retention, simple in their nature and easily relieved by medical treatment, which from error in diagnosis have been aggravated to the imminent danger of the patient, by unnecessary and unsuccessful attempts to introduce an instrument into the urethra under circumstances of inflammation or spasm. These causes of retention are so frequent, that the elder Grainger was once heard to say that he had never met with a case of retention which he could not relieve by medicine. Few practitioners can go so far as this: yet, in my own practice, and in that of several medical friends with whom I have conversed, the cases of retention, requiring the catheter, have formed a very small proportion of the whole. I do not refer, of course, to cases of stricture, in which there is an evident mechanical obstruction, which must be removed by mechanical means, guided in some instances by all the resources of surgical skill; nor to cases of obviously enlarged prostate pressing mechanically on the urethra. I am thinking of those every-day cases, in which, without any apparent cause, a patient suddenly finds that he cannot micturate, and sends to the surgeon in great alarm. The use of the catheter in these cases, without any previous trial of other means of relief, is, I fear, too common a practice with young and inconsiderate practitioners, and as frequently leading to disastrous consequences, merits exposure and severe reprobation.

That the officious and indiscriminate use of the catheter in retention of urine, is not always a harmless error, will be better illustrated by the following case than by mere declamation:—

In the autumn of 1836, a neighbouring practitioner who was esteemed a skilful operator, requested me to try my hand at the introduction of a catheter in a case of extreme danger, in which, after many fruitless attempts on his part, alarming symptoms had appeared. I found a middle-aged man, with a distended bladder, and a copious infiltration of urine into the cellular tissue of the pubis, preputium, and scrotum, the two latter organs having already become extensively sphacelated. The whole of the scrotum, and the greater portion of the prepuce were perfectly black, cold, and insensible; but the pulse had considerable force. The patient had formerly been troubled with hernia, and the tumefied state of the inguinal region and scrotum was mistaken by the surgeon for a large hernial tumour; no suspicion having been entertained of the real nature of the case. I declined making any further attempt at catheterism, but advised that free incisions should be made into the tumefied cellular membrane, the skin being tense and crepitant. This was accordingly done, giving exit to a pint or more of urine, which flowed freely from each incision. A small vessel was accidentally wounded, from which lucky event the patient lost a considerable quantity of blood; the hæmorrhage yielded to slight pressure, and in half an hour or less, without any other means being used for his relief, the patient evacuated his bladder in a full stream from the urethra, to the extent of three or four pints of urine. Under subsequent medical treatment the sphacelated portions soon separated and sloughed away, and the patient recovered, not without deplorable mutilation.

It is needless to add, that a few leeches to the perineum with saline aperients, in the first instance, would have reduced the local inflammation which had caused the retention, and thus rendered surgical treatment as unnecessary as it proved to be mischievous and destructive.

Retention of urine in the female very frequently occurs from causes which seldom affect the bladder of the male subject. After difficult labours, and in some cases of hysteria, the bladder loses its contractile power, and the catheter is required. The operation is so easy that it is scarcely possible to fail in the attempt, and there is generally no objection to its performance.

It has been observed, however, and very justly, that in hysterical girls, who complain of retention of urine, it is often better to leave the bladder to its own resources than to repeat the operation every time that viscus becomes slightly distended. Both the power and the will to retain the urine are mysteriously exerted in these cases; but both will yield to the urgent distress resulting from a firm refusal to catheterize the patient. Every practitioner is familiar with these cases, and I know of no absolute rule to determine our conduct.

(To be continued.)

CASES FROM PRIVATE PRACTICE.*

By JOHN RICHARD WARDELL, M.D., Edin.

Late President of the Royal Physical and Hunterian Medical Societies, Assistant Pathologist in the Royal Infirmary, Edinburgh, &c. &c.

CASE VIII.

SUBCLAVIAN ANEURISM.

"A spontaneous aneurism," says Mr. Guthrie, "is generally slow in its growth, not, perhaps, exceeding the size of an egg in a year, and rarely that of a flattened orange." In this example was a degree of enlargement far beyond that of which Mr. Guthrie considers to be the maximum ratio of increase. In January the impulse could be felt but one-third of the extent which it could eight or nine months afterwards. In the first admeasurement from the superior pulsatory margin, passing over the tumour downwards, to the inferior pulsatory margin, $4\frac{1}{2}$ inches; horizontally, $3\frac{5}{8}$ inches; but in September the same admeasurements had increased to $12\frac{1}{4}$ inches, and $10\frac{1}{2}$ inches. The pulsatory thrill would be communicated much farther than the parietes of the aneurism extended, for it is not probable that the tumour itself would enlarge to such dimensions. The effusion and organized matter in the subcutaneous cellular tissues was the reason why the impulses could be distinctly felt so far as mentioned. The previously-named rules to be observed in diagnosis, enable us to decide the question, because the impulsion against the parietes, and the retracted impulsion, are only distinguishable when the aneurism itself is pressed upon. We know it

