Such a case, even if but one in a thousand, teaches a grave lesson; and my reflections upon it, and upon that of the colonist above quoted as well as upon some few others, convince me that the expectant treatment—excusable because inevitable before nephrolithotomy was proved to be the safe operation it is—is no longer justifiable.

SUMMARY.

The conclusions at which I have arrived are the following:

- (1) That the aim of the surgical treatment of renal calculus should be to extend the application of nephrolithotomy, and thereby restrict the necessity of nephrotomy and nephrectomy.
- (2) That more frequently than not the failure to find a stone is not in reality a failure of treatment, because there are so many curable morbid conditions which mimic renal calculus, and which are discoverable only by exploration.
- (3) That the theory that a stone in one kidney, whether that kidney is itself painful or not, reflects or transmits pain to the opposite kidney is quite unproven; that it is a dangerous theory, calculated to lead to very erroneous practice; and that the surgical principle with regard to exploratory operations should be that with pain, paroxysmal or continuous, on one side only, the kidney on the painful side should be explored.
- (4) That nephrectomy for calculous conditions is not often called for, and should be done only in exceptional cases. Nephrotomy for calculous pyonephrosis is the proper operation, at any rate as a primary operation, because of the frequency of double calculous disease. Experience has shown that kidneys from which stones weighing 830 gr. and 1,300 gr. have been removed are functionally sufficient to maintain life during the blocking of the ureter or suspended action of the kidney of the opposite side.
- (5) That nephrectomy whilst the opposite organ is occupied by calculus is fraught with the greatest danger to life; whereas nephrectomy, after the opposite kidney has been freed of stone, will probably be followed by recovery from the operation and possibly by very good health for many years afterwards.
- (6) That when renal calculus causes reflected or transferred vesical or ovarian pain, the removal of the calculus will be followed by complete cure of the bladder or ovarian symptoms.
- (7) That in some cases renal calculous conditions are attended by very remarkable nervous symptoms, sometimes with, sometimes without, high temperature, and that information as to the cause of these symptoms is needed.
- (8) That unsuspected renal calculi are a source of very real danger to their possessors; and when, whether by accident or by the systematic examination of the urine, we have cause to suspect the presence of a calculus, we should recommend its immediate removal, regardless of the fact that it is not causing renal or transferred pain.
- (9) That quiescent calculus is as dangerous to the individual as unsuspected calculus, and ought to be removed by operation.
- (10) That the hitherto accepted teaching, that a renal calculus, if causing only mild symptoms, or attacks of severe colic of only recent occurrence, should be treated on the expectant plan, ought to be discarded as unsound in theory and dangerous in practice.
- (11) That the same principle should be applied to renal calculus which has long been the rule in regard to vesical calculus—namely, when suspected it should be searched for, when known to exist removed, without waiting in the hope that it may become encysted or spontaneously expelled.
- (12) That the very low mortality of nephrolithotomy puts this operation upon the same footing for renal calculus as lithotripsy in the most experienced hands for vesical calculus.

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A HOSPITAL for Cancer is about to be erected in Moscow. Funds to the amount of 200,000 roubles have already been subscribed for the purpose.

LOCOMOTOR ATAXIA IN HUSBAND AND WIFE.

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THE following instance of locomotor ataxia in a married couple presents certain features of interest. I am indebted to Messrs. Phillips and Robinson, Resident Medical Officers at the Dispensary, for some of the notes of the cases.

1. A. L., aged 55, married thirty-six years, began to suffer from pains in the legs some twenty-seven years ago. A year later she had difficulty in walking, and a sensation of loss of feeling in the feet and legs. Twenty years ago she was in the Leeds General Infirmary under Dr. Eddison, and five years ago she was again admitted under Dr. Barrs with an arthropathy of the left knee. She has been confined to her bed for more than two years and a half. Nearly a year ago she sustained a spontaneous fracture of the right leg.

Present Condition.—The patient is a rather stout woman with marked myosis. The pupils do not react to light. She can no longer walk or even stand. She suffers from occasional attacks of pains in the legs, but they are not as severe now as formerly. There have been attacks of gastric pain and vomiting, but not during the past few months. There is no girdle pain. There is no very definite loss of tactile sensation as tested by the brush except perhaps over the outer side of the thighs. Here also the skin and subcutaneous tissue can be strongly pinched without causing pain. At times she is unable to hold her water, and at other times she has to strain to pass it. Both knees are swollen and the left is considerably deformed, but there is little evidence of fluid in them. There is some slight creaking on passive movement, but there has never been much pain, if any, in the knees apart from the legs. At the site of the fracture of the tibia there is a considerable amount of callus present, but the union appears firm. The arms are unaffected with the exception of occasional pains, and she can sew with ease.

