which I have just alluded. As the patient improves, the vapour-bath must be used, and the iodide of iron given. There may be many other syphilitic symptoms present, with the pustular disease of the skin and its consequences. Pustules are commonly complicated with tubercles, tophi, and almost always in advanced forms, with pains or diseases in the bones. Such states, of course, require modifications in the treatment suited to the exigencies of each particular case.

ON THE DIAGNOSIS OF CHRONIC OVARIAN TUMOURS.

By E. J. TILT, M.D.,

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"Hydrops ovariorum ut plurimum steriles annosaeque mulieres occupat difficilius cognoscitur et vix sine sectio cadavere."—Boerhaave (*Aph.* 1233.)

(k) *Renal Cysts may be mistaken for Ovarian Tumours.*

ENCYSTED cysts of the kidney, containing a fluid which has none of the characteristics of urine are sometimes met with, and Dr. Bright judiciously observes, that perhaps of all errors made in the diagnosis of kidney disease, the most frequent has been to consider the enlarged kidney as an ovarian or an uterine tumour.

Case.—We have seen, says Caseau, (*Bul. de la Société Anatomique*), a renal tumour which gave the abdomen the appearance of a woman six months gone with child. It lifted up the ribs and filled the left side of the abdomen, extending into the iliac fossa. The tumour was fluctuating in part of its extent, and it had displaced the intestines right and left. All who examined the patient, except M. Caillard, thought that the left ovary was the seat of the disorder, but on opening the body, an encephaloid cancer of the kidney was found.

M. Ripault presented to the same Society an acephalocystic cyst of the kidney, which had been mistaken for ovarian dropsy; but the most interesting case of renal cyst simulating an ovarian, not only in its general appearance, but even in its termination, is given by Dr. James Johnson in his Review, (Vol. ii.)

Case.—A woman about 30 years of age, complained of considerable pain in the side when pregnant of her third child. She became easier after her delivery, which was not impeded by a tumour, easily felt after her confinement, and supposed to be ovarian, by Dr. Johnson and five other medical men. A few days after delivery the patient was drenched, while in bed, by a milky fluid, which she said was similar to the milky water she had sometimes passed before pregnancy, so the tumour disappeared, but the patient's strength failed and she died. This fluid was by some supposed to have come from the Fallopian tube, by others from the bladder, but a *post-mortem* examination proved that the ovaries and tubes

were perfectly healthy, and that the cyst was found to be an immense bag formed by the capsule of the kidney, prodigiously distended, communicating with the bladder. It contained full three pints of the fluid and had probably contained five or six quarts. The pelvis of the kidney had become sufficiently distended to line the inner surface of the sac, while the glandular substance expanded between the pelvic and capsular tissues, formed papillary bodies which covered the cyst, and secreted the milky fluid. There was no trace of peritoneal inflammation. The milky urine and the invariable exacerbations of pain in the lumbar region, when the urine became scanty or assumed its natural or a higher colour would furnish a help to diagnosis in a similar case. Here the accoucheur was to blame for not having investigated the tumour immediately after parturition.

In the beginning of renal enlargements it would be difficult to fall into this error. The pain, if any, would be referred more to the seat of the kidneys than to the ovarian region, the tumour would be found more or less isolated from the iliac region occupying the upper portion of the abdomen, and descending from it, but when the practitioner only sees the case after the tumour has attained its greatest size, the diagnosis is extremely difficult. The tumour will present the same abdominal appearance—the same fluctuating tumour surrounded by intestines; the general symptoms are the same; the menstrual function is not seriously deranged, and even if an exploratory tapping were made, it would not decide the question. It is true that we may gather presumptive evidence from the previous history of the case, but in the absence of decisive proof, encysted tumours of the kidney are liable to be taken for ovarian dropsy so long as the one disease remains frequent and the other rare.

(l) *A Distended Bladder has been mistaken for an Ovarian Cyst.*

We are ashamed to say, that there are well authenticated instances of this mistake besides the one Dr. Copland mentions having seen, and this shows to what fatal results an unpardonable want of care may lead. By following the precept to empty the bladder before making any very minute investigation of a patient's case, such mistakes may generally be avoided, when the bladder is healthy. It may however be, that the retroverted womb presses so hard upon the neck of the bladder that the free passage of the urine is prevented, and the distended bladder rises like a smooth round tumour from the pelvic region; but then the position of the tumour, and its distinct fluctuation, points out its nature, and when the uterus is replaced by means of the uterine sound, a catheter may be introduced to draw off the contents of the bladder. But the bladder may be pressed upon by a tumour so as to be divided into two equal cavities, as in the following interesting case, related in our work "*On Diseases of Menstruation and Ovarian Inflammation*," p. 36:—

Case.—A woman, aged forty-five, had been long suffering from some undefined abdominal complaint

before entering La Charité, on February 15th, 1848. The abdomen was uniformly enlarged, and tender when pressed; there was also retention of urine; and on introducing the catheter the instrument took a perpendicular direction against the pubes, and only a few ounces of urine were voided, though on percussion, the bladder still sounded as if full. The male catheter was then substituted for the female, and Dr. Blanche, with some trouble, and by exercising a moderate degree of force, penetrated into a second portion of the bladder, and evacuated from two to three pints of urine. This operation was daily performed with the same difficulties. All this was esteemed by Dr. Caseau to be the result of an ovarian tumour; in Professor Velpeau's opinion it was caused by an uterine tumour; but Dr. Rayer prudently forebore giving any diagnosis. The patient lingered for several days with increased abdominal pain, fever, and weakness, and then died.

