receipt in a book; for so many grossly mistake, and do themselves more harm than good."

Our lives as practitioners of medicine can never be tame or monotonous. Constantly on the stretch, with unknown responsibilities facing us on all sides, liable to all the varied misconceptions and misunderstandings which the anxieties among which we work engender, we cannot wonder that it has been written:

"Unhappy he, whom fate does urge on
To practise as a country surgeon."

When we consider the great proneness of each atom of matter to take on the action of surrounding atoms, and regard ourselves as each one the centre of a following of devoted friends and patients, to whom we are as oracles, we can, on a larger and calmer view of the whole case as it stands, welcome our losses and rebuffs as a wholesome corrective, reducing us to our proper level, and preventing us from becoming the victims of what Dr. W. B. Carpenter calls "disease of the ideational faculties."

—What effect upon ourselves has our daily contact with human suffering? Does it make us callous? A ready reply is to be found in the crowd of impostors who throng our consulting-rooms, in the charitable appeals which crowd upon us, and in this fact, that none in our various neighbourhoods are to be found more forward in promoting good and kindly social schemes than those who have retired from active practice.

In truth, there is no calling which is more exercised in the daily practice of altruism. Ease, pleasure, needful rest, and that study necessary to keep pace with the times, must all give way to the calls of duty; and ours were a dreary daily round, did we not idealise it and bring our common love for humanity into work as a motive power; so that it may be truly said of the medical worker:

"Love took up the harp of Time, and smote on all its cords with might,
Smote the chord of Self, which, trembling, passed in music out of sight."

So heavy are the demands upon our vital energy for the discharge of our work, and for influencing the hopes and allaying the fears of its subjects, that the yearly holiday is a necessity of our continued usefulness. This should be taken thoroughly, and not in the spirit of—

"'Heigho!' yawned one day King Francis,
'Distance all value enhances.
When a man's busy, why leisure
Strikes him as wonderful pleasure.
Faith! and at leisure then is he,
Straightway he longs to be busy.'"

In the present day, the work of medicine includes many outside questions of sanitation; and, although we often preach to deaf ears, we must be reconciled to do our duty, regardless of its success or want of success, recognising in our work a grand field for the growth of the higher qualities of humanity. And I close my short summary in the words of Robert Browning.

"So grind away, mouth-wise and pen-wise,
Do all that we can to make men wise;
But, if men prefer to be foolish,
Ourselves have proved horse-like, not mulish.
Sent grist, a good sackful, to hopper,
And worked as the Master thought proper."

ASYLUM FIRE-ESCAPES.—Trials were recently made with two improved telescopic fire-escapes, sent to the Hants County Asylum by Messrs. Merryweather and Sons, of Long Acre. The escapes will reach third story windows, and an ingenious apparatus has been adapted to travel with the sliding ladders, so as to be available for rescuing persons from either second or third floor windows with equal ease; and helpless patients can be rapidly put in at the top, and allowed to slide down to the ground without assistance or danger of injury. The escapes can each be raised, lowered, or wheeled about by one man, and a close box is fixed to contain and preserve the canvas shoot when out of use. In two minutes, an escape was wheeled 120 yards, and placed in position at an upper window ready for service.

EDUCATIONAL OVERPRESSURE.—A return has been presented to Parliament of the evidence given before the coroner relative to the death, on February 12th, of a child, aged 8, named Elizabeth Emma Rowley, who had been attending a school at Cheltenham, and whose death, according to the evidence, was caused by inflammation of the brain, and hastened by the mental strain from overwork. Dr. W. A. Moseley of Cheltenham, who attended the child, stated that the lessons which the deceased had to learn at school were too great a mental strain for a healthy child of seven or eight years to bear. In the condition in which this child was the strain would be more severe, and he most certainly thought that the mental strain she had to bear hastened her death.

LECTURES ON SOME IMPORTANT POINTS IN CON- NECTION WITH THE SURGERY OF THE URINARY ORGANS.

Delivered at the Royal College of Surgeons, June 1884.

By SIR HENRY THOMPSON, F.R.C.S.,

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LECTURE IV.—IMPAIRED VESICAL FUNCTION: ITS VARIOUS FORMS AND CONSEQUENCES.

