ing pus of a very fetid nature; and he gradually sank on the twelfth day after his admission.

At the *post mortem* examination, besides the slough in the superficial parts visible during life, we found a sloughing condition of the whole length of the urethra, which was black throughout.

This was clearly one of the cases where abscess formed outside the urethra behind the stricture, in consequence of great irritation produced by the patient's mode of life, and where the canal gave way suddenly and extravasation followed.

CASE CXXI. W. C., aged 49, the subject of an old stricture, which had undergone various treatment, found that the difficulty of passing water increased suddenly, and soon afterwards he noticed that the scrotum began to swell. This was followed by pain, shivering, swelling of the penis and perineum; and in this condition he was admitted under my care. I opened the perineum and scrotum very freely, and also the penis, on which a spreading black patch had formed. His pulse kept tolerably good, but the local condition did not mend, although the slough on the penis did not extend much. He gradually sank, and died on the twentieth day after his admission.

Nothing worthy of any special notice, besides the local damage, was found at the *post mortem* examination.

REMARKS. As some operative measures were requisite in the management of these cases of extravasation of urine, I thought it fair to introduce them here, although they would hardly be included in a systematic work on operative surgery. The results were as good as usual in such very severe and generally unsatisfactory cases, for six recovered out of ten. There are few professional emergencies which we have to deal with requiring more skill and patience and surgical courage, than these wretched accidents of urinary infiltration; occurring, as they generally do, in men of broken down health and dissipated habits, in whom an ordinary cutting operation would very probably prove fatal. This accident, I suppose, is in these days almost unknown in the middle and upper classes of society; but, as the foregoing list will prove, among the lower classes in large cities they are not very rare.

In performing the necessary operations in these cases, the free incisions should be made *before* the attempt to introduce the catheter, for the urine and serum, and pus if it is present, soon leak out of the tissues, and the tension is taken away from the urethra immediately, and the catheter is more likely to pass readily into the bladder. I have on more than one occasion been able to pass an instrument after the perineum has been opened, having failed immediately before.

In each of the successful cases, the patient was able to make water much more freely than before; in other language, the extravasation of urine was the perilous and complex method in which nature attempted to cure the stricture and the retention; the narrowed urethra sloughs, and a better one is made, provided the patient has strength to undergo the process and to survive it.

Hæmorrhage from the Urethra. I have had under my care two cases of severe hæmorrhage from the urethra; and as they are productive of considerable anxiety to the surgeon, and much alarm to the patient and his friends, I will describe them here, without numbering them among the cases of operation, with which they cannot be classed.

The first was aged 44, and the hæmorrhage came on suddenly four days after a catheter had been passed. He was brought to the Infirmary after he had lost a considerable quantity of blood, and had tried various means to stop the bleeding. A full sized catheter was introduced, and kept for some time (a quarter of an hour) in the urethra, and the bleeding ceased entirely.

The second occurred in a young man in whom I had passed a catheter (No. 8) twenty-four hours before at my house, and he had walked home easily; no mark of blood having appeared at the time the instrument was used. I received an urgent message to go to see him, and found him faint and pale, sitting in despair, with his drawers and trousers saturated with blood, which had commenced to flow without any pain or exertion on his part. After getting rid of all his incumbrances, I rolled up a hard pad, and put him to sit with his bulb pressing upon it, for I knew that the stricture was there; and I gave him half-drachm doses of turpentine every two hours, and he had no further bleeding.

The blood in these cases came on some time after the use of the instrument, namely, four days and one day, and is therefore likely to be more obstinate than when it occurs at

the time. Ulceration in the mucous membrane and an aperture into the vascular part of the spongy body are the pathological conditions giving rise to the symptoms.

My two cases illustrate well the effect of pressure applied internally and externally, and I believe that by one or other or both of these methods hæmorrhage may be checked readily; and I may add, that turpentine is the best styptic; so much so, that in a case where an operation was called for and loss of blood to be avoided, I should like to give my patient half an ounce of turpentine about half an hour previously; but this I have not yet had occasion to do.

[To be continued.]

EXCERPTS FROM DAILY PRACTICE.

By T. HERBERT BARKER, M.D.Lond., F.R.C.S.,
President of the South-Midland Branch.

