may be guided into the lower end of the oblique sinus past the termination of the inferior cava, and another one towards the base of the heart on its right side. The edges of the pericardial wound should be sewn to the parietes whenever possible to try to avoid suppurative mediastinitis. Irrigation at the time of the operation is only necessary if masses of lymph or false membranes can be felt by the finger, and care must be taken to use two tubes side by side to ensure a free exit for the fluid, which may otherwise compress the heart; Mr. Parker believed this was the cause of death in his case. Daily irrigations may be used in the after-treatment. About 60 cases of operations for suppurative pericarditis have been recorded, with a mortality of about 65 per cent.; the real mortality is certain to be higher than this, for it is no doubt true that many unsuccessful operations have not been recorded.

REFERENCES.

¹ BRITISH MEDICAL JOURNAL, 1903, I, pp. 361. ² Ibid., 1903, II, pp. 359. ³ Trans. Amer. Surg. Assoc. ⁴ Lancet, June, 1900.

NOTE ON THE METHOD OF DEMONSTRATING TUBERCLE BACILLI IN THE URINE.

By EDGAR TREVITHICK, M.D. CAMB.,
Physician, Cheltenham General Hospital.

I have heard it remarked by observers that tubercle bacilli, when occurring in urine, are usually only to be found in very scanty numbers, and are to be considered as being somewhat difficult of demonstration. My own experience is opposed to this. And I am led to believe that the secret of finding representative numbers of bacilli in film preparations made from urinary deposits depends upon the thorough washing of such deposits with distilled water before the films are made from them. I have lately compared films made from urinary deposit after being thus washed with films made from the same deposit without this precaution being taken, and I find that in the latter very many fewer bacilli are to be found. The explanation of this appears to be that the urinary salts prevent the bacilli and even the pus cells from adhering sufficiently well to the cover slip to withstand the subsequent treatment necessitated in the process of staining, and that in reality in some parts of this process many, and I believe the majority of them, get dislodged and washed away.

The method which I have found eminently successful is as follows. The lower part of the urine which has been resting in a conical glass is transferred to the receiver of the centrifugal machine. After centrifugalizing, the supernatant fluid is carefully decanted from the minute collection of deposit which will be found adhering to the bottom of the glass. The glass is then filled with distilled water, and the centrifugate shaken up with it. This is once more centrifugalized, and after that the foregoing process is once more repeated. From the final centrifugate the films are prepared. In my experience the number of tubercle bacilli found in such films will be very greatly in excess of those that will be demonstrated from the same urine where this precaution of washing away the urinary salts is not followed.

In my experience the demonstration of tubercle bacilli in tuberculous urine is not more difficult, but on the contrary more simple and certain than their demonstration when occurring in sputum, and I find, moreover, that in the urinary films their numbers are not less, but on the contrary much greater, than is the case with films made from tuberculous sputum.

This is not surprising, seeing that in the case of urine one is able to take advantage of the concentration brought about by the process of centrifugalizing, an advantage which is not easily possible in dealing with sputum.

REACTION WITH PERCHLORIDE OF IRON IN THE URINE OF GRAVE CASES OF HEPATIC CIRRHOSIS.

By F. PARKES WEBER, M.D., F.R.C.P.,
Physician, German Hospital.

I HAVE lately been struck by the presence of a strong perchloride of iron reaction in the urine of several patients with hepatic cirrhosis. On adding a weak solution of perchloride of iron to the urine the colour obtained was sometimes similar to that obtained from the presence of diacetic acid in

cases of diabetes mellitus, but sometimes it appeared to me more like that obtained in the urine of patients taking sodium salicylate, so that I should have expected that some drug like aspirin had been taken. In only one of the cases was there any history of there ever having been any glycosuria. The appearance of the reaction sometimes coincided with very threatening general symptoms, such as drowsiness in Case I. I unfortunately delayed exact analysis, and at present can obtain no urine giving the reaction. I therefore am unable to say that the reaction is due to the presence of diacetic acid in the urine, and must content myself by giving a few clinical details of the cases in which the reaction was present, hoping that it will be detected in other cases of hepatic cirrhosis when its nature can be fully investigated.

CASE I.—Mrs. T. B., aged 42, admitted to the German Hospital June 20th, 1903. A fat woman, with slight jaundice, ascites, and epigastric pains. No cardiac or renal disease. No vomiting. Menses absent last two months. History of free use of beer and whisky during last five years. Ascites commenced apparently about three months before admission. Soon after admission the patient became drowsy and more jaundiced, and her pulse was very weak. She was treated by magnesium sulphate, digitalis, camphor hypodermics, and the temporary use of alcohol, and her general condition soon improved. A strong perchloride of iron reaction was first noted on July 2nd (the first time the urine was tested in that way), and the reaction was present after that date whenever the urine was tested. Paracentesis abdominis was twice performed. The patient left the hospital without permission on July 10th, and died not long afterwards.

