When, therefore, you feel compelled to resort to the more sweeping measure of total ablation of the penis, I think the consideration of the patient's condition in the future, should he recover from the operation, should be laid fully before him, should be carefully explained to him beforehand, and, should he determine to submit to the removal of the testes, as well as of the penis, I should not often hesitate to make the operation complete. So long as any portion of the penis is left, this question will never, of course, arise; but, when that organ is completely and entirely removed, it becomes a very essential part of the consideration to be placed before the patient.

Pray, gentlemen, remembering what I said to you in my last lecture on the unwisdom of claiming priority in any surgical proceeding, bear in mind that I claim no precedence as to this; I derived it from a German source, and, whilst I find that my own countrymen are nearly as tenacious of their claims to priority and inventiveness as is possible, I fear our foreign colleagues are just a little more so.

As concerns the next operation to which I desire to draw your attention, I might, I think with safety, be a little more venturesome in this respect, without running any very serious risk; for, without any attempt on my part to claim originality or priority in the method of performing perineal section or external urethrotomy, as you will see it performed in Leeds, my colleagues first, and the profession generally afterwards, have done me the honour to call the operation mine, and to assign it a high rank among surgical proceedings. Certainly in our hands it has proved a very successful one, and, I think I may say without fear of contradiction, has enabled us to find the correct and safe way into the bladder in many cases in which, by any other, it would have been impossible to do so. I do not claim for it anything in the way of originality; it has been entirely a matter of observation, and is, after all, only an improvement on former methods of operating in certain points, at which, when I have either been myself, or have seen others, met by unusual difficulty, I have set myself to think how those difficulties might best be overcome. It happened to me, in my early days, to see so many mishaps in attempting to reach the bladder from the perineum without any actual guide, that I resolved, if possible, to find or to invent some better method than the old operation. But perhaps I had better describe that to you first, then the earliest modifications of it that I saw, and, lastly, my own operation, as the result of my observations.

Given a case of stricture which, by reason of long continued neglect has at last become practically impervious, or, so nearly so that, though a fine catgut or whalebone bougie may sometimes, and at others may not, be capable of being passed through it, the patient's life is endangered by the mischief arising from backward pressure upon the bladder, the ureters, and the kidneys. It has manifestly become necessary that the stricture must, in some way, be overcome if your patient is to be saved. Already his life is rendered burdensome, for day and night alike he is answering repeated calls to micturate; and, on very trifling provocation, a little indulgence at table, a little imprudence in exercise, a trifling exposure to cold and damp, complete retention comes on. This, so long as a catheter cannot be passed, involves hours of agonising suffering, and can only be temporarily relieved by long continued medical and topical treatment, hot baths, antimony, opium, and so on, and, even with the aid of these means, is only too likely to be followed by such irritation around the stricture as will end in the formation of local abscesses, and, in process of time, by fistulæ with which the perineum eventually comes to be riddled.

Such, then, is the case to which you may at any time be called, and for the relief of which you ought to be prepared to act; and I will endeavour to show you how I am able, notwithstanding all difficulties, as a rule, to reach the bladder along the true track of the urethra, and with safety. In the old operation, the knife, guided by the forefinger in the rectum, was passed steadily onward from the surface until it entered the urethra somewhere in the neighbourhood of the prostate; and, once relief was afforded to the distended bladder, and the risk of extravasation was avoided, the surgeon was content, and the stricture was henceforward disregarded. Upon this procedure, Mr. Cock, of Guy's Hospital, was the first, I believe, to introduce a great element of precision. Having ascertained two pathological facts—(1) that the portion of the urethra which lies immediately in front of the apex of the prostate is never strictured, and (2) that it is usually dilated—he made it a *sine quâ non*, in operating, that this point should first of all be clearly defined by the forefinger of the left hand in the rectum; next, that the knife, entered half an inch in front of the anus, should be plunged deeply into the perineum, and be then carried steadily and unflinchingly onward until it was felt by the left forefinger to have penetrated the urethra at that point. Then, the knife being withdrawn, it was followed by a catheter to

the same spot, which catheter was then passed through the prostate into the bladder, and there retained. Retention having been thus relieved, and the danger of extravasation prevented, he would, as circumstances seemed to dictate, either rest content with having effected so much, or would make a further attempt to divide the stricture also, attacking that from behind, and making the healthy but dilated portion of the tube, which he had already found and opened, his new starting-point. You will see at once how much more likely it is that a fine probe will follow even a tortuous urethra in the natural line of outflow than in opposition to it; and by this manoeuvre Mr. Cock was, I believe, almost invariably able to succeed in accurately incising the stricture, as well as in relieving the distended bladder. But it is not given to all men to possess the hands of Mr. Cock, and skill such as he possessed is only attainable by few; and hence, notwithstanding his almost invariable success, some simpler and more attainable method for the many remained a desideratum.

