Dittel's Operation or Lateral Prostatectomy.—This was devised by Dittel as a means for dealing with the lateral lobes, but was first performed by Küster. A catheter is passed into the urethra and the rectum plugged. An incision is then made around the sphincter ani on one side, opening up the ischio-rectal fossa; the rectum is separated from the prostate, and a wedge-shaped portion excised from the under or posterior surface of each lobe. The object is to allow the inner or urethral surfaces to recede from each other, and leave a wider channel. The 3 cases in which Küster operated succeeded fairly well so far as the return of voluntary urination was concerned; but in one a vesicula seminalis was opened, and in 2 a urethral fistula was left. Hæmorrhage does not appear to have been severe. The operation is interesting as showing the very great importance attached by Dittel to the usually neglected lateral lobes. McGill, however, has proved that they can nearly always be excised as freely through the suprapubic incision; and there is no doubt this is the preferable route so long as the bladder is of fair size, and not small or rigid; when this is the case, if drainage will not suffice and prostatectomy is indicated, Dittel's operation is the only one that fulfils the conditions.

CLINICAL LECTURES

ON

ILLUSTRATIONS OF THE VARIABILITY OF THE SYMPTOMS OF ANEURYSM OF THE ARCH OF THE AORTA.

Delivered at the Western Infirmary, Glasgow.

By T. MCCALL ANDERSON, M.D.,

Professor of Clinical Medicine in the University of Glasgow.

LECTURE II.

IN my last lecture I read to you the notes of a case of aneurysm of the aortic arch, in which direct symptoms were almost entirely absent. Such cases are not so rare as some might imagine, and I propose giving you to-day three more illustrations.

2. A seaman, aged 49, was admitted into the Western Infirmary on September 14th, 1882, suffering from pain in the chest and hoarseness, with some cough and expectoration. With regard to his family history, all that could be made out was that his father was alive, and that his mother died at the age of 65 from the bursting of a blood vessel. He had a sore upon the penis eighteen years before, which was followed by secondary syphilis, but with this exception he enjoyed good health until five months before he was admitted. He then began to suffer from severe paroxysms of pain in the left breast, which were brought on by exertion, and about six weeks thereafter he complained of hoarseness. This symptom did not last very long, but it returned in a month, soon after which the paroxysms of pain became much more severe, and cough and expectoration set in, the latter being for the most part mucous in character, though occasionally tinged with blood.

On examination, the usual symptoms and physical signs of slight bronchitis were found, but, in addition, there was slight dulness at the bases of the lungs, especially on the right side. There were the usual physical signs of an enlarged left ventricle, the apex beat being a little lowered, and to the left of the nipple line. At mid-sternum there was a well-marked diastolic murmur, so that the case so far had all the appearance of being one of aortic regurgitation which had led to an enlargement of the left ventricle, and secondarily to passive congestion of the lungs. A further examination, however, led to the diagnosis of aneurysm, for although there were no undoubted direct symptoms, with the exception of a suspicion of dulness over the manubrium sterni, and the diastolic basic murmur, which was probably due to aortic regurgitation, there were certain indirect (pressure) symptoms which arrested our attention.

(a) He complained of pain in the præcordial region on exertion: this might have been of the nature of angina pectoris consequent upon heart affection; but, on inquiry, it was noted

that he frequently suffered from pain at the root of the neck between the shoulders, which is always a suspicious symptom, resulting from pressure upon the nerves.

(b) He spoke with a thick, hoarse voice, and he had dyspnoea, which latterly was distinctly paroxysmal, and threatened suffocation. A laryngoscopic examination yielded negative results, and the opinion which I formed was that the persistent dyspnoea was probably due to pressure upon the trachea, and the paroxysmal attacks to irritation of the left recurrent nerve.

(c) The carotid and radial pulses felt equal with the finger, but the latter were shown by the sphygmograph to be of unequal strength, the left being the stronger.

I could therefore come to no other conclusion than that there was a deep-seated aneurysm springing probably from the posterior aspect of the left part of the arch of the aorta.

The sequel of the case was as follows: At 4 A.M. on the morning of November 11th, one of the man's asthmatic attacks set in, and so grave were the symptoms, which at this time pointed to spasm of the glottis, that Dr. Patullo, my house-physician, found it necessary to perform laryngotomy. This gave instant relief to the more urgent symptoms, and in a short time he fell into a sleep which lasted for some hours. The tube then became displaced, and, as the breathing was easy, it was not reinserted. On November 16th, at 10.30 A.M., he had another attack of dyspnoea, and, just as it was passing off, large quantities of blood escaped from the mouth and through the laryngeal aperture, and in a few minutes he was dead.