2. J. L., aged 58, first had lightning pains some twenty-six years ago. Difficulty in walking soon followed, and the inco-ordination ultimately became so marked that he could only follow his occupation on his knees. He was also in the Leeds General Infirmary some twenty-three years ago under Dr. Eddison. He has been confined to his bed for the past fourteen months. Less than a year ago he was seized with a left hemiplegia, which soon, however, began to improve.

Present Condition.—The pupils are small and unequal, the right being the larger; they do not react to light. There is marked inco-ordination in the legs. The knee-jerks are absent. The patient has more severe pains than his wife, but has no gastric symptoms. There is no certain loss of tactile sensation. He has occasional difficulty in passing his urine. There is some degree of inco-ordination in the arms. The left arm and leg are distinctly weaker than the right, but there is no trace of rigidity.

There have been twelve children, of whom only three (Nos. 1, 3, and 4) are now living. No. 2 died of rheumatism and cardiac disease, aged 15. Nos. 4, 6, 7, and 9 died in infancy. No. 5 died at birth, and No. 10 was a miscarriage. There is now marked loss of sexual power in both patients, and in the man it is nearly abolished.

The diagnosis in these cases requires no discussion, for it is obvious, but there are two points that may be referred to here, namely, the hemiplegia in the man and the occurrence of the double arthropathy and spontaneous fracture in the woman. Both temporary and permanent hemiplegias have been noted in the course of locomotor ataxia. Minor has specially dealt with this subject. They have been looked upon as syphilitic manifestations, and to some extent as confirmatory of the part played by syphilis in the causation of locomotor ataxia. In this case the weakness still persists, but it is not marked. As far as is known, there has been no return of the knee-jerk here, as has been noted by some observers. An interesting case of arthropathy with spontaneous fracture was reported by Pitres and Carrière,¹ with special reference to the morbid changes in the nerves to the parts affected.

The onset of the locomotor ataxia was apparently within ten years of marriage. It is interesting to note the interval between the commencement of the disease in the two partners, so far as it is possible to fix the onset of so insidious an affection as locomotor ataxia is. In the above instance this interval appeared to be one year and a half; in other recorded cases, as far as can be ascertained from the notes, it has generally been from two to five years, but occasionally it is stated that the disease has existed in one partner for many years. Apparently the longest interval precisely stated (twenty years) is in Pearce's case, but there is admittedly some doubt here as to the nature of the disease in the husband.

The number of cases in which locomotor ataxia has been noted in married couples is comparatively few. Such cases have been recorded by Erb,² Strümpell,³ Goldflam,⁴ Dawson Turner,⁵ Moebius⁶ (3 instances), Mendel⁷ (2 instances), and Pearce and Weir Mitchell⁸ (4 instances). There have been other cases in which one of the partners has suffered from

locomotor ataxia and the other from combined locomotor ataxia and general paralysis, or from general paralysis alone (Lührmann,⁹ Redlich,¹⁰ Mendel⁷). Finally, to complete the series it may also be mentioned that general paralysis has been known to occur in husband and wife (Siemerling, Westphal, Mendel, and others). Of combined general paralysis and locomotor ataxia in both parties I have found no record.

The occurrence of locomotor ataxia in married couples has been looked upon as confirming the current view of the relationship of this disease to syphilis. Erb,¹¹ writing in 1892, goes so far as to say that tabes dorsalis occurring in husband and wife without previous syphilis does not appear to exist. This view is perhaps rather an extreme one. In the case recorded here the history of the offspring gave the clearest possible indication of past syphilis in the parents, but an exhaustive inquiry into the personal history was precluded for obvious reasons in this bedridden couple. A more special interest is perhaps attached to the cases in which an undoubted syphilitic manifestation has been observed in one partner during the course of the locomotor ataxia, such, for instance, as the syphilide seen in Strümpell's case or the gumma of bone in Lührmann's patient. During the past 20 years and more the evidence in favour of a close relationship between syphilis and tabes dorsalis has been accumulated to an almost overwhelming degree by Fournier, Erb, Grasset, Gowers, Moebius, Oppenheim, and others. It is true that the statistical method has been chiefly relied upon in these researches, but very large numbers have been dealt with, and it seems almost impossible to resist the direct conclusion which these figures naturally lead to. It is certainly a striking fact how rare it is not to obtain a distinct and unmistakable history of syphilis in the very large majority of tabetics presenting themselves in an ordinary out-patient room. Yet obviously only very large figures can be of service in the statistical method, and the percentage of syphilis obtained is then compared with that found in other patients. There are, however, still one or two distinguished authorities, such as Leyden, etc., who deny to syphilis almost any part whatever in the causation of locomotor ataxia. The doctrine is once again attacked by Leyden and Goldscheider¹² in their recent and interesting volume in Nothnagel's *Handbook*, where it is stated that cold is the most important and frequent cause of tabes. Still others are disposed to think that the part attributed to syphilis has been overdone (Carderelli,¹³ Redlich¹⁰). Few, if any, observers believe that syphilis is the sole and only cause of locomotor ataxia, although the renewed statistics published by nearly every author have shown a steadily advancing increase in the percentage of past syphilis among tabetics; thus, for instance, Erb² has reached the formidable figure of over 90 per cent.

