tember of this year by Dr. Laing, of Burscough. He was a fairly healthy-looking man of spare frame, who had never had an illness in his life, and whose family history presented nothing remarkable. Some weeks before his admission, while engaged in ditching, he felt pain and a feeling of beating in the right groin. This occurred after midday, but he continued to work for the remainder of the day, getting relief from the pain and beating by occasionally resting. On reaching his home at night he examined his right groin, and found a lump there about the size of a small nut; he also noticed that the lump throbbed. He struggled to keep at his work for about a fortnight, the pain meantime becoming much worse, and the swelling daily increasing in size. At the end of that time he was compelled to give up work, and remained at home resting. Finally, he consulted Dr. Laing, who sent him into the Liverpool Royal Infirmary. A large pulsating tumour as big as the fist occupied the upper part of the right triangle of Scarpa, pushing its way upwards beneath Poupart's ligament. The pulsation was expansile, and there was a distinct *bruit*. The general signs left no doubt that the tumour was aneurysmal.

On September 20th the abdominal cavity was opened by an incision about 3 inches in length along the right linea semilunaris. The cæcum and small intestines came into view, and were held apart by the hands of an assistant. My finger immediately detected the position of the external iliac artery. The peritoneum over it was raised and slit up for about $\frac{3}{4}$ of an inch, and the artery came clearly into view. It was exposed high up in its course, and seemed perfectly healthy. It was tied with catgut, which had been soaked in carbolic oil, with just the exact amount of pressure necessary to stop all pulsation in the aneurysm, and no more. No attempt at tight ligaturing with the object of dividing the internal coat was made. The peritoneal incision was stitched up with a fine bit of catgut, so as to make the artery and ligature once more extraperitoneal. The abdominal wound was closed with fishing gut and dressed with cyanide gauze. The patient's recovery was uninterruptedly successful except for one incident. On the eleventh day after the operation my house-surgeon was hastily summoned to him at 8 A.M., and found that he had suddenly experienced acute pain of a stabbing nature in the precordial region, while his breathing had become painful and difficult. His face was deeply cyanosed, and he was in a state of great collapse. Ether and brandy were administered, and after about twenty minutes he rallied. I imagine that a piece of clot had become detached from the neighbourhood of the ligature, and by its lodgment in the circulatory round had caused the sudden and alarming symptoms mentioned. No investigation of the chest was made for the simple reason that, while it might satisfy curiosity, it could do no real good to the patient, whose best chance of recovery consisted in absolute repose. This was the only drawback. The limb, which had been wrapped up in cotton wadding, remained warm all the time. The temperature never rose a single degree. The pain disappeared and the appetite returned. For some time the aneurysm contained fluid at one part, evidently blood serum, but this became absorbed and only a hard swelling remained, steadily contracting in size. He left the infirmary on November 1st, 1892, the forty-second day after the operation, in good general health, and asserting that he could walk as well as ever.

About this aneurysm and its cure there is nothing of any special interest, because ligature of the external iliac is always a very successful operation. But the idea of tying an iliac artery through the peritoneum had many times occurred to me, and I thought this a fair and proper case to try it in, for the reason that the aneurysm pushed well up beneath Poupart's ligament, and I could not make out with any certainty whether the vessel in its immediate vicinity was healthy or whether it was thinned and dilated. It was obvious that the artery being once exposed through the peritoneum, I could select any point of it for ligature, going as high up as I chose till I came on sound vessel. As it happened, I struck the artery high up, and found it quite healthy. Nothing could have been simpler than the operation; nothing more satisfactory than the cure.

I have tied the external iliac artery twice previously by the ordinary method; once for the cure of aneurysm, and once in the hope of retarding the growth of a pulsating tumour of the

iliac bone. It is true that it is a sufficiently easy operation, but I think the operation through the peritoneum easier still. As for ligature of the common and internal iliac arteries, in future these will always be tied through the peritoneum; and the next editions of works on operative surgery will be able to dispense with operose descriptions of the old, dangerous, and difficult methods of reaching them. As Mr. Keetley most justly observes, it is Listerism that has enabled us to reach this pitch. For ligature of the external iliac artery the ordinary operation is so safe and simple, that it will probably be retained in all cases where the aneurysm is low down, and where there is a good probability of sound vessel being found immediately above Poupart's ligament. This is reasonable, because a patient may quite well recover from the ordinary operation, even when it has been clumsily done, or when the wound has become septic; but if by evil chance an abdominal wound becomes septic it is quite a different matter. Because laparotomy has succeeded *à merveille*, that is no reason why we should do it recklessly. But where the aneurysm is high, and there is a doubt as to the soundness of the artery near it, as in my case, then I think it will be the most judicious thing to ligature the vessel through the peritoneum.

