dence and *post mortem* examination. Let it not be said that this capacity in the judge for taking the place of his own witness was a gain to the public. I hold it to be entirely the contrary. He acquired the capacity by a special education, which of itself guarantees that he shall not possess the knowledge of law required for the due discharge of his function, and this ignorance of law he has no power of supplementing by calling, in ordinary cases at least, a legal adviser, and hence gross and irremediable mistakes and omissions frequently occur. The position of a medical coroner must often, I should suppose, be as uncomfortable as it is undignified. Having obtained it by an expensive election and, perhaps, a servile canvass, he finds the remuneration too small for a sole source of income, and has, therefore, to make its duties fit in with the toils and anxieties of private practice; and he is also restrained in the inquiries he may think it necessary to make by objections, on the score of expense, made by an irresponsible authority to whom the circumstances are unknown. The position of these gentlemen as well as the interests of society have been, I should suppose, damaged by the change made, in late years, in their mode of remuneration. It was surely better for society that the coroner should be tempted by the fees and mileage to hold or adjourn an inquest unnecessarily than that he should, by the exigencies of his private practice and his fixed salary, be led to suppress or hurry over an important inquiry.

While writing this paper, I have seen the letter of Mr. Serjeant Cox, quoted in our JOURNAL of the 22nd ult., and it seems to me full of important suggestions. The difficulty as to the appointment of coroners which perplexes the learned serjeant would perhaps be lessened if the local government of the country were vested in such county boards as were suggested in the able paper read by Mr. Michael before the united conference of our own Association and the Social Science Congress in May last.

MAY STRICTURE OF THE URETHRA BE HEREDITARY?

By MARCUS ALLEN, L.R.C.P.Ed., Surgeon R.N.

THE pathology and treatment of stricture of the urethra, even in the dawn of his art and science, greatly exercised the mind of the surgeon; and, in our own day, the writings of Thompson, the researches of Otis, and the labours of Hill prove that the interest of the profession in the question is neither dead nor sleeping. Less frequently in the etiology of surgical, perhaps, than of medical maladies, has the hereditary influence been sought for or recognised in investigating the causation of disease, and in neither of these great branches of the profession does our knowledge approach to completion of the various disorders that may be transmitted by descent. To enumerate here the several causes of stricture of the urethra, generally admitted by those who have made its phenomena a special study, would be foreign to the scope and object of the present paper. Suffice it, then, to say that congenital predisposition approaches most closely to the point for which I am contending.

Several years ago, I occasionally met, in the ordinary relations of social life, an elderly gentleman, who was then under treatment for irritability of the bladder, and who was also afflicted with stricture of the urethra and enlargement of the prostate gland. In addition to possessing a highly educated mind, he had acquired no inconsiderable knowledge of medicine as an amateur student when an undergraduate at the University, and the vesical affection was attributed by him to the effects on his nervous system of a severe crushing sustained many years before in the gallery of the House of Commons, and aggravated at a later period by an unexpected domestic bereavement; but the stricture of the urethra he considered to be hereditary. On inquiring his grounds for this opinion, he informed me that his father had succumbed to an operation for retention of urine necessitated by an organic stricture, and that he believed his grandfather had also been the subject of some affection of the urinary system—most probably a stricture. The father of my friend had in early life been engaged in practice as a doctor of medicine; subsequently, he succeeded to the family property, after which he followed the usual avocations of a country gentleman. At an exceptionally early age, he had contracted marriage, and there was not (so far as I could learn) the slightest suspicion that he had been in any degree accessory before the fact. The argument appeared to me to be the reverse of untenable, more especially as I knew the son of my friend to be the subject of a similar affection, for which he was unable to assign a cause, except that the disease was hereditary. The medical history of the representative of the fourth generation is briefly as follows. In childhood, he had suffered from nocturnal incontinence;

in boyhood, the incontinence of urine ceased, and he formed the habit of urinating twice in the course of the night; and, at the age of 14, he was for the first time discovered to be the subject of stricture of the urethra. Frequent call to micturate was the symptom which led to this discovery; riding had not been his favourite exercise, and no exciting cause could be named for developing the congenital predisposition, if merely a predisposition had existed from his birth.

