dix invaginated into the cæcum in such a way that only a very small portion of its distal extremity was visible. Its wall and the wall of the cæcum over a circular area around it were hard and indurated. The appendix except for this was apparently healthy and contained no concretion; it was removed and the abdomen closed.

After-History.—The wound was dressed and the stitches removed on September 7th, and the boy was discharged on the 21st, having had no pain since the operation.

The case is of interest in relation to (a) the mildness of the symptoms and (b) the invagination of the appendix. The boy had attacks of pain for four weeks before admission, and only on one occasion was there any discharge of blood or mucus from the bowel. The invagination was never found to reach the splenic flexure, and at the operation the swelling of the apex was not extreme, rather a hard induration than a marked congestion; there was never in fact any real strangulation. If the variety of intussusception is to be named according to the portion of gut which forms the apex of the intussusceptum, such a case must be called appendico-cæcal. There are now a sufficient number of similar cases recorded to justify their grouping as a distinct variety; their number, as far as I have been able to discover, being eight.

In none of the above 4 cases were injections given a trial, and though it is not proper to argue from one or two examples, the reasons for this course of procedure may be given. After the use of injections, however apparently successful, the complete reduction of the intussusception must remain to a certain extent in doubt. The frequency of relapse after recorded success with this treatment is evidence of this. To leave a child whose limit of endurance has been probably almost reached in this questionable condition seems to me an unsatisfactory course to pursue. The operative results in the simple easily reducible cases are now good and are gradually improving; in the cases where reduction is difficult or impossible operation is the only chance. In what cases, then, is it worth while spending valuable hours waiting to see whether the treatment by injections has been successful or not?

A CASE OF APPENDICITIS WITH ABSCESS PERFORATING INTO THE BLADDER : RECOVERY.

By A. PERCY ALLAN, M.D., B.S.LOND.
Croydon.

THE following case—from all I can gather, one of extreme rarity—is of peculiar interest owing to the complete recovery the patient made. Dr. Pye-Smith has thought a similar case, which also recovered, worthy of mention in Fagge's *Principles and Practice of Medicine*:

F. E., aged 16 years, an electric workman, I saw first on June 23rd, the day after his symptoms had begun.

History.—I learned that he had had a similar attack some seven years before, which had been diagnosed, the mother informed me, as "inflammation of the bowels."

Present Attack.—This commenced with abdominal pain, sickness, and diarrhoea. The sickness started after well-marked rigors the previous afternoon, and it had continued on and off all night. When I saw him the vomiting was frequent and the vomit thin and bile-stained.

Condition on Examination.—The abdomen was full and tender, especially in the right iliac region, where dullness was uniform and well marked. McBurney's tender point was very obvious. The temperature was 102° F.

Treatment.—The patient was given a mixture of bismuth carbonate, a dose every two hours, and as soon as possible got under the influence of opium, ext. opii. gr. j being given every 4 hours. Ice poultices were constantly applied to relieve the pain. For a week he was on small quantities of milk and somatose. In a day or two the patient was fairly comfortable, but I continued the opium as before.

After-History.—He complained of great difficulty at times in passing water. The temperature never remained high, the maximum being 103° F. on one or two occasions, but it was frequently normal or nearly so, though rising at night to 100° to 101° F. There were no more rigors, nor were there any exacerbations of pain. The dullness continued as before, being very sharply defined internally, but shading off indefinitely at the lower part. As the case developed I noted a very tender process, feeling like a mass of scybala, deep down, extending

towards the inguinal region, about an inch above Poupart's ligament, and continuous apparently with the general mass. After a week the patient's bowels were moved by an olive-oil enema, the motion being passed with a small quantity of slime and a little blood. The temperature some days afterwards being normal or but little raised, no pain being present, I gradually cut down the opium, and added small quantities of beef-tea, jelly, and custard to his milk diet. The general dullness in the iliac region gradually diminished, but the tender prolongation above mentioned still remained unaltered.

Rupture into Bladder.—On July 4th I left the case to my *locum tenens*, Dr. Sear, having drawn his attention to the tender mass. Three days after I left home the patient was seized with much pain and total inability to pass water. The tender mass had disappeared and the iliac region was more resonant. A catheter was passed and a quantity of putrid urine drawn off. A rectal examination revealed nothing. Dr. Sear called in a local consultant, and the conclusion was come to that an abscess had formed round the appendix, which, burrowing downwards and inwards, had ruptured into the bladder. They decided to drive the patient up at once to a London hospital. There, owing to some mistake, he was kept waiting three hours in the surgery, and sent home again, a distance of twelve miles. He arrived back in a very exhausted condition.

Treatment.—Dr. Sear continued to wash out the bladder daily with a solution of Sanitas for four days, until my return, and gave him a mixture containing hyoscyamus. I found the patient much altered on my return, very thin, weak, and sunken round the eyes. I continued to wash out the bladder daily, using a solution of chinosol, and gave him hexamethylene tetramine, gr. v, t. d. s. After a week the urine became less foetid, and I then washed out the bladder on alternate days. Finally the urine became quite normal, and all pain and physical signs disappeared. I got the patient up each day until July 28th, when he was again seized with rigors, and the urine became again as foul as ever. I concluded from this that the opening had temporarily closed, and that the pus had again collected.

Convalescence.—After daily washing out, I got the urine into a normal condition. His appetite was good all the time, and I kept him well fed, so that he gained strength and put on flesh. He made an uninterrupted recovery, except that two weeks after I had given up attending he developed double orchitis after a long walk which he injudiciously took. In a few days the testicular swelling went down under treatment, leaving the patient perfectly well. There have been no relapses since, nor are there signs that any mischief remains.

OPERATION FOR SEVERE HYPOSPADIAS.

By R. HAMILTON RUSSELL, F.R.C.S.ENG.,
Surgeon to the Melbourne Hospital for Sick Children.

THE operative treatment of the severer forms of hypospadias has always been a source of despair to surgeons. Various methods have been from time to time designed for the purpose of improving the lamentable condition of the unfortunate subjects who have been born with this hideous deformity; but the success that has hitherto attended all such efforts has been so meagre, and the results of operation in even the most successful cases so unsatisfactory, that it is not surprising to find many authorities holding the opinion that operation in bad perineo-scrotal hypospadias is not worth attempting. On the other hand it has been suggested that, in view of the hopelessness of providing the subject with an effective sexual organ, it would be a wise and humane proceeding to perform castration during childhood. I need make no apology, therefore, for bringing before the profession a new method of operating which appears to me to hold out a prospect of benefit such as has never been offered by any method previously devised. Let me first set forth the difficulties with which we are confronted in a case of severe hypospadias such as is depicted in Fig. 1.

While the urethra opens in the perineum at A, there is seen extending forwards from the orifice for a short distance a sulcus (A, B) lined with mucous membrane, which for convenience of description I will designate the "perineal urethra."