(To be continued.)

THE PREMONITORY SYMPTOMS OF INSANITY.

Read before the South-Eastern Branch.

BY HENRY SUTHERLAND, M.D., M.R.C.P.,

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It will be my object, in the time I have at my disposal, to describe as briefly as possible the most important premonitory symptoms of insanity, and to conclude by making a few remarks upon their treatment.

Esquirol recognised three distinct stages of insanity. In the first, there is a change of habits; in the second, perversion of the affections; and the third constitutes true insanity. The first set are usually seen only by the relatives of the patient; the second, by the family-physician; and the third, by the asylum-superintendent, when they are now so far advanced that any attempt at prophylactic treatment is out of the question.

It is almost impossible to say from the premonitory symptoms what form the insanity will assume, unless, indeed, the patient have suffered from a previous attack. Almost all authors agree, however, that insanity rarely commences with excitement. As an exception, may be mentioned the mania which is produced suddenly, after a moderate amount of alcohol, in a person who has previously sustained an injury to the head, or has had a sunstroke. But the majority of cases are preceded by a stage of depression, which has been called by Guislain the "stadium melancholicum."

To estimate the duration of these premonitory symptoms is, as a rule, impossible, as the relations of the patient, either from deficiency of experience or from a wilful perversion of the truth, only throw obstacles in the way of the practitioner, who is trying his best to get at the real etiology of the case.

From a long experience of such matters, I have no hesitation in saying that, in my opinion, some eccentric act on the part of the patient, done many years before the actual outbreak of the mental disease, can be detected in the majority of cases, if the early history of the patient be only carefully investigated. For instance, in 1856, a schoolfellow of mine stole some money from another boy, although he was at the time, comparatively speaking, well off. In 1870, fourteen years afterwards, this same schoolfellow, who was then a clergyman, was admitted to Bethlem Hospital, suffering from a first attack of insanity.

Again, in 1868, I was acquainted at college with a student who had the insane temperament strongly marked, as indicated by unnecessary outbursts of temper and abnormal conduct. In 1880, twelve years later, he committed suicide on board a steamer, his conduct for some days previous having been noticed to be very peculiar.

Again, in 1874, a friend of mine sent to me to rescue him, as he said, from an action-at-law. He had taken lodgings near a line of railway, and the trains, in passing, kept him awake at night. He had not the moral courage to leave without my assistance. I paid the landlady a week's rent, and took my friend back to his house. In 1881, seven years later, he had an attack of mania.

Now, in all these cases there were, to my certain knowledge, other acts of eccentricity committed between the first of them and the actual outbreak of insanity; and I have every reason to believe that, if these patients had chosen some quiet pursuit in life, and if their conduct had been closely watched by their relations, much trouble and expense connected with their mental diseases would have been prevented.

Sometimes a large pecuniary interest depends upon the evidence

we can obtain concerning the date of the first appearance of the premonitory symptoms of insanity; as, for instance, in will-cases, in deeds of settlement, and in attempts to prove nullity of marriage on the ground that one of the contracting parties was insane at the time of the ceremony.

The premonitory symptoms of insanity are most commonly represented by a contrary abnormality in different cases; for instance, in one case an unusual volubility may be found; and in another, unusual silence. Some alteration of character of this description is most often displayed, but in certain rare cases an exaggeration of the natural disposition is noticed. The forms of insanity in which this last is most usual, are hypochondriacal melancholia and hysterical mania.

In one case recently under my care, the patient suffered from what he called an "*idée fixe*," a remembrance of some trifling event, the importance of which he exaggerated to such an extent, that it almost amounted to a delusion. In this patient, hepatic congestion and insomnia were the accompanying bodily conditions. Under appropriate treatment, the threatened attack of insanity was averted.

In most cases in which mental disease is coming on, there is, as Dr. Maudsley says, a "something different, which the nearest friends do not fail to feel, although they cannot always describe it."

