[Table of Wounds of Joints, continued.]

No.	Name and Age.	Date of Admission, Operation, and Discharge; with Result.	Disease.	Treatment.	Remarks.
29	Jane D., 50.	<i>Ad.</i> , Oct. 15, 1878. <i>Op.</i> , Oct. 15, " <i>Dis.</i> , June 20, 1879. <i>Result</i> , cured.	Compound fracture of the lower end of the femur, with splintering of the condyles into the joint. Patient was seen one hour and a half after the accident.	The opening in the skin was enlarged. The projecting end of the femur was sawn off, and reduction was effected. The wound was washed out with 1 to 20 carbolic lotion. An incision was made into the knee-joint on the outer side, and a drainage-tube was inserted into the joint, to prevent accumulation of fluid.	Aseptic course. The drainage-tube was removed from the joint on October 28th, and the wound of the joint had completely healed on November 24th: the wound in the thigh healed on December 13th. As the fracture remained united, Mr. Lister injected iodine between the ends of the fragments on February 14th. Union not yet occurring, Mr. Lister cut off the ends of the bones and wired them together with thick silver wire. The femur is still united, but is under treatment.
30	Maria L., 60.	<i>Ad.</i> , Nov. 12, 1878. <i>Op.</i> , Nov. 12, " <i>Dis.</i> , April 19, 1879. <i>Result</i> , in process of cure.	Compound dislocation of the left ankle-joint, with comminuted fracture of the fibula and fracture of the internal malleolus. Skin in the neighbourhood of the wound much contused.	The detached portions of bone were removed; wound syringed out with 1 to 20 carbolic lotion. Dislocation reduced. Drainage-tubes inserted. Dupuytren's splint.	Aseptic course. Some portions of the skin sloughed. When discharged, the wound was almost healed, but the ankle-joint was stiff.
31	Henry B., 22.	<i>Ad.</i> , April 20, 1879. <i>Op.</i> , April 21, " <i>Dis.</i> , May 30th, to come as out-patient. <i>Result</i> , cured.	Patient jumped over Waterloo Bridge; in his descent, struck his left elbow against the side of the parapet. The result was an oblique fracture into the elbow-joint, detaching the internal condyle. There was a small opening in the skin communicating with the fracture.	Wound enlarged; some small fragments of bone removed, and the wound and joint syringed out with 1 to 20 carbolic lotion. Drainage-tubes inserted.	Aseptic course. Wound completely healed on June 30th. The movements of the joint were then very good, and have since that time steadily improved.
32	Samuel M., 54.	<i>Ad.</i> , July 8, 1879. <i>Op.</i> , July 8, " <i>Dis.</i> , July 24, " <i>Result</i> , cured.	Punctured wound of the left knee-joint, just above the patella. The finger, when introduced into the wound, passed into the joint, and felt the under surface of the patella. Synovial fluid escaped. Great pain on movement of the joint. The wound was inflicted about fourteen hours before the patient came to the hospital.	Joint washed out with 1 in 20 carbolic lotion, and with a solution of carbolic acid in rectified spirit (1.5). Drainage-tube inserted; posterior splint applied.	Aseptic course. Pain on moving the knee ceased a few hours after it had been washed out. The wound was quite superficial when the patient was discharged, and the knee was quite movable. Healing was complete on July 31st. The patient was seen in October, the movements of the knee being then perfect.

ON THE INSIDIOUS PROGRESS OF GRANULAR DISEASE OF THE KIDNEY.*

By W. R. THOMAS, M.D., M.R.C.P.,

Physician to the Sheffield Public Hospital and Dispensary; Lecturer on Medicine, Sheffield Medical School.

GRANULAR disease of the kidney is often very slow in its progress, and the symptoms are frequently slight, apparently trivial, and such as are not likely to direct our attention to these organs. The urine may not contain albumen for some time, and the symptoms complained of may be attributed to disease of other organs. I bring the following cases of that kind before the notice of this Society.

