which had been gradually increasing in severity for twenty years. There was nothing remarkable in her family history, nor had she previously had any serious illness. Her family consisted of ten children, including twins, and the youngest was 15 years of age. The patient was of a very nervous temperament, and, despite the attacks described below, had been too diffident to consult a medical man.

Symptoms.—Twenty years ago she first began to feel pain in her left loin, but attributed it to indigestion or rheumatism. This pain has gradually got worse, and is now always present to some extent. Three years ago she began to have "attacks," at first about every two or three weeks, but with increasing frequency, till when first seen fifteen months ago they came on six or seven times a week on an average. During a bad attack "the pain in the left loin becomes agonising, and shoots down the front of the abdomen to the inner side of the left thigh." She "rolls about in agony, and becomes bathed in sweat, and frequently vomits." The duration of the attacks varies, but usually they last two or three hours, and leave her very collapsed. Such was the nature of her attacks fifteen months ago. Curiously, she did not suspect renal trouble, and had never noticed her urine, but said she micturated too frequently, especially during an attack.

Condition on Examination.—Great tenderness was present below the left lower ribs posteriorly. Bimanual palpation of the kidney was difficult on account of the great rigidity of the abdominal walls, and the kidney could not be distinctly felt to be enlarged. Tenderness and rigidity were also noted along the course of the ureter. She said she had never had blood in her urine, and that walking about or riding in an omnibus did not increase the pain unless she had an attack on when she went to bed. I diagnosed an encysted renal calculus provisionally. On examining her urine the same evening, I found it neutral in reaction; a haze of albumen was also present, and microscopically a few leucocytes were seen, but no pus.

Description of Casts.—A few days later I saw her in a typical attack of colic as described above, and on examining the next specimen of urine passed, I found it slightly acid with a smoky tinge, and containing a distinct cloud of albumen and a few blood cells. The most remarkable objects, however, were a number of semitransparent mucoid strings about an inch long, and obviously derived from the ureter. She had never noticed these previously, but during the last fifteen months they have always followed a bad attack of colic. Microscopically they are hollow, elongated, cylindrical bodies of clear mucus held together by a few threads of fibrin, and contain a few small granules and the remains of a few epithelial cells, which occasionally show a transitional character. From the flimsiness of the casts it was difficult to believe they could mechanically cause any serious obstruction.

Treatment.—She was put on an alkaline mixture containing 2 grs. of potassium iodide three times a day, and at once began to improve, and soon was able to walk about, and this summer (1900) even went for a summer holiday, which she had been unable to do for three years. During her absence, however, she left off the mixture, and had several bad attacks of colic. On her return I thought I would try an acid mixture, and gave her some nitrohydrochloric acid with belladonna, but she did not improve, and I was obliged to return to the old mixture, when she again ceased to have the spasms. She has now been under observation for fifteen months, and instead of getting attacks of colic every two or three days she will go a month without a bad attack. During the spasms she gets relief from chlorodyne and belladonna draughts, and tells me that before consulting me she took large quantities of spirits during her attacks with considerable relief.

This case is paralleled by one recorded by Professor von Jaksch.[1] In his case, however, the patient had previously passed a renal calculus, and this was followed by periodical attacks of colic attended by the passage of casts of the ureter 10 cm. long. His patient was relieved by rendering the urine acid, whereas no relief followed in my case after the administration of mineral acids. Probably the iodide was the active ingredient, and produced its beneficial effects by rendering the secretion of the ureteral mucous membrane more fluid and less coagulable than before.

Von Jaksch compares the condition to Curschmann's spirals in certain forms of bronchitis, and to cases of membranous colitis in which casts of the colon are passed. Fenwick, of New Zealand,[2] has related a case in which a membranous cast of the gall bladder and duct produced attacks of biliary colic.

Besides von Jaksch's case I am unable to find further records of ureteral membranous casts. In my own case, as in von Jaksch's, I think it very probable that an encysted renal calculus may be present, and this by irritating the renal plexus produces nutritive disorders of the ureteral mucous membrane on that side. It is difficult, in view of the apparently unilateral nature of the disease and its long duration to suspect a microbic origin, at any rate without strong bacteriological evidence. The colic is probably due to irregular peristalsis of the ureter produced by the irritation of the separating casts, and not to ureteral obstruction.

In a similar case, supposing relief could not be obtained medicinally, and in view of acute pain caused by the passage of the casts, it is possble that an exploratory nephrotomy might be necessary in order to discover any possible source of irritation, such as a stone; and, failing relief from this, even nephrectomy might be necessary. Israel[3] describes a case of ureteritis attended with renal colic in which this procedure was necessary.

REFERENCES.
1 *Ziet. f. klin. Med.*, 1893. 2 Fenwick, BRITISH MEDICAL JOURNAL, vol. i., 1898. 3 Israel, *Berl. klin. Woch.*, July 3rd, 1893.

