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