Post-mortem Examination.—We found general peritonitis, with considerable effusion. The bladder was enlarged, and presented traces of chronic inflammation, and a few gangrenous spots; the uterus and ovaries were without adhesion. To explain the peculiarity of the patient's symptoms, we found between the bladder and the rectum a globular tumour, about the size of a cocoa-nut. Its parietes were very thin, firm, and fibrous. It contained a yellow fluid, of the colour and fluidity of ordinary urine. It was this tumour which pressed on the bladder against the pubes, and so divided it into two cavities, that on sounding the woman it was not difficult to penetrate into the smaller cavity, but it required greater force and a longer instrument to enter the second portion. This woman had been carefully examined by some of the most eminent men in Paris, yet the explorations per rectum and per vaginam separately, did not lead to the detection of the tumour, perhaps on account of its uniform elasticity; but had the double touch been put in practice, the tumour would have been detected; and if its detection had taken place before the supervention of general peritonitis, the patient's life might have been prolonged. In reference to this case we may remark, that had the patient fallen into inexperienced hands, force might have been employed in the usual direction of the female urethra, the cyst might have been perforated, and its contents evacuated, and looked upon as urine. One of two things would then have occurred—the inflammation of the cyst, as a consequence of the ingress of urine to its cavity, and ultimate death; or adhesive inflammation might have taken place, and the patient have been cured without the nature of her complaint being ascertained.

If the tumour itself cannot be easily made out, it will be difficult not to be impressed that the bladder is not the principal seat of the disease. By careful manipulations with the male sound, it will be possible to penetrate into the second cavity of the bladder, and if so, by the withdrawal of the urine it contains, we also subtract from the complicated problem the element bladder; if that be not possible, we may attempt, in some cases, to do like Madame Boivin, to force up the tumour. "I

introduced, (says this eminent lady,) a bent instrument, shaped like a spoon, between a tumour and the internal face of the pubis, and then, by pressing from above downwards, and from before towards the back, I was at last able so to compress the tumour as to permit the introduction of the catheter." Should it be impossible to displace the tumour, we must then be guided by the history of the case,—by the state of the urine, which will be little affected if the bladder is not the principal disease, and the practitioner must wait until the growth of the tumour relieves the bladder from its pernicious interference. If the bladder is in itself diseased, it may give rise to a very pardonable error of diagnosis. Thus we read in Morgagni:—

Case.—A woman, 40 years of age, was much troubled with floodings, leucorrhœa, hypogastric pain, and that a swelling was felt, rising from the pubes to within an inch of the navel. The patient was also subject to vomiting, and to strangury, and was supposed to be afflicted with cancer of the womb. On examination after death the tumour was found to be an enormous bladder, the walls of which were so hypertrophied as to be formed of a hard white substance, as thick as the little finger. Above the pubes this bladder was united to the abdominal walls. Uterine lesions explained the uterine symptoms.

Remarks.—This case is interesting, not only in itself, but as a proof of the gratifying improvement of medical art. Such a case in these days would not be mistaken for cancer of the womb. The speculum would have shown that the womb was not thus affected, the passing of a catheter would have shown the dimensions to which the bladder had attained, the nature of the urine would probably have been shown by chemical tests.

A large abscess developed in the anterior wall of the bladder has, it appeared, (Sepul., sect. 21, obs. 25,) been taken for pregnancy, and might, therefore, be taken for ovarian dropsy, but the modes of examination already alluded to would prevent such a mistake.

(m) *An Ovarian Tumour have been mistaken for a Distended Bladder.*

An interesting case of this has been communicated to us.

Case.—A lady came under Mr. Harvey's care for disease of the middle ear, and consequent meningitis, of which she died, but two or three days previous to her decease a supposed retention of urine took place. As the patient was comatose, no information could be obtained from her, and it was natural to suppose that a regular round tumour, about the size of a child's head, situated in the centre of the hypogastric region, was the distended bladder, but on passing the catheter, no urine was withdrawn, and the tumour remained undiminished. Its appearance was so similar to that of the bladder, that both Mr. Harvey and another practitioner were deceived, and from time to time reintroduced the catheter, but with no better success.