III.—*Case of Extensive Pelvic Abscess. Fluctuation felt first in the Right Lumbar Region, afterwards in the Right Iliac Fossa, and in the Upper and Inner Region of the Thigh. Splashing and Tympanitic Sounds. Difference of opinion on Treatment. Spontaneous Discharge of Fetid Pus. Recovery. Remarks. Diagnosis. Inflammation of the Cecum. Abscess of the Kidney. Abdominal Parietal Abscess. Subperitoneal Abscess. Postfacial Iliac Abscess. Psoas Abscess. Diagnosis of Psoas Abscess not always easy. Whence came the Air? Treatment. Dr. Gordon Buck's Plan of Opening Iliac Abscess. Prognosis.*

ON April 17th, 1857, I was requested to see a gentleman, a member of the medical profession, who was said to be very ill from some internal injury. I gleaned the following history of the case: namely, that for some time he had complained of pain, which at first was confined to the loins, and was not severe, but became gradually more so, and extended to the right iliac region. About three weeks before my visit, the pain had become so severe as to prevent the possibility of his dressing. At first he considered it to be of a rheumatic character, and took aperients freely, but without relief; he then called a neighbouring practitioner to his assistance. His friend, suspecting some fecal accumulation within the cæcum, prescribed the compound decoction of aloes; and believing that there was inflammatory mischief about the cæcum, ordered the application of leeches. The pain still continued, and every attempt to move was accompanied with the most excruciating pain in the right iliac and lumbar regions. He became rapidly much weaker; and pain of a "scalding" "burning" character came on in the front and inner side of the thigh, extending nearly to the knee. Along the crest of the ilium, there was considerable tenderness on pressure; and some slight œdema was present in the neighbourhood. Blisters were applied extensively and frequently. The bowels were freely acted on by aloetic purgatives, and some scybala passed. No relief followed; and he was put under a course of calomel and opium to slight ptialism.

This was the state of things up to the time of my first visit, on the 17th of April. Our patient was 52 years old, usually of spare habit of body, but now wretchedly reduced. He complained severely of the "burning" pain in the thigh as far as to the knee. His pulse was 95; his tongue was moist and clean; his countenance was somewhat anxious; the bowels were regular; but sleep was very deficient. The thigh was kept in a flexed position, and any attempt to extend it was accompanied with severe pain. On careful examination, I thought I could detect deep fluctuation in the right lumbar region, immediately above the crest of the ilium posteriorly; but it was evident, that as yet the matter was deeply seated. Pressure here increased the pain down the thigh. We agreed upon the constant application of the spongio-piline to the back; on the administration of a generous, nutritious, but unstimulating diet, and a morphia draught each night; and enjoined the strictest rest.

On April 23rd, our patient was still weaker, and suffering much pain when not under the influence of morphia. The fluctuation had become more distinct in the lumbar region, and the fluid was evidently somewhat nearer the surface. Deep in the right iliac fossa, I could detect a circumscribed swelling, and fluctuation. On placing the left hand firmly over the lumbar region, and pressing the deep iliac swelling with the fingers of the right hand, the fluctuation could be distinctly

felt by the former. Spongio-piline was directed to be applied to the iliac region as well as to the loin.

In three days I examined him again. The swelling in the iliac region was found to be still larger and nearer the surface. There was, too, an appearance of slight oedema in the upper and inner part of the thigh. The fluctuation in the back was much more distinct, and diffused over a greater extent of surface. The pain in the thigh was still severe, but the morphia had the happiest effect in lulling it.

On May 1st, the lumbar and iliac tumefaction had increased in size. The swelling in the upper and inner part of the thigh was also more marked; but I could not detect fluctuation there. The abdominal wall in the iliac region was distinct from the cyst, and could be pinched up and separated from it. Our patient was not suffering much pain when under the influence of morphia. He had become extremely weak and reduced to a mere skeleton; the feet and legs were oedematous. We feared that he would rapidly sink, whenever and however this large collection of fluid should be discharged. It was a subject of grave discussion whether we should evacuate the fluid or not; and we decided yet to wait some time longer. Not only did we dread the speedy effects of opening so large a collection of pus; but it was not evident to us where we should open it, if we were inclined to do so. In the back it was, in our opinion, still too deep to warrant an incision; and in the iliac region, the cyst had not yet contracted adhesion to the abdominal parietes.

At my visit on the 5th, the iliac swelling was not quite so prominent. For the first time I detected a splashing sound on smartly jerking the swelling; and this sound could at will be made evident to the by-standers. Fluctuation was now evident at the upper and inner part of the thigh, and percussion here brought out a distinctly tympanitic sound. The swelling in the thigh had a direct communication with that in the lumbar region; on placing a hand over each swelling, smart pressure by one gave a distinct sense of fluctuation to the other. For a few days there had been a tympanitic condition of the abdomen; and on his own responsibility, the patient took a brisk aperient, which acted freely. The day before my visit, immediately after the bowels had been acted upon, he complained of severe "burning" pain in the abdomen, which came on suddenly, and continued for a few hours. He had latterly taken but little nourishment; the pulse had been generally over 120, and very feeble.

