eases there are vesicles which are crowded together, but the character of the fluid uplifting the cuticle, and its subsequent behaviour, the source of this fluid, the anatomical seat of the disease, are wholly and entirely different. The disease is not the hydroa of Bazin, under which term a host of different things have been classed—urticaria bullosa, erythema papulatum, miliaria, and the like.

Of course, in many diseases, excessive sweating occurs, as in the case of idrosis, miliaria, and sudamina; but then the sweating is only an accidental feature, and accounted for by the general disturbance; but in this disease, the sweat-disorder is the main and sole disease present. But I have noticed that it always occurs in those who too freely perspire, in those who are depressed, weak, and get quickly exhausted, and in connection with, oftentimes, anomalous nerve-symptoms. The cause of the sudden outpouring of sweat is doubtful. It is, probably, some disturbance of the nerve-influence.

Now as to treatment. It is of no use trying to cure the disease by local measures, though you can moderate the irritation, and inflammation, and prevent the sweat from becoming sour and irritating. The internal remedies are diuretics, with a view to relieve the skin, with large doses of quinine and nux vomica. Locally, I cover up the parts in the acute and early stage, with some simple cerate, with liquor plumbi, rubbed into it, and perhaps carbolic acid, in small quantity. Then, later on, I coat the parts with starch and calamine powder, and later on prescribe the balsam of Peru, twenty grains to an ounce of lard, with a little white precipitate. Most cases do well. In the simpler instances of the disease you give the quinine internally, with arsenic if you like, and diuretics if need be, and locally protect the parts with calamine lotion.

I have termed the disease dysidrosis, because nature seems to have a difficulty in getting rid of the secreted sweat, which remains to distend the follicles, and to macerate the tissues. The disease is nothing more than retention of sweat and its results. Dysidrosis bears the same relation to the sweat-glands that acne does to the sebaceous glands.

RARE CASE OF EPISPADIAS (WITHOUT EXTRO-VERSION OF THE BLADDER), AND ACCOUNT OF OPERATION.*

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T. B., aged 9 years, presented himself in January, 1872, at the German Hospital, with the following malformation of the penis. The urethra was entirely deficient at the upper part, from the os pubis down to the glans, presenting merely a slight groove lined with mucous membrane, and leading at the symphysis pubis, which latter part was not divided, into a wide infundibulum, through which, during narcotisation of the patient, my little finger could be easily introduced into the bladder. The distal half of the glans was not divided, but also at the same time not perforated, nor were any traces of the meatus to be seen, while the other half was bifid. The whole penis, of a very diminutive size, was in the natural condition, drawn upwards, with a slight tendency to the left side, towards the abdominal walls, and withdrew, in the recumbent position of the patient, the infundibulum almost from view, though it would not prevent the urine from continually dribbling away, even if the patient were in this position. The prepuce, as usual in these cases, of comparatively large size, was hanging down apron-like from the under portion of the malformed glans. Both testes were in the scrotum, and I noticed once an imperfect erection at the beginning of the narcotisation. The bladder seemed to be fully developed, although, on account of the constant dribbling away of the urine, of an extremely small size; but it decidedly gained during the different operations, which were afterwards performed, more power of retaining the urine. Around the infundibulum one could notice some small folds of the skin running in a convergent direction towards the orifice, and the finger had to overcome a certain resistance before it could be fully introduced into the bladder.

In order to improve this truly miserable condition of the patient, I endeavoured to follow Professor Thiersch's ingenious method, for the first time practised by him with good result in 1857 and 1858; but, in consequence of several failures, I had to employ partly another method in order to accomplish my object.

The whole operation had to be divided into four distinct acts: the first comprising the formation of a canal through the distal half of the

glans; the second, the transformation of the groove of the second half of the glans into a regular canal, communicating with the newly formed one; the third act had for its object to transform likewise the groove from the glans up to the infundibulum into a canal; and, lastly, the fourth act comprised the covering of the infundibulum itself.