On *post-mortem* examination the bronchial tubes were found to contain a large quantity of dark-red frothy material, and the lungs posteriorly were infiltrated with blood—indeed, almost solidified—while a large amount of blood was also found in the trachea at its lower part. There was a round bulging of its anterior and left wall, extending longitudinally for about an inch and a-half, and beginning half an inch above the bifurcation. On the surface of this projection, near the middle, a very ragged aperture, large enough to admit the tip of the index finger, was discovered, in the centre of which one of the cartilages was exposed, ruptured transversely, and projecting. The bulging was caused by an aneurysm of the aorta, springing from the posterior wall of the arch, between the origins of the left carotid and subclavian arteries, and communicating with it by an aperture just large enough to admit the point of the forefinger. The sac, which formed a rounded pouch about 2 inches in its vertical measurement, projected directly backwards. The left recurrent nerve was lost on the surface of the aneurysm. The wall of the aorta presented very great thickening of the internal coat, and this thickening was much more continuous than usual. The valvular structures of the heart presented nothing remarkable, but the aortic orifice was dilated. The mitral orifice admitted four fingers, the tricuspid five. The left ventricle was hypertrophied, and the heart weighed $14\frac{1}{2}$ ounces. There were extensive degenerative changes of all the arteries.

3. On August 9th, 1881, I was asked by Dr. Samuel Sloan to see with him a foreman printer, aged 46.¹ His family and personal history were good, he was temperate in his habits, and his home life was one of comfort and happiness. His recreations were walking and rowing. About eight years before I saw him he began to take an interest in rowing, and for several years rowed at the press regatta. This necessitated about six weeks of preparatory training before each annual race. After a few years he determined to give it up, but on the next occasion he was unfortunately asked, at a day's notice, to take the place of one of the crew who took ill, being then out of training. Towards the end of the race it was noticed that he suddenly became flurried, and his stroke seemed weak and unsteady. He stated afterwards that at this time his sight left him, and he felt a sudden rush of blood to the head. At the termination of the race his sight returned, but his companions noticed that his face was intensely flushed, and this continued for a considerable period of time. From this time he often said that he did not feel "the same man," and he vowed that "he would race no more." He very soon gave up the long walks which he formerly enjoyed so much, and remained in bed till 4 o'clock in the afternoon instead of rising, as formerly, at noon. He

¹ For the details I am indebted to Dr. Sloan's notes of the case.

now frequently complained of pain in the chest, especially on the left side, which he attributed to indigestion and rheumatism.

About the commencement of 1881 he began to suffer from paroxysms of distressing cough, which his friends said were most painful to hear. He thought that he had caught cold, and hoped to be better when warm weather set in. The cough, however, persisted, and was accompanied by dyspnoea on exertion, and was not benefited by a fortnight's holiday. No alarming symptom showed itself, however, till July 17th. On the afternoon of that day, while walking quietly to his work, he was suddenly seized with a sense of choking, and was so breathless that he could only answer the questions of his companion by putting his hand up to his neck. Eight days afterwards he had a similar attack, and a few days thereafter a third.

When I saw him I suspected an aneurysm, partly from the history, partly as the result of my examination, an opinion which was also shared by Dr. Sloan. The breathing was noisy and the cough severe and laryngeal in character, while alarming attacks of dyspnoea occurred on exertion or excitement. The laryngoscopic examination yielded negative results; the pulses—radial and carotid—and the pupils were equal, and there was no dysphagia; but the breath sounds were feebler over the left than over the right lung, especially in the infraclavicular region, in which position there was less resonance on percussion than on the opposite side. There was a systolic—and perhaps also a diastolic—murmur, whose maximum intensity was about mid-sternum. The heart was displaced downwards and to the left, the apex beat being in the sixth intercostal space, and a little to the left of the nipple line.

On September 1st, in a severe and prolonged attack of breathlessness, he died.

The *post-mortem* examination was made by the late Dr. Foulis on the following day. "On opening the body and removing the heart, larynx, and lungs together, there is found a greatly dilated condition of the arch of the aorta, the lining of which is studded over with raised, thickened, yellow patches. This dilatation admits four fingers. At the level of the bifurcation of the trachea there is a small false aneurysm, less than the size of a hen's egg, and with an opening in the aorta of a circular shape as large as a shilling. This false aneurysm impinges on the trachea at the bifurcation, and also on the left bronchus for about an inch. The external wall of the bronchus forms part of the wall of the aneurysm, but there is no rupture of the aneurysm into the air passage. The size and appearance of the dilated arch of the aorta do not render it probable that the recurrent laryngeal nerve can have been interfered with. The larynx and air tubes, although somewhat injected, present nothing remarkable otherwise. The aortic valve segments are slightly thickened and contracted, the mitral valve is normal, and the heart appears slightly enlarged."

