injection was an immediate improvement of the pulse-rate and the deep and superficial sutures. A noticeable effect of the spinal anaesthetic was then trimmed and the laparotomy wound closed by a post-mortem examination was not obtained. 

The recovery was uneventful and the stitches were removed from a perfectly healed wound on the tenth day. The bowels were opened, and the patient was an undersized weakly infant, and at the end of a fortnight was sent home with a cessation of retching and vomiting.

Unfortunately this was not the case, and he died a fortnight later, the cause of death being certified as marasmus. A post-mortem examination was not obtained.

The patient, aged 31 years, was sent to me on Dec. 9th, 1909, by Mr. C. A. James, of Stamford-hill, and Mr. E. J. Jobson, the surgeon to the hospital. For 11 years she had suffered from attacks of vertigo. Their onset was sudden, with a feeling of falling, in which direction she could not say, nor could she determine the direction of the horizontal movement which was apparent in surrounding objects. They were frequently followed by vertigo lasting for hours, often prolonged. Her last attack had been on Dec. 7th, when she had awakened suddenly at 3 A.M., with a sensation of giddiness, got out of bed, fell, vomited, and was incapacitated by vertigo and sickness until 5 P.M. Occasionally slight hissing or buzzing tinnitus occurred and was worse during the vertigo, but these noises were by no means always present. The frequency of the vertigo attacks varied; she had passed three years and nine months without one of any severity, but they had of late become more frequent and more severe, and, during the summer of 1910, she had four bad attacks in ten days.

The patient was a hard worker, abstemious, and, apart from her vertigo, in good health. She began, however, to be in constant dread of the attacks, fearing lest she should fall into the fire or sustain other serious injury during their occurrence. Her appetite was not good, but she had no dyspeptic symptoms and never vomited save during an attack of giddiness. A general examination revealed no physical signs.

The patient was deaf on the right side, and she stated that she had discharge from that ear for 18 months after an attack of diphtheria at 10 years of age. On examination the lower half of the inferior segment of the right tympanic membrane was thickened and opaque. The remainder of the membrane was thin and放眼, especially in the superior posterior quadrant, which appeared to be adherent to the head of the stapes. The left membrane showed inferior thickening. There was nothing noteworthy to be seen in the nose and throat.

Caloric tests were postponed, as the patient was some way from home and did not wish to risk the possible induction of an attack of vertigo. She showed slight horizontal nystagmus on lateral deviation to either side, equal, and probably physiological. Romberg's test showed a tendency to sway towards the right.

Functional tests gave the following results:—

1. Q. Do you have attacks of giddiness such as you used to experience on the road while travelling on the South London Omnibus?—A. Occasionally.

2. Q. Have you any noises in the ear operated upon?—A. Occasionally.

3. Q. What is the state of your health generally?—A. Excellent.

4. Q. Have you any attacks of vomiting?—A. None, and never felt the slightest whatever.

5. Q. Have you still a tendency to lean towards the right side while walking?—A. Yes, but it is getting less.

6. Q. Have you any difficulty in walking straight?—A. I am afraid that I have. I feel as if I am going to stumble, and after retiring to bed quite well, I was woke up by being sick, but felt no giddiness whatever. I, however, have a tendency to fall, or rather to sway towards the right.

7. Q. Do you have any attacks of giddiness when the room is lighted?—A. No.

8. Q. Can you walk straight when you are in the dark?—A. Yes; I seem to get a very unpleasant sensation when in the dark; seems to lose control of myself; afraid to venture further on; cannot imagine a clear space before me, although I may be certain in myself that the way is clear.

I think, from these replies, that the case may be regarded as a success. The patient is able to live in comfort and go out alone. She has improved immensely since the mastoid operation was performed; the spine of Henle was well marked, the mastoid being of the infantile type. The antrum was reached quickly, and was found to be of about the size of a split pea. The bridge was removed, leaving the cavity membranous; there was no pus in the mastoid, and the incus through the antrum, was removed by cutting round with a Sexton's knife. The stapes, with the tendon of the circumflex, was cut, and the wound was packed, and the sutures were removed.

On June 15th she mentioned that she experienced slight staggering when walking, and there was marked nystagmus on deviation to the right. On June 29th she stated that she could walk better and had no vertigo, but on July 6th she said there was always a slight dizziness after walking. The ear healed without complication in about six weeks. The last occasion that she was seen was on Oct. 5th, 1910. She could then walk quite straight; there was no vertigo, and the feeling of giddiness after walking had almost disappeared.

The patient subsequently obtained a post some distance away, and in a letter dated May 3rd, 1911, she wrote:—

I am pleased to say that my health generally is much improved and that I had no vertigo when I was in the hospital. After retiring to bed quite well, I was woke up by being sick, but felt no giddiness whatever. I, however, have a tendency to fall, or rather to sway towards the right.