Sometimes the patient perceives that he is not quite right, and consults a physician. A lady who has been four times under my care now lives in a lodging near my asylum, and, when she feels the attack approaching, sends for qualified practitioners to certify that she is insane, returns to her usual room in the asylum, and places herself thus not only voluntarily but legally under restraint.

A gentleman, who has been under my care on not fewer than six separate occasions, comes to me of his own accord when he feels the attack approaching. He appears distressed, and says, "I don't think this is one of my regular illnesses coming on; I only feel bilious." His skin, which is usually clear, becomes yellow, there is a pinched anxious look on his face, he gradually becomes silent and morose, and in a few days he develops suicidal tendencies, after which an onset of acute mania supervenes. But it is not always that patients are aware of the insidious approach of mental disease. In some cases, and notably those of general paralysis, the patient feels in an unusually good state of health, and altogether repudiates the notion that there is anything the matter with him. Cases of senile dementia, for the same reason, that they feel so well, are very troublesome to deal with, and also on account of the unwillingness of the patient to acknowledge the necessity for anyone but himself taking the lead in a house where he has always been accustomed to command. This class of cases taxes our ingenuity and firmness to a most trying degree; but, although they are incurable, yet we can prolong life, and this is sometimes of the greatest importance, as for instance where the family of a clergyman will be turned out of house and home, should the incumbent die.

We must now briefly enumerate the mental and bodily symptoms which are most common in incipient insanity.

Irritability and a tendency to take offence are very common at this stage, sometimes accompanied by moroseness and silence, or again by noisy scolding and fault-finding with servants. There may be an indifference to usual employments, or, on the other hand, a restless pursuit of novel occupations. Delusions of suspicion and jealousy are now developed against those with whom the patient has always lived on good terms. And it must be remembered, in sifting evidence, that there are occasionally good grounds for these delusions.

Sometimes the patient thinks he is ruined, and again he may launch out into endless extravagance, giving orders for carriages and horses which he will never be able to pay for.

Loss of memory is also a very marked symptom. A patient will remain seated in your consulting room much longer than is necessary, and long after you believe the interview is concluded. He will get up in the night, and think it is the morning. He will take three or four hours to dress, owing to his performing parts of the toilet more than once, and forgetting that he has done so. He will eat voraciously, or he will neglect to take his food, simply from loss of memory.

The mental and the bodily symptoms now begin to act and to react upon one another. Through forgetfulness, the patient neglects to take exercise, and to attend to his bowels, and through the stagnation and constipation thus produced an increased feeling of malaise and depression comes over him. A general neglect of personal appearance will not escape the eye of the expert practitioner. The expression of the face is also strangely altered, the lines of the features becoming more marked in melancholia, but obliterated and dim in epileptic cases. In acute hysterical mania, and in puerperal insanity, the cornea becomes bright, prominent, and staring. But, on the contrary,

in masturbating insanity, the patient seldom looks you in the face, and, when he does so, there is an absence of that expression of the sympathetic eye, the "*σύντροφον ὄμμα*" of De Quincey, which is so eloquently characteristic of a healthy mind. A row of paupers at work on a road can thus be distinguished from a gang of lunatics. In the one case they will all "catch your eye," as you drive past; in the other case they will not.

A word as to bodily symptoms. The posture, and even the gait, of an insane patient is abnormal. The skin, as a rule, is harsh and dry, although sometimes perspiring. It emits, in some cases, a peculiar odour, although this has been denied by the highest authorities. Occasionally rigors, feverish heat of skin, and elevation of temperature, are noticed, which, however, are usually due to some accompanying somatic condition, the cuticle being, as a rule, dry or clammy. The tongue is usually white and coated, and the breath offensive, from refusal of food and neglect of the bowels, which are, at this stage, almost invariably confined. The appetite is generally deficient from want of fresh air and exercise, and from constipation. The circulation is commonly feeble at first. The pulse is either slow (50 to 60) or too rapid (120), in delirious cases.

Generally speaking, the face is pale, but in very rare cases there is great congestion of the head, heat of the scalp, and throbbing of the carotid and temporal arteries. Headache is a very common symptom. This is produced partly by the changes, functional or organic, which are going on in the brain and its membranes, partly by the presence of an excess of bile in the system, due to the neglect of his health on the part of the patient, and also from a condition either of plethora or of anæmia, local or general, in the head and whole system.