* Continued from page 519.

to be a law in acoustics, that sound and the vibrations of tumours are more transmissible through the medium of a solid, than a liquid, body; and thus we judge of the nature of morbid collections in the thoracic and abdominal cavities. Two or three weeks ago, when in the wards of one of the London hospitals, the visiting physician showed me a patient who had an obscure pectoral affection, and where it was very difficult to determine from what the circumscribed dulness proceeded. It was considered, and with the most probability, that the cause of this was a collection of some description of fluid, because the thrill given by the heart's action was inaudible. The sounds, on application of the stethoscope, were weak and distant, and that resistless sensation given to the fingers on percussion, indicated that a fluid, (not a solid body,) was present. In instances of hypertrophy of the heart, with large liver, the pulsations will be distinctly felt in the hypochondrio-epigastric region, dependent upon powerful and anormally-increased action of the heart being communicated through the diaphragm to the engorged hepatic viscus, and so distinctly are the pulsations transmitted, that in one case which I now well remember, two talented professors maintained very diverse opinions relative to the true nature of the disease; one contended for cardiac hypertrophy, with enlarged liver, the other for aneurism of the descending aorta.

In external aneurisms, there are differences, not only in the progress of morbid conditions of the tumour, but also in the manner in which the mortal results supervene. In the former they die gradually, by the incessant oozing of blood; in the latter, by laceration of the sac, when death momentarily ensues. The integumentary coverings of an external aneurism are too distensible to give way suddenly; as the tumour enlarges, greater pressure and distension are produced, the cutaneous and subcutaneous tissues become engorged and swollen from obstruction in the circulation. Thus inflammatory action is instituted, and at that particular part on the external surface of the tumour where there is the greatest degree of pressure, an ill-defined pointing is observed, and at the apex of this a slough is formed, on the giving way of which the blood slowly discharges, until a mortal syncope supervenes. Armstrong, it is seen, had this oozing for many hours before he sank. On reference to his case, it is stated that at one time the tumour was an irregular tri-nodulated swelling; before long one of the prominences became much larger than the others, and ultimately upon the point of it was found the fatal eschar. Internal aneurisms not having the tegumentary coverings, and thus wanting that support to the distended parietes, burst by laceration, and not by the formation of an eschar, as in Armstrong. The external coat is so put upon the stretch, that at length it divides, and death instantly ensues, as in the case of the patient in the North London Hospital, when the man died

momentarily, and on the posterior surface of the aneurism, which I personally examined, was a rent in the wall of the sac. Mr. Hodgson, when speaking on this point, says, "When the sac points externally, it rarely or never bursts by laceration, but by the extreme distension causes the integuments and investing parts to slough, and upon the separation of the eschar the blood issues from the tumour."

The treatment of this alarming affection very importantly depends upon the locality of the disease, and the more distant an aneurism is situated from the centre of the circulation, the greater are our chances of effecting a cure. In cases where operative means can be had recourse to, there are great hopes of success, but where dependence is to be placed upon medicinal measures, such measures are almost invariably impotent—are a mere nullity. Occasional blood-letting, in small quantities, but so as to avoid the occurrence of reaction,—low non-stimulating diet,—abstaining from fermented liquors,—the avoidance of every cause of vascular excitement, whether of a mental or physical description,—such medicines as lower the action of the heart, may always, with propriety, be recommended. The only hope is in the knife, and where such is impossible, vain, nearly invariably, are all essays at the cure. Pressure has been recommended, and cases have been recorded where it has absolutely succeeded, yet when we consider that such pressure is only applicable in external aneurisms, and when so situated that there is a firm basis against which the pressure can be accurately applied, without injury to the subjacent parts, where the collateral branches are sufficient to carry on the circulation requisite for nutrition; and further, that the pressure treatment is apt to produce sloughing of the integuments, and is uncertain in the results, it thus, as a means of cure, does not merit much attention. Popliteal aneurisms are, perhaps, most eligible for this method, because the pressure can be accurately adopted, the vessel is distant from the heart, and the collateral branches are sufficient to nourish the limb.

