to day, and the patient must not be dependent upon the periodical visits of his surgeon for instrumental relief, but should learn to pass a catheter for himself, or have a skilful attendant always at hand. If no urine is passed naturally, the catheter must be used whenever the desire to micturate comes on. Patients often try to postpone the use of the catheter as long as possible, and look upon the instrument as a source of irritation; the reverse is exactly true, and it is better to pass the catheter even oftener than is really necessary, than too seldom.

3. After complete retention of urine, all the care just insisted upon is specially important. After relief by the catheter, the patient should go to bed. If the amount of retained urine be great, the bladder must not be emptied suddenly, as such a proceeding has been followed by fatal syncope. If the amount be not great, *e.g.*, under a pint and a half, the patient should be watched, and, if he be able, in time, to pass urine naturally, the catheter should be employed after he has done all he can by his own efforts, to see if he really can empty his bladder. In the few cases where the patient regains his vesical power completely, he should keep his bed twenty-four hours, and his house for two or three days, and take a little calomel or blue-pill, with some mild laxative. But if, as is usual, the regular use of the catheter is required, the patient should be kept in bed until the urinary fever, which is usually to be expected within the first five or six days, has passed away. During the first few days of catheterism, hæmorrhage into the bladder not unfrequently occurs; this need not excite alarm, provided the necessary instrumentation is practiced with gentleness and skill, and that the patient is kept absolutely at rest. In such cases, morphia is often very useful; astringents by mouth are really useless, and injections into the bladder are to be deprecated as long as bleeding lasts.

Thus, the main points to be observed in the early treatment of prostatic retention of urine, are:

1. The reduction of the urethral shock to its minimum;
2. The care necessary to enable the kidney to maintain, or regain, its equilibrium, often rudely disturbed by reflex irritation, conveyed from the urethra.

CASE OF INTERCURRENT HEPATITIS AND RETAINED GALL-STONES.

Read before the Glasgow Medico-Chirurgical Society, April 2nd, 1886

By ALEXANDER NAPIER, M.D.,

Assistant to the Professor of Materia Medica and Therapeutics in the University of Glasgow.

MRS. W. T., aged 43, had been subject to occasional "bilious" seizures for at least six years, and to a tendency to prolapse of the womb for several years; for the latter affection she wore a pessary. She stated she had "gastric fever" twice, once twenty-three years ago, and again fourteen years ago; she was five weeks in bed in the last attack, not so long in the first.

With the exception of the "biliousness" referred to, there was no indication of grave involvement of the liver till June 21st, 1884, when Mrs. T. suffered from well marked symptoms of hepatitis: acute pain in the right hypochondrium, enlargement of the liver, feverishness, nausea, and sickness, but no rigors, and no jaundice. She was confined to bed about two weeks. Mrs. T. then continued tolerably well with occasional "bilious" attacks, always with want of appetite, till May, 1885, when she had another similar illness (apparently hepatitis) but much slighter, lasting only a few days.

In the end of July or beginning of August, 1885, she received a severe blow with a tennis-ball in the pit of the stomach. This caused intense pain at the time. From this date onwards the general indisposition, and the uneasiness in the region of the stomach, increased; there were a constant, dull, heavy pain in the hepatic region, entire loss of appetite, and progressive debility.

On September 10th, 1885, the pain suddenly became very acute, and was accompanied by sickness and vomiting, which lasted for three days; this was followed by marked jaundice, the urine becoming very dark in colour, and the stools white, or pipe-clay coloured. The patient at this time was twelve days in bed, but the jaundice did not disappear till six weeks had elapsed. She then improved a good deal in general condition, and suffered no longer from headache or sickness; but there was still entire absence of appetite.

On November 18th, 1885, there was another sudden attack of severe pain in the hepatic region, which had been preceded for a day or two

by an increased sense of uneasiness in the liver. It was then that I saw her for the first time. The attack was one of typical gall-stone colic; the pain was spasmodic, exceedingly severe, shooting up to the shoulder and through to the spine, causing the patient to cry out; it was accompanied by marked and severe rigors, and by vomiting. Pulse 96; skin cool; tongue whitish and moist. Relief was obtained from the use of morphia subcutaneously.