Sexual appetite is in abeyance in some cases, as in those of bilious melancholia. It is in excess in others, as in those of general paralysis, and, oddly enough, is conspicuously so in senile dementia. The maid-servant is frequently found to be pregnant by the master, before any mental aberration is discovered by the relations, in this form of mental disorder.

The catamenia are frequently suppressed, although many attacks occur and run their course without any abnormality being observed in this function.

Impairment of some of the special senses, real or imaginary, is sometimes noticed. Deafness is occasionally simulated. Real abnormal sensations of heat and cold, of pricking and electrical shocks, of attempts to shake the bed of the patient, and of irritation, referred to the ends of the fingers and toes, are also frequently noticed.

The voice of the patient is almost always altered, becoming low and almost inaudible in the stadium melancholicum, but high in pitch, should mania be developed. Sometimes the patient talks more rapidly, sometimes more slowly and deliberately, than usual. Sometimes he will raise his voice and shout; in other cases, he will speak only in a whisper, or not at all.

Articulation is rarely affected, excepting in general paralysis. The style of conversation, is, however, often changed, oaths and obscene language being uttered by those who were never previously known to be guilty of such conduct. Muttering and talking aloud to the patient's self is frequently noticed.

Not unfrequently the patient will roam about the house, or wander away from home on an objectless journey. One patient, now in my asylum, walked barefooted from London to Portsmouth, before admission, under some religious delusion.

Delusions, illusions, and hallucinations are, however, comparatively rare during the premonitory stage. When they are developed the disease may, as a rule, be pronounced as being insanity, and all prophylactic treatment is now useless. The ship must go before the wind, and you must steer it, as best you can, through the tempestuous course which will lead to recovery, to death, or to hopeless dementia.

A word, if I am not trespassing too long on your valuable time, as to treatment prophylactic, medical, moral, and hygienic.

1. *Prophylactic.* If a patient have been known to have an attack regularly every year, which is not uncommon, send him for a trip with an expert and agreeable medical man, a month before the time of the onset of the mental disorder is expected. This frequently not only staves off one attack, but sometimes even prevents an accession of future attacks. But, if the slightest premonitory symptom should exist, keep him at home, as he must undoubtedly undergo the course of the disorder, and it is extremely dangerous that he should do so, if far away from good medical advice.

2. *Medical.* Bromide of potassium, or chloral, or belladonna, may be used where there is heat of head or sexual excitement. Opium and morphia in anæmic cases. Judge by the condition of the pupil whether opium or belladonna be indicated. Antimony is

the sheet-anchor in violent cases. Do not add digitalis. Calabar bean is indicated in the early stages of general paralysis. Iodide of potassium and mercury often allay excitement, when the mental symptoms are due to some syphilitic taint.

Hydrocyanic acid, with or without the bromides, is useful in robust cases of mania.

Henbane, in my hands, has proved a disappointing remedy. It is feeble as a sedative, and only valuable as such in large doses, such as half an ounce of the tincture; and even in small doses it often produces headache.

Combinations of drugs are invaluable, such as chloral with bromide of potassium, chloral with the liquor morphine bimeconatis, bromide with cannabis Indica, in acute mania; bromide with ergot, in recurrent insanity; morphia with assafoetida, in hysteria.

Conium is useful where there is much motility; quinine in intermittent insanity; and sumbul or chloral in the status epilepticus.

Aperients are almost always required in the early stages. The milder purges are, as a rule, indicated. These are: Æsculap and Hunyadi János waters; granular effervescent citrate of magnesia; stewed prunes, oranges, and similar domestic remedies. In extreme cases, enemata are necessary, which must sometimes be administered daily, and, if there be no obstruction, croton-oil. Avoid pills, as the patient, if suicidal, will hoard them up, and then take a poisonous quantity.

Should medicine be refused, a subcutaneous injection is occasionally useful, but I prefer disguising my remedies. Chloral in beer or portwine, tincture of opium in coffee, antimony in any liquid (as it is tasteless); and, as regards aperients, calomel between thin slices of bread and butter; syrup of senna in a cup of tea, in lieu of sugar; and other similar harmless modes of deception are now allowable.

3. The *moral treatment* must consist of a mixture of kindness and firmness; and, above all things, we must remember that each case requires different treatment.

4. The *hygienic treatment* is obvious. Let the patient walk out daily till he nearly drops from fatigue, and soon all complaints of loss of sleep and want of appetite will cease; and, although the disease may yet have to run its course, the symptoms will be milder, and the outlook more hopeful, than would have been the case if the patient had been allowed to have his own way.