CASE II.—Mrs. E. D., aged 53, admitted October 5th, 1903. A very sallow woman, with uniform great enlargement of the liver, but without ascites. History of taking whisky and beer. Enlargement of the abdomen noted two years before admission. Brought up blood three weeks before admission. The urine was free from albumen and sugar, and on many occasions gave a strong perchloride of iron reaction, though it had been rendered alkaline by giving the patient sodium bicarbonate. The patient left the hospital on November 17th. On December 12th, when in her own home, she became unconscious, and died on the following day. No necropsy.

CASE III.—J. A., aged 45, a carter, admitted September 22nd, 1903, for ascites, apparently of recent onset. History of habitual indulgence in beer and whisky. After paracentesis abdominis the liver could be felt enlarged. The urine was free from albumen and sugar, but dark, and at one time showed a distinct urobilin band by spectroscopic examination. On several occasions it gave a marked perchloride of iron reaction, but this has been invariably absent of late, though diligently searched for. The patient has been tapped for ascites six times, and is still in the hospital.

CASE IV.—Mrs. A. B., aged 53, admitted November 13th, 1903, on account of ascites, vomiting, and great frequency of cardiac action. The patient, a fat woman with a bloated face, used to drink much ale and whisky. About seven years before admission she was told she had "diabetes"; this disappeared after some time, and she has generally enjoyed good health. Her abdomen began to swell about six months before admission, and before her admission it had already been tapped twice at another hospital. The urine was free from albumen and sugar, but, although often alkaline, usually gave a marked perchloride of iron reaction. Her general condition has improved, she has had no vomiting lately, and her appetite is better; recently the perchloride of iron reaction has been absent. She has been tapped twice since admission, and is still an in-patient.

A METHOD FOR ANASTOMOSING A SEVERED VAS DEFERENS.

By J. LYNN THOMAS, C.B., F.R.C.S.,

Surgeon, Cardiff Infirmary; Consulting Surgeon, Hamadryad Hospital, Porth Hospital, Bridgend Hospital, and the Cardiff Provident Dispensary.

ABOUT twelve months ago I had under my care a gentleman who had his vasa deferentia tampered with, one being completely divided, and the other one incompletely severed by his wife during a fit of jealousy. I was consulted in the matter about a week after the somewhat tragical episode had taken place, and I found two scars in the scrotum anteriorly, one on each lateral aspect. I was informed that they had been performed by the patient's wife by means of a surgical knife whilst the patient was in a state of advanced semicomatose intoxication. On the side where the vas deferens had been completely divided there was a rounded hard swelling in the spermatic cord about 1 in. above the testis of the size of a big pea; the testis itself being more sensitive than the one on the other side. I was asked if anything could be done in the case, as the participants in the tragedy had become very much concerned as to the result with regard to sexual impotence, for the effect of double vasectomy was

considered by the husband and wife to lead to atrophy of the testis with consequent unsexing of the individual.

After experimenting I carried out the following method of uniting the vas deferens.

An oblique incision was made along the course of the inguinal canal similar to that used in the operation for the radical cure of an inguinal hernia, the spermatic cord was exposed, and the testis dislodged through the wound, carrying with it the small swelling described above as being the size of a large pea. This turned out to be a collection of semen confined in a fascial sheath between the ends of the divided vas deferens. The vas was found to be completely divided and its ends were separated for about half an inch.

The following diagram will assist in elucidating the method adopted for the anastomosis. Very small curved needles had to be used for applying fine silk sutures in the operation performed.

Fig. 1.—Method of preparation of the urethral end of the vas deferens. The tails, A, A, are wrapped round the testicular end of the vas and fixed by sutures after the obliquely cut end of the testicular portion is fixed to the grooved wall beyond the tails (see 3, Fig. 2).

Fig. 2.—J. Union of urethral and testicular portions of the vas deferens. A. The tail wrapped round testicular end of vas. ← shows direction of semen travelling along vas.

The testicular end of the vas deferens was cut obliquely by means of a cataract knife. The distal or urethral portion of the vas was split up longitudinally for about 1 in.; this free end was further divided up for about half an inch from its extremity so as to provide two tails of equal size; in other words, each tail consisted of one half of the longitudinally split vas deferens. The utility of these tails will, I think, be appreciated from the diagram representing the completed anastomosis. The obliquely cut free end of the testicular portion of the vas was placed with its lumen in contact with that of the testicular portion, and was fixed by means of fine silk sutures as closely applied as the whipcord-like tube would admit. The two tails of the distal end were then enveloped round the testicular portion of the vas in order to counteract the disruptive force of the weight of the testis. Afterwards layers of fascia were wrapped round the anastomosed vas deferens and fixed by sutures.