On opening the body, death was explained by the

ordinary lesions of meningitis. The suppression of urine might, perhaps, be accounted for, by a granular state of the kidneys; and the hypogastric tumour was a piliferous ovarian cyst, containing atheromatous matter, with hair, and a fragment of bone, resembling a portion of the maxilla bone, from which arose five teeth. If the patient had not been moribund, we have no doubt that those who attended the case would have required the conviction of its being ovarian, by examining it carefully; as it was, they provided against the retention of urine. The urine, had it passed, would have indicated the granular state of the kidneys.

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[To be continued.]

ON SYPHILIS AND GONORRHOEA.

By W. A. COX, Esq., BATH.

Read at the Quarterly Meeting of the Bath and Bristol Branch, Oct. 7, 1852.

THE question I submit to the consideration of this meeting is,—“Can Syphilis and Gonorrhoea coexist in the same person?”

This, it appears to me, is not a mere abstract and theoretical question, but one of deep importance, because bearing on every-day practice. The more than half a century that has elapsed since John Hunter's death, has not only very much modified our practice in the treatment of venereal disease, but in its experience has shown us that the determination of what is and what is not a true syphilitic sore is not assisted by the existence of such marked characters as that great surgeon appears to have thought. Sores of a character apparently the most innocent will every now and then be followed by well-marked secondary symptoms; so that at last we seem driven to M. Ricord's conclusion, that there is absolutely no sufficient test of what is and what is not a true syphilitic sore, except the production of another sore of a similar character in the same patient by inoculation from the virus of the original; a conclusion which Mr. B. Cooper has also arrived at. (*Medical Gazette*, vol. xliii., p. 996.)

There is no doubt that a surgeon's reputation may be very seriously affected by this difficulty, if not impossibility, of absolute diagnosis. Mr. Lawrence says:—“The first effect of the venereal poison may be an ulcer quite superficial, or a mere excoriation without loss of substance. Many consider that such appearances are not syphilitic. I regard them just as much so as the other forms: they give rise to secondary syphilitic symptoms:” and then he gives a case in a gentleman of “acute syphilitic iritis, of which (he says) the characters were so well marked that I immediately told him he had venereal disease of the eye.” He denied having contracted a venereal affection; but there was a scaly venereal eruption about him, and he acknowledged to a slight excoriation which did not heal completely for a few weeks, and was declared by a

medical man not to be venereal. (*Medical Gazette*, vol. xxi., p. 743.)

Let me take another case:—A young man applies with gonorrhoea, which he says he has had two months. He has also a sore on the prepuce, which is indurated and in a state of phimosis. I do not mean that the sore, but that the prepuce, was indurated;—that kind of induration so well described by Mr. Skey as “soft thickening.” There was, besides, an incipient tumour in the right groin. In this case the opinion entertained by the surgeon is, that the ulceration is syphilitic—that it would lead to secondary symptoms; and, therefore, that it should be treated with mercury. It is so treated, and the sore heals.

By some this has been considered as of great importance in forming a diagnosis; and no doubt it is. But suppose a different case; suppose such a case as the above, complicated with such a state of health as to render the exhibition of mercury hardly admissible, how invaluable would be any means of determining that the ulcer was absolutely not syphilitic. Suppose that such test is to be found in the coexistence of gonorrhoea, how cheerfully should we speak to our patient, and point out to him that, smarting as he might be, under ardor urinae,—racked as he might be during the still midnight with terrible chordee;—labour as he might, to squeeze some few drops of urine through a strictured urethra—yet, he had this consolation, that as he had gonorrhoea, the sore which accompanied it was innocent and not syphilitic;—that now there was no necessity of loosening his teeth with mercury, whilst we sickened his stomach with copaiba. Nay, we might add, that as gonorrhoea and syphilis could not coexist, he, for the time at least, bore a charmed life; that if, unhappily, he should, whilst having a gonorrhoea, fall again into temptation, under the consequences of which he was then smarting, he might make his mind easy. It would not be necessary, at any rate, to attend the schools of Paris to learn how he might indulge in his amours without danger; for he was safe—he had gonorrhoea; possibly he might increase it, but syphilis he could not contract; and though he might tell us that this sore had appeared some considerable time after the gonorrhoea, and, indeed, after another illicit intercourse into which he had been tempted, we might assure him there was no danger;—syphilis it could not be, and secondary symptoms it would not produce. It might not, indeed, be so easy to determine what was a true syphilitic sore; but about the gonorrhoea there could be no doubt; and where it was, syphilis could not exist. It is only to be feared that such a scientific discovery, presenting us as it does with perfect diagnosis and absolute prophylaxis, might be seized on by the faster portion of our population, and that our Lotharios might be willing to compound for an immunity from syphilis by possessing an unimportant gonorrhoea; and thus our respect for the public morals might compel us to keep to ourselves a fact so dangerous to their purity.

But, is it a fact that syphilis and gonorrhoea cannot coexist? I am not aware of any authority which can be quoted in support of the assertion. So far from its