RUPTURE OF THE BULBAR BRANCH OF THE INTERNAL PUDIC ARTERY.

By J. S. MACKINTOSH, M.R.C.S.ENG., L.R.C.P.LOND.,
HAMPSTEAD.

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 haemorrhage, 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.

Haemorrhage 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 haemorrhagic 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.

BY

JANIE HAMILTON McILROY, M.B., B.Sc., M.A.,
EXTRA DISPENSARY SURGEON FOR DISEASES OF THE EYE, ROYAL
INFIRMARY, GLASGOW.

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

he sleeps with the eyes a little open. The eyeballs are enlarged to nearly twice the normal size. There is constant fine lateral nystagmus, so that measurement of the corneae is difficult. The horizontal diameter of each cornea seems to be about $\frac{3}{4}$ in. The distension of the globe is more or less uniform throughout. There is no great flattening of the cornea. The outline of the cornea is very irregular, the corneal tissue shelving off in an ill-defined way, to become sclerotic. The cornea has a distinctly bluish appearance, and the bluish tint extends past the limbus into the sclerotic for some distance. It indicates that the external coats of the eyeball are thinned out at and near the limbus, and the darker underlying structures (iris and choroid) are therefore more or less visible. The corneal surface is extensively ulcerated, especially in the right eye, and in the lower quadrant (that is, exposed part where lids are open). Numerous fine vessels run in from the sclerotic and are lost in the corneal tissue. The anterior chambers are deep, and the pupils circular and semidilated. The irides are tremulous on account of the loss of support from behind. The lenses are seen as dense white plaques. The lens in the left eye almost fills up the pupil, but that in the right is partially dislocated downwards and backwards. It is difficult to ascertain the exact condition of affairs within the eye, on account of the opacities in the cornea, but, on the whole, the iridic tissue seems to be fairly healthy. No view of the fundus is possible. The tension is at least $= +1$, and there is slight tenderness on palpation, especially in R. His mother says the discharge from the right eye has been present only within the last nine months.

With regard to the vision, there is still perception of light in the left eye. With the right he is able to count fingers with accuracy. He recognizes various objects, such as a pen, bottle, nailbrush, when held at about 1 ft. He moves his head from side to side, in order to see the object from various aspects. Flat surfaces are recognized more quickly than raised, and he can tell the difference between coloured pieces of paper, naming red and blue correctly.

Convex lenses seem to be of very doubtful assistance, and concave lenses do not help at all. When treated with eserine there did not seem to be any change in the pupil or any decrease in tension.

REMARKS.—The case is evidently one of congenital buphthalmia, or infantile glaucoma. The etiology of these cases is obscure, the condition probably being established *in utero*. There is nothing in the history of this case to account for the condition. Consanguinity of parents, which seems to be a frequent factor, is absent here. The patient is one of a large family, none of whom seem to suffer from any allied developmental defect, for example, aniridia, etc. The mother had one miscarriage (previous to birth of patient) which seems to have resulted from accident rather than disease. One child died in infancy of convulsions, but all the other members of the family have grown up healthy. We note the extremely slow progress of the disease, the condition not having changed to any great extent during the last eight years. In this it differs considerably from the analogous condition of glaucoma in the adult, where degenerative changes take place more quickly. In the infant the tissues of the eyeball are plastic, and distension of the coats of the eye takes place without destruction of the underlying tissues (retina, choroid, etc.). The involvement of the latter, as a rule, takes place only at a much later stage. In the present case, although there is great thinning of the cornea and sclerotic, the fair amount of vision indicates that the visual structures proper are tolerably intact. The dimness of vision would be accounted for by the blurred cornea and cataractous lenses.

Treatment has consisted in gutt. eserinae $\frac{1}{2}$ per cent., t.i.d., for relief of the glaucomatous condition. The septic condition of the conjunctival sac received attention.

AT a recent meeting of the Board of Directors of the Rockefeller Institute for Medical Research, Dr. Rufus I. Cole, of the Johns Hopkins Medical School, Baltimore, was appointed Director of the Hospital of the Rockefeller Institute for Medical Research, and Dr. Christian A. Herter was appointed one of the physicians to the hospital. Work on the hospital buildings is in progress, and it is expected that they will be completed and the hospital be ready for opening in November, 1909.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

SPONTANEOUS RUPTURE OF THE GALL BLADDER.

THE following case of sudden death from syncope, due to spontaneous rupture of a gall bladder full of gall stones, seems to be a sufficiently uncommon event to be worth recording.

On the morning of February 8th, 1908, a man, J. A., aged 45 years, grocer and previously general labourer, had, before breakfast, been helping to harness a horse; he went back to the house and sat down to breakfast, but before eating anything he suddenly leaned back in his chair and died. He had not recently been complaining of feeling ill at all.

The previous October—that is, five months before—he had been ill for about a week, complaining of dull pains in the abdomen about the right iliac region; there was no jaundice, and I diagnosed this at the time as a mild attack of appendicitis, which cleared up.

On making a *post-mortem* examination on February 9th a gall stone about the size of a large pea, but irregular in shape and faceted, was found lying free in the abdominal cavity between the gall bladder and the transverse colon. The gall bladder, which was of normal size, was packed full of gall stones which grated together on handling the organ. There was a small round perforation about a third of an inch in diameter on the posterior surface of the fundus of the gall bladder; the wall, for about half an inch all round this opening, was thinned extremely, so as to be translucent and showed the striation of the muscular coat on holding it up to the light; the rest of the wall of the gall bladder was abnormally thick and tough. One gall stone, about the largest amongst them, being the size of a small cherry, was found firmly impacted in the neck of the gall bladder where it becomes continuous with the cystic duct. The gall bladder contained no bile and scarcely any mucus. The gall stones were of the usual cholesterolin type, over seventy in number, dark brown in colour, faceted, and varying in size from a pin's head to a small cherry. With regard to the other organs the heart was normal and contained a moderate amount of blood on each side; the appendix was quite healthy, showing no adhesions nor signs of previous inflammation; the right lung showed old pleuritic adhesions; the other organs were all normal.

What had evidently taken place was that the constant irritation of the gall stones had caused marked thickening of the walls all over the gall bladder, excepting at the place where a constant pressure, probably increased by the blocking of the cystic duct, had caused marked thinning, resulting in the sudden perforation, which, it will be noticed, did not occur during any special muscular exertion. This sudden perforation apparently caused fatal syncope so abruptly that the man had not time to utter a single word.

The attack of pain he had five months previously was possibly the occasion when the stone, found at the entrance to the cystic duct, became impacted there, or it was possibly due to the passage of a small gall stone, though the character of the pain did not suggest that.

I have thought this case worth recording, as the leading textbooks on medical jurisprudence do not mention such an accident as one of the causes of sudden death due to natural causes. They all describe gall stone colic as one such cause, and Dixon Mann mentions rupture of most of the other hollow viscera, either from trauma or disease, but I have not found described any case quite like this, though doubtless it has often occurred.—I am, etc.,

Bury.

P. F. BRAITHWAITE, M.B.Lond.

A METHOD OF ENUCLEATING THE APPENDIX.
In cases operated upon for appendicitis, when it is found that no meso-appendix exists, the simplest method of enucleation is as follows: Make a circular incision through the serous coat near the base, and then introduce an ordinary blunt-pointed hook, the lower end of which has been bent at a right angle, and encircle the stump in a similar manner to that in which an aneurysm needle