testes became distended, and he died with all the symptoms of intestinal obstruction. The examination of the body in the post-mortem room showed that the intestines were distended with flatus to within a foot of the ileo-cæcal valve. The distension stopped suddenly, although there was no visible cause for its arrest either outside or within the intestine or abdomen. The colon, like the lower part of the ileum, was collapsed. There was no intussusception and no peritonitis. A similar case is recorded by Mr. Pick.²⁴ Brun's case recorded by Müller²⁵ seems to have been of a similar kind. It occurred in a boy aged 12 years, who died on the ninth day after excision of a piece of the small intestine for the cure of a chronic irreducible intussusception of the ascending colon, associated with a retrograde but reducible invagination of the upper part of the descending colon. The intestinal wound was found to be soundly healed after death, but the stomach and small intestines were greatly distended with flatus without any apparent cause.

The histological appearances to which your attention has been called already show that the bowel in these cases is paralysed at the seat of invagination, for it is sufficiently injured to destroy its functional activity, but not badly enough to destroy its vitality. If a similar case should unfortunately happen again in my practice, I shall inject hypodermically a grain or two of barium chloride in solution. The drug is a powerful stimulant of peristalsis, but its action is less severe than eserine. Either drug should be serviceable, for it is only in rare and advanced cases of intussusception that both the circular and longitudinal layers of muscle are involved; in the early stages one layer is injured more seriously than the other, and the circular layer more often than the longitudinal.

When an intussusception has been successfully reduced after laparotomy, the surgeon should satisfy himself before he closes the abdomen that he has overcome the only cause of obstruction, and that the case he is treating is really as simple as it appears to be, for an intussusception may be complicated by a variety of troublesome and dangerous conditions. Dr. Handfield Jones and Mr. Page²⁶ published the details of such a complicated case in which there were two intussusceptions of the colon and one of the ordinary ileo-colic type in a boy aged 5 years, and I have already mentioned the less uncommon cases of double intussusceptions. Double intussusceptions usually run in opposite directions, and are separated by an interval of healthy intestine, but occasionally²⁷ they may overlap each other so that the retrograde invagination, which is generally the distal one, has to be reduced before the upper one can be released.

Another complicated case, coming under the care of Dr. Whipham and Mr. Turner,²⁸ occurred in a woman aged 29, in whom an intussusception associated with a polypus was complicated with a volvulus at two different parts of the intestine. In yet another case—occurring in a girl of six months old—recorded by Mr. Clinton Dent,⁴ a double intussusception, ileo-colic as well as ileo-cæcal, was still further complicated by an internal hernia which was apparently secondary. The hernia was strangulated by the sharp edge of a fold of mesentery attached to the ileum, and it was buried deeply in the cavity of the pelvis.

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(To be continued.)

DR. GARDNER, of Melbourne, has been elected a foreign correspondent of the Paris Société de Chirurgie.

A CASE OF SUPRAPUBIC PROSTATECTOMY, WITH THE SUBSEQUENT HISTORY OF THE PATIENT.

By A. W. MAYO ROBSON, F.R.C.S.,

Senior Surgeon to the General Infirmary at Leeds; Professor of Surgery in the Yorkshire College of the Victoria University.

THE appearance of the patient whose case is related below as he stepped into my consulting room after an interval of ten months, when from being a thin, feeble, decrepit old man, he had changed to a healthy-looking, brisk, and vigorous adult, suggested to me the propriety of reporting his case. I am indebted to my friend, Dr. H. Colligan Donald, who assisted me with the operation, for the notes.

D. J., aged 61, a saddler, was sent to me by Dr. Mitchell, of Topcliffe, in October, 1894, complaining of painful and difficult micturition. He gave the following history: About two years previously, that is, in 1892, he first experienced difficulty and pain in micturition, and after the act he passed involuntarily a few drops of water, wetting his dress. Soon after this he experienced a desire when in bed to pass water, compelling him to get up two or three times nightly. Before this, for some years, he had had to get up in the night once or twice, but he had thought nothing of this, as he was otherwise well. This feeling was always more pronounced and accompanied by pain if he had been exposed to fatigue or jolting of any kind during the day. Six months previous to my seeing him he developed cystitis, and passed a considerable quantity of blood with the urine, noticeably after the use of the catheter. One month before I saw him he had complete retention of urine, which was relieved by a large-sized soft catheter. Since then he had required to use the catheter from day to day, the frequency of micturition increasing. His general condition had always been good, and he had always led a temperate life, but owing to the suffering and distress during the day, and the frequent disturbances at night, he had become thin and looked very ill.

