pressing down the lever, is cut through beyond the crushed portion by a concealed blade working on hinges. The crushed portion of adhesion left behind is three-sixteenths of an inch in breadth. Some saving of time and trouble may be effected by the use of this instrument.

Tapping the Cyst.—All the trocars with which I am acquainted are liable to permit of an escape of fluid by the sides of the puncture. To obviate this, I use a forceps which, when closed, forms a hollow tube accurately fitting the simple trocar used. The trocar is plunged in, and is tilted, so that its contour bulges the cyst-wall; the forceps then grasps cyst-wall and trocar where the puncture is made. Thus about an inch of cyst-wall is firmly compressed against the trocar, and a firm grip of the tumour is got, enabling us to move it about without risk of the fluid escaping.

Rapidity of Operation.—Much of the mortality after ovariotomy is caused by shock. Most of the other death-giving factors have been overcome or made to recede; but the influence of shock remains about stationary. There can be no doubt that, over and above the mere operation, the prolonged anæsthesia must be an important contributor to the patient's collapse. In one of my cases, where the patient was taken to the operation-room, anæsthetised, and returned to bed within half an hour, the absence of anything like shock impressed me very much. The amputation of a finger might have been attended with no more immediate general disturbance. Consistently with carrying out a thoroughgoing treatment of every detail, I think we ought to be as rapid as possible. A few moments saved here and there in such a proceeding as ovariotomy will sum up to a goodly aggregate before the operation is over. And these five or ten minutes in a case which is hovering between life and death may kick the beam on the right side.

FOREIGN BODY IN THE BLADDER.

By F. SWINFORD EDWARDS, F.R.C.S.,
Assistant-Surgeon to the West London Hospital, etc.

J. L., aged 40, a labourer, was admitted into St. Peter's Hospital on November 8th, 1881. He had suffered with stricture of the urethra for six or seven years. Twelve months previously, the stricture was dilated by catheters up to No. 10 English. As his urine was continually dribbling away, and no instrument could be passed, he had sought admission into the hospital.

After hot baths and a morphia suppository, a catgut bougie, No. 2 French, was passed by our house-surgeon, Mr. Woolley. On the following day, a No. 4 French bougie was successfully introduced. On November 10th, the same bougie was again passed in the morning. Toward 7 P.M., as the patient had not been able to empty his bladder all day, the house-surgeon endeavoured to pass a catheter, but without avail —so he introduced a No. 4 pilot bougie and screwed on a catheter, which was passed on into the bladder. By this means, the patient's urine was drawn off. On withdrawing the instrument, the patient gave a violent twist, just as the junction between the pilot bougie and catheter was passing through the stricture, the effect of which was that the bougie was left behind on the proximal side of the stricture, so as to occupy the bladder and prostatic urethra; the stricture being situate in the membranous urethra. The long urethral forceps were at once passed down, but without success. As the stricture had been dilated to No. 12, and the patient was suffering no pain nor inconvenience, he was left for awhile.

Two days after this (November 12th), I saw the patient for the first time; and decided, without further delay, to divide his stricture, and, if possible, to extract the bougie from the bladder through the urethra. The patient being placed under ether, internal urethrotomy was performed by means of a Teevan-Maisonneuve urethrotome. After which, I was enabled to pass a small-sized lithotrite, by which the pilot bougie was quickly seized and removed from the bladder. The bougie, which was twelve inches long and of No. 4 French gauge, was found already to have, in places, a considerable coating of phosphates.

The after-history of this case is not in any way remarkable. The patient left the hospital a fortnight later, able to micturate freely and comfortably. He passes a No. 22 bougie occasionally.

Mr. Lund of Manchester records a case, in which, after performing Holt's operation, he removed a bougie from the bladder by means of a lithotrite. (*Liverpool and Manchester Medical and Surgical Reports*, 1873.) Also, Mr. Harrison of Liverpool, in his work on *Surgical Disorders of the Urinary Organs*, 1880, narrates a similar case, in which he extracted a pilot bougie, No. 3, by means of a lithotrite. The bougie had been introduced by a surgeon as a pilot to an urethrotome; but, becoming detached just beyond the screw, remained behind in the bladder. The surgeon ruptured the stricture by Holt's method, and left the bougie for future extraction.

