ache and no vomiting, and no complaint of difficulty in walking nor of giddiness.

On examination the pupils were found to be unequal in size, the right being larger than the left; the right pupil reacted briskly to light and accommodation; the left pupil was contracted, slightly irregular in shape, and reacted only very sluggishly to light. There was no nystagmus and no ocular paralysis. The fundi were normal. With the exception of the deafness the functions of the other cranial nerves were not disturbed in any way. There was practically complete bilateral nerve deafness. He was examined by Mr. Muecke, who considered that the nerve conduction from the labyrinth was almost completely blocked on both sides, more so on the left.

There were no other signs of disease in the central nervous system. But there were present three subcutaneous tumours whose characters suggested that they were fibromata or neurofibromata. These were exceedingly interesting and important in view of the condition of the auditory apparatus and the family history. In the right side of the neck, underneath the sterno-mastoid muscle, was a large, rather spindle-shaped tumour, about the size of an elongated lemon, extending from the angle of the jaw nearly to the sterno-clavicular joint. It was hard, freely mobile, and quite painless. There was no evidence of surrounding inflammation and no enlargement of lymphatic glands. A second but smaller tumour was found in the subcutaneous tissues of the chest wall, just over the right costal margin in the anterior axillary line. It was about the size of a walnut, hard, irregular in shape, freely movable, and painless. A third tumour, about the size of a small date, with similar characteristics, was situated in the upper part of the left gluteal region. The patient stated that he had had these tumours as long as he could remember. The smaller one, in the chest wall, was removed under local anaesthesia for histological examination. Dr. Canti reported that it showed the structure of a soft fibroma. It is more than likely, however, that it arose from a nerve sheath, since it is not easy to demonstrate the existence of nerve tissue in these neurofibromata which have been present for a long time. Operation on the skull was not advised.

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THE OPERATIVE TREATMENT OF ULCERATIVE COLITIS.

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THE discussion on ulcerative colitis which took place at the Royal Society of Medicine in 1909 first revealed the importance of the disease both as regards its prevalence and commonly fatal consequences. Since then our knowledge of it has advanced considerably, but chiefly in respect of the epidemic forms rather than the sporadic chronic cases which are more common in this country.

Very little advance seems to have been made in the diagnosis and treatment of the truly chronic ulcerative forms. There are many reasons for this, one being that the chronic cases have proved almost a complete failure from the point of view of bacteriological investigation. In a large number of cases the stools have been investigated by most competent bacteriologists, but so many different micro-organisms are found, and the difficulties of deciding which is responsible for the disease are so great, that no useful information is, as a rule, obtained. My own experience has been that, with one or two conspicuous exceptions, bacteriology has been of little assistance.

Medical treatment also has not been very successful except in the mild cases, though here I must admit I may be prejudiced by the fact that as a surgeon I am more likely to see the cases in which medical treatment has failed.

Some of the worst cases of ulcerative colitis are those in which the chronic condition is secondary to an acute epidemic form such as amoebic or bacillary dysentery. There is a certain similarity between these cases and the

ordinary form of chronic phthisis. In both we find an acute specific infection causing lesions which become secondarily infected with other septic organisms, and it is this latter secondary infection which causes much of the trouble.

These cases of chronic ulcerative colitis are particularly important at the present time, because very large numbers of men have been infected with acute dysentery while fighting at different parts of the front during the last five years, and are now suffering from the chronic and often much more serious condition.

Not only have a large number of these cases returned to this country during the last eighteen months, but quite a considerable number of cases have occurred among men who have never left England, and among women. These latter cases do not start with acute amoebic dysentery, but are chronic from the beginning. I have little doubt, however, that they have in many cases become infected from the class of cases first mentioned. This is rather borne out by the fact that several cases of ulcerative colitis which came under my observation last year came from one seaport town where many troops from abroad were landed.

A typical case would be that of a man who contracted acute dysentery in Africa or Arabia during the war and had been more or less successfully treated at the time, but the diarrhoea has recurred subsequently until it has become almost continuous, and he has gradually begun to go downhill with constant liquid blood-stained stools, progressive loss of weight, failure of appetite, etc.

An examination with the sigmoidoscope (the value of which in these cases as a means of diagnosis does not even yet appear to be fully appreciated) shows deep and extensive ulceration of the mucous membrane of the rectum and colon. In a bad case islands of mucous membrane can be seen standing up from the ulcerated surface, presenting an appearance closely resembling a polypoid condition.

