What are phleboliths? Makins in *Heath's Dictionary of Practical Surgery* says:

A phlebolith is a calcareous concretion developed within a vein. Phleboliths are the result of calcareous degeneration of laminated thrombi; they are met with chiefly in the veins of the lower extremity and pelvis, most commonly lying loose in ampullae, behind the valves. They are usually rounded or oval in shape, and are constituted of phosphate of lime, with 20 per cent. of protein matter, and a little sulphate of lime and potash. (Frankland.)

During the last eighteen years I have taken, or superintended the taking of, over 20,000 radiographs, and so far have failed to obtain the image of a phlebolith outside the pelvic area; whilst in a number of instances I have detected the presence of calcareous deposits in the walls of the arteries in all parts of the body.

Phleboliths are rarely seen in patients under 40 years of age, but above that age they are said to be fairly common. Hurry Fenwick examined 30 bodies by means of the *x* rays in the *post-mortem* room, and found phleboliths in seven instances, four being males and three females. The ages of the patients varied between 43 and 47 years. The phleboliths were all found in the plexus of veins running along the side walls of the bladder, uterus, or rectum. None of these phlebolithic patients had had any signs of calculus during their lifetime. He does not state, however, whether they were picked at random, or whether there were any signs of renal disease. He says:

Phlebolithic markings in the pelvic area are of frequent occurrence in cases with renal pain. There does not seem to be any correspondence between systemic disease, unless it be atheroma, and phlebolithic change; but there is no doubt in my mind that the varied inflammatory processes incidental to disease of the sexual organs in both sexes influence very materially the production of phlebolithic concretions.

In order to ascertain what amount of significance is given to the presence of phleboliths, I interviewed the pathologist of a large general hospital, who informed me that although he had performed over a thousand *post-mortem* examinations, his attention had so far never been drawn to their presence. I next talked the matter over with Professor Peter Thompson, who holds the Chair of Anatomy at the University of Birmingham. He was much interested in the subject, and promised to ask his students to look out for phleboliths in the dissecting-room. Within a week, he telephoned to me that they had been found in one of his subjects. On my visiting the dissecting-room I was shown the bladder and sexual organs of a man, aged 60, in which numerous phleboliths were present; these were chiefly found on the side walls of the bladder, and were much more numerous on the right side than on the left. There could also be felt numerous concretions in the seminal vesicles. I borrowed the specimen and submitted it to an *x*-ray examination. In the resulting radiograph all the concretions which could be felt were visible; the images of the phleboliths, however, were much more strongly marked and clearly defined than those of the concretions in the seminal vesicles. In the case of the latter I doubt whether a visible image would have been obtained in a radiograph taken under ordinary conditions through the living body.

In all cases in which phlebolithic images are found it must be assumed that a phlebitis has been present at some period of the patient's life, and that a dilated condition of the veins still exists. The significance of their presence, therefore, must vary inversely with the patient's age. In young subjects (under 40 years of age) their presence indicates early degenerative changes of a degree of importance nearly approaching that ascribed to the presence of atheroma.

There is plenty of evidence to prove that phleboliths do not exist in perfectly healthy and normal individuals—at any rate, until advanced age is reached—whilst there is little or no proof that they are the natural result of senility.

Granting that the latter assumption were proved, the early appearance of phleboliths should be of as great significance as if (as I venture to think) they are direct evidence of existing or pre-existing disease.

I submit this short and imperfect article simply in the spirit of inquiry, in the hope that others with greater experience may give us their views upon an interesting subject.

APPENDICECTOMY IN GENERAL PRACTICE.

BY
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IN the JOURNAL for November 15th Dr. Robert Hutchison, in a letter headed "The Craze for Appendicectomy," asks for the testimony of the family doctor as to the condition of patients after the surgeon has done with them. To that request the following account of my own experiences in this connexion is a reply.

I have been in general practice in a small way for over seventeen years, yet can give little information owing to the small number of patients of mine that have required operation. Hospital surgeons are called in when the family doctor believes operation is necessary (and sometimes when he is not)—that is to say, in the worst cases; but they are hardly ever called in to see cases that do perfectly well without their assistance. Hence there is a considerable class of cases of appendicitis which they never see, and as to the treatment of which they have no experience. This leads them, I think, to take an erroneous view of the disease as a whole, for they seem to imagine that appendicitis is of necessity a very fatal disease unless the appendix is immediately removed. In my limited experience this is not in accord with the facts, and I am entirely unconvinced that operation is necessary in every case.

I will dismiss at once the comparatively large number of patients who come to the doctor and "think they have appendicitis," but merely have some pain and tenderness in the region of the appendix, which clears up in about ten days or a fortnight with medicine appropriate to the individual. I dismiss them because such cases do not amount to appendicitis. There is no rise of temperature, no enlargement of the appendix, no quickening of the pulse; and when they have recovered one does not hear anything more about their appendices.

In regard to cases of true appendicitis, I deal first with those in my practice which have required operation:

CASE I.