Mr. Footner's case of iliac aneurysm, which burst just as he was going to tie the common iliac through the peritoneum, is most interesting. I may be prejudiced, but since catgut ligatures and surgical cleanliness became understood, I have never seen compression of arteries for the cure of aneurysm: do anything which well-conducted ligature could not do more easily, more quickly, and more safely. Moreover, it has seemed to me that where compression has been tried and failed, subsequent ligature has never had the same fair play as if it had been done at first. I have never yet seen anything but absolute and satisfactory cure after tying the femoral for popliteal aneurysm, for instance, until I have come to regard it as one of the safest and easiest operations in all surgery. What better is desired? The only cases where I have seen trouble has been where flexion has been tried and failed; so that I am sure Mr. Footner will agree with me that if he chances on another iliac aneurysm he will promptly tie the common iliac through the peritoneum, and not waste any time over aortic compression.

Some fifteen years ago a man came into the infirmary under my care in a dreadful state of pain and distress generally. He had been out of work, and half starved. He had noticed a swelling in the left side of his abdomen for some time. In urgent search of employment he had performed a very long journey on foot, and reached Liverpool just in time to crawl exhausted into hospital. The swelling had increased rapidly, and was daily growing bigger. It was made out to be an aneurysm occupying the left iliac region, reaching to the middle line in front and to the umbilicus above. It was impossible to say where it sprang from, but as the man evidently had only a very short time to live it was necessary to act promptly. I opened the abdomen in the middle line, which was thought rather an adventurous proceeding in those days, with the intention of tying the common iliac or the aorta itself if I got a chance. But it was found impossible to do anything. The aneurysm overlapped the left common iliac and the lower portion of the aorta, so that neither of them could be reached. It was a gigantic thing, and had been leaking for some time at the back, tearing up the tissues behind the peritoneum in all directions. I shut the wound up, when I found the case hopeless, and the patient lived for a few days, which was all that we expected him to do under any circumstances. So that what was done did no real harm, and showed us that we had omitted no reasonable chance of cure.

CONGENITAL SYPHILIS AS A CAUSE OF NERVOUS DISEASES IN CHILDREN.¹

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SCANTY as are the records of morbid anatomy, there is, nevertheless, reason to believe that "nearly every variety of nervous affection of acquired syphilis has its parallel among con-

¹ Read before the Medical Society of London, November 21st, 1892.

genital examples."² But the question arises whether congenital syphilis is an important agent in the causation of such nervous disorders as infantile hemiplegia, cervical opisthotonos, and the clinical conditions which are due to sclerosis of the convolutions.

Hemiplegia.—Infantile hemiplegia is conveniently classified on clinical grounds into cases (a) having an acute onset, (b) having no definite onset. Many of the latter are, no doubt, due to meningeal hæmorrhage occurring during labour; but this cause cannot always be invoked. In fifteen cases of this class I found evidence of congenital syphilis in the family or personal history in four or five instances, without any history of difficult labour. Hemiplegia with acute onset is particularly common under the age of 3 years, and although a certain number follow the acute specific fevers, the greater proportion arise without apparent cause. Embolism at this period of life may be practically excluded. There is reason to think that the lesion is usually either thrombosis or hæmorrhage, so the inquiry resolves itself into the causation of arterial degeneration in young children. Pathological investigations on the condition of the vessels in inherited syphilis are not numerous, but sufficient evidence has accumulated to show that arterial disease is not so uncommon as was formerly supposed.³ I have lately found marked arterial changes in an infant, aged 6 weeks, in whom there was advanced cirrhosis of the liver, with unmistakable evidences of congenital syphilis.

There is considerable divergence of opinion among purely clinical observers as to the influence of congenital syphilis as a cause of infantile hemiplegia. Osler⁴ ascribed only one case out of 120 to syphilis; but it must be remembered that many of his observations were made years after the attack, when the evidences of syphilis were not readily to be made out. Abercrombie, whose investigations were made soon after the attack, ascribed 4 at least to syphilis, probably 6, out of a series of 50 cases;⁵ 2 cases only out of 83 analysed by Sachs and Peterson were ascribed to inherited syphilis.⁶ Marie, Fournier, Hénoc, and Hutchinson evidently consider infantile hemiplegia as being rarely syphilitic. Clinical observations at hospitals devoted to children's diseases appear to indicate that syphilis may have a more important etiological share than is generally allowed. Out of 25 cases of hemiplegia with acute onset, I found no history bearing on syphilis in 9; in 3 instances special inquiries were not made on this point; in 5 there was a suspicion of syphilis, and in 6 the evidence was stronger; in 2 cases the children were certainly syphilitic.

CASE I.—In a child, aged 9 years, there was ulceration of the palate and caries of the nasal bones, as well as iritis and keratitis. The patient had been taking mercury for three months, when epileptiform attacks occurred. At the end of six months, in spite of treatment by mercury, hemiplegia supervened and the child subsequently became idiotic.

CASE II.—A boy, aged 10 years; hemiplegia had occurred when he was 1 year and 9 months old. He had interstitial keratitis and extensive choroidal atrophy.

CASE III.—Syphilis was suspected in a child, aged 14 months, who had two distinct attacks of hemiplegia.