Examination of the stools show numerous bacteria, mostly of the *coli* or streptococci groups, but no sign of protozoa.

The clinical history of cases of ulcerative colitis varies considerably. In those cases in which the disease is not secondary to acute dysentery the condition often starts insidiously. The patient appears to recover satisfactorily from the initial attack, but recurrences become more and more frequent and less amenable to treatment, until the condition becomes so serious that no treatment seems to have any effect. It is generally at this stage that the surgeon is called in.

There may sometimes be confusion between chronic ulcerative colitis and other forms of chronic recurring diarrhoea, but this can at once be cleared up by an examination with the sigmoidoscope. In true ulcerative colitis the temperature is almost always raised 1° to 2° F. at night. Blood is more or less constantly present in the stools, and wasting is a marked feature of the case.

The best treatment for ulcerative colitis is appendicostomy, and I have seen very many really desperate cases recover as a result of this operation, which I and those associated with me were certain must otherwise have died. Unfortunately the surgeon is too often only called in when the patient is already very seriously ill and the ulceration has become very extensive. The operation should be performed at a much earlier stage of the disease, and recovery would be then much more rapid and more certain.

In true ulcerative colitis non-operative treatment appears to be of very little use. Even when recovery does occur it is a slow and tedious process. One of the reasons for this is that the ulcerated surface is very large and cannot be directly dealt with. Douches and enemas cannot be tolerated in sufficient quantities to ensure that they reach the whole of the diseased area.

Appendicostomy acts in two ways. The first and most important action is to allow of the large ulcerated area being kept clean and free from pus and accumulated discharge. The frequent washing of the colon by removing the products of inflammation allows the ulcers a chance to heal, and to a large extent prevents the absorption of septic by-products into the blood.

The second important action is to compensate for the great loss of body fluid, which is always present owing to the constant diarrhoea. Many of these patients are wasted till they are little more than skin and bone, and it is often quite remarkable to see the improvement that follows

frequent irrigation of the colon through an appendicostomy opening.

As already stated, the proper time to perform appendicostomy is as soon as the condition has been diagnosed; but in practice it has been my experience that the surgeon is usually not called in until medical treatment has been tried for months and failed. Then when appendicostomy is suggested it is argued that the patient is in such a poor condition that he will not stand the operation. This is, however, not the case, as the operation can quite well be performed under local anaesthesia without running any risk at all.

In a bad case the patient should after the operation be treated by continuous saline irrigation for six or eight hours at a time. This is easily arranged by using a metal bed-pan with a tap and a rubber tube attachment. Very careful nursing is, however, necessary to prevent the formation of bedsores.

As soon as the diarrhoea has been checked and improvement has set in, a 3 or 4 pint wash through twice or three times a day will be sufficient. On no account should any antiseptic be added to the fluid used for irrigation, as poisoning symptoms are almost sure to result. Solutions of silver nitrate or protargol can be used, but in the case of the former only for a short time. I have seen a very bad case of staining of the skin with silver which resulted from frequent washing through with silver nitrate. Salt water seems to give the best result in most cases.

There still are people who think that an appendicostomy opening is an objectionable thing and that it results in the escape of gas and faeces. This is, of course, not the case with a properly made opening. In ulcerative colitis the opening should be kept patent for at least six months after all symptoms have subsided, but after this it may be allowed to close, which as a rule it will readily do.

CONCLUSIONS.

1. Chronic ulcerative colitis is a very serious and often fatal disease.
2. The best treatment is by frequent washing through with saline solution after an appendicostomy opening has been established.
3. The operation should be performed as soon as a diagnosis has been made and not left as a last resort, although it may sometimes succeed even then.
4. The diagnosis should always be confirmed by sigmoidoscopy.

FIBROIDS COMPLICATING PREGNANCY: HYSTERECTOMY: RECOVERY.

BY

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PREGNANCY with fibroids of the uterus, especially subserous ones, is, of course, not uncommon, but a case which I have recently had to deal with presented somewhat unusual features, and showed what a remarkable condition may be associated with a normal menstrual history and pregnancy, in the early months.

A healthy nullipara of 38, from whose mother I had, by the way, removed an ovarian cyst and subserous fibroid some years ago, had been married fourteen months, and the menstrual periods, which had always been perfectly regular and normal, had ceased for four and a half months. She had had some morning sickness, and the breasts were enlarged and tender. Pregnancy had therefore been diagnosed, but no suspicions of abnormality aroused. I was sent for on account of troublesome vomiting for two days, constipation, and sharp abdominal pain.

