Post Mortem Examination.—The body was like half a hogshead—as hard as a drum; the skin was tense and polished; the muscles were absorbed; the skin and peritoneum were transparent and as thin as a wafer; the large intestine was much distended; the sigmoid flexure lay across the abdomen; it measured nine inches in diameter; the lower part was ten and a half inches; the head of the colon was nine inches across; the small intestines were empty; their muscular coats thickened.

Injured Hernial Protrusions.—On January 23rd, 1833, Mr. Key read a paper on Injured Hernial Protrusions. He adverted to the mischievous consequences that sometimes ensue from endeavours to return a hernia after a blow upon it. A man in a struggle was kicked on the scrotum. Pain came on in the lower part of the belly; and this was followed by the usual symptoms of peritonitis, and he died in forty-eight hours. He denied having had a rupture; but the *post mortem* examination proved that he had been ruptured, for the lower part of the ileum was found lacerated, and the whole internal surface of the intestines inflamed.

Another man was brought into Guy's Hospital having a hernia, in which he had been struck two days before. He had vomiting, etc., which justified the performance of an operation; but, when the sac was laid open, it was found to contain pus, and not intestine. Two days afterwards, there came down an immense quantity of fecal matter; the intestine had clearly sloughed. The discharge continued for three days, and the patient recovered. Death, said Mr. Key, in these cases, does not arise from strangulation, but from extravasation.

Hernia, with Gangrenous Bowel.—Again, on December 14th, 1836, Mr. Key read a case of femoral hernia in a lady aged 45, in which the bowel was gangrenous. Mr. Key divided the stricture, and left the mortified bowel uncut in the wound. In six weeks the patient recovered, the feces taking their natural course. Mr. Key had seen this plan succeed in four other cases. He had departed from prescribed rules in this case, because persons usually died after a gangrenous bowel had been opened, which by itself produced extreme prostration. Also time was given for new adhesions to shut out the gangrenous bowel from the peritoneum, for adhesions brought the bowel and sac together long before gangrene took place, and the knife was not employed—perchance to destroy those adhesions and cause fatal extravasation.

What splendid surgery is indicated in these cases; how far in advance of the time in which they were related!

Wound of Abdomen.—On March 26th, 1834, Dr. Babington, junior, narrated a case of a woman who stabbed herself so high up in the abdomen that the contents of the stomach passed out of the wound. She was in a state of collapse afterwards, though sensible enough to be alarmed at her own act. Total abstinence from food and medicine were directed for thirty-six hours; and at the end of the second day she took castor-oil. The woman recovered.

Fractured Thigh in an Old Man.—On the same day, Mr. Curling related a case which Sir W. Blizard had described, of fractured thigh in a person 108 years of age, in which union took place.

Removal of Loose Cartilages.—On June 15th, 1834, Mr. Key reported that he had removed loose cartilages from the knee-joint four times, keeping the knee quiet for eight or ten days. No danger resulted.

Dislocation of Knee.—On January 21st, 1835, Mr. Key related the following case of injury to the knee. A man had his knee injured by the leg being turned outwards till the foot touched the trochanter. All the parts, except the skin, were torn through. By pressure and manipulation, the parts were replaced; and, nine months afterwards, the man was well, with good motion of the knee. A second case like it was recorded.

Tracheotomy in Scarlet Fever.—On January 8th, 1834, Dr. Whiting related a case of tracheotomy by Mr. Mackmurdo, in a patient of his, with scarlet fever, aged two years, in which recovery took place. He knew of no other case in which the operation had been performed for glandular swelling, etc.

Absence of Testes from Scrotum.—On December 24th, 1823, Dr. Hamilton was well acquainted with a gentleman who, though the scrotum contained no testes, was the father of a numerous progeny. I would commend this case to Mr. Curling's attention.

Ruptured Urethra.—On November 1st, 1826, Mr. B. Travers related the case of a boy, aged 14, who had rupture of the urethra from accident. He inquired whether any case of similar injury could be adduced in which the patient had survived the injury, and had become a father. He was of opinion that it would prove an instance of distressing impotence, in consequence of no erection taking place owing to the situation of the injury, it being just anterior to the bulb.