I found it necessary to form the tails in order to secure a firm and permanent approximation of the divided end. It seemed to me that end-to-end anastomosis was not practicable, owing to the smallness of the tissues for suturing. Invagination of the ends was impossible on account of the rigidity and size of the walls of the vas deferens.

One can demonstrate the practicability of the above method of anastomosis of the vas deferens on the cadaver by injecting fluid along its lumen by means of a syringe.

As far as I know this case is unique, and I venture to record the method I devised on account of its being, I believe, a suitable operation in the conservative surgery of an injured vas deferens.

I saw my patient about nine months after the operation, and on careful examination I could find nothing abnormal in the testis as regards its sensitiveness and size. Thickening of the spermatic cord at the seat of the operation was inevitable from its nature, and I thought it was about the same size as it was at the time of its performance.

The patient informed me that his wife was four months pregnant, and that he considered the operation had been a perfect success.

GERMAN CONGRESS OF INTERNAL MEDICINE.—The twenty-first annual session of the German Congress of Internal Medicine will be held at Leipzig, April 18th to 21st, 1904. Communications should be addressed to the Perpetual Secretary of the Congress, Dr. Emil Pfeiffer, Parstrasse, 13, Wiesbaden.

PILEWORT OINTMENT AND SUPPOSITORY.

BY SIR JAMES SAWYER, M.D.LOND., F.R.C.P.,
Senior Consulting Physician, Queen's Hospital, Birmingham.

MORE than two years ago I published a formula for pilewort ointment, *unguentum ranunculi ficariae*.¹ Many cases of haemorrhoids are surgical in nature, management, and cure, and rightly are not usually included in a physician's practice. But there are many diseased conditions, haemorrhoidal or haemorrhoidaloid, affecting the mucous covering of the lower part of the rectum and the anal margins which come into a physician's daily work, as incidents in the course of greater or more general maladies, and he must even often relieve by medicinal methods haemorrhoids which are distinct tumours within or without the anus, which, for sufficient reasons in particular cases, are not submitted to the usual surgical methods of cure. In such cases various ointments are used locally, and I have used pilewort ointment for several years with much therapeutic success. Of course, local medication in such cases can only be supplementary to the relief or cure of the well-known visceral obstructions and constitutional conditions which occasion the local disease.

To prepare this ointment I direct that the whole fresh plant be used, gathered in the spring. The plants, cut into small fragments, are kept immersed in melted hog's lard, at a temperature of about 100° F. for twenty-four hours, in the proportion of one part by weight of the plant to three parts of lard. Then the portions of infused herb in the fused lard are pressed to cause the further yielding of their juices to the fatty infusion, which infusion is afterwards strained to form, when cold, the ointment. The heat of the mixture must not be too high lest the bright green of the ointment be spoiled.

In some cases in practice in which the use of this ointment may be indicated, the prescriber may wish to exhibit the remedy as a suppository. To harden the ointment up to an adequate consistency for a suppository, I am accustomed to direct that one part by weight of spermaceti be mixed with four parts of the ointment, by fusion by heat. Of such a mixture 1½ drachm, is a serviceable quantity for a rectal suppository. In a mixture of spermaceti and *unguentum ranunculi ficariae*, in the proportion of 1 to 4, the melting point of the solidified mixture would be kept well below the normal temperature of the rectum, taking the melting point of spermaceti at 120° F., and that of the ointment at 83° F., the mixture of them here recommended would melt at a temperature of about 90.4° F., and it will be found in practice that a suppository so made will be sufficiently firm for easy introduction within the rectal cavity. The only reason why a rectal suppository should be sufficiently hard is, that it should be stiff enough to be easily placeable in the site of its employment; once in that position, its qualities of softness and lowness of melting point favour the application of the remedy it carries under conditions propitious for remedial action. For such a suppository the prescriber's formula may be as follows:—℞ Ung. ranunc. ficar., gr. lxxij, cœtacei, gr. xvijj. Misce leni calore, et fiat suppositorium.

Pilewort has an ancient vogue amongst our country people as a local remedy for "piles."

REFERENCE.

¹ *Birmingham Medical Review*, May, 1901.

A FEMALE HOSPITAL PHYSICIAN IN HUNGARY.—It is announced that Dr. Ida Szentesz has been appointed Assistant Physician to the Buda-Pesth Hospital. She is said to be the first medical woman to be elected to the staff of a public hospital in Hungary.

THE SPITTING NUISANCE IN MONTREAL.—Dr. Laberge, Medical Officer of Health of Montreal, reports that for some time past his department has been conducting an active campaign for the suppression of the practice of spitting in churches, theatres, halls, and other public places. Ministers and priests of congregations have promised to make public appeals to their congregations to do all in their power to abate the unpleasant custom. Many petitions have been sent in to the Health Department asking that every effort should be made to suppress the filthy practice.