While in practice in North London for eight years I had only one case. The patient was a middle-aged lady, who had been treated by another practitioner for "gastric influenza." There was a large mass of plastic peritonitis around the appendix, and this suppurated. She was sent to hospital and an operation was performed. She recovered, but was not free from abdominal discomfort when I left London, and I do not know her after-history.

CASE II.

A young man said he had had influenza, and that for a week he had had pain in the abdomen. The appendix—not adherent—was enlarged, about the size of an elongated filbert. There was pain also in the epigastrium on pressure. Three days later the pulse was 92, temperature 98.4°. There was no pain on walking, but the abdomen was still tender, and there was some spasm of the muscles on pressure. Four days later he had severe pain in the night. Pulse 100, weak, and not quite regular; temperature 98.4°. The appendix was very tender, and the size of my thumb. He was sent to hospital and had it removed, after it had been found that it could be emptied by massage, but it filled up again. He is now (four years after) quite well.

CASE III.

This was a small boy, who got a tender enlarged appendix. I have not the notes now, but being satisfied that operation was required, I sent him to hospital and had the appendix removed. He is now (after over seven years) quite well.

CASE IV.

This was a boy who got measles, followed by bronchopneumonia and pleurisy. He began to complain of pain in the right iliac fossa, where some indefinite swelling was felt. The pulse was 100, respirations 44, temperature 100.2°. He had vomited. The symptoms gradually subsided, and the pulse was 80, and temperature 99°. Still a smouldering appendicitis was suspected, and a tender fluctuating swelling like an abscess was felt per rectum. The appendix was removed the next day. It appeared normal to the naked eye, and just above it was a small abscess containing from 1 to 2 drachms of pus. A week later he passed a shower of small uric acid calculi, some blood, albumin, and granular casts. I do not know whether the abscess was due to the appendix or to the right ureter. He made an uninterrupted recovery, and is now quite well, three years after.

CASE V.

This was a dustman of middle age who had previously been attended for appendicitis by another doctor. The abdomen was held tense, and was tender at McBurney's point; no dullness and no mass were found about the appendix; pulse 56,

temperature 98.2°. I sent him to bed. Three days later the appendix was still tender; pulse 52, temperature 98.2°. The tenderness continued for some time, but in a week he was fairly convalescent, and at the end of a month he could bend about freely any way and no mass could be felt. The next month I treated him for herpes zona, from which he recovered, and he then reverted to his contract practice doctor. A few months later I was informed that he had gone to London, had his appendix removed, and died there.

This last is the only case in which I have been concerned in which death resulted from appendicitis, and the other four are the only cases in which I can remember advising prompt operation.

Now let us look at the other side of the picture, the class of case that operating surgeons do not see—those not requiring operation:

CASE I.

A young collier had severe appendicitis, and his doctor advised no operation. A doctor in charge of a hospital had seen him and advised immediate operation. I was asked to decide between them, but not to meet them. He had noticed pain in the abdomen for three days, getting worse, and had vomited and was constipated; pulse 108, temperature 103°. Tongue fairly clean and moist; abdomen retracted, but moving with respiration. Very tender in the right iliac fossa over the appendix, and some spasm present; nothing felt above or below the appendix; no tenderness per rectum. I considered he had severe but not fulminating appendicitis; that there was no necessity for immediate operation, as he seemed to be just getting over the worst of it.

I saw him again two days after; his pulse was then 70, temperature 100°, tongue furred, but moist. The pain was less, but the abdomen was tender as before, but no mass was felt. No operation was advised, and he recovered. This was five years ago, and about a month ago I inquired about him, and was informed that he is doing his usual work as a collier.

CASE II.

This was a man who had had a previous attack, with suppuration, and had had the abdomen opened, but the appendix not removed. He fell down, and two days after got pain in the abdomen. Pulse 62, respirations 26, temperature 98.2°. An ill-defined mass, like intestines matted together, was felt in the right iliac fossa. Nothing on the left side and nothing per rectum. Later in the evening the pulse was 104, temperature 101.6°, and the swelling was larger and softer, but did not extend up to the liver. It was very tender. The next day the pulse was 86, temperature 99.2°. The swelling gradually melted away and he recovered.

This was nearly six years ago; he left Ebbw Vale about a year after, and I do not know his after-history, but expect I should have heard if he had died.

CASE III.

A man, who had been treated by another practitioner as "gastric influenza." He had had gripping pains about the umbilicus for some days, on and off, and had vomited a little. Pulse 104, respirations 24, temperature 103°. Tongue furred. A tender mass like matted intestine was felt on the right side up to the level of the umbilicus. Some muscular resistance was present, and nothing was felt per rectum. The mass gradually cleared up under medical treatment, and a week later the appendix could be felt as a hard mass. It was less tender, and gradually got smaller, and now cannot be felt. He has quite recovered. This case occurred five and a half years ago.

CASE IV.