Fracture of Spine.—On June 6th, 1838, Mr. Adams read a case of fracture of the odontoid process of the second vertebra. It was in a man, aged 30, who walked into the London Hospital on May 17th, and reported that, as he was descending a ladder, he fell a few feet, and pitched upon the back of his head and neck. There was no external

mark of injury. After the fall, he became deaf; and, when admitted, he was still so. He was stupid, and spoke with reluctance. The pulse was slow; the pupils acted freely. He was cupped, with relief. On the 18th, or day following, he was loquacious. On the 19th, he was delirious and required restraint. Towards night, he became unconscious. On the 20th, stertor came on, and death occurred at 10 p.m. After death, the brain was found congested, and excess of serum existed. The odontoid process was in position, but it was completely separated from the remainder of the vertebra.

Extension in Fracture of the Spine.—On January 12th, 1842, Mr. Luke stated that extension of the spine was frequently followed with marked relief of local pain. He brought forward the following case as an example. A carpenter received an injury about the sixth and seventh cervical vertebrae, in consequence of which, the arms were paralysed. On moving his head from side to side, Mr. Luke fancied he detected fracture at the seat of injury. On the next day, the man stated that what he had done had cured him; whilst his head was being rotated, he felt something snap and return to its place, and the use of his arms was restored to him.

Trephining for Head-Injuries.—On December 18th, 1844, the subject of trephining was brought on, when it was reported that Sir A. Cooper, at the latter period of his life, believed that in cases of head injuries, where the edge of the fractured bone was thrown beneath the line of the other bone, he would recommend its being raised, although the injury was not attended with any symptoms; indeed, he had often been sorry that he had not operated, though he never had occasion to regret having done so; and the reason assigned was that, though the patient might recover, yet the after-consequences were often of a very serious nature.

[To be concluded.]

TWO CASES OF COMPLICATED LITHOTOMY.*

By EDWIN MORRIS, M.D., F.R.C.S., Spalding.

IN the whole range of operative surgery, there is no operation more telling, or which shows forth the triumph of surgical science more, than that of lithotomy. Under ordinary circumstances, the operation itself is simple enough in the hands of a surgeon who is thoroughly conversant with the relative anatomy of the parts implicated. There is, however, something more necessary—that the operator should be calm and collected; and, should any difficulty arise, he should never for a moment lose his self-possession, or be hurried, but face the difficulty with great composure and confidence. And I would here remark that, when once the operation is commenced, not a word should be said or remark made to the operator—as to do so mystifies, confuses, and is trying to the surgeon—unless he himself make an appeal to those around him. I have witnessed several lamentable failures, owing entirely to the suggestions and remarks made by the bystanders. Those gentlemen who are present and are accustomed to perform this and kindred operations, will readily understand this. For a provincial surgeon, more than my share of stone-cases has fallen under my care; and, up to the present time, I have never lost a patient. The ages of my patients have varied from three to seventy-three years; and my practice has extended over a period of twenty-six years. I have, however, in two cases met with considerable difficulty during the operation; and in one I failed altogether to extract the stone. It is these two cases that I wish briefly to bring before the notice of the members of this Association, and thus make practical experience available as a guide and encouragement to others who may be, in the course of their surgical career, placed in a similar position.

The first case is that of John Sirkett, aged 34, who, a few years previously, had received a severe kick on the perineum from a sheep which he was shearing. For some time afterwards he had pain deep in the perineum, and difficulty in passing urine. For several years his life had been one of misery. During this time he had tried a variety of remedies, all of which had a charlatanic origin. There is one person who professes to have discovered a water capable of dissolving stones in the bladder and of relieving gravel; it is sent out in wine-bottles, and is very clear. I do not know its constituent parts, but this I do know, that it considerably relieves the suffering of the patient; but, as you may suppose, fails in every instance to dissolve the stone. It has gained great notoriety in our neighbourhood, and is much used. When Sirkett first consulted me, I had no difficulty in finding a stone, and advised an operation. When the man was bound upon the table, I observed a bulging of the perineum which was very unusual. I passed the staff,