I HAVE selected the subject embodied in the following title—"Impaired Vesical Function and its Results"—because I venture to think that it is one which has not received that degree of attention from the profession which its importance demands. I feel little doubt you will concede that such an opinion is not likely to be expressed without sufficient warrant and due consideration. It is, however, a fact which many years' intercourse with my brethren, by way of consultation, not only here but abroad, has brought very prominently under my notice, that impaired vesical function is, among the many cases brought to me for solution, a morbid condition which is the cause of symptoms more frequently overlooked than any other in the range of urinary pathology.

[The lecturer cited various illustrations in support of this statement, and proceeded.]

Let it be understood at the outset, that the cases now alluded to do not necessarily belong to that large category in which hypertrophied prostate is the mechanical obstacle to the due performance of vesical function, and the indications of which are pretty generally, although not always, recognised. Prostatic change accounts for incompetency on the part of the bladder in a large proportion of cases, but it is by no means the cause in all. There are indeed numerous examples of impaired function due to causes in which disease of the prostate has no share.

But, before proceeding further, we will inquire what are the natural functions of the bladder regarded as a reservoir of urine.

The first function of the bladder is its ability to retain a considerable quantity of urine without occasioning any inconvenience to the individual, and without arousing in him any consciousness of its presence; and the mechanical attribute essential to the healthy organ is large extensibility of all its coats.

The second function of the bladder is the ability to empty itself, easily and completely, at the will of the individual; and in order to accomplish this, the coats of the reservoir must possess elasticity, which is a mechanical attribute, and also contractility, which is to be regarded as a "vital" one.

[The minute anatomy of the structures constituting the walls of the bladder was then briefly sketched, and their actions in relation to function described. He then continued:]

It will now become sufficiently obvious how strong is the probability that various morbid conditions may have the effect of impairing the two vesical functions—namely, the one, of expanding, to retain a quantity of urine; the other, of contracting, to expel the whole of it—and that so delicate an apparatus may be deranged by more than one form of disease. And such is the fact.

Regarding the views now generally received, I think that three chief modes by which impairment of the vesical-retaining function takes place are recognised, and may be represented as designating three classes, as follows:

Class I. Enlargement of growth from the prostate, obstructing more or less completely the urethra at its entrance to the bladder, and so presenting an obstacle, which the expulsive power of the bladder and associated muscles cannot surmount.

Class II. Loss of nerve-power to the muscles of the organ, constituting paralysis.

Class III. "Atony" of the structures of the bladder, invalidating their action: a term of doubtful import, and ordinarily so employed as to comprehend all other forms of vesical incompetence not designated by Classes I and II.

The first class, constituted by prostatic hypertrophy and outgrowth, is familiar to all surgeons; and the frequency with which this condition impairs the vesical functions is sufficiently obvious. Nevertheless, its proneness to occasion habitual retention of urine is more frequently overlooked or disregarded than it ought to be.

It is not my intention to devote much time to this familiar topic; but, in connection with it, there is a fact having an important bearing on practice, to which I desire to call attention. An elderly man, who has been for some time annoyed with unduly frequent micturition, seeks advice, and is treated by his medical attendant, who at first naturally endeavours to improve the general health, and does so, probably, with some slight advantage to the local trouble complained of. Subsequently, he suspects prostatic enlargement, examines his patient by rectum, and, finding no trace of it there, concludes that it is absent.

Nevertheless, the most complete form of organic occlusion at the neck of the bladder may be present, giving rise to the symptoms complained of. There is little doubt that a very small prominence at the point named is not seldom the occasion of absolute incompetence on the part of the patient to relieve his bladder. While the effect of a very large hypertrophy is generally a modification, more or less considerable, of that function, the very small growth often arrests it altogether. The existence of the little eminence is not demonstrable during life by any means that I know of; although its presence may be suspected, and, on good grounds, be regarded as probable.

Now, the morbid condition before us is one which possesses an interest, not merely for the collector of varied specimens for pathological classification, but also for the practical surgeon who aims at restoring a lost function, in this case one of extreme importance. It is notorious that during the present century, if not before, operations have been devised, chiefly by foreign surgeons, for dividing prostatic enlargements from the neck of the bladder by cutting instruments introduced by way of the urethra. These operations, it is quite certain, have not been attended with much success, although their partisans claim to have achieved excellent results by certain methods. Nevertheless, I do not hesitate to make this statement, because nothing would be easier than to produce persons who, having lost for years the function of micturition, and having depended solely upon the catheter, had regained their natural power as the result of operation; and no proof would be so strikingly conclusive as the production of one such patient. Such evidence, however, has not been forthcoming; individuals have been met with, who, suffering from retention due to some temporary although chronic cause, were submitted to operation; and the results have been claimed as examples of successful treatment by operation on an hypertrophied prostate.