This patient was a woman who had not been well for a fortnight; pains in the right iliac region, nausea, chilliness, and a little vomiting. Pulse 80, temperature 98.4°. Tongue coated; tenderness in the right iliac fossa. No definite mass was found, but something which seemed appendix, the size of a thumb, was felt. It was free, and on pressing on it pain was felt above the umbilicus.

Next day the pulse was 116, temperature 100.4°. The bowels were open and the pain less. The appendix was enlarged and tender; no mass was felt around it. The prognosis seemed uncertain, but on the following day the temperature was 99.6°, and she rapidly recovered. This was eighteen months ago, and she is still quite well.

CASE V.

This patient, a woman, had pain in the epigastrium and abdomen at night. She had been told by one London doctor that she had appendicitis, and by another that her condition was due to floating kidney. Pulse 88, temperature 99°. Tenderness and spasm over the appendix and caecum. A mass like hard faeces was felt in the caecum. The appendix was not felt. Neither appendicitis nor floating kidney was found. A purge and hyoscyamus was given.

Next day an ill-defined mass was felt in the situation of the ascending colon; no appendix. The following day there was spasm and tenderness over the appendix, which could not be felt. I suspected a growth and considered the appendix trouble did not amount to appendicitis.

She went to London and was operated on. A small tumour in connexion with the right ovary was removed, and as the appendix was "not normal" it also was removed, but no appendicitis was found. Perhaps this case should not have been included. She is now—ten months after—quite well.

CASE VI.

This was an elderly woman seen in a large provincial city. Her family doctor had diagnosed appendicitis, then an eminent consulting physician was called in, who stated that the condition was "cancer." I agreed with the family doctor, and found a tender enlarged appendix and indefinite adhesions, but no cancer. We treated her for appendicitis medically, and she made a slow but uninterrupted recovery. She never had any more trouble with it, and died from pneumonia some three years later.

CASE VII.

This patient was myself. Two years ago I got chilled after scrambling about in a most uncomfortable coal level where one could not stand upright, and sweating profusely. It was a simple catarrhal attack, and the diagnosis was confirmed by two medical men. Of course I was advised to have the appendix removed, but, on finding that it could be emptied by manipulation, and as there was no suppuration, I left it.

After a week or ten days in bed and then a fortnight's holiday, I returned to work and have continued at it ever since. I refrained from tennis and cycling for a year, and for months there were twinges of pain when there was any flatulence or constipation. This any one would expect when adhesions are dragged, but they gradually became less and less, and now I am practically, but not absolutely, free from them. They merely amount to a trivial discomfort now and then. As far as I can judge, the appendix may last me for another twenty years, and in the meantime one has a very good chance of dying from something else.

The treatment followed in the above cases was on these lines:—

For bad cases: Confinement to bed, salol three or more times a day to disinfect the bowel, fomentations and hyoscyamus to relieve pain. Where there is a localized inflammatory mass I leave the bowels alone, and do not try to move them before the end of a week. If they do not act spontaneously, they can be stimulated gently by repeated small doses of sulphur and belladonna; enemata by the rectum. Practically no food, neither milk or slops should be given until the bowels have moved.

Water or barley water, together with a biscuit or bit of toast are enough; when the bowel is free the patient can have something to eat.

For the mild cases, and those who "think" they have it, the treatment is naturally varied. If there is nothing beyond pain and tenderness, some iodide and liq. hydrarg. perchlor. 10 minims in decoction of sarsaparilla co. will generally clear up the cases. Salol is useful in all cases. Where there is chronic dyspepsia, some mixture such as gent. c. rheo. with nux vomica and valerian, or possibly euonymin or pepsin will suit, and the caecum and sacculi of the colon can be emptied by nightly doses of confection of senna, and flatulence treated by asafoetida pills when required.

In gouty cases, colchicum and potassium citrate or lithia and plenty of water to drink will do. In one case in which the iodide and mercury mixture did not improve matters, colchicum and potassium citrate cleared it up in two or three days. That was five years ago, and there has been no recurrence.

Though faecal concretions are supposed to be responsible for some cases of appendicitis, they are not uncommonly found in healthy people. In making *post-mortem* examinations on men who have died from accidents I have found 2 in about 20 cases. In neither was there any history of pain or inconvenience.

If such concretions block up the opening of the appendix and this becomes distended, I think they can be dislodged by gentle massage upwards and to the left; the appendix seems to empty itself, and symptoms are relieved at once, but I cannot be sure whether the result is due to a shifting of a concretion or of wind.

My conclusion from a small experience is that something like half the real cases of appendicitis require operation and the other half do not.

UNDER the will of the late Mr. Thomas Ford, a former Mayor of Tiverton, the infirmary in that town receives a bequest of £1,000.

THE seventh International Congress of Medico-Electrology and Radiology will be held in Lyons in July (27th to 31st), 1914. The City of Lyons has given its support to the Organizing Committee, which has as honorary presidents MM. d'Arsonval, Bouchard, and A. Tripier, and as President Professor Renault. The general secretary, to whom all communications relative to the Congress should be addressed, is Professor Cluzet, 282, Avenue de Saxe, Lyons.