After the first night, the pain was not so severe; but the liver continued tender to pressure. The irritability of the stomach lasted for several days, only small quantities of liquid food being tolerated. Then vomiting ceased; the pulse rose to 120, and the temperature to 100° and 101°, for many days in succession; marked jaundice came on, with constipation, whitish stools, very dark (almost black) urine, headache, and nausea. The liver was tender to pressure over the left lobe and over the region of the gall-bladder; in the latter situation, a well-defined rounded mass could be felt. Hepatic dulness was not perceptibly increased in the axillary line, nor over the left lobe; but at the median edge of the right lobe, in the region of the gall-bladder, it came far past its normal limits downwards, exactly corresponding to the firm mass above referred to. The swelling was smooth, firm, and resistant, but gave no sense of fluctuation, or of rubbing, when grasped.

Treatment consisted in the use of morphia at first, to relieve pain, the occasional administration of saline purgatives, chloride of ammonium, and pancreatised food, together with persistent poulticing of the hepatic swelling.

The patient was seen early in December by Professor Gairdner; he, without rejecting the theory of gall-stone, rather favoured the view that we had to do with an abscess or tumour of some kind.

The patient's general condition gradually improved, though the mass projecting from the lower border of the liver continued rather tender to pressure, and quite unaltered in size, till January 8th, 1886, when she had a severe rigor, vomiting, and acute hepatic pain; while the mass became distinctly larger, and much more tender. The skin and superficial tissues were freely movable over the swelling. Pulse 120; temperature not noted, but certainly not febrile. In a couple of days, the pulse had fallen to 90, the sickness had ceased, and the local pain much diminished; this attack passed off without any jaundice.

On January 18th, the patient complained much of severe darting pains, with considerable tenderness to pressure over the whole abdominal surface, not specially over the swelling, though this continued tender. These pains, probably connected with the formation of adhesions between the swelling and the abdominal parietes, lasted for several days, but yielded to persistent poulticing.

On January 22nd, she was ordered capsules containing ether and turpentine.

On January 25th, there was slight vomiting once, and the capsules were stopped.

On January 27th, very severe and persistent vomiting set in. Absolutely nothing, not even a drop of water or broken ice, remained in the stomach. The pulse ran up to 135, and the patient became exceedingly prostrate. She was supported by nutrient enemata.

On January 29th, she was seen by Professors Gairdner and Buchanan, and was apparently sinking. The general abdominal pain had gone, but the tumour was unchanged in character, except that it felt more adherent to the skin. It was agreed that the swelling should be opened next day. Morphia, given subcutaneously, procured for the patient a fair night's sleep; and small quantities of milk and brandy were retained by the stomach.

On Saturday, January 30th, Professor Buchanan performed the operation, which he describes in the following article.

CHOLECYSTOTOMY FOR THE REMOVAL OF BILIARY CALCULI, RETAINED IN A GALL-BLADDER WITH OCCLUDED CYSTIC DUCT.

Read before the Glasgow Medico-Chirurgical Society.

By GEORGE BUCHANAN,

Professor of Clinical Surgery in the University of Glasgow.

ON January 29th, I was asked by Dr. Napier to consult, along with Professor Gairdner, in the case of Mrs. T., aged 43. She had been suffering, for eighteen months, with intercurrent attacks of hepatitis, followed, for the last three months, by symptoms of retained gall-stones; this last condition following on a blow she received on the epigastrium from a tennis-ball. The details of her illness were related

to us by Dr. Napier, in a clinical history, which appears as a separate part of this communication.

At the time of my visit, the patient was much emaciated, could take no nourishment, and vomiting had been almost continuous for the last forty-eight hours. It was obvious that, if any surgical interference were required, there could be no great delay.

