was stitched to the abdominal wall, a drainage-tube inserted, and dry dressing applied. For a few days the urine was black like porter, but then it cleared, the patient made a capital recovery, and remains perfectly well.

CASE OF SUPRAPUBIC LITHOTOMY IN A CHILD.

By WILLIAM SYKES, M.R.C.S., Moxborough.

As few cases of suprapubic lithotomy in private practice have been reported, I venture to send the following, declaring at the same time my opinion that, from the comparative simplicity of the operation and from the generally good results obtained, it is destined to replace the lateral operation, in the same way as it was itself replaced by the latter.

J. T., aged 9½ years, but looking not older than 6, with lateral curvature of the spine and a strumous appearance, came under my care in November, 1886. He was suffering from all the usual symptoms of stone in the bladder. The urine was loaded with pus and mucus, and the child seemed in great pain. The history of the symptoms extended over two years. On sounding, a stone was felt; indeed, the sound had some difficulty in entering the bladder, as it at once impinged on the calculus, which appeared to be fixed.

I operated on November 25th, making the incision of the length recommended by Sir H. Thompson. I found that the bladder was not sufficiently distended, and had to make my final incisions dangerously near the peritoneum. I had no difficulty in extracting the stone between my two fingers when once I had entered the bladder. There was very little hæmorrhage. I put only one suture in the upper part of the wound, and I afterwards regretted placing this one in, as it caused some dragging. The wound was dressed with lint dipped in carbolised oil, merely laid on, and frequently renewed during the first three days; afterwards only changed night and morning, and moistened externally with the oil.

For the first week the urine passed exclusively through the wound, then began to come through both the natural and artificial passages, and finally ceased to trickle from the wound about one month after the date of operation. The wound itself, however, took on the appearance of a strumous ulcer, and did not finally heal until the end of January of the present year.

The stone was phosphatic, of the dumb-bell shape, with one end much larger than the other. It appeared as though it had been tightly grasped in the middle, and the resistance to the passage of the sound gave one the same impression. It weighed, when dried, a quarter of an ounce.

REMARKS.—The only difficulty in the operation was caused by the bladder not rising sufficiently over the pubes, owing to insufficient distension. The ivory instrument recommended by Sir H. Thompson for tearing the connective tissue could have been well dispensed with, and is of an unfair cost. After enjoying fair health and entire freedom from any difficulty with the bladder until the beginning of the present month (June), the child was attacked by broncho-pneumonia, and died from that disease, having only been ill three days.

SUPPURATIVE OTITIS MEDIA: PERFORATION OF MASTOID: TREPHINING AND EXPLORATION OF THE TEMPORO-SPHENOIDAL LOBE.¹

By JAMES BLACK, M.B., F.R.C.S.

H. H., aged 22, a lamplighter, was admitted into the Bouverie Ward of the Westminster Hospital on November 30th, under the care of Dr. Allchin. The note taken by the house-physician, Dr. Scott Sanders, at the time of his admission, states that: "On November 27th, the patient shivered and felt very sick, but did not vomit. For some days he had not been feeling well, 'had a dull sort of pain in his head, and lost his appetite.' The headache became very severe, and had been getting worse ever since. From a child he had had otorrhœa, for which he could not attribute a cause; he had never had scarlet fever, small-pox, nor syphilis. There was no history of a blow on the head."

¹ Abstract of a paper read on this case before the Medical Society of London on February 25th.

