escaping by the perineal wound and the boy having a good deal of pain. 11 days after admission the suprapubic drain was withdrawn and on the following day the urethral one. On Oct. 21st the patient was dismissed well but with a stricture which admitted nothing bigger than No. 5-8 Lister. On Nov. 30th the boy was brought back by his mother with the statement that he had difficulty in passing urine, spent a long time over it, and was wetting his bed at night. The bladder was found distended; urine was dribbling away and on a first attempt no instrument could be passed. On Dec. 12th, under chloroform, a whalebone guide was passed and the stricture was dissected through and cut out (for about three-eighths of an inch). The ends of the urethra having been dissected free were brought together by catgut sutures over a catheter, which was then withdrawn. Before beginning the resection the bladder was punctured for a drain as usual. The suprapubic drain did well. It was noted on Dec. 23rd that he passed urine occasionally per urethram and that some had come by the perineal wound. The suprapubic drain was withdrawn. On the 28th both wounds were soundly healed and the patient passed urine in a full strong stream. Bougies could be passed in easily up to No. 10-13 though there was an irregularity in the urethra opposite the middle of the scar. On Jan. 13th, 1897, he seemed to pass urine easily enough but for the last two nights he had been found wet in bed by midnight. On Feb. 8th he was at home again and had to be awakened to empty the bladder or he would pass urine in bed. Bougie No. 9-12 was passed with a slight hitch. This incoördination passed off and in October when he came by request for examination there was no inconvenience. On May 12th, 1901, the boy was in good health and without symptoms; bougies were passed up to No. 13-16. On March 6th, 1904, being at this time nearly 18 years old, he was at work, in good health, and without symptoms. Conical bougie No. 13-16 was passed without difficulty. The penis was well developed.

CASE 4.—The patient, a youth, aged 18 years, was admitted to Ward 25 on April 7th, 1898, having bruised the perineum against the rung of a ladder. Here the injury was compound, there being a tear running outwards into the right buttock. The treatment was as in the previous cases. On April 19th, after withdrawing the catheter, it was noted that there was a considerable escape of urine by the perineal wound, but this soon healed and he was dismissed on May 16th with both wounds healed and able to pass urine freely. He was examined on May 10th, 1901. There were no symptoms and he was in excellent health. Bougies up to No. 10-13 were passed as before. On Feb. 10th, 1904, he reported himself well and free from symptoms and was at his usual work. At that time he was 24 years old and had been married more than a year.

CASE 5.—The patient, a man, aged 38 years, was admitted to Ward 25 on August 11th, 1900. Four months previously he was kicked in the perineum from in front. Not much swelling formed but discolouration showed itself and oozing of blood went on for about three weeks. He had no actual retention, but there had been gradually increasing difficulty in micturition and he had to rise three or four times in the night. On examination it was found that medium-sized bougies were stopped about five and a quarter inches from the meatus and the point of the instrument could be felt from the perineum to enter a mass, the posterior extremity of which became lost in the bulb. It would seem that the worst part of the stricture was about one and a half inches in front of the triangular ligament. On August 17th, 1901, the strictured portion was resected; it was shorter than had been supposed, the part removed not being more than half an inch long. A complete section of the corpus spongiosum was removed for that extent. Seven or eight fine silk sutures were used to bring the cut ends together, care being taken that they did not pass into the lumen of the urethra. Combined drainage was established. Eight days later the urethral catheter was withdrawn and a few days later the suprapubic one. There had been only a trace of urine escaping by the perineal wound but there was a considerable extravasation of blood which formed a hæmatoma in the scrotum. On Sept. 18th both wounds were sound. The patient could pass urine in a good stream and was not disturbed during the night. On Dec. 7th No. 10-13 was the largest size of bougie that could be passed without violence. The patient was free from troubles of any kind. On May 17th, 1902, his condition was the same as when last noted. On July 23rd he was well and free from symptoms.

CASE 6.—The patient, a man, aged 38 years, was admitted to Ward 25 on Sept. 27th, 1900. Four days previously he fell on the leg of an upturned stool which caught him between the legs, immediately after which blood began to ooze from the urethra and this had persisted since, showing itself at the beginning of micturition. Pain and swelling had for the most part disappeared, though there was ecchymosis from the scrotum to the tip of the coccyx. On the 30th a metallic catheter was passed with some difficulty and the bladder was distended, after which it was punctured and drained. A staff was then cut down on in the perineum and the urethra was found to be torn on its perineal aspect just in front of the triangular ligament. There was no wide tearing of tissues, but a pocket ran backwards under the proximal portion of the urethra from which oozing was rather free. Double drainage was established as usual and was carried on satisfactorily, though there was a rigor on the day following the operation. Six days after the operation the urethral catheter was expelled and it was not thought necessary to reintroduce it. There may have been blocking by discharge but there was trouble in fixing the catheter to the long lax prepuce. On Oct. 11th the patient had passed urine several times per urethram without any leakage: the suprapubic drain was withdrawn. On the 18th micturition was free and painless. Bougies up to No. 11-14 could be passed with something of a hitch. The wound in the perineum was practically healed. On the 30th he was dismissed. On Dec. 8th he was at work. There was no discomfort and he could pass urine as freely as ever. On Feb. 13th, 1902, he was quite well. Bougie No. 13-16 was passed.