I shall not discuss this topic at length; but, having recently had the opportunity of investigating the latest proposal for thus operating, in the hands of my friend, Professor Bottini, the accomplished Professor of Surgery of Pavia, I shall report the result of my observations in the following remarks.

First, there is no ground for believing that any section or resection, applied to cases of the enlarged prostate ordinarily met with, can be resorted to with fair chances of success for restoring the lost function of micturition to the subject of it. On the other hand, any incisions or resections in a considerably hypertrophied prostate, which are adequate for the establishment of a permanently patent passage, must be regarded as extremely dangerous.

Secondly, whether the obstruction be considerable, or whether it consist only of the little outgrowth which has just been described, when absolute retention has existed for several years, it is highly improbable that any operation will restore the natural power, and enable the patient to dispense with the habitual use of the catheter.

Thirdly, there is reason to believe that, in respect of the little outgrowth just named, should it be dealt with during the early stage of its existence, a division of the tissues may overcome the obstruction, and restore wholly or partially the function of the bladder. But Professor Bottini divides such an obstruction, not with the knife, but by means of the electric cautery, considering the latter a safer and more efficient agent than the cutting instruments which he and others formerly employed for the purpose.

Limited to the conditions named, I can conceive that the operation may be a legitimate one; but circumstances so conditioned are not of frequent occurrence, and, when compared with those which characterise the cases ordinarily met with, are very exceptional. Professor Bottini's proposal differs widely from those methods which had been previously advocated as applicable to ordinary cases of hypertrophy, without the special discrimination or qualifications made above.

Now, taking into consideration the degree of uncertainty which must exist as to the exact physical condition of the neck of the

bladder in these cases, it appears to me that a more certain diagnosis, and, therefore, a more accurate division, if ever deemed necessary, might be achieved by the small perineal opening, adopted for digital exploration, and described in a preceding lecture. The patient, No. 41 in the series of cases then presented, offers an example closely resembling the condition described. I incised the neck of the bladder for him on account of its extreme rigidity, the only abnormal sign I could discover, and the relief it afforded was very marked, and it has been permanent.

In relation to the second class of cases, namely, those in which impaired or lost vesical function is manifestly due to an injured or diseased nerve-centre, there is no occasion for discussion here; they are mentioned chiefly in order to define the residue which after them will remain for consideration. The examples of this condition, which occur from sudden injury to the spine, and from advanced and obvious disease of it, are sufficiently familiar to us all. It is necessary, however, to be watchful for slight defects in the supply of nerve-power impairing the vesical function, and usually associated with other slight local signs, indicating that chronic change is taking place in some part of the nervous system. Thus, a man, at or under middle age, states that for some time past the act of relieving his bladder has gradually required greater effort for its performance than formerly, so gradually that he does not know when he first noticed any change; that the stream has become habitually small; sometimes that the frequency has increased, sometimes the reverse, for he feels no want to pass it; generally he feels no pain; the urine is healthy in appearance and by tests. The stream, moreover, does not cease definitely and unhesitatingly as in health, for, after a little waiting and repeated effort, more urine can always be expelled, and the act may be considerably prolonged before the sense of having finished arrives, which, perhaps, after all is not experienced. The local sensibility is diminished, for the consciousness of passing a stream is slight, a situation differing greatly from that which pertains to the small stream of stricture. Examination shows a healthy urethra, and can detect no enlargement or other physical deviation from the normal state of the bladder, prostate, and rectum. There is no history of over-distension, but the catheter finds two or three ounces habitually remaining in the bladder after a prolonged attempt to empty it. No other sign of a lesion in the system is discoverable.

Such a condition may turn out to be the beginning of a very grave history. It is possible that it may be the first indication of that affection of the cord known as *tabes dorsalis*, since that malady, in a few exceptional instances, is manifested by bladder-symptoms at the outset, which appear at the close of the series in the usual order of its development long after the gait and the vision have been affected. As Dr. Buzzard has pointed out, the absence of the patellar tendon-reflex in such a case would go far to indicate that it was an example of *tabes*, a point relative to which I am seeking clinical facts.