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sense of locality. In this case both ears have been destroyed—
the one by operation, the other by disease—and the patient is
stone-deaf. I was, therefore, inclined to attribute the effect
of darkness to his inability to hear, as much as to the loss of
the sense of space. In the later case, however, the patient
was able to find their way and to experience no sense of localisation in space. Most of
these children had no idea of what giddiness meant.
I have surmised, therefore, that in the case of congenitally
deaf children the absence of function in the vestibular
apparatus has been compensated by a better development of
the muscular sense; and that, in the two adult cases here
to refer to, that sense has not yet had time to adapt itself to
the altered circumstances.

So far as I know, no record has yet been made as to the
sensations experienced when in the dark by those who have
been deprived of their vestibular apparatus by operation or
disease. Perhaps others who have operated upon the laby-
rinth may be able to throw further light upon the subject.

The following method of closing the bladder, with remove-
table sutures, after suprapubic cystotomy, worked so satis-
factorily in a recent case that I have ventured to describe
briefly the operation.

A private in the 2nd Devonshire Regiment was admitted
into the Military Hospital, Cottourna, Malta, in July, 1911,
suffering from stone in the bladder. Owing to the cystitis
present it was decided to remove the stone by suprapubic
cystotomy. Under general anaesthesia the bladder was
opened above the pubes and a large, nodular, oxalate stone
was removed. The bladder was well washed out with borel
acrid lotion and a No. 8 rubber catheter was secured in the
urethra. The incision in the bladder wall, about 2 inches
long, was closed by means of seven tube sutures.

The tube sutures consist of the following parts:—
(1) Strands of ordinary strong silkworm gut;
(2) short pieces of glass-tubing, 2 inches long and \(\frac{1}{2}\) inch in diameter;
and (3) small brass or steel rings, \(\frac{3}{4}\) to 1 inch across. The

FIG. 1.

FIG. 2.

sutures of silkworm gut are passed with a curved needle
through the muscular coat of the bladder at both sides of
the opening. Each suture is inserted not less than \(\frac{1}{4}\)
inch from the edge of the incision and emerges on the cut surface,
just short of the mucous membrane of the bladder, as in
Fig. 1. The two free ends of the suture are threaded through
a glass tube and drawn tight; they are then secured in this
position by being firmly tied over the rim of one of the metal
rings, as in Fig. 2. The loop of silkworm gut which projects
from the end of the tube and passes through the bladder
wall acts like the loop of a wire polypus snare and holds
the two sides of the bladder incision firmly in contact
with each other. The other end of the silkworm-gut suture,
knotted over the edge of a ring, as in Fig. 2, is on a level
with the surface of the abdomen and is easily accessible for
removal. In the case of foreign bodies the suture is
divided close to the knot, and the knotted end is then
pulled on until the suture is withdrawn. One band at
the same time holds the glass tube steady in the wound. The
silkworm gut remains quite taut after ligature in the tubes,
and does not adhere to the bladder wall on removal.

In the case mentionedabove seven sutures were inserted to
close the bladder opening and five glass tubes were used to
hold them. The two lowest tubes carried two sutures in
each, as, for example, to arrest haemorrhage, remove
clot, or provide drainage, the suture tubes afford a ready
channel of escape for any inflammatory
exudates which may collect along the bladder incision.

In five cases where the bladder has to be reopened after
operation, as, for example, to arrest haemorrhage, remove
clots, or provide drainage, the suture tubes afford a ready
guide to the bladder incision.

Malta.

ASSOCIATION DES MÉDECINS DE LANGUE FRANÇAISE.—The Thirteenth Congress of French-speaking
Physicians will be held at Paris from Oct. 13th to 16th
inclusive. The subjects appointed for communications
and discussion are: 1. Oxalæmia and Oxaluria. M. Loeppe,
of Berlin, will open the subject with a general exposition,
and M. Lamblieg, of Lille, will give a Chemical Study of
Oxalæmia and Oxaluria. 2. Acute Infectious Colitis. M.
Cade, of Lyons, will speak of Acute Infectious Colitis in
the Adult, and M. Hutinel and Nobécourt, of Paris, of
Acute Infectious Colitis in Children. M. Nolf, of Geneva,
will discuss the Examination of the Blood in the
Diagnosis of Hemorrhagic Syndromes. M. Carnot, of Paris,
will open with a general exposition of the subject. M.
Sabranès, of Bordeaux, will discuss the Examination of the
Blood in the Diagnosis of Hemorrhagic Syndromes, and M.
Nolf, of Geneva, the Physiological Changes in the Blood.
Other proposed subjects are: (1) Anaesthetics Clinically
Considered; and (2) Antityphoid Vaccination. The
secretary-general is Professor Bard, 44, Boulevard des
Tranchées, Geneva.