route. No attempt was made to remove the stones entire through the bladder wound; they were first broken through a small opening, with a lithotrite of the usual pattern, into a few small fragments. These were extracted, with fine dressing forceps, thus avoiding unnecessary wounding of, or damage to, the bladder.

Though suprapubic lithotomy is the operation of election with surgeons in England, it would seem to be looked upon with a certain amount of disfavour by surgeons of experience in India, who appear to prefer the perineal route, a crushing operation being performed through a median urethral incision. By this route I have myself crushed and evacuated, with excellent results, a stone weighing 8 oz., but cases are often met with where this method is not available. In India the after-treatment of operative cases is often beset with much difficulty, as it is, at times, impossible to procure efficient nursing. In the majority of cases the patient has to be left to the care of his "friends," who are usually of small intelligence and most unreliable.

A point that requires to be taken into consideration is the damage which is not infrequently sustained by the bladder during the extraction of a large stone entire with forceps, which, though intended for that purpose, are clumsy, and take up a great deal of space. This difficulty is largely obviated by using, before extraction, a lithotrite to break the stone, and by then employing (to remove the fragments) ordinary dressing forceps, whose blades have been dressed with a flake of cotton-wool, whilst a stream of boracic solution is kept flowing through the bladder by means of a cannula passed either through the urethra or, where this is not possible (as in Case II), into the wound. By this method the damage to the bladder and its mucous membrane is reduced to a minimum.

The operation is lengthened a little by the crushing procedure; this, however, is not of much importance in the majority of cases. In cases where a saving of time is a consideration, as in a litholapaxy in small children, where a large stone has to be crushed very fine to admit of its being evacuated through a fine cannula, I have found the binaural sound (of my own design) most useful in rapidly locating the fragments, and thus preventing the delay in searching for them, which is unavoidable if they are felt for in the ordinary way.

Another very simple expedient is to allow the patient, after the first crushing and evacuation, partially to regain consciousness, and the bladder will then contract, driving the particles of stone into the trigone, whence they can be removed without difficulty.

CASE I.

A Mohammedan male child, aged 7 years, of poor physique, who had had symptoms of stone for eight months, was sounded on June 7th, and the stone found to be too large to be crushed by the largest lithotrite that could be passed.

On June 8th I performed suprapubic cystotomy, assisted by Mr. David Heron, F.R.C.S.E. A small opening only was made in the bladder, through which the stone was broken into a few fragments with a No. 10 lithotrite. The fragments were removed separately with a fine dressing forceps, while a stream of boracic solution was kept flowing through the bladder by means of a cannula passed through the urethra. The fragments of stone (phosphatic) weighed $\frac{1}{2}$ oz. The bladder and abdominal wounds were sutured, a small piece of rubber drainage tube being placed in the lower part of the abdominal wound. Urine was passed by the urethra for three days. The patient received an aperient on the third day, after which, probably from straining, the urine began to pass through the wound. On June 22nd all urine passed in the natural way, and patient left the hospital, cured, on June 29th, twenty-one days after the operation.

CASE II.

A Sweeper male child, aged 3 years, was, as regards bodily development, more like an infant of 9 months. He was very weak and emaciated and the subject of chronic malaria. Symptoms of stone, present since 1 year of age, had very much increased for the past five months. No ordinary sound could be passed owing to the smallness of the parts. A stone was felt with a bent probe, passed into the bladder, and found to be of considerable size. On June 27th I removed the stone, as in Case I, with the exception that the stream of boracic solution was kept flowing into the bladder through the abdominal wound, as no catheter could be passed by the urethra. The bladder was sutured, but urine passed through the wound from the first; it passed by natural channel on July 6th, and the patient left hospital on July 11th, the local conditions being perfectly satisfactory, the wound healed, and the general condition much improved. Quinine was administered during convalescence, owing to a sharp attack of malarial fever the

day after the operation. In this case the stone (uric acid) weighed 100 grains.

I have also removed another stone by the same method in the case of a boy 7 years of age, in whose bladder the blade of the lithotrite broke after partial crushing of the stone. The boy was practically well twelve days after the operation.

SUPPURATING VAGINAL CYSTS.

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SUPPURATION in vaginal cysts may cause severe and irritating leucorrhoea. These cases are rare, but it is important that their occasional occurrence should be recognized.

The first case I saw was that of a young girl of about 17, who was brought to me by her mother several years ago, because of severe purulent leucorrhoea. The hymen was normal. On rectal examination it was easy to feel an elongated, soft oval swelling in the vagina. Vaginal examination showed that this lay between the anterior vaginal wall and the bladder, and it was discharging by a small aperture near the os uteri. Incision and packing soon cured the abscess, which was not very large, but which extended from near the meatus urinarius to the cervix.

I now quote a case which is quite recent, and I am indebted to Dr. Mary E. Phillips, of Leeds, for the opportunity of treating it.

Miss Y., aged 35, had enjoyed perfectly good health till six months before I saw her, and had always menstruated regularly without pain and without excess. For the last six months she had not felt very well, but four months previously she had some vaginal haemorrhage. A fortnight previously she had some symptoms which she ascribed to influenza and at the same time began to have a very offensive purulent vaginal discharge. When I first entered the room which she occupied the fetor was so extreme that I suspected malignant disease. She had a healthy aspect, and was not emaciated. The vulva, perineum, and adjacent parts were reddened and inflamed on account of the irritant action of the thin sero-purulent leucorrhoea. The vagina was of virgin type, and the os was reached with difficulty. The anterior vaginal wall bulged into the canal like a cystocele, but the insertion of a bladder sound showed that the bladder did not extend into the swelling. No pain or other local symptom was complained of. On May 4th I incised the cyst wall freely, and let out a considerable quantity of thin fetid pus. I made no attempt to dissect out the cyst wall, but scraped it thoroughly, swabbed it with tincture of iodine, and packed with gauze. The cavity healed up by granulation in a very satisfactory way.

It is most probable that both these cysts were derived from Gaertner's duct. The aperture by which the abscess was discharging in the second case was not seen. If in either of these cases the discharge had flowed through a somewhat larger opening, so that the cyst cavity had ceased to be obviously distended, the true diagnosis might have long remained undiscovered, and such a case might be treated for an almost indefinite period by vaginal injections without cure.

Systematic examination in some other cases of purulent vaginal discharge may reveal discharging sinuses. There was no gonorrhoea in either of these patients, but this is a condition that might have been thought of on account of sudden purulent leucorrhoea arising without obvious cause, and a serious and unjustified suspicion might have been entertained. Gonorrhoeal vaginal discharge is, however, not strikingly offensive except in patients who fail to cleanse the external parts, and who suffer from eczematous vulvitis, etc. Apart from pregnancy and the puerperal state, there are only four causes of very offensive vaginal discharge which are at all common: First, retained pessaries or foreign bodies; secondly, malignant disease; thirdly, necrotic changes in myomata or polypi; fourthly, discharging sinuses or fistulae.

THE provincial meeting of the Incorporated Society of Medical Officers of Health will be held at the Town Hall, Colchester, on Saturday, July 13th, at 11.15 a.m. After the transaction of formal business, Dr. W. G. Savage, President of the Eastern Counties Branch of the Society, will open a discussion on recent work upon the bacteriology of typhoid fever in its relationship to preventive measures. After luncheon a visit will be paid to the Byfleet oyster beds, where the methods of the oyster fishery will be illustrated by hauls in different parts of the beds. Dr. W. G. Savage will provide afternoon tea on board the hospital ship.