His danger was now most imminent; and we keenly felt our responsibility. We had determined not to incur the risk of opening the abscess, but wished to have our decision strengthened; consequently, on May 11th, I took with me an old friend and fellow-practitioner, whose soundness of judgment I greatly respected. It was arranged that he should examine the patient, and give his opinion, without knowing our previous decision. He recommended a free deep incision in the lumbar region. This greatly increased our anxiety, and we determined to ask the attendance, on the following day, of an eminent surgeon in a neighbouring county. It was also arranged that he should examine the patient alone, and give us his opinion without a word from us on the point at issue. He was most decidedly averse to any operative interference. He considered that the chance for our poor patient was but slender, and that it would be materially lessened by opening the abscess. He exhorted us to persevere with the most concentrated forms of nourishment which could be introduced into the system. We determined to act upon this advice and to prepare for the worst.

The report from day to day was of very similar import. The spongio-piline was most assiduously applied night and day. It became probable that the matter would point in the iliac region, and on the 27th the integuments gave way in two places, about an inch internally to the anterior superior spinous process of the ilium, followed by a large quantity of thick, foetid, brown-coloured pus.

On the following day I saw the patient. The larger opening was half an inch in diameter, the other one about half that size. They were both discharging freely. The ordinary probe of a dressing-case, very gently introduced, met with no resistance in any direction, save in the direction of the ilium, and no part of that bone could be found to be denuded of periosteum. The swelling in the thigh had entirely gone down. His exhaustion was extreme. The pulse was 135; he had no sickness. He was ordered to take wine and strong soups as freely as possible. The morphia was directed to be given in diminished doses more frequently. Linseed-meal poultices were substituted for the spongio-piline. For two weeks from this date, his position was most critical; the discharge was

profuse, and the debility excessive, the pulse ranging from 120 to 140, and thready. An immense quantity of highly concentrated nourishment was administered and borne well.

At my visit on the 18th of June, I noticed, for the first time, an improvement in the pulse. It was below 120, and had more force. The openings showed some disposition to granulate; and the discharge was gradually diminishing. By the beginning of August the openings had quite healed, and after this he steadily improved. For a few months there was some contraction of the thigh, and inability to straighten it. This inconvenience was gradually overcome; and he was afterwards able to ride long journeys on horseback, as well as before. He has ever since had numbness down the front of the thigh.

REMARKS. There are some points in this case worthy of special remark. With regard to the diagnosis, at first, the case had the appearance of lumbar abscess; and at another stage of its progress it might have been mistaken for psoas abscess. The fluctuation at first was the most distinct in the lumbar region; and the pain all along was more severe in the iliac region and in the thigh than in the back. The absence of fixed pain in the cæcum, and of severe paroxysms of pain shooting in various directions over the abdomen, as well as of diarrhoea and vomiting, will, I think, satisfactorily disconnect this case from inflammation of the cæcum. If the kidney had been involved, we should have had more decided renal symptoms. There would have been more distinct pain in the lumbar region, and some disturbance of the urinary functions. Nor was there reason for supposing that the pus proceeded from any more distant part, although sometimes the contents of an abscess will travel great distances, and show themselves in parts of the body where they are the least expected. A striking and unusual illustration of this came under my notice some time ago. I was consulted in a case in which pus had escaped from the left side of the chest, between the ninth and tenth ribs, had travelled between the internal and external oblique muscles in the abdominal parietes, and had pointed and escaped beneath the umbilicus on the right side. This state of things was revealed by *post mortem* examination. Iliac abscess would be distinguished from abscess of the abdominal walls by the fact that in the early stages of iliac abscess the abdominal walls are freely movable over the tumour; whereas, in abscess involving the abdominal parietes, the tumour moves with the abdominal walls. It must be difficult, if at all possible, to diagnose an abscess between the peritoneum and the iliac fascia (subperitoneal abscess), and between the fascia iliaca and the iliacus internus muscle (postfascial abscess), and Dr. De Saussure gives no diagnostic points (*Ranking's Half-Yearly Abstract*, vol. x, p. 108).

The case which has been recited more nearly resembled psoas abscess than any other, especially after the swelling beneath Poupert's ligament made its appearance. The pain in the thigh and its flexed condition upon the pelvis, the inability to extend the limb with the pain accompanying this attempt, bore a strong resemblance to the symptoms of psoas abscess. The iliac swelling was deep, too, in the direction of the psoas muscle, and appeared to be travelling in the direction of that muscle towards its insertion. From the first, and throughout, however, there was an absence of that peculiar pain in the back which is so characteristic of psoas abscess, and of its most frequent origin in vertebral mischief.