It is not proposed here to touch upon other evidence adduced for or against the above-mentioned view—such, for instance, as the nature of the pathological lesions sometimes found, the inefficiency or otherwise of other causes, etc. The relation of syphilis to tabes dorsalis is not of theoretical interest alone, because the question arises as to whether the disease may be benefited in its earlier stages by antisiphilitic treatment. Very divergent views are held upon this subject; but it, may, perhaps, safely be stated with Moebius¹⁴ that an antisiphilitic course judiciously carried out will not harm the individual, and may do good, and this is especially true if there is a comparatively recent history of syphilis, and the more so if some syphilitic manifestation is still present.

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According to *Hinrich's Catalogue*, recently issued at Leipzig, the number of works dealing with medical science which appeared in Germany during 1897 was 1,521. In 1896 the number was 1,545.

A CASE OF CESOPHAGEAL POUCH.

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Mr. W., aged 45, stated that when he was 7 years old he swallowed a toy metal disc, but does not remember that he had any serious trouble with his throat till about ten years ago. Since that time he has had difficulty in getting his food down, and after he has finished eating some food lodges in his throat and is regurgitated.

He has for many years observed that he cannot swallow as quickly as other people. He has no pain, and has never brought up any blood. If he holds his head down after eating some of the food returns, and if it has lodged for an hour or two the regurgitated matter is frothy, but it never tastes sour. He can usually take ordinary solids, but sometimes at the beginning of a meal cannot swallow at all. He has had more difficulty since he had influenza in May or June, 1897.

After a meal overnight he can always bring up some of his food the next morning. By pressure on the right side of the neck above the sternoclavicular joint he can force the food up into the mouth, and such pressure causes air to escape with a squeaking noise. At times air escapes with a clicking sound without any pressure. Certain twisting movements of the head cause pain and a feeling of wanting to swallow. After drinking, which he does with an effort, pressure on the side of the neck causes escape of fluid and gas into the mouth. There is no history of any injury or of abscess in the neck. He believes that his mother suffers from the same condition. Mr. W. is a great oboe player, and has been in the habit of holding air in the throat to keep up a continuous blast.

The above notes were taken by one of us on December 9th, 1897. There seemed no doubt that the case was one of cesophageal pouch, and he was advised to empty the pouch by pressure after each meal and to try the effect of wearing a sort of truss to press upon and obliterate the sac.

Shortly after this patient was seen Mr. Butlin's interesting paper was published.¹ In our case we did not think any operation was required, and by later accounts, though he is unable to bear the pressure of the truss, he is quite comfortable now that he empties the pouch each time after he eats or drinks anything.

ACUTE RHEUMATISM: HYPERPYREXIA: TREATMENT BY COLD BATHS: RECOVERY.

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The following case seems to us to be worth recording, as it shows very clearly the value of the cold-water treatment in the hyperpyrexial state, when, as in private practice, the patient cannot be under constant supervision, and may not be seen until he is in almost a moribund condition.

At the end of May and early in June, A. A., aged 28 years, was suffering from apparently an ordinary attack of acute rheumatism, without cardiac complication, but his condition had latterly given rise to some uneasiness, as his temperature was rather erratic, and showed little disposition to fall even when the swelling and pain had disappeared from the joints under the influence of large doses of sodium salicylate. On the evening of June 5th the patient was quite comfortable; joints free from pain; temperature 103°.

On the morning of June 6th we were summoned hurriedly as the patient had been unconscious for some time, and his appearance had much alarmed his friends. He was found to be very deeply comatose, with reddish-purple countenance, convulsive twitchings of the limbs and face, and he had a petechial rash scattered over the body. The fæces were passed involuntarily. As hyperpyrexia was expected to account for the condition the temperature was taken, and in a few moments the thermometer had reached 110° in the

¹ BRITISH MEDICAL JOURNAL, January 1st, 1898.