These cases show how important it is to see that the connection between the pilot bougie and catheter (or whatever form of instrument is intended to be passed) is firm. Again, the guide, at its junction with the screw, needs careful inspection, as I have frequently found the gum-elastic quite rotten there, and in an unfit state to be used. The chance of this occurring is lessened by careful attention to cleansing and drying after use.

SURGICAL MEMORANDA.

SYPHILIS VERSUS CANCER.

APROPOS of cases already related in the JOURNAL, where a differential diagnosis as regards these two diseases presented some difficulty, the following case of pharyngeal disease may be of interest.

History.—A very respectable married woman, aged 50, living far out in the country, with no family, began to suffer from her throat four months previously to my seeing her; the first symptom being pricking pains like a knife running through both sides of throat. Since then, steady increase of difficulty and pain in swallowing, so that for the past month only liquid nourishment could be taken, and she was obliged to hold the fluid for some time in her mouth, and let it trickle down into the gullet by very slow degrees. Flesh and strength were reduced; she had no appetite, and was confined to bed. She had been treated in Dublin with gargle and bitter mixture without results. Pulse 120, small and thready. The attention was at once arrested, on entering her room, by the extraordinary fœtor emanating from the patient. It was of that peculiarly pungent stinking quality, characteristic of cancer in its later stages. Its sickening taint pervaded the room, and clung to the hand, despite repeated washings, after examining the diseased part.

Physical Condition.—The uvula and soft palate were unaffected on the buccal surface. The back of the pharynx was covered thickly with purulent secretion. On examination with the finger, a rugged irregular mass was felt, occupying the back and right side of the pharynx: the surface was knobbed, hard and bossy: the secretion very adherent, even after repeated douching, so that the colour of the part could not be ascertained satisfactorily. Laryngoscopic inspection was unsuccessful, owing to irritability of the throat, and constant welling of frothy fluid: the voice was unaffected. There was tenderness on pressing laterally over the transverse processes of the vertebræ, and on rotating the head, which she could not do herself; a distinct grating sensation was felt, not easily localised.

The age of the patient, the circumstances, and especially the peculiar fœtor, seemed to me to indicate cancerous disease. A gloomy prognosis was made, and palliative treatment, with iron, was adopted without benefit. Shortly afterwards, I learned from the apothecary that the patient had consulted him, two years before, for a rash over her entire body, including the face, which went away after taking medicine, which, she said, "rotted her teeth." Moreover, her husband had been treated for syphilis at some establishment a year or so before that. Acting on this information, mercurial inunction was prescribed, and in a few days, along with it, three-grain doses of iodide of potassium thrice daily in treacle, as viscid fluids were more easily swallowed. Immediate improvement took place: in a week she could eat meat, and, in a few days more, anything she liked. The fœtor and discharge rapidly and permanently disappeared; the gummatous infiltration also diminished steadily, and perfect cure resulted; leaving, however, an adherent condition of the soft palate and the wall of the pharynx, which produced considerable contraction of the naso-pharyngeal aperture, with consequent obstruction to nasal respiration. An accidental discovery saved the patient's life, as the disease was, to all appearance, advancing surely to a fatal termination.

THOMAS DRAPES, M.B., Enniscorthy.

RETENTION OF URINE.

THE following case may be of some practical interest in showing the value of opium in certain conditions of stricture. W. A., aged 50, was the subject of a tight stricture of the urethra, both in the bulbous and the prostatic portion. When I was called to him he was in great distress, not having passed his urine for about 24 hours. Knowing by experience, in his case, the inutility, if not mischief, of using a catheter, I gave him two grains of opium, ordered fomentations and gruel, and left two more grains to be given, if necessary, during the night. In the morning, I found he had passed a tolerably easy night. He had taken the second dose of opium, the spasm had subsided, and he passed his urine naturally. No other treatment was needed.

HENRY MEYMOTT, Ludlow.

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