged. A globular, elastic tumour, extended from the pubes to within two inches of the umbilicus. A catheter brought away an ounce of urine. In the act of introducing the instrument an elastic tumour, which bulged outwards between the labia, was felt by the finger. It was found that pressure over the abdominal swelling increased the tension of the tumour at the vulva. This condition, on further examination, proved to be due to the presence of an imperforate hymen. The patient, who was of a nervous temperament, was anæsthetised. The vulva and adjacent parts having been well washed with perchloride solution, a medium-sized trocar was passed through the centre of the hymen. A chocolate-coloured fluid, inodorous and of the consistency of syrup, escaped through the cannula with considerable force, to the amount of fifty-four ounces. After the discharge ceased to flow the cannula was withdrawn, and the hymen divided by crucial incisions. The vagina was then well washed out with antiseptic solution. A plug of cotton wool was placed within the orifice, and a pad of the same material placed over the vulva. A dark-coloured discharge continued to come away in small but constant quantities for three weeks, at the end of which period it increased in quantity and assumed the character and appearance of ordinary menstrual fluid. The patient experienced complete relief after the operation. For the first week she remained in bed; her temperature never exceeded 99°, and she has menstruated painlessly and with perfect regularity since.

The membrane forming the hymen in this case was exceedingly strong and dense on its external surface; running in an antero-posterior direction were several serrated ridges, having the appearance of the comb of a cock in miniature. The internal surface was perfectly smooth. Microscopical examination showed no trace of muscular fibre. It was evidently composed of mucous membrane and strong fibrous tissue.

Tillicoultry, N.B.

D. W. CURRIE, M.B.

CLINICAL MEMORANDA.

ABSENCE OF MAMMÆ IN A WOMAN.

A CHILD, prematurely born, was brought to me for treatment aged about one week. I was told that the mother had "no nipples, and was like a boy." On examining her, I found she had no mamme, also no nipples, the position of the latter being marked by pigmented skin, about the size of a sixpence. On inquiry, I was told that in other ways she was as women usually are, and that labour had been performed quickly and naturally.

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Queenstown, Cape Colony.

A CASE OF MALFORMATION.

A CASE of multiform deformity which came under my care lately may be worth noting. When I first saw the child it was a few hours old, the mother having been attended by a midwife. In the lumbar region the child was the subject of a well-marked spina bifida. Arrest of development had also occurred in the frontal bone, a deep sulcus indicating the absence of bone leading from the supraorbital ridge to the anterior fontanelle, which was very large. The scrotum was represented by a very small loose pouch of smooth skin entirely empty, the testes being absent. The child was also the subject of talipes varus, or rather talipes equino-varus, in both feet, the latter being so much turned that the soles were uppermost. Hydrocephalus, as might have been expected, was very speedily developed, and the spina bifida became a large rounded semi-translucent tumour. Operative procedure was obviously out of the question. The vegetative life was well maintained. The child took the breast greedily and the bowels acted regularly. The usual nervous symptoms soon presented themselves, and the child died in convulsions at the end of three months.

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