* Read before the Midland Branch.

which immediately came into contact with the stone. By the usual lateral incision, I made an opening into the bladder, and urine escaped freely. Upon passing my finger into its cavity, I could not feel the stone. After many attempts, both with the forceps and scoop, I was about to give up any further search, when, in withdrawing my finger for the last time, I felt the stones (for there were more than one) embedded in a cyst in the front lobe of the prostate gland. The bulging in the perinæum was at once accounted for. I immediately opened the cyst and turned out five stones weighing three-fourths of an ounce; and I now have the satisfaction of showing them to you. I had not the least idea, before operating, but that the stone was within the bladder; others felt it as well as myself. Had I been aware of its exact position, there would have been no necessity to open the bladder at all, as an incision through the median line of the perinæum would have enabled me to at once remove the stones without so much risk or difficulty as that which attends the operation by the lateral method. I invariably retain the staff until after the extraction of the stone; and in this instance it certainly did me great service. I read a paper "On the advantage of retaining the staff in the bladder until after the extraction of the stone in lithotomy," before the meeting of this Branch at Lincoln in 1862, which was published in the *BRITISH MEDICAL JOURNAL* for 1864, vol. ii, page 490. To this paper I respectfully beg to draw your attention. This case was clearly one of prostatic calculi; and the operation which I have just indicated would have been amply sufficient.

The next case is that of Mr. John Major, aged 66, a respectable farmer. He had suffered from irritation about the bladder for the past twelve years; and, two years previously to my seeing him, he had been under Mr. Poland's care, at Guy's Hospital, who had endeavoured to crush the stone, but failed to lay hold of it. He first consulted me in June 1867; and, after a tedious and lengthened examination, I succeeded in detecting a stone. Several surgeons examined him, and only a few found the stone. Mr. Major resided fourteen miles from me. I went over to his house and operated upon him in the usual way, in the presence of his ordinary medical attendant and several other surgeons from the neighbourhood. Chloroform was administered in this case as well as in Sirkett's. I had a deep perinæum to contend with; and, after I had made an opening into the bladder, I had considerable difficulty in reaching and exploring its cavity with my forefinger. I found but a small portion of the stone projecting into the bladder; the rest was deeply imbedded in the substance of the bladder, and I failed to get hold of or disturb it from its impacted position. After a consultation with my surgical friends present, I determined to relinquish my endeavours to extract it. I ordered the patient to bed, and gave an opiate. He passed a good night, and the next day was comfortable and free from pain, and the urine escaped freely from the wound. He continued to improve daily; at the end of the week, the urine passed freely through the penis, and the wound in the perinæum healed rapidly up. One remarkable feature in the case was, that the man's symptoms were much relieved by the operation, and he considered that it "had done him good." The man suffered no inconvenience whatever, and did not succumb to his malady until May 1868, nearly twelve months after the operation. I regret very much that I was not present at the *post mortem* examination, which was made by Mr. Lane, his surgeon in attendance, under very hurried and unfavourable circumstances.

In answer to a letter which I addressed to that gentleman respecting the *post mortem* examination, he states: "The reason you have not been informed of the results of the *post mortem* examination of the late Mr. Major is, that I have not been able to send a proper statement. Mr. Major died on the 29th of May. Leave was given the next morning to search for the stone if I could do it that day; therefore I appointed 4 P.M.; but, being engaged with a midwifery case, I did not get to the house till past seven in the evening; and, so far was I from taking the calculus away, I had not a chance, for the son and brother-in-law were with me the whole of the time. The son said he should keep the stone, and the bladder they desired me to return into the body, for I had removed it altogether, intending to send it to you. When I opened the body, I found the bladder deep in the pelvis, containing a little urine, and firmly adherent to the pelvic portion of the colon, so that I had a difficulty in dissecting it away. The stone occupied the middle third of the posterior part of the bladder, in a complete bag, only a small portion presenting. The mucous membrane was thickened, as also the muscular portion, the bladder being much contracted, showing evidence of great irritation." I am pleased to say that the son, upon my applying to him, forwarded the stone, so that I might show it to you this day. It weighs four ounces two drachms. Upon examining it, you will at once see the small portion which presented within the cavity of the bladder, and which made it difficult to touch with a sound.

