Fig. 22. Kidney with uric acid calculus impacted in pelvis (Westminster Hospital Museum).

Fig. 23. The same kidney seen from within with uric acid calculus impacted in pelvis and bound down by fibrous bands (Westminster Hospital Museum).

When the renal cavity is sacculated and suppurating, it should be freely irrigated with a hot, weak solution of Condy's fluid, perchloride, or carbolic acid. In a few instances the calyces have been found packed with a putty-like mass of muco-pus, which was thoroughly cleared out with the finger and little swabs of cotton wool.

In every case a drainage tube is inserted into the wound around the kidney, but not into the kidney cavity itself. I prefer a tube to iodoform gauze; the latter, by sucking up and retaining the serum and blood, keeps the surfaces of the wound apart, and prevents immediate healing.

In closing the parietal wound I transfix the whole of the layers, skin, muscle, and fasciæ, with the same sutures carried by means of Hagedorn's large curved needles. I have for some considerable time abandoned the use of buried sutures for the separate layers of muscles and fasciæ.

The length of time required for convalescence of course varies. In cases of simple nephrolithotomy patients are often able to sit up on the eleventh or twelfth day, with their

wounds healed; and many have returned to their houses between the second and third weeks after the operation. Nephrectomy is frequently as rapidly followed by complete recovery. When the kidney and the perinephric tissues are much disorganised, healing is apt to take place for the most part by granulations, and then four or five weeks are required.

It now only remains for me to express the hope that the scope of these lectures has not seemed to those who have listened to them to be altogether inadequate to the title under which they have been announced.

I had, in the first place, intended to give my personal experience of the several different renal affections which it has been my lot to treat surgically; but when I came face to face with my materials, I found that to do so would necessitate a very cursory survey of a considerable number of subjects.

I therefore preferred to lay before you in tabular form a brief abstract of 267 operations which I have performed upon the kidney, and to limit the lectures themselves to calculous disorders.

REFERENCES.

- ¹ *Anatomie des Formes Extérieures du Corps Humain*, Paris, 1829. ² *Arch. f. klin. Chir.*, Von Langenbeck, 1893, xlv, 418.

MECHANICAL IMPEDIMENT TO RESPIRATION DURING ANÆSTHESIA, ETC.

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THAT the *alæ nasi* and flaccid lips often obstruct the entrance of air into the lungs during anæsthesia is a fact well known to those who have frequently given anæsthetics; but the obstruction thus offered is nothing in comparison with the obstruction caused by the tongue and the epiglottis valving against the posterior pharyngeal wall during the inspiratory efforts of the unconscious individual.

In deep anæsthesia, a condition bordering on death, all the muscles which pass between the lower jaw and the hyoid bone gradually lose their tone, and become relaxed to such an extent that the hyoid bone, with the tongue and epiglottis, fall backwards, moving on the thyro-hyoid membrane as a hinge, until they actually come in contact with the posterior pharyngeal wall, and may remain fixed there at the end of an expiratory effort, thus entirely preventing the ingress of air at the next inspiratory effort (see Fig. 1).

Fig. 1.—From a photograph of a dead body, showing the curved line (a) that exists between the chin and the upper border of the thyroid cartilage in the middle line. In this case examination showed that the tongue was lying in contact with the pharyngeal wall.

The simplest and most reliable way of removing all such obstructions at one and the same time is as follows:

Allow the head of the insensible patient to fall back over the end of the operating table, or place a pillow or two under his shoulders, and thus allow the head to fall back as far as possible. Then insert the handle of an ordinary tablespoon, or of a fork (instruments generally at hand) between the teeth, and push it downwards and backwards on

the dorsum of the tongue until it comes in contact with the pharyngeal wall. Then, by a simple leverage action of the wrist, the whole tongue with the epiglottis and hyoid bone may be made to move upwards and away from the pharyngeal wall as far as the thyro-hyoid membrane will allow such a movement; and in a moment all obstruction to the entrance of air in and out of the lungs is thus removed. As long as the spoon handle thus supports the tongue, hyoid bone, and epiglottis, none of these structures can possibly interfere with the entrance of air into the lungs during the movements of artificial respiration (see Fig. 2).

Fig. 2.—A photograph of the same body, showing the appearance of the neck below the chin in the middle line (a) when the spoon handle is held in proper position during artificial respiration. In this case examination showed that the whole tongue was well removed from the pharyngeal wall, and that the epiglottis was raised, and the aryteno-epiglottic folds were quite tense.

In all cases of deep insensibility, as in anaesthesia, and in the apparently drowned, this method of removing all possible obstructions to the entrance of air into the lungs during artificial respiration is at once both safe and reliable, and in combination with Howard's method of pumping air in and out of the chest gives the most satisfactory results. The sword swallower has no difficulty in passing the sword down his gullet when his head is thrown well back; and there is even less difficulty in lifting up the tongue, epiglottis, and hyoid bone in the way I have described.