It must be confessed, however, that these are nice points of diagnosis, and that this is not so easy in all cases as is generally made out. With regard to iliac abscess, Stanley remarks, that "the difficulty of extending the thigh, so constant in psoas abscess, is absent" (cited by Druitt in his *Surgeon's Vade-Mecum*, 6th edit. p. 330); but here it was a prominent symptom, and persistent throughout. Grisolle maintains that the diagnosis of iliac abscess is easy, and refers to the absence of weakness of the loins, difficulty in walking, and inability to extend the leg, which are characteristic of psoas abscess; and to the fact that in iliac abscess the first symptoms are referred to the groin, and a tumour is perceptible there long before the pain in that region, and the difficulty in walking become marked (*Phlegmon des Fosses Iliques*, in *Archiv. Gén.*, 3rd sér., vol. iv). Dr. De Saussure observes, that the diagnosis is not so easy; and refers to the fact that Velpeau was deceived in one case, and actually mistook an idiopathic iliac abscess for a psoas abscess. He also gives a case of psoas abscess in which the symptoms were remarkably similar to the cases of iliac abscess which he has recorded, and to the one which has called forth these remarks (*Ranking's Half-Yearly Abstract*, vol. x, p. 108). He further remarks that, in cases of this kind, the fact of the

tumour in the iliac fossa, over which the abdominal walls can be freely moved, at once establishes the true nature of the affection; but when the inflammation and swelling have extended to the abdominal walls, it becomes doubtful whether the disease is simple abscess of the iliac fossa, or whether the suppurative is the result of caries and necrosis of the bodies of the lumbar vertebrae (*Charlestown Med. Journ.*, No. vi, 1848: Ranking's *Half-Yearly Abstract*, vol. x, p. 106). Some excellent remarks on the diagnosis of pelvic abscess were given by Mr. Erichsen in a clinical lecture, delivered at the University College Hospital (*Medical Times and Gazette*, Nov. 3, 1860, p. 484.)

One circumstance was somewhat puzzling. Whence came the air, which had evidently gained access to the cavity of the abscess before my visit, on the 5th of May? The splashing sound on succussion was most marked, and the foetid condition of the pus, when it was discharged, indicated the contact of air. It was our impression that, when our patient felt the 'burning' sensation over the abdomen at stool, the abscess burst into some part of the track of intestine. We had not then an opportunity of examining what passed the bowels, and afterwards saw nothing like purulent fluid with the faeces, although careful examination was made for some time. Nevertheless, we thought it probable that a portion of the contents had escaped into the intestine, which produced the comparative flaccidity of the swelling, and led to the subsequent admixture of air with the pus. Copland cites cases in which abscess had burst into the intestine, and pointed, at the same time or soon afterwards, externally (*Diet. Pract. Med.*, Art. *Cæcum*).

The treatment of the case claims a few observations. Valuable as must be regarded the surgical axiom, that the sooner an abscess, especially if beneath a fascial membrane, is opened the better; there are cases where this axiom cannot early be acted upon, and I believe that this case was one of them. Until the collection had contracted some adhesion to the abdominal walls in the iliac region, it would be difficult to decide upon the correct spot for introducing a bistoury. The depth at which the fluctuation could be felt in the lumbar region would preclude the choice of that spot; and the fear of involving the peritoneum would deter one from plunging a bistoury into the tumour in the iliac region, if the walls of the abdomen could be loosely pinched over it in that direction. In this case, too, the laxness of the swelling caused by the probable escape of a portion of its contents into some part of the intestinal canal, diminished the urgency of opening it, at the same time that it rendered it more difficult to fix upon a spot for opening it, until it had shown some disposition to point. Perhaps the safest and most practicable mode of opening it would have been the plan recommended by Abernethy in chronic abscess; to have made an opening in the most depending part of the swelling below Poupart's ligament, and gradually to have discharged the contents at intervals, as it could have been borne by the patient. We decided upon not doing this; in the first place, because it was not clear that the abscess showed any disposition to point in this direction; and in the second place, and for the same reason which would apply with equal force to opening it in any direction, the effects of the discharge were specially to be dreaded however and wherever brought about. The constitutional disturbance was so extreme that we feared that the vital powers would give way upon the establishment of this extensive drain, and that the patient's only chance consisted in gaining time, and in fortifying the system to the utmost possible extent. The fortunate result of leaving to nature the choice of the spot for emptying the contents of the abscess, I think, amply justifies the course which was pursued. An earlier indication of this spot by adhesion to the cutaneous tissues, and the appearance of an incipient redness of the skin, would perhaps have justified the use of the bistoury; but under no other circumstance can I come to the conclusion that we should have given the patient a better chance of recovery by opening the abscess. As to the possibility of producing resolution of the inflammation and preventing suppuration, it is obvious that means to bring about this effect can only be resorted to in the earlier stages of the case. I was recently consulted in two cases where there was every threatening of abscess in the iliac region; and in one case, indeed, we could distinctly feel deep fluctuation. We decided to push on vigorously with those measures, both local and constitutional, which were most likely to produce resolution and absorption; and we did so with the most marked success.