CASE I.—A gentleman aged 42, who had worked hard for many years, and who had found that he had great difficulties to encounter in endeavouring to make his way in the world, but had ultimately attained a very good position and had amassed a good deal of wealth, found that, during the last twelve months, he had become weaker day by day; his appetite had been impaired; he had not that aptitude for mental work he used to have; he had a desire to micturate about thrice every night; his sight had gradually become more and more dim; and work, which to him had hitherto been a pleasure, was now looked upon by him with a sense of dislike. He had frequently suffered from pains across the forehead, and had come to the conclusion that he had overworked his brain and that he required rest. I was called in because he suffered from an attack of severe vomiting, which, in spite of treatment, lasted for many weeks. His urine, when examined, was loaded with albumen, and casts were found on making a microscopic examination; it was alkaline, and phosphates were plentiful. The vomiting continued for several weeks, and was always worse in the morning. The quantity of albumen diminished, casts of tubes continued to show themselves, and at last slight general anasarca became visible; the patient one evening suddenly became comatose, and died. On making a *post mortem* examination, the kidneys were found to be very much diminished in size; the capsules were quite adherent; their surface was granular. It was an ordinary granular kidney, in which large cysts were found.

CASE II.—Mrs. —, aged 34, married had borne four children, and had always enjoyed perfect health until two years ago. Ever since that time, she had noticed that her strength was gradually failing her; she suffered from severe dyspeptic symptoms, with frequent vomiting and diarrhoea, the latter alternating with severe cough from bronchitis, but there was not any evidence of phthisis; frequent desire to micturate

was complained of, and the act of micturition was accompanied by pain; the urine was loaded with albumen, exhibited casts, and oxalates were plentiful. No history of alcoholism could be found, nor could the disease be accounted for. The severe vomiting continued, the diarrhoea also. Then for a few weeks but very little urine was passed, uræmic convulsions came on, and the patient died. *Post mortem*, granular kidney was found.

CASE III.—Mr. — complained that, for the last four years, his health had gradually become more and more shattered; he had suffered from aching pains in all his limbs, nausea with vomiting, constipation; his sight had lately failed him; his legs tottered; the urine contained albumen and casts. A distinct blue line could be seen along the gums. He had been in the habit for the last twenty years of taking snuff; he was recommended to abstain from using it. The symptoms to a certain extent now subsided, and he partly regained his former state of health; but, in a few months afterwards, he caught a severe cold, and died of pneumonia. After death, among other appearances, the kidneys were found to be very small and in a granular state.

The first patient was a gentleman who had always undergone a great deal of mental exertion and worry, which had ultimately brought on serious renal disease. This is a case somewhat similar to those ably described by Dr. Clifford Allbutt, in a paper written by him in 1877. The symptoms complained of by him at first were simply those of dyspepsia, with head-symptoms, from which we would naturally expect one who had overworked his brain to suffer, yet, at the same time, grave disease was, I have no doubt, progressing in the kidneys, which would have been found out had medical advice been sought for earlier.

The second patient complained at first only of dyspeptic symptoms, with failing health; then came on severe vomiting and diarrhoea, and death ensued from convulsions. As the patient's health had been becoming worse for two years, I doubt not that the renal disease had been steadily progressing long before the more serious symptoms appeared.

The third patient had a number of the symptoms complained of by patients poisoned by lead, and at the same time chronic renal disease was progressing, owing no doubt to the irritation produced by the presence of lead in the blood circulating through the kidneys.

I have brought these cases before the notice of this Society because, in the first place, *post mortem* examinations were made, which proved (though I have not troubled you with the other *post mortem* appearances) that granular disease of the kidney was the principal cause of death in every instance; and to remark, that our attention may often be drawn to the fact of renal disease being present by the patient complaining of such symptoms as persistent frontal headache; symptoms of cardiac hypertrophy, without valvular disease; dyspepsia; vomiting;

* Read before the Yorkshire Branch of the British Medical Association

gradually increasing debility, with no evidence of other disease to account for it; frequent micturition at night; impaired vision; and other symptoms, which may not directly turn our attention to the kidneys. In fact, I consider that it is always advisable, whenever such symptoms evince themselves, to examine the urine; and then probably some abnormal conditions of it may be found, which will aid us in forming our diagnosis and in treating the patient.