A rounded movable tumour, about the size of a fetal head, was felt in the upper abdomen as high as the ensiform cartilage. It was attached below to what appeared to be a pregnant uterus reaching well above the umbilicus, irregular in shape, and unduly high up. On vaginal examination the pelvis was found to be occupied by a large fixed firm rounded mass lying between the rectum and vagina, and displacing the uterus upwards, so that the cervix could only just be reached round the front of the tumour. A diagnosis of fibroids complicating pregnancy was made, and operation advised, as, owing to the size and position of the tumours, symptoms suggestive of commencing pressure, and the risk of degeneration and infection, it seemed unsafe to wait for viability of the child.

The patient was brought into a nursing home; an enema produced a fair result, the sickness and pain ceased; her general condition was good. A catheter, passed with a little difficulty, showed no distension of the bladder.

Operation.

In the Trendelenburg position, under ether, skilfully given by Dr. A. Simpson with Shipway's apparatus, an incision was made from the pubes to well above the umbilicus. A gravid uterus was revealed, covered with subserous fibroids of all sizes; many were small, but from the fundus grew two large pedunculated masses, each the size of a fetal head. These were delivered from the wound with the uterus. On lifting the viscus forward sharp haemorrhage occurred from the posterior part of the cervix, where it was attached to the pelvic tumour. There were many large veins, and everything was very vascular. The bleeding could only be controlled by pressure with pads, for it took place from a considerable torn surface in dense tissue, and no vessels could be secured. Efforts to bring up the pelvic mass, which was extra-peritoneal, by traction with strong vulsella, helped by the pressure of an assistant's fingers in vagina and rectum, failed. In view of the risk of meeting with uncontrollable bleeding if further attempts were made to remove the pelvic block, hampered as one was by the presence of the bulky uterus, it was judged that the right course was to diminish its size and vascularity, at the cost of the child. Pituitrin was therefore injected, the uterus incised where it was free from growths, and the fetus and placenta removed. The edges of the incision were clamped together, and haemorrhage quickly arrested. In spite of the advantage now obtained it seemed impracticable to save the uterus, and a subtotal hysterectomy was performed, the ovaries being spared. On the right side a small dermoid cyst, intimately adherent to the pelvis, was encountered, but left to be dealt with if necessary subsequently. The peritoneum over the pelvic fibroid was now freely divided and separated off, and the tumour brought up with the vulsellum sufficiently to give room for the fingers being worked down and round it, gradually enucleating it from its bed, a watch being kept for the ureters. No definite connexion with the cervix could be identified. Haemorrhage was readily arrested, all peritoneal edges brought together with catgut sutures, and the abdomen closed.

The patient made an uninterrupted recovery, and was back at home in three weeks.

The case was of special interest to me in connexion with Dr. Herbert Spencer's Lettsomian lectures. Dr. Spencer states that he has never found it necessary to remove a uterus in the early months of pregnancy, and expresses the opinion that the practice of hysterectomy in this condition is much too common, but I believe the difficulties encountered in this case justified what I did.

Instead of panhysterectomy, subtotal hysterectomy was performed, as the position of the cervix made it easier; nor did I split the cervix for drainage, as Sir John Bland-Sutton suggests, as all looked so dry and tidy that I was tempted to leave it.

On section the tumours presented the ordinary appearance of myomata, no "red degeneration" being observed; but the pelvic fibroid showed signs of fibrocystic change. This, Dr. Herman states, is often associated with rapid growth, which presumably was the case here.

PHAGEDAENA OF HUNTERIAN CHANCRE

FOLLOWING TREATMENT WITH NOVARSENO BENZOL.

BY

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In both these cases there was bacterial infection of the Hunterian chancre. In both chancre, bacteria, and the "reacting" tissue became more or less completely shut up together by the very effect of the reaction on the tissues around the chancre.

CASE I.

A labourer, aged 39, six weeks after coitus, noticed a painless lump on the under side of the penis, and three days later a "running," thin at first, then thicker. During the ensuing seven days he noticed slowly increasing discharge and difficulty in passing water, but had no pain. He denied previous gonorrhoea or chancre.

Examination showed a thick yellow discharge from meatus, and, on micturition, thin, twisted, interrupted stream. On the ventrum of the penis, in the line of the urethra, about 4 cm. from the meatus, could be seen and felt a dull red, hard mass, 1 by 0.5 cm., not tender, apparently including the urethra. The inguinal glands on both sides were large, hard, and discrete. There was no rash. No attempt was made to pass instrument.