incision into the bowel, and removed the stone, which measured 3½ in. in circumference; stitched up the gut with Lembert sutures, tied and divided the band, and sewed up the peritoneal cavity. The patient recovered consciousness, and knew her friends, but her heart continued to fail, and she expired about 5 o'clock the following morning. Three months previously she had had a fall, injuring her right side near the liver, and suffered much pain. There was a tumour in the region of the gall bladder, which, with the pain and tenderness, passed away after a few days. It is possible that at this time the gall stone ulcerated through into the bowel.

Acton, W. JOHN GARRETT, L.S.A.

CONGENITAL STRICTURE OF THE URETHRA.

On Tuesday afternoon I was sent for by the house surgeon of the hospital to see an infant 24 hours old, who was sent in by Dr. Kent, it not having passed water since its birth. On examination the penis presented the appearance as if it had been circumcised—namely, the foreskin was very slightly developed and the meatal orifice was larger than usual. On passing a No. 1 gum-elastic catheter it came to an obstruction about 1 in. from the meatus, and after trying for a short time I came to the conclusion that I must operate. I passed a probe down as far as it would go, and cut down on the point which was made to bulge. I then tried to find an opening in the distal end of the urethra but was unable, so I carefully dissected the urethra and found it almost completely occluded for a quarter of an inch, after which I had no difficulty in getting a No. 2 into the bladder, which contained 3 or 4 ozs. of urine. I then passed a catheter through the meatus into the bladder and sewed up the urethra and skin and fixed the instrument in. The catheter was kept in for 16 hours, and the child has passed urine naturally ever since. I think the case extremely interesting, I have never seen or read of one like it. I fear the child stands a fair chance of developing a stricture again, although up to the present time it seems to have no difficulty in micturition.

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Visiting Surgeon Dover Hospital.

REPORTS
ON
MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

WESTERN INFIRMARY, GLASGOW.

CASES OF ABDOMINAL DISEASE TREATED BY OPERATION.

(Reported by J. CRAWFORD RENTON, M.D., Surgeon and Lecturer on Clinical Surgery in the Infirmary.)

CASE I. *Excision of the Caecum with Four Inches of the Ascending Colon.*—J. N., aged 48, was sent to me by Dr. Moyes suffering from a malignant tumour of the caecum, which showed itself four months after stitching of a floating kidney. The caecum and four inches of the colon were removed, and the ileum and caecum joined over a Mayo Robson bobbin; the patient progressed favourably, and remains well at the end of a year without any discomfort. The case is of some interest as a companion to Mr. Edmund Owen's two cases of the same nature. At first it seemed as if the kidney had been displaced from its moorings, but on examination under chloroform it was found fixed.

CASE II. *Distended Gall Bladder Simulating Movable Kidney.*—J. D., aged 35, was admitted with symptoms of movable kidney, and diagnosed as such by several. On examination under chloroform, the kidney was found to be in place, and the swelling proved to be a distended gall bladder, which was drained by an anterior incision, the gall bladder being stitched to the fascia. The opening closed in a month, and the patient has continued well.

CASE III. *Enterectomy for Malignant Tumour in the Sigmoid Flexure.*—R. C., aged 54, was sent to me by Dr. Syme, of Kilmalcolm, suffering from recurrent attacks of obstruction of the bowels, which, under chloroform, were found to be due to a small tumour in the sigmoid flexure. This was removed, O'Hara's forceps being used in effecting end-to-end suture. The patient progressed favourably, and has had no trouble since the operation six months ago.

CASES IV TO XVIII. *Operations for Appendicitis.*—During the last few months 14 cases of appendicitis have been operated on, with recovery in each case. Three of these were cases of burst appendix with general peritonitis, and in two the burst appendix was removed. The case in which the appendix was not removed seemed on arrival at the infirmary too ill for operation, but recovered after being in an apparently hopeless condition for twenty-four hours. Washing out the stomach and bowel seemed to assist him greatly. Five cases of local abscess were operated on, being drained with rubber tubes, either anteriorly or posteriorly, according to the situation of the abscess. One patient at the end of a month had acute intestinal obstruction due to a band round a coil of ileum, which was relieved by operation, the condition being tuberculous, as many nodules on the peritoneum showed. The other six cases were operated on in the quiescent stage, the appendix being treated by Mayo Robson's method of crushing which proved very satisfactory.

CASES XIX TO XXVI. *Seven Cases of Femoral Hernia.*—Seven cases were operated on by Roux's method, and have given such satisfactory results that it seems right to mention them; the more so, that operations for femoral hernia have not been very satisfactory. The method consists in passing a metal staple obliquely through Poupart's ligament into the pubes which remains permanently *in situ*. It is not put in tightly, but sufficiently to prevent any escape of abdominal contents.