On examination, I found an ovoid tumour extending from the lower margin of the costal cartilages, to about an inch above the level of the umbilicus. Its situation corresponded with the linea semilunaris, below which it lay, with a measurement across, at the upper end, of about three inches. The tumour could be moved slightly from side to side; but the movement was communicated to the abdominal walls, to which it seemed to me to be adherent. It was firm and resistant, with an obscure feeling of deep elasticity, rather than fluctuation. The opinion I formed of it was, that it was an enlarged thickened gall-bladder, adhering to the abdominal walls; probably containing imprisoned calculi. And I stated that, in my opinion, it was a clear case for an incision of an exploratory kind. In this, Professor Gairdner and Dr. Napier concurred; this being the view they had already discussed before sending for me.

Accordingly, on the morning of January 30th, Mrs. T. was put under the influence of ether, that anæsthetic being chosen in consequence of the feebleness of the circulation.

I made an incision, three inches long, from the edge of the costal cartilages opposite the site of the gall-bladder, extending perpendicularly downwards to nearly opposite the umbilicus. After cutting through the skin and fascia and muscular walls of the abdomen, I came to a white, dense, tight membrane. To the knife, it felt tough and rigid; and, on dividing it by careful application of the instrument, I became aware I was cutting into a condensed fibrous tissue, evidently the bond of union between the gall-bladder and the abdominal wall. Proceeding carefully, I at length opened a cavity, from which some dark brown purulent fluid escaped. Though discoloured, it was not foul or putrid. I now passed the point of my finger into the cavity, and found a number of smooth gall-stones, lying in a bag with smooth soft walls. I had no difficulty in removing them with the point of my finger and the scoop-end of a director. The form of the cavity was pear-shaped; it admitted the whole length of the forefinger, and was evidently the gall-bladder. I washed it out with tepid water, and then carefully explored with a fine probe, to ascertain if the cystic duct could be entered; but no orifice could be found. I therefore concluded that the duct must have been occluded by the inflammatory process, by which the gall-bladder had become adherent to the wall of the abdomen. A drainage-tube was introduced into the cavity, and the wound was lightly dressed with absorbent gauze.

It is unnecessary to go into details as to the progress of the case. The relief to the agony, distress, and sickness and vomiting was instantaneous. Sleep and appetite returned, and Mrs. T. was practically well in a fortnight, getting out of bed during the day, and relishing her food. Suddenly, on the evening of March 8th, Mrs. T. had a rigor, followed by feverishness and a distinct attack of jaundice. Next day she was better; but the wound, which was not quite closed, became inflamed, and the surrounding tissue swollen. On the third day, a gush of pus, tinged with bile, took place; and this was followed by the spontaneous discharge of a gall-stone. From this attack she rapidly recovered, and has continued quite well till now (April 2nd); except that, two days ago, without any pain or any indicative symptoms, two more gall-stones came away in the slight discharge from the wound, which still continues.

Query: Are these gall-stones being formed in the common duct, and finding their way into the gall-bladder by a fistulous opening, the result of an ulceration which did not exist at the time of the operation?

BIRMINGHAM AND MIDLAND SKIN AND LOCK HOSPITAL.—The fifth annual meeting of the governors of this hospital was held on April 15th. The report stated that, during the past year, 1,142 patients were treated for skin-disease, 810 for venereal disease, and 45 for miscellaneous diseases. The attendances were 13,616. There had been an increase over last year in annual subscriptions of £30 11s. After referring with regret to the death of Dr. Russell and Dr. Heslop, the report showed that the necessity for larger premises became yearly more urgent; and that, after careful consideration, it was decided to build a new hospital, with provision for beds and baths, as originally intended. For this purpose, a piece of land in the centre of the town had been secured. The cost of erecting and suitably furnishing the building was estimated at £5,000. Towards this sum, legacies, donations, and the surplus of ordinary income amounted to £1,200. The Committee earnestly commended the matter to the public.