With respect to the application of a ligature, in all cases of spontaneous aneurism the vessel should be secured at some distance from the tumour, because in such, the diseased condition of the arterial tunics extends generally both above and below the actual seat of enlargement; hence, if it is not taken up where the walls of the vessel are positively healthy, instead of the fibrinous plug being formed, and the canal being rendered impervious, ulceration takes place, and secondary hæmorrhage is the result. Some authorities have recommended the ligature to be applied on the distal instead of the cardiac side, but experience, and the opinion of more recent writers, have incontestably decided in favour of the latter. In a vessel of such large calibre, and so near the heart as this was, it would have been plausible to presume, had we not been

supplied with proofs confirmative of the point, that the application of a ligature would not be attended with the same felicitous results, as in others of the arterial trunks, and the reasons for supposing so, are,—1st, because the only place at which the ligature could have been applied, with any hopes of success, would have been at the innominate artery, which vessel it was highly probable was also diseased; and again, in four cases which I find where the innominate has been tied, all the patients died; 2ndly, because the innominate artery, (supposing it to be in a state of positive health,) by being so near the heart, might, by the inflammation which would necessarily be induced, extend that inflammation to the lining membrane of the heart, and thus institute a dangerous attack of endo-carditis; and again, the powerful impetus with which a large column of blood would be propelled into the remaining portion of the innominate canal would be such as to prevent the deposition of fibrinous matter; 3rdly, two such large canals as the carotid and subclavian being cut off, would the anastomosing branches be sufficient to maintain with due nourishment, those parts which are, for a supply of blood, dependent upon those trunks?—and would not such an unequal stress being thrown upon the left side tend to engorgement in the left cerebral hemisphere? Duly weighing these conditions over, the improbabilities of cure founded on physiological and pathological reasoning, together with the results which *have* followed tying of the innominate, it was conclusive that the only recommendation to be given to the patient, (who was very desirous of an operation being performed,) was, to allow the disease to progress, and not run the imminent risk of having his life shortened still further by surgical interference. I may here mention in conclusion, that, not very long ago, M. Rossi tried the distal method, by taking up the carotid and subclavian, (for aneurism, of course, of the innominate,) but without success, as the patient died after the lapse of six days.

27, Acacia Road, Regent's Park, London.

(To be continued.)

Hospital Reports.

QUEEN'S HOSPITAL, BIRMINGHAM.

CLINICAL REPORTS OF SURGICAL CASES UNDER THE TREATMENT OF PROFESSOR SANDS COX, F.R.S., SENIOR SURGEON TO THE HOSPITAL.

Reported by PETER HINCKES BIRD, Resident Medical Officer.

CASE V.

DISLOCATION OF THE SHOULDER FORWARDS.

John Johnson, aged 35, smith, admitted July 10th, 1847, under the care of Professor Cox. He states that about a quarter of an hour ago he was heaving forwards

a heavy weight with considerable force, when he felt something "give way" at his shoulder, and immediately lost the use of his arm.

When admitted, the right shoulder appeared much flatter than that of the opposite side; the acromion process was more pointed, and the hollow below it, from the depression of the deltoid muscle, was very considerable; the head of the humerus could be seen just below the clavicle, and when the arm was rotated from the elbow, the protuberance was observed to follow the motions of the arm. The arm appeared slightly shortened; the elbow was separated from the side, and inclined a little backwards; the hand was supinated, and he could not flex his fingers; he complained of some pain, especially on moving the arm forwards; the motion of the joint was very much lessened.

About a year ago he dislocated the same shoulder. The dislocation was easily reduced in the following manner:—The bone was first dislodged by forcible extension, the scapula was well fixed with one hand, and the arm slowly raised perpendicularly by the side of the head, by the other; a peculiar noise was heard when the bone slipped into the glenoid cavity. After the reduction he expressed himself much relieved.

Ordered to use a fomentation of poppy-heads to the shoulder.

12th. Discharged.

CASE VI.

DISLOCATION OF THE SHOULDER FORWARDS.

Emma Standly, aged 20, admitted July 10th, 1847, under the care of Professor Cox. She states that about an hour ago, while haymaking, she was pushed down;* she instantly "felt something give way at the shoulder," and lost the use of her arm.

On admittance, the right shoulder was flattened, and the acromion process prominent, having a hollow space below it; the head of the humerus could be felt below the clavicle, and could be seen to follow the motions of the arm; the elbow was separated from the side, and the motion of the arm forwards caused her much pain. She complained that the fingers were numbed, and also of much pain in the shoulder.

The dislocation was easily reduced, in the same manner as in the above case.

12th. Discharged.

The shoulder-joint enjoys a greater extent and variety of motion than any other articulation of the body, and consequently, its dislocations are more frequent than those of all the other joints taken collectively; those of the ankle-joint being next in frequency. Everything seems, indeed, to facilitate the escape of the bone from its natural cavity; a shallow cavity receives a large head, and is protected only by a capsular ligament, by the subjacent muscles, and by the acromion and coracoid processes; and the bone is exposed more than all others to the effect of the force of external bodies.

The dislocation of the shoulder forwards is much less frequent than that in the axilla; and Dupuytren†

* She fell on her elbow, which was at the time placed rather backwards.

† Clin. Chir., t. iii., p. 102.