I have frequently found that the presence of albumen and of casts may be intermittent or entirely wanting. The urine may be examined time after time, and be found perfectly free for weeks; then, for a week or two, both become apparent; then comes another intermission; and all this time the disease is steadily progressing; and at last, as has happened in a case which came under my eye lately, the patient dies suddenly from uræmic convulsions, or some of the other accompaniments of this disease.

I believe that, whatever the cause of the disease may be; whether in the gouty patient there be excess of lithic acid in the blood; whether the drunkard have his blood poisoned by alcohol; whether the plumber have lead in his; whether there be excess of phosphates in the blood from too much mental work, in the case of the over-anxious or worried merchant; whether there be excess of lithates or oxalates, oftentimes produced by faulty digestion; whether some other material be thrown upon the kidney for excretion by imperfect actions of skin or other organs—all act in a similar way. Owing to the increased amount of work the kidneys have to do, this disease is produced; and not only are the kidneys acted upon by the fluid circulating through them, but other parts—such as the blood-vessels, heart, and even the nervous centres; but, as the kidneys have the principal work of excretion to perform, they become sooner affected, and are to the physician the local manifestations of a constitutional disease.

Hence the necessity there is for us, when the most trivial symptoms tend to point out renal disease, to examine the urine; and, from the result of such and other examinations, to form a proper idea of the cause of the disease and of the treatment to be adopted.

CASE OF CARCINOMATOUS DISEASE OF THE RECTUM TREATED BY EXCISION.

By KELBURNE KING, F.R.C.S.,
Surgeon to the General Infirmary, Hull.

WILLIAM COUSINS, aged 54, was admitted into the Hull General Infirmary on December 21st, 1878, on account of the following symptoms. He had constant calls to evacuate the bowel, with much straining and bloody discharge, getting quit occasionally of small, hard, round faeces, which he compared to nuts. He had no real relief, except in consequence of purgative medicines, which caused him great pain. He had of late had much pain in sitting, and even in walking. His symptoms had been much increased in severity during the last six months, though they had existed more or less for a long period. On passing the finger into the bowel, three hard tumours were felt occupying the whole circumference, about the size of small walnuts. They were quite within the anus; but the finger could be passed beyond them, and the surface of the rectum could be felt healthy above them. They were sensitive to the touch and of preternatural hardness. Until the last six months, the man had enjoyed very good health, attributing any ailment he had to slight attacks of piles. He had recently fallen off in strength and health, owing to the constant state of pain and straining of the bowel.

On January 11th, 1879, I made an incision from the anus in the middle line straight backwards towards the coccyx. This gave me ample room to pull down the growths and the adjacent mucous membrane. Grasping them in my left hand, I carefully removed them with the right, cutting away the whole circumference of the bowel from the depth of between an inch and a half and two inches. Three or four vessels required to be ligatured. The wound at first presented a rather formidable appearance; but no bad symptom of any kind took place. The temperature never rose above 100°, and that only happened for two or three nights. He had immediate relief from all his sufferings, and left the infirmary on April 14th, 1879, apparently perfectly cured, and with complete command of the sphincter muscle.

I have thought this case of sufficient interest to bring before you, as operative procedures for malignant disease of the rectum have been usually strongly condemned until quite a recent period. Mr. Henry Smith, writing in Holmes's *System of Surgery*, makes the following remarks. "Some surgeons were a few years since in the habit of performing excision of the lower part of the rectum when affected with cancer; but this proceeding must be looked upon both as barbarous and unscientific, and it is now happily exploded from the catalogue of

surgical operations." Of late, however, Mr. Cripps and others have published several cases demonstrating its practicability and giving very good results. The above is the first case in which I have had an opportunity of putting the operation to the test, and the results seem to justify its performance; and I would certainly be inclined in similar cases to perform it and to recommend its performance.

