orange; who had passed no urine except by catheter for years, whose urine was loaded with mucus, was offensive, and at short intervals was filled with blood. At this time—fourteen weeks later—while he has not yet urinated spontaneously, rectal examination shows a reduction of the size of the prostate to about its normal dimensions. The catheter, which was formerly introduced for $9\frac{1}{2}$ inches before reaching urine, now goes in only 8 inches, when urine begins to flow. Its introduction is easy and painless, instead of difficult and very painful. No blood has appeared in the urine for two months. The urine itself is entirely normal in appearance, odour, and in all other respects. I have during this time suggested the operation to three other patients, all of whom have declined it on account of my frank statement that it was yet in the experimental stage, and that no promise of benefit could be given.

The idea seems to have occurred vaguely to several persons, but certainly no one had made it public, or even formulated any distinct suggestion in regard to the matter, prior to my paper. Ramm's cases, though not published until between three and four months after my paper, appear to give him the operative priority in Europe, while Haynes undoubtedly did the first operation of the kind in the United States.

This, so far as I know, is the evidence existing on this subject up to this date. It would certainly seem to establish the claim of the operation to further and much more extended trial, and it shows, I think, that even on a basis of experiment and theory alone I was justified in suggesting it to the profession.

A CASE OF CHLOROSIS AND AMENORRHOEA WITH SYMPTOMS OF BRAIN DISEASE.

By F. W. BURTON-FANNING, M.B., M.R.C.P.,
Norwich.

DR. G. CRAWFORD THOMSON'S interesting communication in the BRITISH MEDICAL JOURNAL of May 19th induces me to record briefly two cases which strongly suggested to my mind that the brain might be affected in those cases of chlorosis that manifest optic neuritis.

S. G., aged 14, domestic servant, was admitted into Addenbrooke's Hospital in December, 1890, as a case of cerebellar tumour. There was no history of syphilis or phthisis, and her previous health had been very good. Menstruation occurred for the first time in September, but had not reappeared. For a month she had had severe pain in the occiput, neck, and shoulder of the right side. On admission the headache was intense—"as if the head was being cut open"—and gave her an oppressed and dazed appearance. She had frequent vomiting, which bore no necessary relation to food. She complained of "pins and needles" in both legs and in the trunk as high as the axillæ. There was no anæsthesia or paralysis, and the reflexes were normal. Double optic neuritis of moderate intensity was present. She was distinctly chlorotic, and her bowels were constipated; under treatment with iron and aperients she lost all her symptoms in a few weeks.

Last June I saw with Mr. Everett a case that reminded me forcibly of the above. A seamstress, aged 19, presenting a moderate degree of chlorosis, had not menstruated for three months. Somewhat suddenly she was attacked by severe headache and vomiting. When I saw her ten days later she had intense and persistent pain in the right frontal and occipital regions, whence it shot into the neck and down the posterior surface of the right arm and forearm, which felt numb. The headache was unbearable; she bored her head into the pillow, and was unable to attend to any questions. Antipyrin and croton chloral gave her no relief, and subcutaneous injections of morphine alone gave her any respite. Ophthalmoscopic examination revealed blurred margins to each disc, with full and tortuous veins, and in the left fundus obscuration of the vessels by inflammatory tissue.

On the following day Mr. Everett found her in a "delirious, semi-conscious condition," but after a few days' administration of citrate of iron and ammonium she began to improve, and in a month was well.

In both these cases the intensity of the headache was much in excess of what one ordinarily meets with in chlorosis, besides which there were vomiting, giddiness, and sensory disturbances in addition to the optic neuritis. Both patients complained of pain in the neck, which was also noticed in a case recorded by Dr. Stephen Mackenzie.¹ The absence of paralysis of any cranial nerve and of fever was a little opposed to the diagnosis of basic meningitis in my cases, and I inclined rather to the theory that there was increased intracranial tension from oedema of the brain, which again was caused by the condition of the blood.

Dr. Gowers² holds that amenorrhœa is certainly not the cause of optic neuritis but an associated symptom, which is supported by a third case that I have lately seen with Dr. Johnson Taylor.

A chlorotic girl, whose loss had certainly been scanty but who had never missed a period, developed slight optic neuritis on the left side, her vision with this eye was reduced to $\frac{1}{8}$ and 18 Jaeger, but it improved rapidly under iron, with aperients.

A CASE OF AMENORRHOEA WITH BRAIN SYMPTOMS.

By F. W. JOLLYE, M.R.C.S., L.R.C.P. LOND., D.P.H.,
Medical Officer of Health to the Alresford Sanitary Authority.

