copious and watery, and of a light-brown colour. There was no further sickness, and the abdominal pain had almost entirely gone. She took nourishment well. The pulse was 104; the temperature 99°.

March 21st. The bowels were well opened twice to-day; the stools were normal. She was very much better in all respects, but still complained of pain in the left hypochondriac region.

March 22nd. The wound was dressed for the first time; it was looking well; the bowels had been open seven times since the previous day. She slept and took food well.

March 24th. The sutures were all removed; the wound was quite healed, except superficially, where there was a shallow raw groove. The patient slept and ate well, and was taking solid food. There was still slight pain as before.

March 26th. The wound had quite healed, and the pain had left her. The bowels were rather freely open, and she had required a little astringent medicine, but is otherwise almost well. From this date she rapidly recovered, and left for the country in April, all abdominal symptoms having disappeared, and the bowels acting regularly.

Towards the end of 1885 I again heard of this patient at University College Hospital, where she had gone on account of constipation, but the usual treatment had soon removed all her symptoms.

REMARKS.—I have thought this case worthy of publication on account of the obscure nature of the cause of the obstruction. At the time of the operation those present, as well as myself, looked upon the case as being one of volvulus at the splenic flexure or thereabouts, and on further consideration of the case I think this offers the best explanation of the symptoms. In favour of this view, I would submit the following facts for consideration: first, the sudden onset of the attack and the early occurrence of severe pain, which gradually increased, so much so that morphine had to be given hypodermically. This pain was felt most at the navel and in the left hypochondriac region, and there was also general tenderness, due to the peritonitis, which I look upon as a secondary condition. Secondly, the vomiting was not at all a marked symptom, and although it consisted later on of the contents of the small gut, it never became stercoraceous. Again, the temperature remained normal throughout, but on the second or third day after the onset of the attack, it rose once to 100°, probably owing to the peritonitis; although I am aware that too much stress must not be laid on this point, since it is well known that acute peritonitis may run its course with a normal or even subnormal temperature. The condition of the gut below and above the splenic flexure, and the result of the operation, seem to me to point very strongly to the fact that there must have been a slight twist at this point.

Mr. Treves, in his excellent work on *Intestinal Obstruction*, points out that in cases of volvulus the distension of the abdomen is a marked symptom; but in this case it did not come on until the third day, and then was not very marked, and was most perceptible at the upper part of the abdomen. At the operation I did not detect any elongation of the meso-colon, as is usually the case in volvulus; nor, according to the patient's account, had there been any previous constipation. In conclusion, it seems to me that a point of great interest in this case is the fact that the twist (as I suppose it to have been) was reduced without any trouble; indeed, one could only judge of its presence by the beneficial effects that were at once produced as the hand passed along the descending and transverse colon. I do not think that the curious assemblage of symptoms and the effects of the treatment in this case bear any other interpretation than the one I here submit.

ADENO-ENCEPHALOID CANCER OF THE BLADDER.

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(With notes of operation by Mr. C. H. MARRIOTT, F.R.C.S. Eng.)

On April 1st, 1886, Mr. T., a retired tradesman, consulted me, giving the following history:—He was 63 years of age, married, with one son; had never suffered from gonorrhœa nor syphilis. More than two years ago he noticed that he occasionally passed a drop or two of blood on completing the act of micturition, but for the last eight months he had been a martyr to precipitate urination. Every ten minutes or so he was compelled to micturate, "passing almost pure blood," the act being accompanied by the most intense suffering. The patient had a worn, haggard, and decidedly cachectic look, over and above the pallor of simple mechanical anæmia. I requested him to make water into a glass in my presence. He passed about an ounce of apparently pure blood, the whole act of micturition amount-

ing to the most intense strangury, which nearly bent the patient double. As the fluid was passed, a pale fibrinous clot immediately separated out as a solid mass and settled at the bottom of the glass. The blood was recent, and I suspected (a) an encysted calculus, (b) a tumour, malignant or non-malignant. A pill containing 3 grains of ergotin had a decided effect in lessening the hæmorrhage.

