RUPTURE OF THE BULBAR BRANCH OF THE INTERNAL PUDIC ARTERY.

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THE patient was a gentleman, aged 54, but young for his age; his father, over 90 years old, is still alive.

On February 6th, 19—, he was leaving the balcony of a theatre and was climbing over the backs of the seats to avoid the crowded gangway. A seat tilted up under pressure of his foot, and he came down astride of the cast-iron coat-of-arms which ornamented the back of the seat.

He felt very numb, but no great pain at the time, about the region of the blow. He took a cab to Baker Street Station, over a mile away, and there passed water without difficulty and saw no blood. He noticed, however, that there was a little swelling of the scrotum.

He took a train to Hampstead and a cab to my house. I found he had a lump in the perineum, with a slight abrasion, to the right of the central raphe, just in front of the "landmark" for the transversus perinei. There was some swelling of the scrotum, and also a slight stain of blood on the shirt. A full-sized red-rubber catheter was passed without difficulty, clear urine was drawn off, and there was no blood seen after withdrawing the catheter.

The patient was told to go home (a minute's walk from my house) and get into bed for a more complete examination. Between leaving my consulting room and getting into bed immense swelling of the scrotum supervened, the skin becoming quite black, and signs of extravasated blood appearing on the abdomen. The patient was now complaining of severe pain.

The indications for treatment were, first to stop the hæmorrhage, and next to relieve the pain. I had in my bag a small, round, glycerine-filled, rubber pessary. This was wrapped in dressing gauze and laid in the fold between thigh and perineum, a pad being so arranged that tight application of a T bandage forced the pessary in its transverse diameter against the perineum at its junction with the ischio-pubic ramus. This converted the round ring into an ellipse, and so exerted elastic pressure over the site of injury.

The scrotum was as tense as a football by the time the bandages were arranged, and the patient was suffering greatly. A puncture was therefore made with antiseptic precautions, sufficient blood being allowed to run out of the scrotum to relieve tension. A hypodermic injection of morphine was also given.

Relaxation of the elastic compression was allowed at the end of twelve hours, but some degree of pressure was maintained for the next seven days, care being taken that it was not damaging the parts. Hot fomentations were also applied to the scrotum, and the urine was at first drawn off with a catheter, but the fomentations appeared to facilitate natural micturition though it was still attended with some difficulty.

On February 13th, the seventh day after the accident, the pressure was removed, the patient finding it irksome. That night, when straining a little to pass water, he felt something give way and the scrotal swelling began to increase. Pressure was again applied and maintained for another three days, when it was finally abandoned without further trouble.

On February 22nd the scrotal effusion, as it showed no sign of absorption, was aspirated, and 10 oz. of thick tarry blood removed. The swelling returned to some extent next day but the abdominal ecchymosis disappeared—no doubt into the scrotum.

On February 25th 6 oz. and on March 3rd 4 oz. were drawn off, and eventually perfect recovery ensued.

The patient was, of course, fortunate in avoiding rupture of the urethra. The injury, on the other hand, was severe, and evidently amounted to something more than a mere "perineal contusion." The maximum force of the blow seemed to have expended itself on a point midway between the bulb and the ramus of the pubes; and, judging by the rapid extravasation that ensued, once the blood had forced its way into the scrotum, there can be no doubt that the artery to the bulb was ruptured.

Hæmorrhage from the artery to the bulb is very profuse and difficult to check on account of the short course of the vessel, its depth, and its close connexion with the layers of the triangular ligament, which prevent it retracting freely when cut (Cunningham). Certain cases of severe perineal contusion have been described by Christopher Fleming.¹ They were all attended by retention of urine although the urethra was uninjured, but none presented the rapid and severe hæmorrhagic distension described in the above case.

REFERENCE.

¹ *Clinical Records of Injuries and Diseases of the Genito-Urinary Organs*, Dublin, 1877.

NOTES ON A CASE OF BUPHTHALMIA.

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THE condition of buphthalmia is of sufficient rarity to make the following notes of some interest to ophthalmologists. To the clinical observer the case may be lacking in interest on account of the advanced stage and the unsatisfactory prognosis, but to the pathologist all phases of the disease are of importance, and serve to make the picture more complete.

The patient, Robert F., aged 12 years, came to me in the out-patient department of Glasgow Royal Infirmary in July, 1908. I learned that he had formerly been a patient in the Royal Infirmary, Aberdeen, and I was able to obtain notes of the case as it appeared at that time. It is by favour of Mr. C. H. Usher that I am at liberty to publish the following.

CASE.

Robert F., aged 5 years, admitted on October 27th, 1900, to the eye wards of the Royal Infirmary, Aberdeen, under the care of Mr. C. H. Usher. The condition then was: R.V. = naming watch, teaspoon, penny at 1 ft. Size of pupil about 6 or 7 mm. Reactions of pupils and ophthalmoscopic examination not obtained on account of photophobia. L.V. = probably no perception of light. Opacity in pupil, probably lens. R. and L. constant fine lateral nystagmus. T. = +1 (at least). A.C. = very deep. Corneae very nebulous all over. Corneae extremely large, difficult to measure owing to patient's resisting opening of the lids. Avoids the light by keeping head depressed. Is able, however, to keep eyes wide open. Marked iridodonesis. Eyeballs covered by lids during sleep.

Fig. 1.

History of Present Complaint.

When 6 months old the patient's mother was struck by the large size of his eyeballs. At 2 years of age he was seen to have great difficulty in catching hold of things. At 4, a doctor was consulted who said nothing could be done. At 4½ years his eyes were noted to be "white and scaled." He had some photophobia and some headache.

Present Condition.

A well-nourished boy. Heart and lungs apparently sound. Urine contained no albumen nor sugar—normal.

Treatment.

Gutt. eserinae, ½ per cent. every six hours to right eye. On November 5th, 1900, R. pupil had contracted only a very little. T. = +1 (difficult to estimate because of contraction of orbicularis).

It will be seen from above that a period of almost eight years has elapsed since the last report on the case. The condition of the patient at present seems to differ only very slightly from that of eight years ago, a fact which illustrates how slowly the disease may advance.

The boy is of average height, and is well nourished although somewhat anaemic-looking. He appears intelligent, but is of rather a shy and timid disposition. His mother states that he has never had any serious illness apart from the eye trouble. He keeps his head constantly a little bent, and his eyelids droop. (See Fig. 1, which represents the patient in a characteristic attitude.) When told to look upwards he keeps his eyes open for a few seconds only. He experiences great discomfort if the eyelids are held open, so that examination is restricted. The eyes can be closed tightly at will, but the mother says