THE following history—notes of which I took while with Mr. Willcox, Warminster, in whose practice I saw the case—may be of interest when taken in conjunction with the one recorded by Dr. Crawford Thomson in the BRITISH MEDICAL JOURNAL of May 19th:

E. D., a girl, aged 17 years, whose family history was good, complained on December 5th, 1888, of occipital and temporal headache, with stiffness of the neck. These symptoms increasing, she had to take to her bed on December 12th. On December 16th she suffered from diplopia, with nausea, constipation, and insomnia. When seen on December 19th she was rather anæmic and had not menstruated for three months. She complained of the above-mentioned symptoms, of tenderness of the muscles at the back of the neck and in the dorsal region of the spine, and of a feeling of soreness down the arms, and she had occasional attacks of vomiting; there was no retraction of the head or loss of power or incoordination in the limbs, face, or tongue. The knee-jerks were exaggerated on both sides, and there was double ankle clonus and front tap contraction; the plantar reflexes were abolished, but the abdominal ones were slightly marked. Tactile sensation and the functions of the bladder and rectum were normal. Homonymous diplopia on looking to the right was present owing to partial paralysis of the right external rectus; the right pupil was larger than the left, and both reacted sluggishly to light and accommodation; there was no limitation of the field of vision or colour blindness, but there was advanced double optic neuritis, the discs being twice their normal size, and there were white spots near the margins. The temperature was 99.2° and the pulse 100; the urine, specific gravity 1022, contained no sugar or albumen, but deposited phosphates. The treatment consisted of keeping her quiet in a dark room with blisters applied to the temporal regions, and she was given a mixture of quinine and arsenic, and antipyrin occasionally to relieve the headache. Under this treatment improvement set in and continued gradually, so that by the end of January, 1889, the diplopia and headache had ceased, but ankle clonus was unobtainable.

The following notes show the subsequent course of the disease. February 20th, 1889. Patient has occasional headache; optic discs swollen and edges indistinct, arteries obscured, and veins dilated and tortuous. $V. = \frac{1}{4}$. July 16th, 1889. Menses regular (for how long is not stated in the notes). Discs pale and vessels very small. February 12th, 1890. $V. = \frac{1}{4}$ with both eyes. February 5th, 1891. Was rather chlorotic, otherwise is very well, but the knee-jerks are still very brisk, and the optic discs are pale and the vessels very small. The tem-

¹ BRITISH MEDICAL JOURNAL, 1885, p. 328.

² BRITISH MEDICAL JOURNAL, 1881, p. 797.

perature was never above the normal after the first day, and the pulse was generally between 80 and 90 per minute.

The paralysis of the sixth nerve in this case made the diagnosis rather uncertain, the lesion being either a basal meningitis of limited extent, or a tuberculous tumour which afterwards became quiescent. If the latter, the amenorrhœa was, perhaps, purely accidental, or, if the former, had they any relation to one another as cause and effect?

RUPTURED INTESTINE FROM ACCIDENT : LAPAROTOMY: SUTURE OF GUT : RECOVERY.

By W. THELWALL THOMAS, F.R.C.S.,

Honorary Assistant Surgeon, Royal Infirmary Liverpool; Assistant Lecturer on Anatomy, University College.

HISTORY.

E. G., single, aged 55, was admitted into the infirmary on April 3rd complaining of abdominal pain and vomiting. Twenty-four hours previously she was returning from her garden into the house carrying a chair before her, which inadvertently struck the doorpost, bringing her abdomen into violent contact with the other side of the chair. This caused her severe pain, and she vomited immediately afterwards; the pain continued, increased, and with difficulty she managed in a doubled-up condition to reach her bed, when she again vomited.

Dr. Pitts, of West Derby, was sent for. She was unable to pass flatus, although feeling a great desire to do so. Four years previously Mr. Mitchell Banks operated on a left femoral hernia, strangulated, since which time she had worn a light truss.

Dr. Pitts examined her, and considered that a small knuckle of bowel had become constricted at the old hernial site. He did not attempt taxis, but advised immediate operation. She vomited again next morning, and the abdomen continued to distend.

Owing to the absence of Mr. Banks, she came under my care. The patient, a thin woman, walked across the casualty room, and without assistance climbed on to a couch for examination. She was in good general condition; the tongue moist, pulse about 80 and strong. The abdomen was distended, and very tender on palpation; the recti muscles were rigid, and standing prominently on the thin walls. In the left Scarpa's triangle could be felt an irregular nodule, the size of a walnut; firmly adherent to a linear cicatrix, and very tender. A recurrence of the hernia was diagnosed.

OPERATION.

Half an hour after admission the swelling in the groin was explored and found to be the old femoral sac firmly adherent to the femoral vein; in the centre was a narrow canal through which the little finger was forced; no bowel was discovered, but there rushed out a few ounces of putrid serum containing flakes of yellowish lymph. It was now clear that the intestine was ruptured. The femoral sac was ligatured, the wound thoroughly carbolicised, and a temporary dressing was applied and held in position by a dresser.