Before concluding these remarks, I would allude to a plan of opening abscess in the iliac fossa, first proposed by Dr. Gurdon Buck of New York, and suggested by a

careful study of the surgical anatomy of the parts involved. It has been very successful. The following is the mode of proceeding in one of his seven cases, as related by Dr. Buck: "An incision, one inch in length, was made at a finger's breadth below the middle of the outer half of Poupart's ligament, through the skin, subcutaneous tissue, and fascia lata; a probe was then passed deeply upward and backward, and, on being withdrawn, was followed by an escape of pus; whereupon the track of the probe was enlarged, and a free outlet afforded for the contents of the abscess, with evident relief to the patient." (*New York Journ. of Med.*, March 1857: Ranking's *Half-Yearly Abstract*, vol. xxviii, 1858, p. 229). The advantages of this operation are, that it gives the most dependent outlet for the matter, and it is not likely to involve the peritoneum or important blood-vessels. I should certainly not hesitate to adopt it in a suitable case. Compared with psoas abscess, the prognosis of iliac abscess would probably be pronounced to be favourable; yet Grisolle (*op. cit.*) shows that it is sufficiently dangerous. He says, that of seventy-three cases twenty were fatal and eleven serious. There can be no doubt of the serious, and fortunately not fatal, nature of the case above recited.

REMARKS ON OBSTRUCTION OF THE BOWELS: WITH CASES.

By EDWARD COPEMAN, M.D., M.R.C.P., F.R.C.S., Physician to the Norfolk and Norwich Hospital.

[Continued from page 937.]

CASE III. *Fatal Obstruction from Constriction of the Colon.* Master —, aged 14, had an attack of peritonitis about a year ago, and a second a few months since, from which he appeared to have quite recovered. About a week ago, whilst at school, he was much distressed from want of relief in the bowels, but his master refused him leave to go to the water-closet; and when he got home he complained of pain in the abdomen: the bowels then acted imperfectly with great effort, and afterwards refused to act at all. When I saw him on the evening of December 22nd, he was breathing rapidly, vomiting frequently, and had a pulse beating 140 or more in a minute. He had been carefully treated by the same medical man who had attended him on former occasions, who told me he had been suffering considerably from pain in the abdomen which had ceased suddenly. The abdomen was tympanitic, and it was evident that he was rapidly sinking from fatal abdominal mischief. He died early the following morning. On examination after death, four or five inches of the colon were found twisted like a cork-screw, and crossed here and there by several strong bands of lymph, forming a sort of network over the bowel. These bands were very firm, and the result, no doubt, of former inflammation. There were also marks of severe recent peritonitis, with sero-purulent effusion into the abdomen.

This case is instructive, inasmuch as it proves that peritoneal inflammation is, at all events, one of the causes, if not the only one, of the formation of those membranous bands which are so often found entangling some portion of the intestines, and producing internal strangulation at some future time. It also points out the danger of neglecting the calls of nature, and the inexcusable conduct of those schoolmasters who refuse the temporary absence of a boy from the schoolroom for a necessity that has no law. I believe this refusal is often made a rule, probably on account of suspected idleness on the part of the scholar; but surely the occurrence of one such case as this, where undoubtedly the inability to attend to the call for relief was the starting point of the fatal attack, should induce every conductor of a school to submit to the possibility of being deceived, rather than run the risk of refusing a boy the opportunity of going to the water-closet when he really has occasion to do so.

CASE IV. *Fatal Peritonitis, probably from Internal Strangulation.* I was summoned, in consultation, to Mrs. B., about 60 years of age, who was attacked last Monday (this being Sunday) with severe pain in the abdomen and sickness. She had taken aperients the day before, which had acted freely; but she was habitually subject to constipation, and years ago had suffered from inflammatory attacks in the abdomen. During the past week she has laboured under acute peritonitis, and been treated with leeching, calomel and opium, fomentations, injections, etc., but the bowels would not act, and her medical attendant considered that internal strangulation of some kind had taken place. No tumour could be discovered in any of the usual