ON TAPPING THE BLADDER FROM THE PERINEUM THROUGH THE HYPERTROPHIED PROSTATE.

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TAPPING the bladder is an operation which is not often necessary; I believe it may occasionally be resorted to even when a catheter can be passed. Assuming it to be required, how is it to be done?

Tapping with the aspirator-needle above the pubes is a safe proceeding, and, for affording temporary relief, is to be recommended. A surgeon who finds himself in difficulties with a distended bladder, a large prostate, and false passages, is likely to do less harm with the needle than with the catheter, and is sure to give relief. Taking off the tension by withdrawing the urine generally permits the instrument to pass on the next trial. This method, however, can only be used for temporary purposes.

Tapping the bladder above the pubes with a trocar, for the purpose of establishing a more or less permanent drain, is very much like opening an abscess at its least dependent spot. Urine ascends the cannula against gravity, and the products of inflammation of the bladder, usually present in some degree, remain behind in the pouch, undischarged. Tapping through the rectum requires the retention of the cannula in the intestine, and is thus an obstacle to defecation. Forcing the end of the catheter through the enlarged prostate is an unsurgical proceeding, not to be entertained. Tapping the membranous urethra leaves us in the position of having the obstructing prostate behind the opening. There is a point in the wall of the bladder, unconnected with peritoneum, through which a trocar and cannula may safely be passed: I refer to the prostate gland, which in old men, where paracentesis is more frequently required, often affords a considerable area for the operation. I will illustrate this method by the following case, only premising that over twelve months ago I recognised its propriety, and tested it on the dead subject. I then had the instrument made for the purpose; but, though having considerable opportunity for dealing with retention of urine under all circumstances, it was not till quite recently that a case in point presented itself. I mention this as explaining how I came to be prepared, instrumentally, for doing that which I will briefly describe.

N. D., aged 84, was admitted into the Liverpool Royal Infirmary at 2 A.M. on November 4th, 1881. My house-surgeon, Mr. Laimbeer, found him bleeding from attempted catheterism, with a large prostate, and a distended bladder. Recognising the urgency of the case, and finding catheterism impracticable, he emptied the bladder with the aspirator above the pubes. I saw the patient a few hours afterwards, and found that he had not passed urine since, and that no catheter could be introduced. His tongue was brown, and he was much exhausted. Later on, I again visited him, when the bladder had become fully distended.

I then had him placed under ether, and succeeded in passing a gum-elastic prostatic catheter. Beyond demonstrating that the difficulty had been overcome, I declined letting any more urine be drawn off, for a reason arising out of recognising that either the catheter must be retained, or re-introduced when required; neither of which proceedings I was disposed to recommend.

Retaining a catheter in the bladder of an old man, somewhat childish and disposed to remove any appliance if not closely watched, is not easy; and, when it is done, it often ends with death, from cystitis, pyelitis, and exhaustion. This was a case where, in my judgment, it was wisest to establish a permanent drain; and to do this in the manner on which I had determined, required a tense, and not a flaccid, bladder. Taking a trocar which had been made for the purpose, with a silver cannula, I introduced it in the median line of the perineum, three-quarters of an inch in front of the anus, and pushed it steadily through the prostate into the bladder, at the same time retaining my left index finger in the rectum for a guide. On withdrawing the trocar, a large quantity of ammoniacal urine escaped. The cannula, being provided with a shield, was secured in its place by tapes much in the same way as a tracheotomy-tube. A piece of India-rubber tubing was attached to the portion of cannula which projected beyond the shield, and conveyed the urine into a vessel placed at the side of the bed. Through this tubing urine continued to dribble. The patient was at once made comfortable by this arrangement, and in forty-eight hours he was up, sitting in an easy-chair—an important matter with old persons. To permit of this, the rubber tubing is shortened during the

day-time, the end of it being tucked through a light abdominal belt, where it is compressed by a small pair of bulldog-forceps, which are removed when the patient desires to pass urine. He is quite as well as most men of eighty-four years of age are. He gets up daily, takes his food, and sleeps comfortably, either on his back or his side, without any narcotic, and is quite free from any urinary inconvenience other than wearing his tube. During the night, his sleep is not broken by calls to micturate or pass catheters, as his urine runs off by the tubing as it is excreted; whilst, in the day-time, when he is up and about, his act of micturition practically resolves itself into something equivalent to the turning of a tap. His urine, which had been fetid and ammoniacal, is now nearly normal, the bladder being readily washed out by applying a syringe to the cannula twice a day. On two or three occasions, the cannula has accidentally slipped out, whilst the tapes were being changed, but has been readily replaced by the nurse. The somewhat enthusiastic manner in which the patient compares his present, with his past condition, cannot be passed by entirely unnoticed.