CASE 7.—The patient, a man, aged 47 years, was admitted to Ward 22 on Sept. 6th, 1902, with injuries due to a plate weighing about three tons falling on him while in a kneeling position. On examination there were found areas of bruising and abrasion all over the body but specially on the back, perineum, and lower limbs. The face was purple and there was ecchymosis of the eyelids and conjunctivæ on both sides. The movements of the legs were painful, the sensation in them being intact. He complained of tenderness in the lower part of the abdomen on both sides and in the middle and there was tenderness in these regions. With a soft rubber catheter ten ounces of urine were drawn off. The first that came contained shreds of clot; the remainder was clear. The pulse on admission was 66. The pupils were equal and active. I examined the patient and was of opinion that there was no fracture of the pelvis. On Sept. 8th the soft catheter had only withdrawn small quantities of bloody urine and the bladder was now distended half-way to the umbilicus. The patient was therefore put under chloroform and the bladder was punctured and drained suprapubically. The urethra was then cut down upon in the perineum; it was found to be completely divided "in front of the prostate." A soft rubber catheter was passed and fixed to the penis in the manner already described. It was found that the pubis was fractured (without displacement) to the right of the symphysis. On the 14th Dr. Knox incised a swelling in the upper third of the right thigh; it contained blood and pus. The urethral catheter was changed several times but drainage by this route was kept up till Nov. 1st (say seven weeks); the suprapubic one was removed at the end of about a fortnight. The patient was sent home on Nov. 19th. On Dec. 19th, one month after leaving hospital, it was noted that the patient passed urine in a good stream. Bougie No. 10-13 slipped in with a slight hitch. On Jan. 28th, 1904, the patient said that he retained his urine as before the accident and was able to rest all night and had resumed his usual work. Bougie No. 10-13 was passed as at the previous note a year ago.

Glasgow.

A CASE OF PSEUDO-LEUKÆMIA (LYMPHOSARCOMA) IN A YOUNG CHILD.

By JOHN J. REDFERN, M.D., M.A.O. R.U.I.,
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(With Note by WILLIAM HUNTER, M.D. Edin.,
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THE following case is of interest on account both of its acuteness and the early age at which it occurred. A note made on Sept. 3rd, 1903, showed that the patient was then a healthy, plump, well-developed little girl, two years and

nine months old, with no history of previous illness. She had several swollen glands in the left side of the neck and some less swollen ones on the right side. These glands were firm, discrete, and somewhat elastic, not painful or tender on pressure. No other glands were swollen. Respiration was normal. On Sept. 18th it was noted that the patient had returned from Bognor, having developed slight dyspnoea. The glands in the neck had become larger. The glands in both axillæ were swollen. On Sept. 30th the swollen glands were larger and more numerous and the dyspnoea was increasing daily. The appetite was good and the general health was fairly stationary, but the limbs were weaker and wasting. On Oct. 6th the dyspnoea was steadily increasing and the glands were pressing more on the trachea. On Oct. 19th it was noted that the anterior mediastinal glands were larger, as shown by percussion, and extended to the right of the sternum. There was definite dulness, with absence of breath-sounds, as far as the third rib on the left side, extending over the two upper intercostal spaces. On Oct. 21st the patient was seen by Dr. William Hunter as her condition was becoming steadily worse. On Oct. 25th it was noted that the right lung moved slightly on respiration, which on both sides was becoming progressively more shallow and frequent, and dyspnoea was very marked, especially on exertion. In one dyspnoeic attack cyanosis was marked, the heart's action being very rapid and feeble. The respirations were about 40 per minute. On Oct. 29th the glands were very much more swollen, especially those on the left side of the neck. The inguinal glands were slightly swollen. There was unilateral perspiration on the left side of the body, face, and limbs. The left pupil was more dilated than the right one. On Nov. 3rd the action of the heart was very rapid and feeble and the dyspnoea was urgent on exertion. The case terminated fatally that day by syncope after about eight weeks' illness. No necropsy was permitted. The disease had of late been progressing rapidly, although the child's general nutrition had remained good. The usual pallor and subcutaneous œdema were not very marked throughout and the general nutrition of the body was maintained until death. The spleen and liver were not markedly enlarged on percussion. There was no pain or cough. Pyrexia was intermittent and under 101° F. Arsenic was administered throughout and at first iodide of iron and cod-liver oil. There was no family history of syphilis or tubercle.