CASE IV.—In another case, an idiotic child, probably syphilitic, was attacked suddenly with hemiplegia.

CASE V.—In another patient, hemiplegia occurred at the age of 7 years, and after the lapse of five years the limbs on the opposite side gradually became rigid, possibly from chronic meningitis or sclerosis of the convolutions.

Cerebral Sclerosis.—There is good evidence that sclerosis of the cerebral convolutions is sometimes due to inherited syphilis. In one case, in which there was slowly increasing rigidity of the arms and legs, with mental impairment, in a child aged 2 years, I found marked sclerosis of the convolutions. In the notes it was simply stated that the child had suffered from snuffles and a rash on the buttocks in babyhood, but I found afterwards that the father had been under the treatment of one of my colleagues for syphilis before the birth of the child.

² Syphilitic (Hereditary) Disease of the Nervous System, by Dr. Barlow and Dr. Judson Bury: *Dictionary of Psychological Medicine*, edited by Dr. Hack Tuke, vol. ii, p. 1259.

³ See article already quoted by Dr. Barlow and Dr. Judson Bury; also cases by Dr. Barlow, and by Drs. Turner and Sutton, in Vol. xxviii *Trans. Path. Soc.*

⁴ The Cerebral Palsies of Young Children.

⁵ Clinical Lecture on Hemiplegia in Children, *BRITISH MEDICAL JOURNAL*, June 18th, 1887.

⁶ A Study of Cerebral Palsies of Early Life, based upon an Analysis of 140 Cases, *Journal of Nervous and Mental Disease*, May, 1890.

Disseminated Sclerosis.—Dr. Moncorvo has brought forward some evidence that disseminated sclerosis in the child may be syphilitic. In a case of this kind occurring in a boy, aged 8 years, a brother was brought to me with a typical syphilitic. In two other cases of this disease I had reason to suspect syphilis.

Idiocy.—The etiology of idiocy is too large a question for discussion now, but I may briefly say that some non-congenital cases are indisputably of syphilitic origin. It is difficult, however, to determine the relative frequency of this cause. Sclerosis of the convolutions or extensive chronic meningitis is sometimes the underlying condition, and the mental defect may or may not be associated with rigidity of the extremities.

Convulsions.—It is important to bear in mind that convulsions may indicate actual structural changes in the brain. Infantile eclampsia may be almost the sole indication of syphilis affecting the higher nervous centres, and it is a clinical fact that seizures of this kind will sometimes yield to mercury, when bromide of potassium and all other remedies have failed.

Cervical Opisthotonos.—In this condition the head is strongly retracted, and attempts to put it forward give rise to pain. The fontanelle is often bulged, and the sutures may widen out. Hydrocephalus, indeed, often supervenes. Paralysis of the cranial nerves and optic neuritis are not generally present. The active symptoms, with partial or even complete remissions, may last for months. Sometimes death ensues at a comparatively early period, sometimes the patient lives to be hydrocephalic, sometimes recovery takes place. This condition is due to simple (non-tuberculous) meningitis, chiefly at the base, more especially affecting the membranes between the medulla and cerebellum. Sometimes there is spinal meningitis, particularly on the posterior surface. Cervical opisthotonos is sometimes associated with clear evidences of congenital syphilis and a causal connection may reasonably be assumed, at any rate in some cases. The frequent coincidence of the two states can scarcely be fortuitous. It is curious, however, that mercury will sometimes be of little use in such cases.

THE TREATMENT OF SO-CALLED IMPASSABLE URETHRAL STRICTURE.¹

By G. BUCKSTON BROWNE, M.R.C.S.

SO-CALLED "impassable urethral strictures" or "difficult strictures" may be defined as cases in which no instrument can be passed in the usual way into the bladder. In many of them the greater part of the urine is passed through perineal fistule, and in some perhaps no urine has been passed through the external meatus for years. Such cases mean great discomfort, suffering, and distress to the patient, and frequently great trouble and anxiety to the surgeon. Happily patients so afflicted are not met with now as often as they were formerly, for the art of surgery is much more widely spread than it used to be, and urethral stricture is well and successfully treated in its earlier stages in all the large centres of civilisation. At the same time, severe cases still occasionally come to us for treatment from remote parts of the world, and even here in London the dread of surgical interference is so great in some minds that patients do not apply for aid until their condition is extremely deplorable. It is to the treatment of these cases that I wish to draw attention, for after an experience of many years I am convinced that very frequently the mode of giving relief is unnecessarily severe, tedious, and dangerous, and that if we apply a few plain surgical principles we shall be able materially to simplify our methods to the great advantage of suffering patients.

Many surgeons, on taking charge of a difficult case of stricture, will often spend weeks in groping through all the dark places of the perineum with instruments introduced through the penis, until by skill or by chance some fine instrument is passed into the bladder; it is then tied in, and worn for some time, or it is used as a guide, and a larger instrument is screwed on, and with more or less success is passed in. Other

¹ Read before the Harveian Society of London, November 17th, 1892.