On December 8th (week after admission) the thermometer registered a temperature of 104° at 4 A.M., but showed a decline to 99° four hours later; and subsequent to this similar elevations and remissions frequently occurred; for example, on December 11th, there was a rise to 104.5°, followed by a rapid fall to 99°. The next day the patient had a rigor lasting twenty minutes. On December 14th (a fortnight after admission) I was first asked to see the patient. He had then a very offensive otorrhœa from his left ear; after cleansing the external auditory meatus of pus, I detected a large perforation at the anterior part of the membrana tympani. The patient informed me that at the age of 17 he became so exceedingly annoyed by the offensive otorrhœa, that he used effectually to plug the external auditory meatus with cotton-wool, so as to prevent the escape of the fetid discharge. This was naturally followed by inflammation about the mastoid process, and a sinus eventually ensued, from which matter for a time gained exit. He never sought advice for his ailment, but there was a depressed scar left at the site of the sinus, which was tender, and which bore out the veracity of the man's statement. Taking into consideration the repeatedly occurring elevations of temperature, and the fact of there having been a well-marked rigor, I was at once convinced of the serious nature of the case, and arranged to perforate the mastoid antrum on the following day, ordering in the meantime a saturated solution of boracic acid to be injected pleasantly warm along the meatus every three or four hours.

On December 15th, at 1 P.M., the patient having been put under the influence of an anæsthetic, a crucial incision was made over the mastoid process, and the soft parts reflected down to the bone. Not being able to detect any signs of a previously existing sinus under the depressed scar, I proceeded to very cautiously perforate the bone at the spot recommended by Mr. Barker, half an inch behind and above the auditory aperture, in a direction forwards and inwards, so as to open the "antrum," and at the same time avoid wounding the lateral sinus. HgCl₂ solution (1 in 2,000) was syringed into the perforation, and as it was believed that the fluid was seen to well up in the external auditory meatus, there appeared to be no doubt that the operation had succeeded in effectually opening up a communication with the tympanic cavity. No pus, however, gained exit through the opening made, and, on December 17th, a severe rigor, lasting twenty-five minutes, occurred. I then arranged with Dr. Allchin to trephine for intracranial abscess.

On December 18th, at 11.45 A.M., having explained the nature of the operation to the patient, and obtained his consent, I had him anæsthetised with chloroform, and, under the carbolic spray, dissected back the soft parts to the mastoid foramen, as advised by Mr. Barker, for the purpose of detecting if there were any matter thus gaining exit, as might possibly occur if suppuration existed beneath the dura mater corresponding to a thromboid lateral sinus, or if the disease had extended in a backward direction sufficiently to have given rise to cerebellar abscess; but as there was no such exit of pus, I proceeded to thoroughly syringe out the external auditory meatus and the perforation in the mastoid portion of the temporal bone with boracic acid lotion, and sprinkled the parts very thoroughly with iodoform, and then made an incision upwards from the original wound, and dissected up a V-shaped flap of soft parts, including the periosteum. The bone was perfectly healthy and normal in appearance. With a trephine having a crown of the circumference of a sixpence, I carefully removed a disc of the skull an inch and a quarter above, and only slightly behind, the external auditory meatus. I chose this in preference to the spot selected by Mr. Barker, namely, an inch and a quarter above, and a like distance behind, the auditory aperture, for I found that in a skull I examined this exactly corresponded to the position of one part of the course of the lateral sinus. The posterior branch of the middle meningeal artery crossed the middle of the hole made in the skull; this I cleared by nicking the dura mater on either side of the vessel, when I was able, with a bent aneurysm-needle, to carry a ligature across beneath the artery, and tie in two places and divide between. I then reflected the dura mater, which was normal in appearance, and exposed the brain, and, with a perfectly clean aspirating syringe, pierced the cerebrum slowly in a direction downwards and inwards, until it impinged on the bone corresponding to the roof of the tympanum. On drawing up the piston, no pus appeared. So soon, therefore, as all bleeding had thoroughly stopped, I brought the edges of the wound into apposition with silver-wire sutures, and, having dredged well with iodoform, applied salicylic-wool dressing.

On December 19th the patient had a rigor lasting twenty minutes, and the temperature mounted to close upon 105°. The rigors were attended with copious sweating, and the patient was getting much emaciated; he had a dry brown fissured tongue and sordes on the lips and teeth. I now, with Dr. Allchin's concurrence, commenced to