4. On November 16th, 1889, a man, aged 36, a driller by trade, was admitted into the Western Infirmary complaining of hoarseness, cough, and expectoration. He stated that he caught a chill in the end of June, and two days afterwards he became hoarse; but, as his medical adviser could not detect anything wrong with the throat, he neglected it. Two months before admission cough set in, and shortly afterwards it became so severe that he had to give up work: expectoration of a clear thick sputum soon accompanied it. Since the onset of his illness he had been troubled with night sweats, but he never complained of pain. He suffered, however, from palpitation and shortness of breath, aggravated by exertion but relieved on sitting or lying down.

On examination of the chest the usual signs of consolidation at the right apex were discovered, and at the left there was prolongation of expiration and sibilant *râles*. The expectoration was frothy and muco-purulent, but contained no tubercle bacilli. The respiratory murmur was much weaker over the left than over the right lung. The heart sounds were normal, the heart was of normal size, and the pulses on the two sides of the body were equal. The left pupil was dilated and fixed, the fundus was normal, but the right optic nerve was pale and cupped at its margin. The voice was reduced to a whisper, and the cough was "incomplete," and laryngeal in character. On examination of the larynx the left vocal cord

was found to be paralysed in the cadaveric position. The scars of old strumous ulceration were numerous on the right side of the neck.

The case was evidently one of intrathoracic pressure, the cause of pressure being seated at the root of the left lung. An aneurysm springing from the back of the left side of the aorta was suspected, but, as there was evidence of old strumous mischief, the presence of enlarged and strumous glands was possible.

On the morning of February 4th he was awakened by cough shortly after midnight, and sat up in bed. Very soon he spat up a mouthful of blood, and immediately thereafter blood gushed in torrents from his mouth, and he was dead in a few minutes.

On *post-mortem* examination a small aneurysm was found springing from the back part of the thoracic aorta just beyond the arch; it communicated by an oval aperture with the left bronchus. The aneurysm pressed upon the trachea and left bronchus, and stretched the left recurrent nerve.

This case was the most remarkable of all, in so far as there was a total absence of distinct physical signs, and it, as well as the other illustrations cited, shows the importance of an accurate knowledge and appreciation of the pressure symptoms of intrathoracic aneurysm.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

ACUTE CANCER OF BOWEL AND LIVER WITH PYREXIA, BUT WITHOUT JAUNDICE OR ASCITES.

L. G., aged 53, a married woman, who had borne nine children, was sent to me on April 20th by Dr. Roosmale-Cocq, of Woolwich. For seven weeks she had complained of severe pain—labour-like in character—in the lower and central portion of the abdomen. This pain spread through both hips to the back. For five weeks she had passed blood several times each day from the rectum, and for four weeks she had suffered occasionally from violent attacks of retching. She stated that her mother died of "cancer of stomach."

The abdomen was so tender that nothing definite was elicited by palpation. On vaginal examination a small swelling, with a mulberry-like surface, was detected to the left of, and somewhat behind, the cervix. This swelling appeared to be in, or closely related to, the sigmoid. By rectal examination, nothing definite was noted.

She was admitted into hospital, and died on May 14th without any special alteration occurring in the symptoms or physical signs. The following is the record of temperature during the first five days of her stay in hospital and during the eight days preceding death.

		Morning.		Evening.
April 20th	...	100.2°	...	101.2°
" 21st	...	99.4°	...	101.4°
" 22nd	...	99.4°	...	102.4°
" 23rd	...	100.8°	...	102.2°
" 24th	...	100.8°	...	101.4°
May 8th	...	101.0°	...	102.4°
" 9th	...	100.2°	...	102.2°
" 10th	...	100.2°	...	101.4°
" 11th	...	99.4°	...	100.8°
" 12th	...	99.2°	...	99.4°
" 13th	...	98.0°	...	98.6°
" 14th	...	98.0°	...	98.0°

Necropsy.—All the organs of the body were healthy, with the exception of the lower portion of the sigmoid flexure and the liver. The lower portion of the sigmoid flexure, to the extent of 2 inches, was the seat of an epithelial growth. The liver, which was enlarged, was almost completely transformed into a malignant tumour. There was no ascites.

In this case the disease apparently ran its course in seventy-five days. It was accompanied with fever. "It is," says Wunderlich, "a peculiarity of cancer cases that elevated temperatures are comparatively rare, and that the temperature generally maintains itself on a normal or even subnormal plane, which, however, by no means precludes the occurrence of high