Having thus eliminated from the list of causes of impaired function, hypertrophy of the prostate in all its forms, and all those of impaired nervous supply, we have now to consider what are the remaining conditions which occur to render the bladder incapable of contracting sufficiently to expel all or any of its fluid contents. Certain of these conditions are, perhaps, less commonly recognised than those just named, and come thus to be regarded as due to an affection termed atony of the bladder. This term has, in fact, become a convenient one, rather for the purpose of indicating that any given case does not belong to either of the two chief categories already mentioned, than of affirming the pathological state of the organ to be that which the word "atony" implies.

1. The first condition to be noticed is chronic inflammation affecting the tissues beneath or outside the mucous membrane of the bladder; and it is worthy of remark that an inflammation affecting the mucous membrane only impairs the function of the organ in a manner exactly contrary to that which is produced by the deeper inflammation referred to. That very common affection, ordinary cystitis, diminishes greatly, as long as it is present, the capacity of the bladder as a reservoir, by impairing its first function, that of extensibility. Disturbance or movement of an inflamed mucous membrane excites pain; and the unfolding and opening out of the inner coat, necessarily produced by entrance of urine into the bladder, soon causes uneasiness; and this is instinctively avoided by repeated acts of micturition, which relieve the patient. Such attacks, as a rule, pass off and leave the bladder almost, if not quite, as complete in its functions as before; but when repeated attacks have taken place, or when prolonged inflammation has occasioned extension of the morbid action to the submucous tissue and the muscular coat, and if this has become also somewhat hypertrophied, a thickened condition of the walls of the bladder results, in which the two functions of extending and of contracting on the fluid

contents are imperfectly exercised. I have verified a few examples of this conjunction of inflammation and hypertrophy affecting the walls of the bladder to such an extent as almost to destroy their mobility, and at the same time to diminish greatly the capacity of the organ. The result has been inability to pass more than a few drachms of urine naturally; while the portion retained also amounts in quantity to very little more, and seems hardly to repay the patient for using the catheter, which nevertheless it is highly desirable that he should do three or four times daily. In such circumstances, urine is passed every half-hour or so; and the interval, after using the catheter, scarcely reaches perhaps an hour.

Another cause of impaired function of the bladder is chronic inflammation of the prostate and neck of the bladder, usually following gonorrhœa.

After aggravated and long continued inflammation of the urethra, usually due to want of ordinary care, or to repeated exposure to fresh infection, with irregular habits, especially to abuse of instruments, inflammation of the prostate occurs, and gives rise to a more or less persistent induration and swelling of the organ. The nature of this enlargement is, of course, wholly unrelated to that which constitutes hypertrophy; but its effect on the function of the bladder in regard of ability to empty itself may be to some extent the same. Although the quantity of urine habitually retained in consequence of this condition is not large, the troublesome symptoms will persist, and tend to increase, if the fact of vesical incompetence is not recognised and met by an adequate use of the catheter. One of the most common forms of muco-purulent urine with unduly frequent micturition, commonly called "catarrh of the bladder," met with before and about middle age, originates in this manner; and the essential cause of the "catarrh" is very frequently overlooked.

Again, failure to empty the bladder sometimes accompanies the presence of calculus there, and may persist for a time after the calculus has been successfully removed by operation.

When calculus produces much pain in micturition—and pain as a symptom of calculus varies greatly in different cases—the patient sometimes learns instinctively, and quite unconsciously, to check the act of micturition before the bladder is empty, in order to prevent the severe smarting which occurs when, all the urine having been evacuated, the calculus remains in direct contact with the sensitive lining of the bladder. A habit of never quite emptying the organ is thus acquired, and persists subsequently to the removal of the stone by lithotripsy, especially if the bladder remains tender and sensitive after the operation. But when lithotomy has been resorted to, and, consequently, the urine issues for several days by a perineal opening, the normal function gradually returns with the healing and closing of the wound, and the habit does not recur. The circumstance in question brings us to the consideration of a more important one, namely, the effect of lithotripsy itself in impairing the vesical function, the two subjects being thus somewhat allied.