NO. 23 STATIONARY HOSPITAL, WARMBATHS, SOUTH AFRICA.

CASE OF GANGRENOUS DYSENTERY: RECOVERY.

(Reported by JOHN EVANS, M.D., Civil Surgeon to the Hospital.)

As cases of gangrenous dysentery in which recovery takes place are rare, the following case may be of interest. G.T., an intelligence scout, aged 44, was admitted to the hospital on December 18th, 1901. He was a wiry, thin man, light haired, and had been a resident in South Africa since 1882. He gave a history of having repeatedly suffered from mild attacks of dysentery.

On admission he presented the following symptoms: His tongue was coated, his breath foul, his temperature was 102°, he was constantly passing small stools containing mucus and blood; he complained of headache, pains in his abdomen and tenesmus. I put him into bed with directions that he should use the bedpan; his diet was milk and beef-tea; I had hot fomentations applied to his abdomen, and on admission he had castor oil ℥j with laudanum ♏x followed by magnesium sulphate ℥ss every two hours. During the two following days the dysentery grew worse, the number of stools increased to thirty or more during the twenty-four hours. On the evening of December 20th, 1901, I gave him tinc. opii ℥j in ♏xx doses every two hours: this treatment had a good effect, the number of stools was reduced to eleven on the 21st, and his temperature became normal the same day. He was apparently better for two days. On the 24th at 6 p.m. I was summoned by the nursing sister in charge of the case, and found him in a state of collapse and sweating profusely. He was in great pain, his belly was tympanitic, he vomited constantly, his extremities were icy cold, he complained of cramping pains in his abdomen and of tenesmus in a marked degree when going to stool.

I gave him whisky ℥ij every two hours until ℥viij had been given. Hot fomentations were applied to his abdomen and a hot water bottle to his feet; I also gave him calomel gr. v. His stools instead of being mucoid became, as Manson so graphically describes them, "like the washing of flesh," and they stank abominably. At 8 p.m. he passed a stool nearly pure blood with a quantity of grey, stinking sloughs; at 10 p.m. a large quantity of blood with sloughs grey and black, and a large, tube-like mass. The patient became delirious, muttering to himself. He had a small running pulse; he lay on his back and his respirations were laboured; however, he still took his nourishment. I gave him an enema of salt and hot water, which relieved him greatly. He slept at intervals during the night, waking up to

stool seven times. Next day he was better; he went to stool fourteen times but did not complain of tenesmus; his stools contained mucus, and the number of sloughs were greatly diminished. I prescribed calomel gr. v morning and evening, also champagne.

During December 26th and 27th the improvement was steady, the number of stools sinking to five in the twenty-four hours, but on the 28th he had a rigor, his temperature rising to 100°, the number of sloughs increasing in his stools, and the latter increasing in number. He was very ill, growing worse, until on January 2nd, 1902, the number of stools passed was twenty-six; he, however, did not vomit. His pulse was normal, and his temperature having fallen to normal on the 29th remained so; faeculent matter was present in the stools. The treatment was calomel as before, and tinct. opii ♏x *ter die*, the diet milk (5 pints), given as hot as the patient could take it, and beef-tea 2 pints per diem.

From January 3rd, 1902, he grew steadily better, passing no mucus or blood after January 6th. He fast regained his strength, and although somewhat thin was perfectly restored to health.

REMARKS.—This patient never complained of pain in the region of his liver; that organ was not swollen during the illness nor was it enlarged, although the patient had previously had dysentery repeatedly. It would be interesting to know if he will escape liver abscess, a frequent sequela of dysentery in Africa.

KINGSTON HOSPITAL, JAMAICA.

TWO GYNAECOLOGICAL CASES.[1]

(By J. ALDRED ALLWOOD, M.B., M.S.)

CASE 1.—*Ruptured Tubal Pregnancy: Operation: Recovery.*

A YOUNG woman was brought into hospital by a man who stated that he saw her drop down in a "faint" at the market, and that he picked her up and brought her in a cab.

Condition on Admission.—Face pinched and anxious; eyes sunken; conjunctivae and mucous surfaces blanched; no pulse to be felt at the wrist; respiration sighing; extremities cold, and body covered with cold sweat. Patient very restless. Abdomen slightly distended and tender on pressure; slight dullness in both iliac fossae. A vaginal examination showed slight bleeding from the os uteri; the os being soft and patulous, and easily admitting tip of forefinger, with some bogginess in Douglas's pouch.

History.—Very little could be got from the patient, except that she had missed two periods (but did not think she was pregnant) and that she was suddenly taken with "cramp" in the abdomen and fainted.