On examination I passed without difficulty a No. 12 catheter, drawing off $4\frac{1}{2}$ ounces of residual urine. The sound failed to detect the presence of a stone, but the walls of the bladder felt roughened. The prostate as felt by the rectum was found to be enlarged, but not tender. Urine, alkaline, 1020, trace of albumen, no sugar, thick white deposit, which a microscopic examination showed to be composed of pus and phosphate of ammonium. He was averse to operation at the time, and returned home, where, under rest, careful catheterism, the use of salol and boracic acid, and the regulation of his diet, he improved considerably and felt fairly comfortable for about a year. He again consulted me in October, 1895, on account of the symptoms recurring with greater severity. I then sounded his bladder, detecting a calculus behind the prostate. By the rectum the prostate was felt to be enormously enlarged, and there was a thickened feeling over the region of the right ureter.

Operation having been decided on, I performed suprapubic cystotomy, removing a lithic acid calculus about the size of a pigeon's egg, which was encysted in a deep pouch behind the prostate. As it was manifest that the enlarged middle lobe of the prostate would continue to obstruct the exit from the bladder, I removed it by means of the ring-cutting forceps, after removing by scissors and forceps a wedge of prostatic tissue, so as to make the bottom of the bladder pouch level with the entrance to the urethra. Considerable hæmorrhage followed, which was controlled by washing out the bladder with tincture of hamamelis (half an ounce to the pint of boracic lotion) used as hot as the hand could bear it. The bladder was drained. The patient made an uneventful recovery, and was discharged at the end of six weeks, the opening into the bladder having healed, and urine passing in the natural way, at regular intervals, and without pain. Ten months after operation the patient came to see me, expressing himself as being in the best of health, having gained 2 stones in weight, and having no difficulty or discomfort of any kind. On two occasions only had he to use the catheter, these within a month after leaving the surgical home.

REMARKS.

The fashion has for a time turned from prostatectomy to

castration in the operative treatment of enlarged prostate, but I am by no means converted. The condition of some of my patients years after prostatectomy is such as to make me feel that in the operation suggested by my lamented colleague McGill and by Belfield, independently, but almost simultaneously, some years ago, we have to chronicle a real advance in the treatment of enlarged prostate which has failed to be relieved by catheterism and other milder measures. The details I gave in a paper at the International Medical Congress at Rome still holds good in my practice, both with regard to the preliminary preparation of the patient, the steps of the operation, and the subsequent treatment during convalescence.

A CASE OF AMPUTATION IN MIDDLE AGE FOR ALBUMINURIA, FOLLOWING TUBERCULOUS KNEE: RECOVERY.

By J. J. H. HOLT, M.B., CH.B. (VICTORIA),
Buckley, Chester.

THE question of operation in cases of albuminuria is one often difficult to decide, more especially when it occurs in patients who are advancing in years. The following report may therefore be of some interest and use in helping to arrive at a decision in some doubtful cases.

J. C., a business man, aged 52, bachelor, was first seen by me in May, 1896. He had been suffering from a deformed knee since childhood, but called me in because he was feeling generally unwell, and complained of obscure lumbar pains and restlessness at night. He had been passing a considerable amount of urine, which was acid, light in colour, specific gravity about 1012, and was distinctly albuminous. Some finely granular casts were seen under the microscope. Physical examination gave no sign of enlarged liver or spleen. The heart and lungs were normal. The left leg was flexed at right angles, and the knee greatly deformed, much swollen, and inflamed. On the outer side there was a large granulating surface, in the centre of which was a sinus leading down to the knee-joint. It was discharging a thin serous-like pus, and was very tender. It was injured when he was 11 years of age, and had been discharging since he was 12. The family history evidenced a tuberculous tendency, two of his sisters having died of consumption at about 27 years of age.