[This and several other causes of inability to empty the bladder by the natural efforts, were considered at length. Then the subject of atony, pure and simple, was considered, and its nature and causes described, with numerous illustrations by preparations from the College Museum. The lecturer then continued.]

It follows from all the preceding considerations, that our chief reliance for successful treatment in all the forms of impaired vesical function which give rise to retained urine, is the habitual use of the catheter; and I must add that the remedy is not only most valuable, but that it is, for the most part, indispensable, and the sooner it is employed in the great majority of cases, the greater is the chance of ultimate recovery, in addition to the immediate relief which the instrument affords. It is the frequent failure to perceive this fact, especially in relation with the less obvious forms of incompetence, which has led, as I said at the outset, to my choice of the subject. The failure is due not only to the oversight of the pathological condition which demands mechanical aid, but to the strong and very natural disinclination which so widely exists to the employment of instruments—I had almost added to the prejudice which is entertained against them—and I fear that this also must be admitted. I cannot resist the temptation to cite in support of this statement an illustration which occurs while writing these very lines, and with an opportuneness which is remarkable, being in itself so completely appropriate to the subject. A gentleman from abroad, aged 64, called on me yesterday for the first time, to consult me after two years of continuous troubles from frequency of micturition, muco-purulent urine, the inevitable "catarrh," as it is termed, for which during that time he had been treated, notwithstanding which he had been steadily getting worse throughout. My first inquiry, after hearing his story was, "Has a catheter ever been used?" The reply was, "No, indeed; my old

friend and adviser (giving the name of a well-known foreign physician) has always said, 'Whatever you do, never permit a catheter to be used; it is a machine which will create for you a worse malady than that which you already have.'" Such is a type of the answers I am accustomed to receive from foreign patients, and occasionally from my own countrymen.

The first sentiment which arises in my mind, is astonishment that so grave a responsibility should be thus readily assumed by him who gives this counsel. Nevertheless, the frequency and the confidence with which it is tendered are very great, and I am bound to say that it has, within my personal knowledge, been the cause of many a premature and painful death; for when such advice is followed, the almost necessary, indeed the most common, result is that the patient, after much suffering and long endurance, becomes at last affected with complete retention of urine, for which a catheter must now be passed for the temporary mitigation of his tortures, and to prevent immediate or impending death. But the catheter is at this crisis not employed in any sense for the purpose of treating the original malady, as at first advised, and for which such relief has come too late, and ere long the patient sinks. The slender consolation at least remains, that at all events his last few days were rendered tranquil and comparatively painless by regular instrumental relief. Nevertheless, one almost invariably hears that the original adviser vaunts his foresight, and cites the catastrophe as a fresh warning against the catheter, which—as he asserts, almost indeed with an air of triumph, "was so soon followed by a fatal result."

Well, terribly unjust as this is, and hard as it is to bear, it must be avowed that the dangerous and unwarrantable aversion to the use of the instrument in many cases has not arisen without some sort of justification from experience in relation to catheterism, and this is the moral of my story, the facts of which are not exaggerated, and are such as I myself have, in varied form, but too often encountered. The surgical practice, at all events, which has preceded our time was not marked, in regard of the use of the catheter, by that gentleness and care, and by that choice of unirritating instruments, the value of which is now becoming recognised. The rigid metal catheters formerly adopted, together with the method of passing them, often studiously designed to exhibit the possession of rare dexterity, as indeed expressed by the very term, *tour de maître*, used to denote it by the French—and mostly due to pretentious affectation—have in time past caused probably as much mischief as benefit to the subjects of it. These fashions have, to a great extent, passed away; but the popular traditions and the popular distrust of instruments will long remain. The rule for the student's guidance which I have long held to be imperative, and the importance of which I have reiterated, and now again repeat, may thus be stated.

The use of the catheter is in itself, to some extent, an evil; a very slight one if properly conducted, capable of becoming considerable in careless or unwise hands. A catheter is, therefore, only to be employed when the evil which is to be removed by its means may be regarded as more grave than that which is incurred by using the instrument; and such conditions as these are daily presented in practice. Let, then, every instrument employed be that which can be most easily passed, and is made of the least irritating material; always of course consistently with the efficient attainment of the object in view. Thus metallic or rigid instruments, as a rule, should only be used when those which are soft and flexible have failed; and for whatever purpose, they should not be larger than the needs of each case demand. By such gentle treatment a very considerable improvement in most cases is certainly attainable; and in the course of time the greatly exaggerated antipathy which widely exists to the use of instrumental treatment in the bladder will gradually but certainly disappear.