1. The formation of a canal through the distal half of the glans penis was easily accomplished with a small trocar, and the canal was then widened with the galvano-caustic wire.

2. To transform the groove of the second half of the glans penis into a regular canal, I made on each side of the groove a longitudinal incision through about two-thirds of the thickness of the glans, giving a convergent direction to the incisions, viz.: the two incisions would have met at one point, if they could have been lengthened to the proper extent. I then pared, to the outer side of these two incisions, the surface to a certain extent, and brought together the two raw surfaces over a catheter with some fine sutures. The catheter was directly afterwards removed. Perfect union took place.

3. In order to transform that part of the groove which was lying between the glans and the infundibulum into a canal, the following operation was undertaken. I made, near to the right edge of this groove, a longitudinal incision through the skin, and at both ends of this likewise a small transverse incision was made, running outwardly; and this flap, thus marked out, was carefully dissected off. After this, a similar flap was formed on the left side of the groove, but with this difference: that the longitudinal incision was not near the groove, but at some distance from it, and the two small transverse incisions at both ends of this had a direction towards the groove instead of from it. This flap, after having likewise been carefully dissected off, was then turned over like the leaf of a book over the groove, and the flap of the right side stretched over this; so that the two raw surfaces were attached to each other, and the epidermal side of the under flap had its aspect towards the groove. The whole was fixed with fine silk sutures.

This operation, however, did not succeed, for the flaps sloughed almost entirely, and I therefore, at a later period, had to submit the same part to another operation. For this purpose, I made use of the very large prepuce by making, at a little distance from the glans, a long transverse incision through the whole thickness of the prepuce, large enough to enable me to pull easily the glans through this buttonhole, and fixed then this part to the base of the glans previously pared. I afterwards, but not on the same day, used this part of the prepuce, which meanwhile had become firmly attached to the glans, as a means to form the upper wall of the urethral canal, which I intended to do by the former operation, but had utterly failed. In order to accomplish this, I pared, on both sides of the urethral groove, the surface to a great extent, and likewise the upper surface of the prepuce, which, by being turned over, had to cover the urethral groove, but, of course, taking care to leave through the entire length of the prepuce a broad strip, which was intended to form the actual upper wall of the urethra untouched by the knife. The flap was then fastened to its position with sutures, and union took place everywhere, although the parts themselves were continually bathed in urine and no precautions whatever were taken to prevent this.

4. To cover the infundibulum, two flaps were taken from the abdominal walls near the infundibulum, in order to cover this part. The first one had almost a triangular shape, and was turned over in such a manner that the infundibulum was covered by its epidermal side; the second flap was almost of a quadrangular shape, and was destined to cover the triangular flap, the raw surfaces touching each other. Both flaps thus united were fastened to the previously pared margin of the original prepuce, and thus a perfect canal was constituted from the glans up to the bladder. After this operation, a catheter was constantly kept in, but, notwithstanding this, sloughing set in to some extent at the left side, and although it did not frustrate the whole operation, nevertheless no union whatever took place between the doubled flap and the margin of the original prepuce; two more operations had, therefore, to be performed in order to carry this point. There now merely remains a fistular opening, or, I might even say, a second meatus urinarius, between the two halves of the glans, which, until now (as the last operation was only performed quite lately), I have not felt it advisable to close; but this I hope to do very soon, and I daresay it will be easily accomplished.

The patient is already able to retain, in the recumbent position, a certain quantity of urine, and will then pass it, partly at least, in a good stream; and, even in the upright position, there is not the continual dribbling of urine going on as formerly. I intend to supply the patient after a while with a truss-like instrument, in order to enable him to retain the urine longer, and am in hopes that in time the power of the bladder may still increase; which improvement, to a certain extent, has already taken place.

* Read before the Surgical Section at the Annual Meeting of the British Medical Association in London, August 1873.