My elderly friend has since died. The surgeon who signed the certificate of death stated that it resulted from stricture of the urethra; and, as his son was unable to give me any fuller information respecting his great-grandfather's health than that he believed him to have been subject to "some affection of the urinary system, most probably a stricture", I recently applied to a gentleman (still living at an advanced age, with all his faculties unimpaired), who can remember the family for four generations, but, unhappily, he is unable to elucidate the point.

REMARKS.—The statement "probably a stricture", referring to the representative of the first generation and coming from a grandson, must necessarily be received with a large amount of reservation, and I lay no further stress upon it than merely as affording presumptive evidence of disease of the urinary system. We have, however, a clear history of the malady in three successive generations. The nature of the disease in the second and third cases of the series was certified to respectively by surgeons of acknowledged ability; and, in addition to neither patient being particularly attached to equestrian exercise, it is worthy of note that neither of them was an officer in the army or navy; in the former service the "military seat" in cavalry regiments being a fertile source of originating as well as aggravating the disorder; and, in the latter service, duty aloft frequently leading to organic disease of the urethral canal (and in the gun-boats of which the practice of instrumentation as a remedial measure is virtually impossible), but were persons moving in the higher circles of home society, with every opportunity of following the instructions of the first surgical opinion of the day. The representative of the fourth generation is now alive, and has trained himself to catheterism at regular intervals, and the question suggests itself how far the incontinence of urine in childhood was a posterior effect, the result of a congenital hereditary stricture of the urethra. "Some sins of parents are visited as diseases upon the children until the third and fourth generation", writes the gifted author of *Diseases of Modern Life*; "but there are other visitations, also descending through many generations, which are due, not to the sins, but to the misfortunes or accidents of those in whom they originated and from whom they have descended." It may be that the remarkable series of cases which forms the basis of these remarks constitutes the proverbial exception essential to establishing the rule that stricture of the urethra is *not* transmissible by descent, or it may be that hereditary proclivities have become more intimately interwoven with the complex fabric of our modern civilisation. Strongly opposed, however, to dogmatism, the writer will have attained his object if he shall succeed in directing the attention of the profession to a possible obscure factor of this disorder as yet unrecognised by the schools.

CASE OF ANEURISM OF THE ABDOMINAL AORTA.

By JOHN C. LUCAS, L.R.C.S.Ed.,

Surgeon in Her Majesty's Indian Army, in Medical Charge 24th Regiment Native Infantry; in Medical Charge Luck Hospital; Officiating Staff Surgeon, etc., Camp Neemuch, India.

PRIVATE Manoo Pavab, aged 39, having twenty years' service, gives the following account of his case. He enjoyed excellent health until about eight years ago. When serving with the regiment, then stationed at Dharwar, in the Deccan, he first began to feel the sensation not unlike that from the pricking of pins and needles in his stomach (pointing to the epigastric region); this was attended at the time with vomiting directly after meals. He has frequently been admitted and readmitted under the care of the various medical officers who have since been in charge of the regiment.

In July last, he was admitted under my care, and, after a stay of twenty days, was discharged, with the recommendation for light duty and to be exempted from parade and musketry. He again presented himself for admission on August 8th, complaining of pain in the belly and vomiting, etc. On inquiry and cross-questioning, no sort of traumatic history could be elicited. The man, however, stated that his father died rather suddenly, after ailing for some time from similar symptoms.