The operation was devised much on the same lines I endeavour to take in commencing my lithotomy incision—namely, the selecting of a point in the perineum which endangers no vessel of importance. My object in planning the operation, was to obtain what I can best describe as a short low-level urethra, adapted to the altered relations of the bladder to the prostate when the latter becomes enlarged, for the purpose of securing the most complete drainage. I should add, that since the tapping, as far as we are aware, the patient has only passed a few drops of urine by the urethra.

What the future of the case will be, I cannot say. Apparently, the old man has a prospect of living comfortably for an indefinite period; but, if it were not so, and he should sink before this communication comes under the notice of my professional brethren, I should never hesitate again to resort to this proceeding, under similar circumstances, for the complete comfort it has so far afforded my patient.

ON THE RELATION OF ANTEFLEXION OF THE UTERUS TO DYSMENORRHOEA.

By LOMBE ATTHILL, M.D.,
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IN the number of the JOURNAL for Saturday, October 29th, there is published an abstract of a paper on the above subject, from the pen of Dr. Herman, with much of which I agree. I concur in the main with his propositions 1, 6, 7, and 8, but disagree entirely from 5, viz., that painless menstruation is as common when the uterus is anteflexed as when it is not; and still more decidedly from 9, that dysmenorrhœa and anteflexion "are not cause and effect, but merely a coincidence". This last is an error of so grave a character, so calculated to lead to malpractice, that I must point out how a careful observer as Dr. Herman evidently is has been led into a mistake by building up a theory on the anatomical examination of the uterus in women who were probably in general free from painful menstruation, and omitting to study during life the cases in which it occurs, with equal care. A *post mortem* examination, made without a knowledge of the previous history of the subject, is nearly always useless; and it is seldom that we are in a position to prove the exact condition of the uterus in cases of dysmenorrhœa, as the disease rarely proves fatal.

But while I agree with Dr. Herman that there is no clear anatomical evidence that anteflexion causes any hindrance to the escape of the menstrual flow, I hold—and, from careful and protracted observation, am convinced—that well-marked anteflexion of the uterus is a common and important factor in cases of, and frequently a primary cause of, dysmenorrhœa in sterile women; and this, I believe, no experienced gynaecologist can for a moment doubt. My opinion on this point is thus expressed in my *Lectures on the Diseases peculiar to Women*, sixth edition, p. 55: "Painful menstruation is frequently observed in women in whom the uterus is flexed; but though flexions of the uterus may, and certainly do, interfere with the exit of the menstrual flow, they seldom do so unless the flexion be complicated by the existence of chronic inflammation." It is because gynaecologists often overlook the existence of this latter condition, that great confusion occurs and contradictory statements are made on the subject.

I hold with Dr. Barnes that anteflexion, in the vast majority of cases, is a congenital condition. I may be asked: How is it, then, that often menstruation is performed in a perfectly normal manner for years, and that then, for the first time, pain is experienced? The answer is obvious; the flexion was of no importance till an additional element was introduced, that being the occurrence of chronic endometritis; but

I hold that endometritis would not have occurred in the great majority of cases, had not the flexion previously existed.

A patient at the present moment under treatment in the Rotunda Hospital is a good illustration of the truth of the foregoing statement. Mrs. —, aged 30, married ten years, has never become pregnant. She enjoyed perfect health up to and for some time subsequent to marriage; but within a few months after marriage, she began to suffer discomfort, and then actual pain, at each menstrual period. As time passed on, she became worse and worse, till her sufferings became so severe that she sought relief, and was admitted into the auxiliary hospital. On examination, the uterus was found to be markedly flexed; the sound penetrated with ease, but on its point touching the fundus the patient complained of severe pain. The uterus measured nearly three inches in depth; and a bimanual examination, which was easily made, also proved that the fundus was much enlarged. Doubtless, I shall not have any opportunity of proving, by a *post mortem* examination, that dilatation of the cavity of the uterus existed in this case; nevertheless, I am quite satisfied that I am dealing with a case of congenital antelexion of the uterus, in which chronic endometritis of long standing has resulted in bringing about hypertrophy of the uterine wall, with dilatation of its cavity.