The abdominal wall was rapidly cleansed with a nail brush, using soap first, then 1 in 20 carbolic lotion. An incision $2\frac{1}{2}$ inches in length was made below the umbilicus when half a pint or so of putrid serum with large yellowish flakes of puriform lymph escaped. The intestines were all distended, no collapsed coils could be found, so the small intestine was withdrawn. After 2 feet had been examined a perforation was found situated opposite the mesentery, oval in shape, measuring $\frac{3}{4}$ inch by $\frac{1}{4}$ inch, from which oozed liquid faecal matter; the long axis of the aperture was parallel to the long axis of the intestine, and the mucous membrane was everted. The intestines were congested and glued together by yellow lymph. The gut was clamped above and below by finger and thumb, and the segment thus isolated washed out with 1 in 100 carbolic lotion, two rows of continuous Lembert sutures were applied, the mucous membrane being carefully tucked in. Subsequently two interrupted Lembert sutures were used where the union was considered weak. Green catgut was employed. On relieving the bowel no leakage took place,

so after thoroughly irrigating the abdomen with 1 in 100 carbolic lotion, the fingers agitating the intestines and liberating pocketed serum, the sutured portion was reintroduced. The wound was closed by four silkworm gut sutures and a small glass drainage tube inserted.

The groin wound was again cleansed and sutured. The dressings used were wood wool tissue over cyanide gauze. At the end of the operation, which lasted 35 minutes, the patient was in good condition.

SUBSEQUENT HISTORY.

No opium was given; sips of warm water or weak tea were ordered if asked for. If any collapse occurred small doses of brandy were ordered, but this was not required. Next morning at 3 A.M. the patient vomited some milk, which had been taken before admission. On the third day redness was noticed around the groin wound. The stitches were removed, some cellular tissue sloughs (probably caused by the putrid serum) removed, and the surface swabbed with pure carbolic acid. This ended the cellulitis. Flatus passed, and the abdomen much less distended.

On the fourth day, the glass tube was removed; 5 ounces of milk were allowed in twenty-four hours. On the sixth day half a pint of beef-tea was added to the diet. On the tenth day the bowels were well moved by enema. On the eleventh day fish was added to the diet. From this day recovery was uninterrupted. She was kept in bed for a month, then allowed up wearing an abdominal belt, to which was attached a firm horsehair pad covered with leather, and buckling around the thigh as a femoral truss.

TEMPERATURE.

On the night of operation the temperature was 100.2° F., next night 99.6°, subsequently it was only once above 99°; this was on the sixth day, when it was 99.2°.

REMARKS.

The case presents some interesting features: 1. The slight accident. 2. The opportunity it presented for examining a case of radical cure. 3. The absence of symptoms in so severe a case of septic peritonitis, only distension and tenderness being present. 4. The intense œcal odour of the serum that escaped from the femoral wound made the diagnosis of ruptured intestine certain. 5. The use of carbolic lotion, on account of the great septicity, without any untoward result. 6. The bowel being normal around the aperture made the suggested tearing away of bowel adherent to site of radical cure improbable.

For assistance at the operation I am indebted to Mr. Agnew, and for the notes to Mr. F. E. Marshall, surgical dresser.

DRS. MICHAUX and De Marbaix of Brussels have started for the Congo. Dr. De Marbaix's mission is purely scientific; he is to be at the head of the laboratory of bacteriology and experimental pathology which the Belgian Government is about to establish at Boma.

RESIDENT MEDICAL OFFICER FOR THE CITY HOSPITAL, ABERDEEN.—The Public Health Committee have agreed to recommend the Town Council to appoint as the resident medical officer at the City Hospital a graduate in medicine at a salary of £50 per annum, with board and lodging. The gentleman appointed will have to devote his whole time to the duties of the office, Dr. Matthew Hay being recognised as the head of the hospital. It cannot be said that the salary recommended is at all extravagant.

MEDICAL MISSIONARIES.—At a meeting of the guild of St. Luke held in St. James's Hall a paper was read by the Rev. Watson King Ormsby on Medical Missions, in which he strongly supported the necessity of sending out only fully qualified persons as medical missionaries. He thought also that they should not be asked or expected to give a lifelong service; it would be wiser, he said, to encourage our young men, after completing their studies and obtaining their diplomas, to go out, say, for five, three, or even two years to a foreign station, and then return to practise at home. Evidently there was a lack of recruits, and he thought their difficulty would be best met by raising the standard, and stamping out the unqualified so-called medical missionary. This is an interesting corroboration of the view we have always held on the subject.