The patient is an intelligent sepoy, about five feet seven and a

half inches in height, but of somewhat spare muscular development. On inspection, the patient lying on the back, there is no visible pulsation; but palpation reveals a pulsating tumour about the size of a hen's egg, situated about an inch to the left of the umbilicus; but, on account of the immobility and resistance of the abdominal muscles, much information as regards the characteristics of the tumour cannot be derived from palpation alone, beyond its expansile pulsation synchronous with the radial pulse. Percussion (after an aperient) over the pulsating area is dull. On auscultation, no murmur is audible in the horizontal posture; but on making him stand up erect, with the arms hanging to the sides just as in the attitude of "standing to attention", a harsh but not loud systolic *bruit* is heard over the dull and pulsating spot, and seems to be to a certain extent prolonged, but less distinctly audible, along the course of the aorta superiorly.

In addition to the above, he has intermittently neuralgic pains, shooting in different directions downwards towards the thighs, the left more especially, and upwards towards the stomach and thorax; beyond these signs of nerve-pressure, there appears to be no pressure exerted on the veins, as shown by the absence of anasarca. No atheroma is detected in the superficial vessels. I may state that, in this case, the subjective feeling of uncomfortable pulsation is well marked. The man is likewise conscious of a cold sensation in the hands and feet.* Physical examination of the heart points to dilatation of its right cavities. The radial pulse is small, feeble, but not intermittent. The kidneys seem healthy, from the examination of the urine and absence of renal symptoms.†

The patient is cautioned against any undue exertion. The digestive organs have been attended to by occasional aperients, and dry and regulated diet. The pain is relieved by belladonna plaisters. A mixture of iodide of potassium and iron is ordered. On account of the dangers which may result from resorting to mechanical interference, and because the patient will shortly be invalided, I have not ventured to attempt any of the modes recommended.

REMARKS.—This case presents several points of singular interest; and I am not ashamed to state that, when it came under my observation for the first time, though the idea of aneurism first passed through my mind, I was more inclined to consider the case as one of a tumour situated over the aorta, the pulsation being communicated from the former to the latter. This simulation, and consequent difficulty in differential diagnosis, are by no means unfrequent. It was only when the patient was the second time admitted under my care, and by examining in different positions, that I was able to arrive at this diagnosis.

A CASE OF PARALYSIS OCCURRING ON THE SAME SIDE AS A LESION OF THE BRAIN, AND ACCOMPANIED BY EPILEPSY.

By W. WILLIAMS, M.D., M.R.C.P., Liverpool.

THIS history is that of a case of partial left hemiplegia, with epilepsy, following a depressed fracture on the corresponding side of the skull; and in connection with this class of cases, towards which so much interest has lately been drawn by the publications of Dr. Brown-Séquard, the present is peculiarly interesting, from the fact that the paralysis can be justly attributed to the effects of the above lesion causing pressure on the contents of the cranium; for the complete recovery, which subsequently took place, followed immediately the relief of this pressure.

On September 25th, 1873, T. D., a boiler-maker, aged 18 years, was admitted into the Royal Southern Hospital, Liverpool, for a recent compound and depressed fracture on the left side of his skull, about half an inch in extent, and situated on the temporal ridge near the point of its division by the coronal suture, caused through a fall against the sharp corner of some iron-plating. At his admission, there was found to be present considerable concussion, but no well-defined symptom of compression of the brain; so, operative interference not being judged imperative, he was placed in bed, with the adoption of the usual course prescribed for the former state. The partially unconscious state in which he was when first seen lasted till the fourth day, when complete consciousness returned; but it was now noticed that the left upper eyelid drooped considerably, and that there was inability to elevate it completely, with defective sight of the same eye. With these exceptions, however, at this time there was no paralysis or weakness of any member of the body; the patient complaining only of a slight but constant and dull pain at the seat of injury continuing unrelieved, even