Such is the brief history of two cases of lithotomy which were beset

with much difficulty, and were very embarrassing and annoying to me at the time. It was as gratifying to me, as it will be to you to hear, that both cases made a rapid recovery from the effects of the operation. Sirkett completely recovered, and is quite well at the present time. Mr. Major sustained not the slightest injury from the operation, and the necessary length of time which was occupied in attempting to get at the stone. I do not know a circumstance more to be deplored, or one more humiliating to the operator, than that of being obliged, after having cut into the bladder, to relinquish the case without removing the stone. Rumour, with her many tongues, is apt to run rampant on such occasions, and to attribute the failure to any but the right cause. No allowance is charitably made by this multilingual reviler for any abnormal condition that might be met with. It is enough that the patient had a stone, and that an operation was done for its removal without obtaining it. Thus rumour spreads this fact far and wide, much to the detriment of the noble art and science of surgery; and with shame do I confess it, that it gains, rather than diminishes, through the medium of ill-natured and competing professional outsiders.

ON THE TREATMENT OF CERTAIN FORMS OF UTERINE CANCER.*

By C. H. F. ROUTH, M.D.,

Senior Physician to the Samaritan Free Hospital for Diseases of Women and Children; Consulting Physician for Diseases of Women to the West London Hospital for Diseases of the Chest; etc.

It is fresh in my recollection, when a student, how we received and discussed cases of uterine cancer. A few leading questions were asked; the finger was passed into the vagina, and as hastily withdrawn. "We can do nothing for you," were generally the few words addressed to the patient; "you have cancer." And she was at once consigned to hopeless misery, and assured of death. I have lived to see considerable modification of this opinion. Hope is not always now excluded; and I am glad to find that others have also written on the subject in more hopeful terms. I now state it as my belief, not only that epithelioma of the uterus is often quite curable, but that other varieties of uterine cancer may be arrested, and their ulcerations in many cases cured.

In affirmation of this opinion, I may refer to some of the facts made out in the present day, and so enunciate certain articles of my belief. The time allotted to this paper positively forbids anything like discussion of the several points, although I should be glad elsewhere to take them up.

1. I do not believe cancer to be *always* and *primarily* a blood-disease. It is often so, no doubt; but more often it may be due to secondary poisoning of the system from a local cause, or the co-operation of another cause, to whose presence, as well as to that of the first, the development of cancer is due.

2. When we say that cancer is a blood-disease, we do not necessarily conclude that local measures are useless. To do this is to lay too much stress on blood-poison. Let me illustrate this by two diseases—scrofula, and syphilis, secondary or tertiary. The blood-origin of these diseases in no way impedes local measures; nay, often these local measures are essential to the cure of the blood-disease.

3. Hereditary taint is made much too important. Would any man hesitate to treat gout or rheumatism, and be doubtful as to probable success, because it was hereditary? And so with cancer. It may exist in the blood primarily; and yet the local sore, if not treated, will only increase the malady. It may exist as an hereditary taint; but this should not necessarily lead us to doubt its possible extirpation from the constitution. A man, perhaps with strong hereditary taint, has lived years before the cancer-poison has developed itself. Clearly, a new phase has come upon him then, which did not exist before. Had it not occurred, the cancer had not shown itself. As clearly, therefore, if we can find out what this new phase is, and so correct it, we necessarily get rid of the cancer. This is a point which, I think, is generally overlooked. And yet examples are not wanting to prove that the removal of this peculiar phase, which gives impetus to cancer, is occasionally a natural process: for instance, where cancerous breasts have sloughed away, or distinctly cancerous tumours have, under inflammatory seizures elsewhere, lost their cancerous character. But, unfortunately, we are too apt to dwell rather on the malignant character which benignant tumours sometimes acquire, because here the evidence is conclusive; and too unwilling to recognise an opposite change, because accustomed for so many years to regard cancer as incurable.

* Read in the Midwifery Section at the Annual Meeting of the British Medical Association in Leeds, July 1869.