Diagnosis.—The sudden pain in the abdomen followed by symptoms of internal haemorrhage, the history (vague though it was), the condition of the os uteri and bogginess in the pelvis pointed strongly in the direction of rupture of a tubal pregnancy.

Operation.—Two hours after rupture. Median incision in abdominal wall 2½ in. long. Peritoneal cavity contained large quantities of fluid blood and blood clot. Left Fallopian tube showed a rent about an inch long in its anterior wall, and a cavity filled with blood clot. No fetus was discovered. The tube was ligatured close to the uterus and removed.

After-Treatment.—The patient was kept warm in bed, with the foot of the bed raised on blocks, and saline enemas were administered every two or three hours during the night. She passed a restless night, but next morning was quiet, fairly strong, and said she felt quite well. Three days after operation she passed a thick fleshy cast of the uterus. Five days after operation she was able to eat solid food. She had no rise of temperature, and the wound healed by first intention.

REMARKS.—Ectopic pregnancies are not uncommon in Jamaica. I have seen 8 cases during the last three years. Three ruptured between the second and third months; four went on to full term after rupture and one was discovered at the necropsy. Six were operated on—four through the abdomen and two through the vagina. Two of the abdominal cases died.

[1] Communicated to the Jamaica Branch of the British Medical Association.

CASE 2.—*An Extraordinary Displacement of the Gravid Uterus.*

History.—The patient, a young primipara, stated that she was straining at stool when she felt her "body come down."

State on Examination.—There was a large perineal tumour over which the perineal skin was tightly stretched like a thin membrane. The vulva was oedematous and the cervix uteri—also oedematous—was protruded through the lower part while the upper part was occupied by a prolapsed portion of bladder. There was prolapse of the rectum and the anus was widely distended by the fundus uteri which, covered by the anterior wall of rectum, protruded through it. The uterus had therefore prolapsed and, describing more than a quarter of a circle, occupied a horizontal position parallel with the plane of the perineum.

Operation.—The patient was chloroformed and the uterus replaced with great difficulty the hand having to, pass up into the rectum to carry the fundus uteri over the sacral promontory. In order to keep it in place the vagina and rectum had to be packed with lint and the legs tied together. When reduction was effected it was found that she was about four months pregnant. She did not abort.

REMARKS.—The interest in this case seems to me to lie as much in the small amount of force necessary to produce such a dramatic condition as in the condition itself.

NO. 34 STATIONARY HOSPITAL, LADYBRAND, O.R.C.

A CASE OF MOIST GANGRENE FOLLOWING GUNSHOT WOUND OF FOREARM: AMPUTATION.

(By Captain G. H. GODDARD, R.A.M.C.)

[Communicated by the DIRECTOR-GENERAL, A.M.S.]

ON October 4th, 1901, the Burgher-Commandant of the Ladybrand district sent into the town of Ladybrand asking for medical assistance for a wounded member of his commando.

On the following day I saw the patient, P. du P., in the laager. Five days previously he had been wounded near Winburg in the forearm by a small-bore bullet from one of our rifles (Lee-Metford). The bullet had entered the anterior surface of the forearm near the inner border and about the middle third, and after producing a compound comminuted fracture of the ulna, had been retained in the extensor muscles on the posterior aspect of the limb.

From the outset no attempt to remove the bullet or to dress the wound antiseptically had been made; the only covering for the arm was a large wet and dirty rag which the women of the laager had applied, and which they were constantly moistening with dirty water from a neighbouring spruit.

Removal of the rag disclosed a swollen, greenish-black, emphysematous limb from finger tips to well above the elbow. It was cold and smelt offensively. The tissues from above the elbow to the clavicle were, in varying degree, from bluish-purple below to erythematous pink in colour above. The skin over the shoulder-joint pitted on pressure, and the usual signs of constitutional absorption of toxic material were present.

My advice—immediate removal to hospital—being taken, I amputated the arm below the deltoid insertion, leaving the flaps without sutures. On the third day after operation right-sided dry pleurisy set in. This having cleared up, and the oedema and redness of the skin flaps having subsided, on the eighteenth day a secondary operation was performed in order to obtain a better stump. Healing by first intention followed, but phlebitis of the left posterior tibial veins set in, followed by extensive abscesses of the calf. However, on April 3rd, 1902, the patient was transferred to the base in a fairly healthy condition.

As I have neither read of nor seen a similar case on our side during the course of this campaign, I should imagine moist gangrene following gunshot wounds to be a somewhat rare event in this period of field dressings and prompt attention to the wounded by modern surgical methods. For this reason I bring to notice the facts of this case, in the treatment of which I have to thank Lieutenant Purser, R.A.M.C., and Dr. C. M. Carter for their help and advice.

IT has been decided that poisonous pigments such as white lead or green paints containing arsenic should no longer be used in the French navy.