I must apologise for the concentrated form in which I have been obliged to put these remarks. Let us not think that, by treating the premonitory symptoms of insanity, medical men will want for work. As long as human nature, sexual intercourse, and alcohol exist, so long will there be excess; and, in consequence, plenty of work for our profession—whether we endeavour to sound a note of warning to the foolish, or to alleviate the distress of those who now undeservedly suffer for the sins of their forefathers.

STRICTURE OF THE SIGMOID FLEXURE OF THE COLON: DEATH.

Read at a Meeting of the Sheffield Medico-Chirurgical Society.

By M. MARTIN DE BARTOLOME, M.D.,

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I WAS first called to Miss A. S., aged 51, on Tuesday, September 29th, 1885. I found her in bed suffering from slight abdominal pains, and looking as well as usual. She informed me that her bowels had not acted since the preceding Wednesday, September 23rd, but that she felt no particular inconvenience, neither was she alarmed, because she had been in the same predicament several times before, particularly upon two or three occasions when the bowels had not acted for above a fortnight; and checking herself, she added, with great emphasis, "certainly beyond a week," and then "had always become all right by themselves." She assured me that, with these exceptions, she had always been healthy; indeed, although I have frequently attended in the family for several years past, I have never heard her complain.

When I first saw her—and, indeed, throughout her illness, with the exception of a few hours which I shall presently mention—her temperature was 98° as a maximum, her pulse 90, also as a maximum, regular, and of good strength, and the respirations 18, and quite tranquil; the abdomen was distended and tympanitic; the only alteration from her usual appearance which struck me at the time, and which continued to the end, was her complexion, which had a decided mahogany tint, very different from her natural healthy bloom.

From the temperature being so normal, and the pulse only 90 as the

maximum, from the absence of any constitutional disturbance, or anything like acute suffering, and from the positive account she gave of her previous attacks, I concluded that the obstruction was caused either by some congenital malformation, or by some chronic disease of the intestines, probably of a malignant character, but of its situation I could form no idea in the absence of any local pain or other symptom, and the abdomen being firmly unyielding and equally resonant all over, rendered percussion useless as a diagnostic.

I requested the patient to take nothing into the stomach which she could avoid taking, and, above all, to turn a deaf ear to the importunities of officious friends, whose proffered nostrums I have found in more than one such case most efficient in making bad worse, and in thus destroying what little chance the patient originally had.

I ordered her a copious injection of gruel with yolk of egg, castor-oil, and turpentine every twelve hours, and a pill containing one grain of calomel, and half a grain of opium, three or four times daily, or oftener if the pain increased. I also directed belladonna ointment to be applied over the abdomen, and a warm linseed poultice to be constantly kept upon the ointment.

She continued in this condition, with occasional bilious vomiting, up till October 8th, when she had a copious and very offensive stercoaceous vomiting, which I may here observe never returned, though the patient continued occasionally to vomit the contents of the stomach and unmistakable bile.

My attention was now called to a prolapsus ani, which, the patient informed me, had existed for many years, and had caused her great inconvenience, because she could but seldom entirely reduce it, and she had been compelled, in consequence, to wear a bandage in order to support and protect it.

I found, upon examination, a protrusion of the rectum about the size of the fist, and covered with skin; the anus was patulous and lax, and would, I think, if the patient had been put under the influence of chloroform, have readily allowed the whole hand to pass. On introducing the finger into the rectum, I fancied I could feel, with the extreme point, a small and rigid stricture; and, while pressing against it, I felt, heard, and smelt, two distinct and separate most offensive "retrograde sighs," which induced me to think that there might be an opening in the obstruction, and that, although I had been forbidden to speak again of any surgical interference, it was my duty to ascertain, if possible, whether surgical dexterity could not do something to save the patient's life. It was then late in the evening, and, as I did not wish to waste time in useless discussion, I hastened home and returned immediately with an O'Beirne's tube, which I tried to introduce into the bowel; but, although I passed it eighteen inches through the anus, I found that the tube had only coiled itself in the rectum; the point of the tube, however, must have pressed against the stricture, because it was slightly besmeared with blood just as my finger had been.

I then desisted from further interference, and again most earnestly pressed upon the patient the possibility of relieving her by an operation, but all to no purpose, for it only distressed and irritated her;