with the exception of *m x tinct. opii* after the first dose of hamamelis. For feeding, recourse was had to nutrient enemata. There was no return of bleeding during December 16th or 17th up to midday; there was a patch of hardness in the mid-epigastric region about the size of a crown-piece, but not much tenderness.

At 1.30 p.m. on December 17th, while standing by the patient's bed I noticed her look a little more pinched about the nose, her pulse began to quicken, and she said, "I must be sick." I at once pulled away the pillows, but at the same moment she vomited some bright blood, about 4 oz. Fortunately I had warned the nurse that haemorrhage might recur, and to have some turpentine in the room; the patient was now almost unconscious; I mixed 20 minims of turpentine with a tablespoonful of water and poured it down her throat. Things looked very bad indeed, and it was obvious that the only chance of saving life was to run in some normal saline solution. Captain Power, medical officer attached to the Royal Horse Guards, came at once when sent for, and stood by the patient while I went for the solution, etc. Dr. W. B. Holderness lent me his Aveling's transfusion apparatus, and very kindly tendered his aid should we need further assistance. As the rubber of the Aveling had got hard we were obliged to improvise, so connected one of the needles to a piece of tubing and ran the solution in by means of a glass funnel.

I was not away more than 20 minutes, but during that time, twice Captain Power thought the end had come and had to raise the patient's arms to revive the circulation; the patient was alive and that was all. While I warmed the solution and coupled up the tubing Captain Power set about opening the vein. This little operation reads as though it were the simplest of tasks, but in this case it was one of no mean order as the vessels were empty and the bandage above the elbow made no alteration in the appearance of the vein; it was only by pressure on the forearm that we were able to distend it enough to make sure that we were opening the vein which looked like a strip of tendon. We ran in a quart of solution, and as we had no special means of keeping it warm and feared to delay, I am sure that towards the end the solution was not of the temperature of the body.

A pad was placed on the opening and a bandage, the patient given $\frac{1}{4}$ gr. of morphine sulphate hypodermically, drachm doses of extract of hamamelis every three hours, a little ice to suck. For the next forty-eight hours she was fed by enemata. The improvement in the pulse was marked, and it steadied. There was, of course, the usual restlessness, but the patient was quite conscious, and had a very comfortable night. After two days, as the patient disliked feeding by the bowel so much, we felt obliged to risk feeding by the mouth, otherwise she would have gone under from sheer exhaustion, and it seemed to us that it would be as well to give the gastric juice something to act on. She was given a teaspoonful of Brand's essence every three hours, and the enemata only every eight hours; the amount of food by the mouth was gradually increased, and the only medicine was the hamamelis in teaspoonful doses every three hours, and silver nitrate pill thrice daily. For the first few days she was given a small hypodermic of morphine, gr. $\frac{1}{4}$. The tenderness gradually disappeared, and, with the exception of a little flatulence, she was quite comfortable.

The wound in the vein healed without causing the slightest trouble, and there was not a trace of soreness along the course of the vessel. The patient improved steadily; when there was a feeling of fullness in the stomach the food was cut down, and a few drops of peppermint water given. The bowels were washed out by simple enemata whenever needed.

On January 4th small doses of haematogen were begun. On January 11th she was allowed to sit up for an hour. There was no return of the bleeding. The progress was steady, and on February 16th she was able to go away to the seaside.

Haematogen proved itself a very valuable preparation, as it was well borne by the stomach. The temperature was subnormal for a few days after the haemorrhage, but when it reached the normal line it remained there.

Since the above was written the husband of the patient died suddenly. She went through the shock and strain remarkably well, and there has been no return of gastric trouble. She is, of course, still very careful with her diet, and continues to take iron.

SINGLE NON-TUBERCULOUS ULCER OF THE BLADDER: SUPRAPUBIC CYSTOTOMY: CURE.

By J. B. CHRISTOPHERSON, M.A., M.D., F.R.C.S.,
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J. H., aged 49, a plumber, was admitted into the Seamen's Hospital Society's Branch Hospital, Albert Docks, on September 24th, passing his urine every half-hour.

History.—He had done only six months' work during the last two years, and this total was made up by adding together a few days at a time. He had had gout (?) twenty-eight years earlier, but gave no history of syphilis. The symptoms dated from October, 1899, when they commenced during an attack of "rheumatism," with pains in his limbs, leaving him with frequency of micturition and pain during and after urination, suprapubic and at the end of the penis; these symptoms had continued since, occasionally improving so that he could work for a few days at a time. He had been an inmate of one of the large London hospitals for two months; he had there been given cod-liver oil. He had been sent to the Royal Sea-Bathing Hospital, Margate, and had returned somewhat improved, but had relapsed.

Condition on Admission.—He weighed only 6 st. 9 lb., though of average height. His face was pale, drawn, anxious. Besides a well-marked blue line on the gums, which coincided with the history of two attacks of lead colic, and some small multiple lipomata on the forearms and thighs, there was no evidence of disease elsewhere. No tubercle could be discovered in any part of the urogenital tract or elsewhere, nor was the tubercle bacillus to be found in the urine, which was examined twice for this purpose. The urine (specific gravity 1012) was acid, cloudy, with one-eighth albumen; it contained no blood or pus. He said that he had only passed blood sufficient to colour his urine on one occasion. The urethra was found to be healthy, and no stone was discovered in his bladder. Rectal examination discovered nothing.

Diagnosis.—As there was no evidence of tubercle elsewhere, it seemed to be a case of primary tuberculous ulceration of the bladder.

Operation.—On October 1st a suprapubic cystotomy was performed. The cavity of the bladder was found to be small and the walls hypertrophied, but otherwise healthy except for a small ragged irregular ulcer with granular surface and thin edges, and about 1.9 cm. in diameter, between the two ureters on the post part of the trigone. When it was brushed over with swabs of wool wet with carbolic acid (1 in 20) the surface bled readily. There were no signs of caseation or tubercles anywhere, and the ulcer looked more like an anal ulcer than anything else. There was no sign of malignant disease; the bladder was drained suprapubically and washed out with a solution of borax and iodine for twenty-eight days.

After-History.—On December 4th he could hold his urine four or five hours, and was not disturbed during the night; the urine, specific gravity 1011, was acid, and contained a trace of albumen and a few pus cells on microscopical examination. Between the date of the operation and December 4th he gained 2st. in weight. He left the hospital apparently cured.

REMARKS BY DR. CHRISTOPHERSON.—I believe this to have been a case of a single simple ulcer of the bladder analogous to an anal ulcer, produced perhaps in much the same way, namely, by some traumatic influence, over-distension or straining to urinate, for instance, prevented from healing for similar reasons, that is, muscular action and contact with irritating material (urine). There seems to be no reason at all for the diagnosis of tubercle. It differs only from Mr. Fenwick's cases in the slight amount of haematuria and in the age (49). Simple ulcer of the bladder has not yet a recognized permanent place in textbooks; amongst the four most frequently read in London there is no mention of it in two. In one a simple "perforating" ulcer is mentioned as described by Rokitsansky. The other textbook makes the same observation. I think the case is worthy of record for this reason. This ulcer was not round, indurated, or perforating, and quite unlike a "gastric" ulcer.

REFERENCE.

1 *Ulceration of the Bladder*, Hurry Fenwick, F.R.C.S., 1900.