CASE OF IRREDUCIBLE INGUINAL HERNIA TREATED BY ELASTIC PRESSURE.

By WILLIAM ELDER, M.B., C.M. Edin.,
Resident Physician Royal Infirmary, Edinburgh.

THE following case of irreducible inguinal hernia, treated by elastic pressure, by means of pads of cotton-wool and an elastic bandage, may be of interest to the readers of the BRITISH MEDICAL JOURNAL.

A. B., a man, aged 56, came to Professor Chiene, of Edinburgh, for advice on July 1st, 1885, complaining of irreducible inguinal hernia on the left side. He stated that he had had a small hernia for more than thirty years, but it had never given him much trouble till within the last few months, when it had been coming down oftener than usual, and had been more difficult to reduce. He had never worn a truss, nor used any means to prevent the hernia from coming down. He said that he was always very particular in getting the bowel reduced immediately he felt it down, but that he did not think there was any danger of strangulating the omentum. He did not consult a medical man till the day before (June 30th), when it had become very much enlarged and irreducible. The surgeon advised him immediately to put himself under the care of Professor Chiene, which he did.

On examination, the swelling was found to consist partly of bowel and partly of omentum. The omentum was much indurated; so much so, that it felt nearly as hard as a stone. There was one large mass larger than a goose's egg, and several smaller ones. There was no pain on pressure. On palpating the tumour, a sort of crepitating sensation was felt, as if there were fluid in the sac. An attempt was made to reduce the hernia, when the bowel was reduced, but very little difference could be made on the omentum.

As there was thought to be danger of strangulation, ice was applied to the part, and the patient kept absolutely at rest on his back. He was kept thus all next day; and, on the evening of that day, he was given chloroform, and an attempt was made to reduce it. This, however, was unsuccessful; and, next day, July 3rd, Professor Chiene applied elastic pressure by means of a padding of salicylic wool, and an elastic bandage in form of a single spica.

On removing this, next day, July 4th, the hernia was found much reduced in size, and all the crepitating sensation was gone on feeling it. The elastic pressure was reapplied, and the hernia improved, becoming gradually smaller till July 10th, when the largest mass was somewhat larger than a duck's egg, and several a little smaller. The masses, however, were softer, and not so much indurated. Next day, July 11th, however, the hernia had increased in size, and the crepitating sensation was again felt. This was thought to be due to the bandage having slipped off the swelling during the night, which it had always a tendency to do. The bandage was reapplied, but not so tightly as before, as it was a little painful.

It was kept on till July 14th, when the hernia was smaller than it was on July 11th, but not in a better state than on July 10th. The bandage was reapplied, and slowly and gradually the swelling became smaller, till July 17th, when I applied the bandage in a different manner, which I will afterwards describe.

This bandage remained on till July 20th, when it was found that the swelling had almost entirely disappeared. The omentum, however, had all gone back, and the swelling that remained was felt to be due to a thickening of the tissues round the cord and the external abdominal ring. The bandage was reapplied; and, next day, this thickening had completely gone, and no difference could be felt on the two sides, except the canal, which could be felt to admit the point of the index finger. The bandage was kept on till a truss could be fitted, which was done on July 24th; and, next day, the patient was able to be up, and gradually regained strength. He is now (May, 1886) as well as ever he was in his life, and the hernia has never been down again.

The two points which, I think, are worthy of notice in this case, are: first, the efficacy of the elastic pressure in the treatment of irreducible hernia; and, secondly, the method of applying the pressure. I think the first of these is quite evident to everyone, namely, that continued elastic pressure, carefully applied, must reduce an indurated hernia in size, and, by reducing its size, must make it more easy to reduce. Secondly, as to the method of applying the pressure; at first, the bandage was applied as a single spica, but it was found that the swelling was very apt to make its way out below the bandage, by passing towards the middle line. On July 17th, however, I applied the bandage more in the form of a double spica, although not a true double spica. I began the bandage at the right anterior superior iliac spine, crossed