after the healing of the wound. Up to January 10th, 1874, nothing of importance occurred; progress towards recovery, it is true, had at that time only advanced to a certain stage; for, although he could go about freely and do any ordinary light work, he was still unable to bear much noise or exposure of the eyes to bright light, and anything approaching violent exercise, or even drinking cold water, gave rise to vertigo. At this date, however, nearly four months after the receipt of the injury, there appeared, and gradually increased, loss of power on the left side; and he became subject to fits of epilepsy, recurring weekly, and characterised by the ordinary signs of a somewhat severe type of the disease—such as foaming at the mouth, biting of the tongue, turgidity of the countenance, short spasmodic expiratory efforts, and violent convulsive movements of the muscles of the face and extremities. During the performance of these latter, the participation of the two sides in the movements was found to be unequal, and much in favour of the left arm and leg; so that, in spite of the fact that epileptic convulsions mostly, if not always, and generally so without apparent cause, are more or less unilateral, in the present instance more than ordinary notice seems drawn to the circumstance, from the association with the paralysis and aura epileptica, that will presently be spoken of, occurring on the same side as the lesion of the skull.

Becoming a confirmed epileptic from January 10th till May 6th, he suffered weekly from persistently recurring paroxysms, each being always preceded by a distinct aura in the form of numbness, commencing in the middle finger of the left hand, but soon extending to the others; and then, on its travelling up the forearm as far as the elbow, a sudden metastasis to the left side of the face would usher in the impending attack. This having lasted a few minutes, would be invariably followed by some somnolency and considerable aggravation of the—since the accident—constant pain at the seat of the injury.

The paralysis, amounting in the case of the leg to the production of but considerable lameness, had, by the date of the operation (May 6th), affected the arm to such a degree that a broad sling had for some time been in use, to afford the necessary support for the all but useless and wasted limb (two inches in circumference above the elbow smaller than the right, which is the smaller of the two at the present time).

In May, it was determined to apply the trephine, with the object of removing the fractured part of the probable evil; and, from its limited extent, this was known to be practicable with a medium-sized instrument. Except some convulsive movements while he was partially under the influence, chloroform was well borne. The piece of skull removed, on examination at the conclusion of the operation, which was performed by Dr. Nottingham, was seen to be traversed by a fissure involving both the outer and inner tables, and which had permitted an attachment through the medium of a tough membranous slip between the pericranium and dura mater; but the most essential peculiarity was to be found in the presence of a sharp-edged spiculum or disc of bone, projecting obliquely inwards for about the one-eighth of an inch from the inner table, and which must, while the piece remained *in situ*, have impinged upon the dura mater sufficiently to give rise to such irritation of the subjacent cerebral surface as would account for the symptoms detailed, though not sufficient, as a subsequent examination proved, to produce any apparent change in the membrane itself.

In a few weeks after the operation, complete control over the affected limbs was regained; indeed, at the end of a fortnight, the patient expressed his feelings by saying that everything now felt all right. But, although he made a rapid and satisfactory recovery, and although the cause might then be said to have been removed, still the predisposition to epilepsy acquired after the accident did not appear to as quickly vanish; for, besides four attacks, similar to previous ones, occurring soon after the operation, and while the wound was in an irritable state from inflammation, a distinct epileptic fit was experienced six weeks later during a residence in the convalescent hospital, brought on, he fancied, through his having taken a glass of beer. Even now, while feeling perfectly well in every respect, and having had no return of his old complaint since June 18th, 1874—the attack already spoken of as having occurred during his convalescence—and able to follow as well as ever his former employment of boiler-maker, there remains the impression that similar indulgence would yet be capable of developing a paroxysm.

As he was not otherwise predisposed in any way to epilepsy, in the absence of all other known causes, it has to be allowed that the spiculum of bone before referred to indicates strongly the starting point; and if it were the cause of the epilepsy, which disappeared soon after its removal, then also, most probably, it not only was the cause of the aura epileptica and predominance of action during the paroxysms occurring on the left side, but, in addition, gave rise to the partial paralysis which became located on the same side as the lesion in the brain.

* These two symptoms are of considerable diagnostic importance, and are worthy of being sought after by young practitioners and students.

† Probably because there is no pressure exerted on these organs; but, should the man survive long enough, and the tumour enlarge and press on the ureters, etc., renal mischief would be set up.