I have one more caution to utter in regard of habitual catheterism, for those elderly patients whose circumstances have been above referred to; which is of great importance. When the bladder has for a long period of time been over-distended—the patient's condition having been overlooked for months, or even for years, in consequence perhaps of catheterism having been forbidden—it is, at this advanced period of the case, a serious matter to resort to it. Rashly undertaken, great as is the relief at first experienced, symptoms of fever—"urinary fever," as it is, I think, properly termed—often appear in a few days; cystitis occurs, catheterism is required more frequently, the urine becomes highly purulent, the powers of life feeble, the tongue dry, nourishment is refused, and the patient sinks—usually in about three or four weeks from the first employment of the instrument. If a necropsy be made, almost invariably the ureters will be found dilated on one or both sides; one of the kidneys diminished in bulk, and wasted, the other enlarged, inflamed, and perhaps the seat of numerous deposits of pus.

It is said that such fatal histories following catheterism for long-continued distension of the bladder have occurred in individuals whose urinary organs, when examined after death, are found free from organic disease. Far be it from me to state that such a sequence of events is impossible; but it must be one of great rarity. No example has occurred within the range of my experience.

When a patient, whose vesical functions have been long impaired, requires artificial relief, the best chance of saving him is to enjoin at once the recumbent position in a warm and equable temperature, usually in his bedroom, in order that the skin may act freely, and that no locomotion may be possible. The catheter should be used skilfully and with great gentleness; not at first emptying the bladder completely, but always removing the instrument when pain is felt, as it often is before that condition is reached; and it must be applied again as soon as relief is manifestly required. I can scarcely over-estimate the value of these precautions, nor advise too strongly the abstinence from movement and exposure of all kinds for a period of a few weeks in these particular cases. We may thus sometimes succeed in prolonging life, even at a very advanced term, and at the same time avoid the groundless but injurious opposition which is often manifested, as we have seen, to the use of the catheter; the want of which at an early period in the patient's history, and not the late recourse to it, has been the real cause of death in almost every one of the fatal cases described.

CLINICAL MEMORANDA.

CYSTIC TUMOUR OF THE THYROID BODY.

THE following case may perhaps be of interest. At 6 P.M. on the evening of June 9th, I was asked to see a woman who "was taken with a rising in the throat," and was thought to be choking. I went at once, and found the patient (a woman about 46 years of age) in an agony of dyspnoea—loud stridulous inspiration, and lividity of face, etc. She had a lump about the size of an orange in the situation of the thyroid isthmus. This lump was stated by a neighbour to have increased in the course of a few minutes from the size of a walnut. There was, however, nothing peculiar in the appearance of the tumour, which looked like a *goitre*, and I concluded that the appearance of sudden enlargement was due to the general engorgement of the neck. The *goitre*, in fact, appeared to be an accidental complication of a case of laryngeal obstruction or spasm. In a few minutes, chloroform and nitrite of amyl were obtained. The patient was by that time senseless, livid, and making a few last desperate efforts at respiration. Both the nitrite of amyl and the chloroform were tried, with artificial respiration, but without the least effect. The most vigorous efforts at artificial respiration failed to draw air into the chest. The lump of unknown nature, in front of all the available part of the larynx and trachea, prevented me from making any attempt to open the windpipe. The time from the first symptom of dyspnoea to the moment of death was about ten minutes.

When, at the post mortem examination, the lump in question was removed, it turned out to be the isthmus of the thyroid gland, hollowed out into a ragged and irregular cavity containing recent blood-clot. The sides of the cavity were covered with old and partly organized clot. The trachea was flattened from before backwards, from pressure of the tumour upon it. The cause of death was evidently the effusion of blood into the cystic tumour (thyroid cyst?), either directly by pressure on the trachea, or indirectly by pressure on the recurrent laryngeal nerves, causing spasm of the glottis. The larynx was healthy. The trachea was, as before mentioned, flattened from before backwards, especially the second, third, and fourth rings, which corresponded to the greatest size of the tumour.