I have already, at page 189, sixth edition, of my *Clinical Lectures*, published my view of the "pathology and causation" of this affection. It is to this effect: that it occurs in women in whom either the cervical canal is contracted and the cervix conical, or in whom congenital antelexion exists; that, before marriage, neither of these conditions has sufficed to cause any difficulty in the exit of the menstrual discharge, but that, under the influence of the excitement caused by sexual intercourse, a greater quantity of blood has been determined towards the uterus and ovaries; the mucous membrane lining the cavity becomes more swollen than previously, and a somewhat increased amount of blood is, at the menstrual period, secreted from its surface. The swollen condition of the mucous membrane at the os internum makes the originally narrow passage still smaller; the menstrual flow is retarded; and, as a result, small clots form, they plug the orifice, and are expelled with pain. Relief for a time may be obtained, but the same process recurs over and over again; and, in time, permanent irritation of the intra-uterine mucous membrane is excited, chronic endometritis is set up, and the cavity of the uterus now always contains a quantity of viscid mucus which slowly exudes. In some cases, by pressing up the end of the speculum, this can be forced out. In the end there is permanent dilatation of the uterine cavity, with hypertrophy, in many cases, of the uterine wall, while the constitution at large suffers seriously.

I do not wish to prolong this paper, and therefore omit all reference to many debatable points raised by Dr. Herman; but I must protest against the treatment of congenital antelexion by pessaries of any kind. They seldom, if ever, do any good; at most, they give for a time some trifling relief by supporting the enlarged fundus. At the present moment, I have a lady under my care, married some years and sterile, who has worn a cradle-pessary for fourteen months, and she tells me she has not benefited in the least. Her case is identical with the one just related, only she is but three years married.

There is but one way of curing these cases; not by attempting to straighten the uterus, for that is impossible, but by division of the cervix so as to give free exit to the viscid contents of the uterus; and then treating the unhealthy intra-uterine mucous membrane. This latter proceeding in sterile women, or in virgins, is useless till a free exit is secured for the tenacious mucus during the intermenstrual period, as well as for the menstrual discharge.

In virgins, in whom dysmenorrhœa occurs as a consequence of congenital antelexion, the course of the disease is the same; only the endometritis in them is induced by exposure to cold, prolonged fatigue, whether in dancing and riding among the upper classes, or among shop-assistants, dressmakers, etc., by excessive fatigue, bad air, insufficient food, etc. The treatment must be the same. Of course, I lay stress on general medical treatment as well, but this will prove useless unless the local disease be cured.

BRENTFORD.—In his report on the health of this district for the quarter ending 30th September last, Mr. Williams reports a death-rate of 16.8 per 1000, a rate almost exactly similar to that returned for the corresponding quarters of 1879 and 1880. The principal causes of death were diarrhœa, which caused nine deaths; phthisis, six deaths; and convulsions, five. Two deaths were registered as due to typhoid fever, one to measles, and one to whooping-cough. Of the 50 deaths which happened during the quarter, 22 were infants under one year of age. One case of small-pox was reported, though the district is now quite free from this disease, as well as from scarlet fever; but there still remain a few cases of whooping-cough, measles, and typhoid fever.

ANTISEPTIC INHALATIONS IN PHTHISIS.

By ROBERT SAUNDBY, M.D.Ed.,

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As the use of antiseptic inhalations has proved useful in phthisis in my own practice, and is supported by those who, like my friend, Dr. Sinclair Coghill, have special opportunities of estimating the value of treatment in this malady, I think it is important that we should try to improve the necessary apparatus as far as possible. I have been using for the last year an inhalation-respirator made for me by Mr. Best, instrument-maker to the General Hospital, of Sumner Lane, Birmingham, and which is figured in the accompanying woodcuts.

The naso-oral form, which I have employed almost exclusively is very well shaped, is light, comfortable, well ventilated, and worn by patients without complaint of inconvenience or fatigue. The antiseptic I have found most suitable is the oil of eucalyptus, in doses of five to ten drops poured on the flax twice daily.

I do not claim, nor do I think we can rationally expect, to cure any cases by them; but many of my patients have found great relief from their use, mainly in checking purulent secretion and allaying cough.

CURIOUS MALFORMATION.—A curious case of malformation has occurred in the practice of Dr. Simon Kovrig, of Szamosujvar in Hungary. The child, which was still-born, has a "Janus head." At a point corresponding to the centre of the normal forehead, commence two completely developed faces with four eyes, two mouths, and two noses. Posteriorly, there is an ear on each side, and at the point of fusion of the faces anteriorly a third undeveloped ear is to be seen.