A CASE IN WHICH MOVABLE KIDNEY PRODUCED THE USUAL SYMPTOMS OF HEPATIC COLIC:

SUCCESSFULLY TREATED BY NEPHRORRHAPHY.

By MACPHERSON LAWRIE, M.D.,
Physician to the Weymouth Sanatorium; Vice-President of the British Gynæcological Society.

C. G., aged 39, a patient of Dr. Allden (Bridport), consulted me on September 26th, 1899. She had been more or less in bad health for the previous ten years. She was weak, thin, and badly nourished, and complained of severe pain, principally over the region of the gall bladder and liver. This pain was intermittent in character, but the attacks were frequent, almost daily and almost every week she was laid up and unable to perform her duties. These attacks were accompanied by sickness, nausea, and vomiting; the bowels were constipated, her complexion sallow, and she had the worn, anxious expression of chronic ill-health. She was afraid to take almost any kind of nourishment, and the slightest indiscretion was followed by renewed suffering. The attacks were usually associated with fever, and on more than one occasion there was a considerable rise of temperature.

While under my observation she developed an attack of jaundice with much pain and the other symptoms already enumerated. On examination there was great tenderness over the epigastrium but no definite swelling could be demonstrated. The right kidney was freely movable.

For a considerable length of time medical treatment had been systematically carried out, followed by more or less benefit, but she was never really well, and it was sometimes necessary to administer morphine for the relief of pain. Medicine having been of only temporary assistance, and as the state of the kidney was clear evidence of an abnormal condition, I recommended surgical interference with a view of fixing that organ in its proper position.

The operation was performed on December 10th, 1899, in the usual way by a lumbar incision, and stitching the kidney to the deep muscles of the back by means of three Chinese silk sutures. The operation gave no trouble, and was followed by a rapid recovery, and in a few weeks she went home. All the troublesome symptoms at once disappeared. She had no return of pain, sickness, fever, or jaundice. I saw her on September 27th, 1900, more than nine months afterwards, when she had gained considerably in weight, looked well and strong; in fact, I did not know her as the same woman, and she told me she could do anything and eat anything.

The interest of this case lies in the evidence it affords that the ordinary symptoms of hepatic colic may be produced by movable kidney, a fact which has not been generally recognised by most well-known authorities on the liver. In the BRITISH MEDICAL JOURNAL of last year, Dr. McLagan and Mr. Treves published a series of three similar cases, in which the evidence pointed strongly to the presence of gall stones, and where a movable kidney had been noted. In each of these cases the abdomen was opened, and closed after the gall bladder had been unsuccessfully explored for stone, and the patients were completely cured by stitching the kidney into its proper position.

THE SEX OF PATIENTS SUFFERING FROM GASTRIC ULCER.

By R. DE S. STAWELL, M.B., F.R.C.S.,
Shrewsbury.

IN connection with the letters of Drs. Saundby and Pye-Smith on this subject, may I venture to give some figures I collected a few years ago from my old hospital records?

In 7,700 *post-mortem* examinations of which full notes were preserved, I found the presence of gastric ulcer recorded in 96—55 males and 41 females. These figures are strikingly like those quoted in Dr. Pye-Smith's edition of Fagge's *Medicine*—59 males and 46 females, and Lebert's observations—57

males and 41 females, and they appear at first sight to indicate a preponderance of males. But going more closely into the matter, they proved to be misleading, for though the number of patients of each sex admitted during the corresponding period was approximately the same, 30,500 males and 30,000 females in round numbers, yet I found there were many more male bodies examined *post mortem* than female. Comparing an equal number of necropsies on each sex, and this of course is the only condition under which the sex prevalence can fairly be estimated, I found the true proportion to be five males to six females. It may be worth mentioning that during life the cases diagnosed as gastric ulcer in males compared with females during the same period were as one to four.

With regard to the figures quoted from published lists of operation cases, these surely are not entirely reliable as statistics? The diagnosis of gastric ulcer, perforated or otherwise, even by the most experienced clinicians, cannot, I think, be regarded as certain; and I believe that more cases are overlooked in males than in females, certainly with regard to perforations. In my own hospital statistics, out of 50 fatal cases of perforation (including, not unreasonably, duodenal ulcers), the male cases predominated in the proportion of 7 to 6; taking gastric ulcers alone, the ratio was 8 to 9. In the later few years 4 cases had been diagnosed and operated on, all females; yet during that time two males had actually had laparotomy performed, but below the umbilicus, and they died of acute perforation, undiscovered till *post mortem*. Such cases are not generally published, even if they are eventually detected.

The great majority of perforations in women occurring between the ages of 18 and 28, while in men there is a much more even distribution over the decades of life, makes the diagnosis easier in the case of the former. And the liability of young women to perforation is so much impressed on our minds that I believe the fact that a similar occurrence is by no means uncommon in the other sex is often lost sight of.