REPORTS OF SOCIETIES.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

TUESDAY, NOVEMBER 25TH, 1879.

JOHN ERIC ERICHSEN, F.R.C.S., F.R.S., President, in the Chair.

TREPHINING FOR TRAUMATIC EPILEPSY.

BY JAMES F. WEST, F.R.C.S., (BIRMINGHAM).

[COMMUNICATED BY THE PRESIDENT.]

MR. WEST of Birmingham brought forward a case in which trephining had been successfully employed by him for traumatic epilepsy in a girl aged 14. The injury was due to a blow from a stone, which caused fracture of the skull and concussion of the brain. Since 1871, when it was inflicted, the girl had been subject to epileptic fits, which had year by year increased in number and severity, until they had at last reduced her to an almost idiotic state. Two circles of bone over the site of the depressed fracture (which was, however, found to involve only the outer table) were removed on November 25th, 1878, with antiseptic precautions. From that date, the girl began to improve: speech returned, also the power of controlling the bladder and rectum. Antiseptic treatment was discontinued on December 3rd, and at the end of the month she left the Queen's Hospital cured; and from that time to the present she had had no return of the epileptic convulsions. Mr. West gave a brief *résumé* of the surgical writings on the operation of trephining for epilepsy, calling special attention to the work of Dr. Lucas-Championnière on the subject (*La Trépanation guidée par les Localisations Cérébrales*, Paris 1878), and to the valuable paper by Dr. Echeverria on Trephining for Epilepsy depending upon Injuries of the Skull, in the *Archives de Médecine* for December 1878. He considered that the trephine might be applied with advantage in many cases where epilepsy was dependent on a traumatic origin; that there were, owing to recent discoveries in physiology, valuable indications to be derived as to the exact nature of the lesion, and the site at which the operation should be performed; and lastly, that, with antiseptic precautions, trephining might at the present day be performed with a greater prospect of success than it formerly could have been, and that it might now, therefore, be looked upon as a justifiable operation.

Dr. ALTHAUS said that Mr. West's paper was one of much interest; but he believed that epilepsy following injury of the cranial bones was extremely rare. In 3,000 cases of epilepsy which had come under his notice during the last fourteen years, he had found none traceable to injury of the cranial bones with depression or decided lesion. There was indeed a history of injury in some cases; but in most of these the patients recovered under the use of iodide of potassium. It was remarkable that in Mr. West's case an injury of the skull on the right side was followed by aphasia; but cases of aphasia had been met with in which the third left frontal convulsion was not affected. The function of speech was evidently bilateral, and was under the control of the right hemisphere as well as of the left. He doubted whether cerebral localisation could guide the surgeon in the selection of the locality for operation. The aphasia would have suggested operation on the left side; and the motor centres were not in the frontal but in the parietal region. As regarded the operation of trephining for injury of the skull, the practice was not so successful as the published cases indicated. In France, the operation had been strongly opposed by M. Gosselin, on account of its danger. The directions given by M. Lucas-Championnière were very difficult to follow, and appeared to be rather calculated for physiological research than for surgical practice.—Mr. BELLAMY had had a case at Charing Cross Hospital, in which he had trephined over the fissure of Rolando with success, in a case of epilepsy, following an injury received thirteen years previously. The fits ceased after the operation: one or two occurred subsequently, probably from the formation of an abscess. The details of the case would be brought before the Clinical Society by Dr. Lees, under whose care the patient was.—Mr. WILLIAM ADAMS said that it was difficult to explain the success in Mr. West's case, as there was no depression of the inner table. He had met with two cases of the kind. In one, the late Mr. Green operated unsuccessfully. A few years ago, a patient was brought to the Great Northern Hospital with fracture of the skull. He became subject to fits. A consultation