COMPLETE INVERSION OF THE URINARY
BLADDER.

BY

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COMPLETE inversion of the urinary bladder is a condition of such extreme rarity that the publication of the clinical details in such a case would seem to be warranted.

An undersized, rather poorly nourished Chinese girl, aged 15, with a facies suggestive of hereditary syphilis, and mentally very stupid, was admitted to hospital on August 10th, 1927.

History.—About two months previously the patient had noticed a small and tender swelling between the vulvae; this she had "pushed back." There was apparently a recurrence some five weeks later. About two days before her admission she was carrying two heavy casks of water when she felt something "give." On reaching home she found a large mass between the vulvae. On the following day she remained in bed and attempted to push back the mass, but failed.

On admission to hospital she was seen and examined by the lady medical officer, Dr. Hewitson, who concluded that the protruding mass was possibly the urinary bladder. Shortly afterwards I saw her, and, under chloroform anaesthesia, made a thorough examination.

Condition on Admission.—I found that the protruding mass was without doubt the entire urinary bladder inverted. The mucous membrane was intensely red and inflamed, bleeding on palpation. On gently raising the mass urine could be seen flowing from the ureteral orifices, which were visible just inside the posterior margin of the enormously dilated urethra. Vaginal examination showed that the hymen was absent, the cervix normal, and the uterus small and normally placed. The anterior fornix was obliterated.

Having thoroughly cleansed the parts with warm sterile saline, I returned the protruding mass by steady and gentle pressure. Digital examination proved that no growth of any sort was present. The urethra easily admitted my thumb. The patient was put to bed with buttocks raised, and for a few days the bladder was washed out with 1 in 2,000 acriflavine. She was kept in the recumbent position for three weeks, by the end of which time she seemed able to retain her urine.

At her own request she was permitted to leave hospital, and was instructed to return at once should inversion recur. During her stay in hospital her pulse and temperature remained

normal; the urine also was normal. I was most disappointed not to have been able at this time to obtain photographs of the condition.

The patient was readmitted to hospital on September 23rd suffering from bronchitis and subtertian malaria. The next day I was sent for, as, following a severe fit of coughing, the bladder had again inverted. She was anaesthetized and photographs were obtained which clearly showed the conditions present.

The bladder was again replaced and the patient was returned to bed, quinine in 10-grain doses being ordered.

It seemed evident that some form of operation was required to prevent further recurrence. A search through all available literature failed to give any information, save

an article entitled "Prolapse of urethra in female children," by Thomas N. Hepburn, F.A.C.S., published in the *American Journal of Surgery* for March, 1927 (p. 400), wherein the writer very clearly describes an operation. I determined to try a similar technique.

On October 10th, under general anaesthesia, the space of Retzius was freely opened up. The peritoneal reflection from the anterior surface of the bladder was defined and drawn upwards. The bladder was gently grasped with rubber-protected forceps and drawn upwards. The posterior aspect of the symphysis pubis was lightly scarified. The anterior surface of the neck of the bladder was rubbed with gauze and then firmly sutured to the pubis. The wound was closed without drainage, and dry dressings were applied. It was noticed that this procedure had the effect of drawing up the urethra, which before operation was pouching.

The patient suffered from considerable post-operative vomiting, but no sign of prolapse of the urethra or bladder occurred.

It will be interesting to see if this operation cures the condition. I should be thankful for any information bearing on the case, both as regards incidence, causes, and treatment.

A CHYLOUS MESENTERIC CYST.

BY

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The following case is noteworthy on account of its rarity, and of the satisfactory immediate result of conservative operative treatment.

A boy, aged 8, was admitted to Mansfield Hospital on April 3rd, 1928, from a neighbouring sanatorium "for relief by laparotomy of ascites due to tuberculous peritonitis."

The first symptoms had been noticed two years previously. The boy was developing a ravenous appetite, especially marked in the early part of the day, and was unusually sleepy in the evening. He would "eat all day"—a mixed diet with an excess of bread, butter, and potatoes—and then sleep ten or eleven hours each night. Shortly after this the abdomen was observed to be rather large, but the increase had been much more marked during the last six months, and it was not until this period that the boy became thin. The bowels were opened each morning urgently following a slight griping sensation; nothing abnormal was noted in the stools. The boy played games, and his general health remained fairly good.

Previous to these symptoms he had been an exceptionally healthy child, being 11 lb. at birth, and but slightly troubled by measles and chicken-pox. When 6 years old (six months before anything of the present trouble was noticed) he broke his leg, but no concomitant injury to the abdomen or back was noted or remembered.

Condition on Admission.—The patient was very thin. No irregularities were palpated in the very large abdomen, but percussion revealed that the umbilical region was as dull as the flanks, the only resonant area being in the epigastrium. There was no thought, however, of questioning the diagnosis.

Operation.—The abdomen was opened through a subumbilical incision, but no fluid was found. Across a soft, white, cystic swelling was stretched a band of small gut, rather bluish in colour. By palpation the swelling was found to extend upwards, pushing the transverse colon, great omentum, and stomach well up under the diaphragm. Laterally the cyst extended behind both ascending and descending portions of the colon; it was pouched in the flanks, thereby becoming trilobular, but all parts communicated freely. In the pelvis were coils of gut. The cyst wall was uniform, and by pinching it was found to be extraordinarily thin. The contents appeared to be opalescent in thin layers, white, in thicker, and a diagnosis of chylous mesenteric cyst was arrived at. A small opening was made, and four and a half pints of fluid, exactly resembling milk, was drained off. The opening was closed by ligature, the cyst wall being so thin that the finest stitch holes caused leaks. A certain quantity of fluid was left behind, probably less than a pint. The abdomen was closed. Convalescence was uneventful.