On April 8th, in company with my colleague, Mr. C. J. Bond, I sounded the patient's bladder, with a negative result so far as stone was concerned, but the following condition was easily made out: occupying the whole of the left side, and encroaching somewhat over the middle line to the right side of the trigone of the bladder, was to be felt a rugged indurated mass, evidently a sessile tumour, springing from the base of the bladder. A fragment that came away in the "eye" of the sound was examined microscopically, and the diagnosis of malignant disease arrived at. Our joint advice to the patient subsequently was that he should submit to an operation that would allow of free drainage of the bladder, and relieve him of the distressing spasm that accompanied each act of micturition.

Accordingly, having first sounded the patient's bladder and confirmed the diagnosis, Mr. Marriott, on May 3rd, performed median perineal section. Digital exploration of the bladder fully bore out the diagnosis, the tumour not only occupying the position indicated, but extending upwards on to the anterior wall, behind the pubes. Mr. Marriott then decided to remove what he could of the growth, using Sir Henry Thompson's recently devised instruments. In all, the masses removed weighed two ounces and a quarter; probably another quarter of an ounce was lost in the *débris* and blood-clots that came away. A rubber drainage-tube (quarter-inch) was passed into the bladder through the perineal opening, and kept in position by tapes. Through this, frequent irrigation with a solution of carbolic acid was ordered.

In a few days the patient became intolerant of the presence of the tube; it was constantly getting blocked with *débris*, and required frequent removal and re-insertion. A glass tube was then substituted, but with no better results.

The urine became alkaline; the tube, as well as the margins of the wound being coated with phosphates. A solution of benzoic acid was then ordered. The perineal wound closed up with remarkable rapidity, and on one occasion, the patient having removed the tube, and twenty-four hours having elapsed before I saw him again, it was with the greatest difficulty that I introduced a No. 10 soft elastic catheter into the bladder. However, he was not to be denied, and in a few days the wound had completely closed. There was a temporary lull, and then the old symptoms gradually returned, in addition to which a somewhat elongated prepuce commenced to slough in a line corresponding to the "corona penis."

[Microscopic section of a portion of the growth (hardened in Müller's fluid), stained with picro-carmin, had the characters of encephaloid cancer. This enabled me at once to give an unfavourable prognosis of the case; but being puzzled by the distinctly adenomatous type of certain portions of the sections examined, I sent a slide to Professor Greenfield, at Edinburgh, giving no particulars of the case, but asking for his independent opinion. He promptly and courteously replied as follows:

"The tumour is usually classed as encephaloid, but is of a form intermediate between malignant adenoma and encephaloid, and is not uncommon both as a primary and secondary growth in various parts."

The patient next complained of a "hard lump" at the site of the wound; this gradually increased until the whole of the perineal region was occupied by a large conical tumour, the apex of which had a gaping aspect. There was no breach of continuity, simply a stretching of the cicatricial tissue. To the outer side could be clearly seen the pale skin cicatrix; internal to this and pinker in colour, the cicatrised mucous membrane of the floor of the urethra, while beneath the latter a reddish-blue fungating mass protruded. The patient rapidly went from bad to worse, the stench of the fluid passed from the bladder was insufferable; he gradually sank, and died on August 5th.

REMARKS.—This case alone appears to me to put a limit to the range of surgical treatment of vesical tumours. Where a polypoid or pedunculated growth is diagnosed, by all means remove it; but in the case of a sessile tumour closely incorporated with the muscular walls of the bladder, the treatment best suited to the requirements of the case seems to me to be to establish and maintain free drainage and so relieve the strangury, leaving the tumour to take its own course. The instantaneous coagulation of the blood passed by the patient by the urethra may have an important significance when viewed in connection with the subject of metastasis and secondary deposits.