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OBSTETRIC MEMORANDA.

NON-GRAVID HYDRORRHŒA.

SOME remarks made by Dr. James Oliver on this subject in the JOURNAL of June 21st, alluding to Dr. Matthews Duncan's lectures in the *Medical Times and Gazette*, and his opinion that "these sudden watery discharges" cannot always be explained, but may come from the glands of Cowper, have reminded me of a case which lately occurred in my practice, where a very hysterical lady, who is approaching the menopause, and already suffers from its advent in many ways, has been again and again attacked of late by a most severe form of pemphigus, affecting various parts of her body, giving rise to great suffer-

ing and profuse losses of serum from the vesicles. Contemporaneous with these neuroses of the skin, she generally has profuse gushes of watery fluid from the vagina. I have ascertained that these are not urine, though I have never been able to collect the fluid for examination. Long since, I suggested to the patient that this fluid proceeds from vesicles of pemphigus occurring on the mucous membrane of the vagina, and perhaps the uterus also. She is perfectly satisfied with this explanation; and I think it is quite as likely to prove correct as some other explanations which have been suggested—such, for example, as a spasmodic contraction of the os uteri, causing retention of a watery secretion in the interior of the uterus, with sudden escape of the fluid on subsequent relaxation. One thing, I think, is certain, regarding these "sudden gushes," at least as far as my experience goes; and that is, that they are usually met with in hysterical subjects.

If the explanation I have suggested be correct, it points to a mode of treatment which I have found most successful in the patient above alluded to—namely, arsenic. We all know the value of arsenic in pemphigus. I can say, from experience of this one case, that it is equally valuable in sudden watery gushes from the vagina.

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SURGICAL MEMORANDA.

THE TREATMENT OF SCROFULOUS PYONEPHROSIS.

A NOTICE appeared in the JOURNAL of June 28th (page 1261) of a ventral nephrectomy performed for a dilated suppurating kidney. May I be allowed to protest against this being considered an advisable method of treatment in such cases? Cases will, no doubt, be occasionally met with where, owing to a mistake in diagnosis, the abdomen is laid open for the removal of an ovarian cyst, and the surgeon finds himself face to face with a renal tumour. Many nephrectomies have thus been performed as it were by accident. But an increasing exactitude in the diagnosis of renal tumours will, I trust, gradually eliminate accidental nephrectomies from our statistics. Simple aspiration of the tumour will, as a rule, materially assist the diagnosis when the urine affords no indication, and careful clinical observation will usually bring to light signs of the tumour having taken origin in the kidney. Supposing a case of abdominal tumour to have been operated upon by abdominal section, and the surgeon then finds he has to deal with a dilated, suppurating, and adherent kidney, it may require some strength of mind to close the abdomen, and proceed to treat the case by another method; but I have little doubt this would be the course least fraught with danger to the patient.

Occasional successes arrived at by a dangerous method must not be allowed to obscure the more rational and safer, though it may be the less brilliant, plan of treatment. What the safer plan is, I think I clearly pointed out in my address before the British Association last year, namely, to cut down upon the kidney through the loin, drain and disinfect it. Afterwards, when the organ has contracted, should it remain a source of discomfort, it may, with comparatively little danger, be removed without opening the peritoneum. There are two cases of scrofulous kidney now lying in Guy's Hospital, under my care, each with a tube in one kidney. To those unfamiliar with the progress which has of late been made in renal surgery, it may still seem strange that these cases were both operated on before any tumour could be felt in the abdomen. The immediate relief from pain, cystitis, and irritable bladder, in one case amounting to incontinence of urine, is as remarkable as the freedom from pyrexia and general constitutional disturbance after this apparently severe operation. Statistics of nephrectomies clearly show the safety gained by first draining the dilated organ before proceeding to remove it; and I am inclined to think that the ventral or transperitoneal operation will one day be regarded as a scarcely justifiable operation for pyonephrosis.

R. CLEMENT LUCAS, B.S., F.R.C.S.

WOUND OF THE SCROTUM AND OF THE ABDOMINAL PARIETES: RECOVERY.

THE following singular and almost unique accident happened to a farm-labourer in the month of June 1866, near Amersham, Buckinghamshire. I made only a short note of the case at the time, and did not report it; but will now relate the principal facts of the case, which were strongly imprinted on my memory.