The question of operation had been considered when he was 12, but had been decided against. In 1891 he was in bed twelve weeks with an attack of rheumatic fever. He made a good recovery and enjoyed fairly good health until August, 1892, when the knee became very painful and discharged more freely. It improved in about four months, and he was again comparatively healthy until about May, 1896. He then began to be troubled with pain in the loins and could not rest well at night. Hoping that the condition might be temporary and that possibly he might improve by resting, he was advised to take a holiday and use boracic dressings for the knee. He went away for a month, and felt better in health whilst away and for some days after his return. Subsequent examination of the urine, however, gave even more distinct evidence of albumen than it did a month previously. Regarding this, therefore, as an indication that the kidneys were becoming secondarily affected, he was advised to consult Mr. W. Whitehead, of Manchester, as to the advisability of amputation. He was strongly advised by that gentleman to undergo the operation, whilst at the same time he was informed of its risk. Declining health and increasing pain, however, made him decide to have it done.

Amputation was performed by Mr. Whitehead on August 19th. Owing to the unhealthy nature of the tissues, it was found necessary to amputate between the upper and middle third of the thigh. Notwithstanding the increased risk from the high operation the patient rallied well and made an excellent recovery. He was kept on a milk diet and simple aperients given to regulate the bowels. He was able to leave his bed early in September, and has progressed most satisfactorily ever since. The albuminuria steadily diminished and has now disappeared. He has resumed work, is sleeping

well, is free from pain, and enjoys better health than he has done for years.

The case is interesting in showing the possibility of relieving secondary albuminuria even after long-standing suppuration. In this case the discharge had continued for forty years, but was followed by recovery, even after such a dangerous operation.

A NOTE ON A FEW SURGICAL USES OF PICRIC ACID.

By C. M. ALLAN, M.A., M.B., C.M.,
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IN the BRITISH MEDICAL JOURNAL of December 26th, 1896, Dr. Maclellan drew attention to some uses of picric acid as a protective and healing agent in skin diseases.

When experimenting with various therapeutic agents, in a study—extending over fourteen years—of varicose ulceration of the leg and allied diseases, among others (including sulphurous, nitric, tannic, and oxalic acids and chlorine) I have used picric acid (a concentrated solution in rectified spirit diluted with two parts of distilled water, and applied with a spray), and found it the most successful in allaying the irritation and stopping the discharge, and irritation from the discharge, from eczematous and ulcerated surfaces.

In the case of ulceration or eczema, or of ulceration and eczema of the leg, the leg is, subsequent to the application of the acid, covered with a medicated adhesive plaster. The smarting and itching resulting from the disease and exposure to the air are immediately allayed, the inflammatory redness and irritation subdued, the parts kept aseptic or rendered so, and the fine coating of coagulated albumen and “epithelial debris” (which disappears before the application of the next dressing in a week) exerts an astringent and slightly compressive action on the dilated venous and lymph radicles in both ulcer and surrounding inflamed surfaces, and healing takes place rapidly, and with comfort to the patient.

In recent wounds, with or without great loss of substance, this treatment is equally beneficial, and is not so troublesome nor so unsuccessful as skin grafting, where the size of the wound would render that advisable. I have under my care a wound of the forearm with loss of skin which a hand could not cover, healing rapidly under this combined treatment after the Thiersch method had failed. In that most dangerous and most intractable form of hæmorrhage from wounds in hæmophilic subjects picric acid solution acts better than any form of treatment I have tried. Within the last few years I have had two such cases, one of which belonged to a distinctly hæmophilic family. The first, a cut several inches long, was sprayed with the acid while the blood was being mopped off with wool; and treated thus several times daily, did better than with iron and other astringents. The second, an abscess of the glands of the neck after scarlet fever, which necessitated incision, was packed with picricised gauze and did well.

In cases of severe cellulitis arising from the introduction of some irritant poison, and when incision or amputation is necessary, the bleeding from the paralysed and dilated radicles becomes almost uncontrollable. If the incision is packed with gauze wrung out of the picric solution the bleeding is soon controlled. For the oozing after the amputation the spray is much more successful than hot water, yet a combination of both may be used with great advantage, the water being used first (as it would decompose the acid if both were combined) and the spray applied immediately after. The acid acts as an astringent and antiseptic hæmostatic, and the parts heal cito, tuto, et jucunde.

OUR Correspondent in Hong Kong writes: The threatened outbreak of small-pox in Hong Kong has been successfully met by the vigorous measures adopted by the Government to stamp out the disease, as only an occasional case is now being reported. The number of cases since the beginning of December has been 25, 19 being in December, and 6 during the first thirteen days of January; and the number of deaths has been 11—7 in December and 4 in January to date. Ten of the cases and three deaths were in Europeans.