MENTAL PECULIARITIES IN HÆMOPHILIA.

By CLINTON T. DENT, F.R.C.S.,
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IN the interesting case of hæmophilia described in the BRITISH MEDICAL JOURNAL of April 2nd (p. 883), passing allusion is made to a point which, though, according to my experience, very common in these patients, has hitherto been little noticed. In the hope of eliciting information on the point, corroborative or other, I venture to trespass on your columns.

Patients subject to hæmophilia—bleeders in short, for that term is surely better than "hæmophilics"—constantly exhibit mental peculiarities of definite form. The most important and the most common mental peculiarity is an inability (it is more than an unwillingness) to tell the truth about their condition even when they have had repeated and alarming experience of their defect. Frequently they will persist in obstinate denial of their liability to bleed, even when the hæmorrhage is going on, and resisting all efforts to check it. I well recall a strongly-marked instance of this unfortunate and misleading propensity that occurred some years ago in hospital practice. A youth, about 16 years of age, was admitted for persistent hæmorrhage following the extraction of a carious lower molar tooth. Every kind of remedy was tried, but the bleeding, though often checked for the time, broke out again and again. Eventually the inferior dental canal was plugged, but after a while the hæmorrhage recommenced and the boy died. From first to last he denied stoutly that he had ever suffered from bleeding, though the condition of hæmophilia was obvious enough to all. Though sane in all other respects, and aware of his serious condition, he maintained this attitude throughout. We were anxious

to communicate with his friends, but he flatly refused to give the address of his relations. Ultimately and by chance the address of his mother was discovered, and she was sent for. There was no need to break the news gently to the woman, for the moment she arrived she said, "I know what has happened; my son has had his tooth taken out, and he is bleeding to death. The same thing almost happened two years ago, and on many occasions his condition has been most serious from slight scratches or wounds." The youth furiously resented his mother's appearance at his bedside, and died actually cursing her, and all who had to do with him, while asserting almost with his last breath the *idée fixe* that he did not bleed more than others.

This distressing case, though exceptional in its circumstances, is no isolated experience, and I doubt not many others have met with patients subject to similar delusions. Hæmarthrosis may easily simulate tuberculous disease in appearance, and most surgeons would probably admit—if only to themselves—that once in a way they have at first been deceived by such cases.

In these days of early and free operative measures the precaution of ascertaining whether there is any history of hæmophilia should, in the case of joint disorders, be a matter of routine. It is not, as I have shown and always taught, sufficient to rely on the patient's word alone, however categorical and clear his statements may seem to be.

The suggestion that bleeders should be tattooed does not seem to be a happy one. Apart from the obvious practical difficulty of gaining consent, the tattoo punctures would be likely to give rise to trouble. If bleeders and epileptic patients could be induced to wear round their necks a small label setting forth their infirmity, they would probably derive advantage. But epileptic patients are far more likely to adopt any such device than bleeders.

THE ALKALINITY OF THE BLOOD IN GOUT.

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It is well known that an attack of gout may be accelerated by the ingestion of certain foods or beverages harmful either as regards their quality or quantity. One view, which has been commonly held for some time, is that such substances when they accelerate an attack of gout reduce the alkalinity of the blood, and so hasten the precipitation of sodium biurate from that medium, or, as is so frequently stated, they cause "an acidity of the system." It is assumed by those who hold this view that a nitrogenous animal diet diminishes the alkalinity of the blood and so causes deposition of sodium biurate, and that a similar result is caused by the acids contained in wines and beers; whilst, on the other hand, it is assumed that a subsequent rise in alkalinity causes solution of the previously-formed deposits. In the Goulstonian Lectures of last year I showed by a series of experiments that a diminution of the alkalinity of blood serum neither diminished the solubility of sodium biurate in that serum, nor did it produce any effect on the rate of decomposition of sodium quadriurate by such serum, and that, therefore, it was extremely improbable that a diminution of the alkalinity of the blood could in any way affect the gouty process.

Although so many writers have inclined to the view that a diminished alkalinity of the blood is associated with gout, it is remarkable that such a view has no basis of positive experimental evidence whatever. As a matter of fact the proof is in the opposite direction. The experiments of Klemperer¹ show (1) that the alkalinity of the blood of gout is but very little, if at all, diminished; (2) that corresponding variations in the alkalinity may frequently be met with in healthy individuals; and (3) that a diminution of the alkalinity of the blood is a common pathological condition in diseases that are in no way associated with uratic precipitation, such as acute rheumatism, leukaemia, diabetes, carcinoma, and pyrexia. I therefore thought it advisable to make systematic determinations of the alkalinity of the blood throughout the duration of an undoubted attack of gout, and to compare such alkalinity with the average alkalinity of specimens of blood drawn from a number of healthy individuals.

The process that I employed for these determinations of the