Note by Dr. HUNTER.—The case is the youngest and most acute that has come under my notice. When seen by me on Oct. 21st the blood condition was the following: red corpuscles, 4,080,000, and leucocytes 8000 per cubic millimetre; lymphocytes, 20 per cent.; hyaline leucocytes, 10 per cent.; polymorphonuclear cells, 68 per cent.; and eosinophile cells, 2 per cent. The cases of pseudo-leukæmia recorded as running an acute course have all occurred in children under 15 years of age and in duration varied from 11 days to four and a half months. The present case was fatal in two months. The blood condition was that generally present in these cases—namely, remarkably slight anæmia. In the majority of cases the leucocytes are normal or diminished in number and there is a tendency towards relative lymphocytosis. In some cases the leucocytes are increased but not to any great extent—e.g., to 50,000 or 60,000 per cubic millimetre.

TENDER SPOTS ON THE SPINE IN RELATION TO PAIN IN VARIOUS PARTS OF THE BODY.¹

By ST. CLAIR B. SHADWELL, M.D. ST. AND.,
L.R.C.P. LOND.

It is with considerable diffidence that I read a paper before you to-day at this the first scientific meeting of our newly formed division of the British Medical Association, for I cannot help feeling that here, in the presence of men of scientific education and training, I am but one of the least of you and that I can but "tell you that which you yourselves do know." Indeed, it is as a learner and not as a teacher that I have ventured to bring notes of some cases

which have come under my notice and to ask the expression of your opinion as to their real nature.

Some nine or ten years ago I was asked to see a girl, aged 16 years, who complained of pain in the epigastric region. She was well nourished and appeared quite healthy. There was apparently nothing abdominal to account for the pain. On examining the spine one of the dorsal vertebræ was slightly prominent and tender on pressure. Regarding this as a case of incipient spinal disease, complete rest was enjoined and the patient was kept in bed for several weeks. She made a good recovery and had no further trouble.

A child, aged six years, complained of severe pain in the abdomen. She was taken to a well-known consultant who makes diseases of children a speciality. He pronounced the case to be one of indigestion and prescribed accordingly. At the end of two months or so the child, having been regularly under observation, was worse rather than better. I was then asked to see her. On making an examination of the spine well-marked evidence of caries was found which sufficiently accounted for the abdominal pain.

Constant acute pain in the calf of the left leg in a man, where nothing local could be detected to account for it, was ultimately found to be due to sarcoma of the spine.

These are not the cases I wish to discuss to-day, but they have been introduced with the sole object of emphasising the fact that pain is often felt at a distance from the actual seat of the disease. Frequently patients come complaining of pain in various regions of the body; cure them of the pain, they are cured of the disease. What are those pains? Too often we are satisfied by giving them a name and treating them accordingly—pleurodynia, dry pleurisy, intercostal neuralgia, false angina, gastrodynia, ovarian neuralgia, neuralgia of kidney, occipital neuralgia, and even acute indigestion and rheumatism. These cases are usually treated generally and locally—tonics, quinine, strychnine, arsenic, salicylates, iodide and bromide of potassium being administered; locally by the application of anodyne liniments, blisters, continuous current, &c. Tedious enough is the treatment and long-suffering the patients. Many of these cases go on for weeks and even months, then change of air or residence in a dry climate is advocated.

In a very large number of these cases I have examined the spine and have found well-marked tender spots at the point of origin of the spinal nerves supplying the region of the body in which pain is complained of, and by treating the tender spots on the spine complete, immediate, and permanent relief has been the result. Time limit prevents me speaking so fully as I might, therefore all that I propose doing to-day is to give you a few brief notes of cases and to leave the subject for you to discuss.

CASE 1.—The patient, a woman, aged 26 years, on October 21st, 1900, complained of severe pain on the left side of her chest which increased on taking a deep breath and shallow breathing was resorted to in order to keep the chest quiet. At night the pain was so severe as to prevent sleeping. She was seen by a medical man who treated her vigorously. Poultices, liniments, and blisters were applied to the chest, but these gave little or no relief. Continuous current gave no better result. I saw her on Nov. 4th. Careful examination showed that there was no pleurisy or lung trouble. The skin of the side was tender to touch. On examination of the spine a very tender spot was found over the seventh dorsal vertebra, causing the patient to flinch when it was pressed on. Up to this time she was quite unconscious of any pain in the spine. I ordered the painful spot, which I marked, to be painted night and morning with linimentum iodi. On the 5th the pain was about the same, on the 6th it was markedly less, and on the 7th it was quite gone. There has been no return of pain.

CASE 2.—The patient, a woman, aged 45 years, was seen in November, 1900. She had severe pain in both shoulders and for a fortnight had been under treatment for rheumatism, but there had been no improvement. I found her sitting in a chair with the body bent forward, the arms in front, and the shoulders contracted. On examining the spine I found a very tender spot over the lower cervical vertebræ. This was painted night and morning with linimentum iodi. On the next day the pains in the shoulders were not so severe. She was obliged to sit still as the least movement increased the pains. On the second day she walked into the room perfectly upright, while on the third day the pains had quite gone and she expressed herself as being quite well. She was seen two years

¹ A paper read at a meeting of the Walthamstow Division of the Metropolitan Counties Branch of the British Medical Association at Leyton Town Hall on Oct. 27th, 1903.