SUPRAPUBIC CYSTOSCOPY.

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I NOTICE in the EPITOME of the BRITISH MEDICAL JOURNAL, March 15th, par. 172, a report of an article by Dr. Kraske (*Centralbl. f. Chir.*, No. 6, 1902), in which he states that he has recently had two opportunities of making cystoscopic examination of the bladder through a suprapubic fistula established by ordinary high cystotomy, and that this method of examination is dignified with the term "novel." I venture to remark that I have used this manœuvre for ten years when necessary. This, however, by the way. Dr. Kraske advocates an instrument devised by himself which consists of a straight cystoscope, which is pointed at the end like a trocar and so makes its own puncture. May I draw the attention of those seriously engaged in cystoscopy to the fact that this method is open to grave objections, for it may lead to dangerous subsequent leakage of urine into the cavity of Retzius? With my own instrument, substantially the same as Dr. Kraske's, the danger of extravasation is lessened. I published this in 1894¹ after two years' trial, and described its use as follows:

Fig. 1.

'The difficulties in sounding for stone in certain cases of much enlarged or in irregularly enlarged prostate are great, for calculi are sometimes so deeply fixed behind and below an upraised median lobe or collar, that the sound introduced *per urethram* cannot reach them, however much rotated it is, or however forcibly it is thrust towards the base over the lobe. Moreover, harmful pressure is often exercised in this manœuvre upon the prostate, and cystopyelitis and haemorrhage are apt to ensue. I suggest that whenever the prostate is very large, or whenever it is difficult to traverse, or if it bleeds easily, that an aspirator trocar and cannula should be thrust suprapubically into the full cleansed bladder, the trocar replaced by a loosely-fitting blunt pilot, and the post-prostatic pouch and bladder base carefully prodded with the latter to ascertain the absence or the presence of the stone without incurring those risks which are consequent upon urethral sounding (Fig. 1). Through the same cannula a straight electric cystoscope can be introduced into the washed-out bladder, and the interior examined (Fig. 2). I advise this latter procedure only in cases of much enlarged prostate in which a suspicion of benign growth exists; for in these cases the ordinary cystoscope cannot be used. If a stone or benign growth is discovered, a director can be passed through the cannula, the latter withdrawn over the director, and the bladder opened by a limited incision on the director. The disease can then be dealt with and the bladder drained. I believe that this method of sounding and cystoscopic

Fig. 2.—Fenwick's Trocar Cystoscope.

saves exploratory suprapubic cystotomy, which is a severe procedure in old age, and one which should not be undertaken lightly." My experience of a hundred suprapubic cystotomies for all forms of bladder disease amply substantiates this latter statement.

REFERENCE.

¹ *Epitome of Modern Urinary Surgery*, p. 82.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

ACUTE ASCENDING PARALYSIS.

THE disease known as Landry's paralysis or acute ascending paralysis is so comparatively rare that scanty as the following notes are they seem worth reporting.

W. P., aged 23 years, a farmer of good physique and leading an exceptionally regular and temperate life was perfectly well on Sunday, October 20th. On the Monday he did his usual work but complained of being "out of sorts" and some time during Monday morning he vomited. He had a bad night that night; he complained of having had no sleep and that he "could not find an easy place." So far as I can learn he was never feverish and certainly had no rigor. On the Tuesday he declared himself better, but stayed all day in the house. He had a better night, and had his breakfast in bed on the Wednesday morning. He dressed about nine but complained of pain in his back and said that his feet were numb, and that he could not walk. He managed, however, to hobble with two sticks into the next room, where he sat till evening. He passed water when he dressed, but was unable to do so during the day, although he made several attempts. He made a fair tea and went to bed about six. By this time he was quite unable to walk, and was wheeled in his chair to his bedside. He had a supper of porridge about nine, but asked to be fed as he could not raise himself nor use his arms. About 10 p.m. the friends seem to have become for the first time alarmed and sent a messenger to my house some nine miles away. About this time he began to complain of shortness of breath and palpitation. The difficulty in breathing grew rapidly worse. His mind remained perfectly clear, and he frequently said, "I cannot breathe—I am dying." The messenger got to my house about midnight, but the patient died some fifteen minutes before I reached the house. When I saw him he was deeply cyanosed. Rigor mortis had not set in. Unfortunately no necropsy could be obtained. These notes are necessarily