Can we say that even to-day, Brinton's words of 1857 do not hold good: "Nothing short of a large number of necropsies can afford any valid basis for our conclusions" on this subject?

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

THE OS TRIGONUM (BARDELEBEN) OF THE TARSUS AS A SOURCE OF ERROR IN THE INTERPRETATION OF SKIAGRAPHS.

ON several occasions recently, while examining skiagraphs of the adult foot taken transversely, I have seen the shadow of the os trigonum of Bardeleben as a separate bone immediately behind the posterior border of the astragalus. In one of these there had been a severe sprain of the ankle, and the presence of this detached shadow gave rise to the suspicion that there might have been a fracture as well. My friend, Dr. Keith, informs me that this bone is found as a separate ossification in 3 or 4 per cent. From the number of times I have seen it I should have felt inclined to put the figure higher than this, but the total of my cases is not sufficiently large to be of any value in a question of statistics.

Ordinarily speaking the os trigonum is represented by the external tubercle of the astragalus. As the posterior fasciculus of the external lateral ligament of the ankle-joint is attached to this process, there is always a possibility of its being torn from the body of the bone by a severe strain. Vollbrecht of Breslau has described two cases in which it was broken off, one by indirect violence (in a cavalry officer who fell from his horse and was dragged some little distance by his foot catching in the stirrup), the other by direct, a horse having trodden upon the inner side of the foot of a man who was lying asleep. In the former case the process was dragged off by the tension of the ligament. In the latter it was crushed off by pressure against the os calcis. In both the fragment was apparently the same size, and in both union took place. It goes without saying that in any such case, with a history of injury, it would be an exceedingly difficult matter for the surgeon to determine at the time whether the isolated shadow was due to a congenital abnormality or to a fracture.

From a medico-legal point of view the matter is of some importance. According to Beck it has already been raised in a court of law in Germany. A workman claimed and obtained damages on the ground of a severe injury to his foot (fracture of the astragalus), which incapacitated him from work. A skiagraph showed a separate piece of bone. Shortly afterwards he was seen to be walking perfectly well and carrying a heavy weight. On reinvestigation a separate os trigonum was found to be present in the other foot.

A sesamoid bone in the tendon of the flexor longus hallucis would throw a shadow in exactly the same spot, but Dr. Keith assures me that he has never seen such a thing, and that if it occurs it must be one of the rarest abnormalities.

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SEBORRHŒA TREATED BY BENZENE.

THE methods hitherto employed for the removal of the crusts of seborrhœa sicca have been either alkalies, by which the crust is more or less saponified, or more usually, oils of one sort or another whereby they are liquefied. Neither of these methods is very satisfactory. It occurred to me that as the crust is composed chiefly of fat, a solvent might act better, and benzene suggested itself. The first patient I tried it on was a young man, aged 25. He was getting very bald, and I found a thick crust of seborrhœa sicca which, he apologetically explained, he was unable to remove. I applied benzene with a shaving brush, and the whole thing disappeared in about two minutes. The benzene naturally leaves the hair and scalp very dry, and inunction must follow. For this I prescribed bay rhum and castor oil aa ʒiss, tr. canth. ʒij, aq. Coloniæ ʒss. to be used every morning, and the benzene to be repeated about once in five days. The effect upon the baldness was very satisfactory.

Its smell is the chief objection to its use, but this soon passes off, and may be partly concealed by the addition of ol. geranii ♏x ad ʒj. For mild cases, of the seborrhœa oleosa type, I combine the benzene with an equal quantity of rectified spirits. My method has the further advantage that no hairs are broken off in the removal of the crust, which is more than can be said of the plans usually adopted. I have now treated a considerable number of cases in this way, and have always experienced the same striking results that I obtained in the first case. I find no mention of this plan in the latest books on skin diseases, and therefore conclude that it is new. But even if this should prove not to be the case, it deserves to be more widely known.

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EXTRAORDINARY WEIGHT OF FŒTUS AT TERM.

As cases of newly-born infants weighing over 12 lbs. are seldom met with, I think it may be interesting to record a case in which the child weighed nearly 15 lbs.

The mother is a married woman, aged 40, of medium height, stout, and broad. The father is also of medium height, and is a labourer. The other children are not remarkable for their size, and the eldest son, who is a soldier, is only about 5 ft. 7 ins. or 5 ft. 8 ins. in height, and is quite slim. The pregnancy was the seventeenth, and the children in previous births had been large, and in the last confinement forceps were used.

I was called in on November 8th, 1900, and found the head in the first vertex position and low down. As it did not move for three hours, I applied forceps and delivered it. Needless to say, the forceps did not lock. The shoulders would not move until the anterior arm (right) had been got down. The child then stuck tightly at the hips, and could not be moved until a towel was tied round the chest and traction made through this.

The child made no effort to breathe, and was greatly cyanosed, but after artificial respiration for about a quarter of an hour, it began to breathe, but remained cyanosed, and