ECTOPIA VESICAE TREATED BY IMPLANTATION OF THE URETERS IN THE RECTUM.

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ECTOPIA VESICAE is a sufficiently rare deformity to justify publication of the following case:

A boy, aged 8 years, was admitted into the Northampton General Hospital in March, 1918, suffering from ectopia vesicae. He was small for his age and pale, exhibiting all the symptoms characteristic of his unhappy condition.

First Operation.

On March 15th, 1918, after the patient had been anaesthetized, a No. 1 gum elastic catheter was passed into each ureter for about three inches and tied in. A median incision was made through the bladder and a circular incision round each ureteral orifice. The ureters were then, in turn, freed by blunt-pointed scissors, taking care not to trespass on their blood supply. After a finger in the rectum had demonstrated its relations, a pair of fully curved forceps were passed through the anus and pressed against the rectal wall below the peritoneal reflection. A small incision was made, the forceps passed through and the right ureter with its catheter drawn into the rectum as far as it would go. The wound in the rectum was closed by one stitch which took a grip of the wall of the ureter. This procedure was repeated on the left side. The rest of the bladder was trimmed away and the wound left open. At the conclusion of the operation the catheters were withdrawn as they seemed calculated to do more harm than good by their presence in the ureters.

Subsequent Progress.

The patient's general condition remained good, but the temperature ran an irregular course for a fortnight, rising each evening to 101° or 102° F. The bowels acted naturally on March 17th, and by March 19th the boy could keep dry during the day. On April 6th there was thought to be some leakage of urine through the wound.

Second Operation.

On April 17th granulations were cut away, the skin edges undercut and brought together. Both ureters could be felt projecting into the rectum. The wound healed by first intention, and there was no leakage of urine.

Present Condition.

In January, 1920, the boy's general health is good and his gait normal. He has complete control over his urine, which he voids two or three times during the night and at intervals of from three to four hours during the day. The operation scar is sound and dry.

The operative procedure in this case was practically that described by Peters,¹ with the minor difference that the ureters were fixed by a stitch into the rectum and the catheters removed at the conclusion of the operation. There was probably some slight infection of the kidneys in this case, as shown by the irregular pyrexia and by thirst. It might be wise in a similar case to allow an interval of some weeks to elapse between the transplantation of each ureter, as suggested by Mayo.² He utilizes the sigmoid in preference to the rectum, but, in the hands of the average surgeon, such a procedure would involve more risk to the patient. Some writers seem to assume that by transplanting the trigone (Maydl) or the whole bladder (Moynihan) the risk of ascending infection of the kidneys is diminished. I know of no statistics which prove this assumption. The statement that the valvular orifice of the ureter is maintained after transplanting the trigone is open to question, as the transplanted portion of the bladder is necessarily severed from its nerve supply.

REFERENCES.

¹ Peters: BRITISH MEDICAL JOURNAL, June 22nd, 1901. ² Mayo: Collected Papers at St. Mary's Hospital, Rochester, 1917.

THE late Mrs. Louise d'Este Oliver has bequeathed £3,000 each to the Elizabeth Garrett Anderson Hospital, Euston Road, N.W., and to the West Cornwall Dispensary and Infirmary, Penzance, £1,000 to the Middlesex Hospital for the Cancer Ward, and £200 to the Dunedin Hospital Guild, Dunedin, New Zealand.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

A CASE OF DERMOGRAPHISM.

(From the Neurological Department, 2nd Northern General Hospital, Leeds.)

PTE. W., aged 20, was admitted to this hospital in May, 1919, with a gunshot wound of the right upper arm and ulnar nerve injury.

His attention had first been drawn to the ease with which his skin whealed three months previously when, while washing himself, he received a slap on his chest from a fellow patient, which was followed by a raised impression of the hand. Since then he noticed that a tight shirt wristband, a tight collar or bandage would cause a raised wheal on the underlying skin.

The words in the photograph were traced by moderately firm pressure with a blunt piece of wood. The urticarial wheals took about three minutes to develop fully. As they rose they were at first uniformly pink, but finally were white and bloodless in the centre with a bright pink border. They subsided in from half to three hours,

according to the pressure used to create them, and vanished rather more quickly from the arms than from the back and chest. There was no itching of the skin. The readiness of the patient to sweat on slight exertion furnishes further evidence of vasomotor instability.

The patient exhibited no signs of hysteria, and examination revealed nothing else abnormal either in the nervous system or elsewhere, except that, although a Yorkshireman, he spoke quickly, almost to the point of clipping and slurring his words, and unintelligibility.

His family history furnished no sign of neurotic heredity, his parents, brothers, and sister being quite healthy, and, as far as the patient knew, none presented this phenomenon of factitious urticaria.

The patient himself stated that he had always been healthy, was classified A1 on joining the army, and during

his six and a half months in France suffered from nothing until he was wounded. The only other feature of interest is that about two months previous to his first noticing the condition he was in hospital in London, and whilst lying in the anaesthetic room waiting for some small operation a bottle of ether exploded and caught fire. He assisted the nurse to extinguish the flames, and was rather scared and tremulous afterwards. He was anaesthetized, however, and the surgical procedure carried out. There were no ill effects on recovering from the anaesthetic.

I have to thank Lieut.-Colonel C. E. Ligertwood, D.S.O., the administrator of this hospital, for permission to record the case.

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SUBLIMED SULPHUR IN MERCURIALISM.

MERCURIALISM is caused by the accumulative action of mercurial salts, but the exact mechanism is not definitely known, though two theories have been advanced, one by Almkvist and the other by Professor Gaucher.

Almkvist's Explanation.

Protein foods are pressed into the sockets of the teeth or into the recesses of the mouth. Here they are attacked by putrefactive anaerobic organisms, such as the *Spirochaeta dentium* and the fusiform bacillus of Plaut-Vincent. These bacilli form sulphuretted hydrogen. The mercury circulating in the capillary loops of the gums is precipitated as black mercury sulphide. The nourishment of the gums and the alveolar process of the jaw is interfered with and degeneration and necrosis of the involved tissue results.

Professor Gaucher's Explanation.

Mercury, on absorption into the system, becomes converted into a chlor-albuminate peroxide of sodium and mercury. It is an irritating salt, and is not allowed to circulate freely, thereby

DERMOGRAPHISM.