trremely regreted the loss of the eye, and was disposed to regard it as accidental and not as a necessary result of the operation.—*British Medical Journal*, November 1, 1890.

JAMES E. PITCHER (U. S. Army.)

II. Trephining in a Case of Actinomycosis of the Brain.

By OTTO E. KELLER, M.D. The patient, a married woman, æt. 40 years, gives a history of suffering, two years previous to the development of the cerebral symptoms, from two actinomycotic abscesses over the left chest. When Keller saw her she complained of gradually increasing weakness of the left arm. At that time a diagnosis of an actinomycotic lesion of the motor regions was made, operation advised but declined. She then developed convulsions of the left arm paresis developed and soon involved the left half of the body. Headache, vomiting and complete loss of consciousness followed. The friends would not consent to operation until the patient was apparently moribund. Then without an anæsthetic trephining was done over the right ascending frontal convolution. The dura and brain substance were incised and two ounces of thin, green pus, containing great quantities of actinomycosis grains, was evacuated. The patient immediately (while on the operating table) awoke from the deep coma and called for a drink of water. The wound did well and patient was able to get about again. A year later grave symptoms again appeared, the brain was again incised and a considerable quantity of pus evacuated. This did not materially improve the patient's condition and she died in a few days. Post-mortem showed the middle third of the right frontal and parietal convolutions occupied by a large mass of newly formed tissue and deeply buried in the white substance, an unopened encapsulated abscess of the size of a nutmeg.—*British Medical Journal*, March 29, 1890.

H. BEECKMAN DELATOUR (Brooklyn).

GENITO-URINARY ORGANS.

I. Operations on the Enlarged Prostate. By DR. W. T. BELFIELD (Chicago). The author claims that accumulated clinical observation proves:

1. That in most cases the failure to evacuate the bladder is due in no wise to degeneration of the vesical muscles, but solely to the mechanical obstruction offered by prostatic growths; since the removal of such obstacles has been followed in over two thirds of the cases previously dependent upon the catheter by restoration of the vesical functions.

2. That the enlargement of the prostate commonly called "senile" hypertrophy is not limited to advanced life.

3. That the prostatic obstruction is usually of such form as to permit excision, for out of seventy-seven cases in which suprapubic section was done, in sixty-two such obstacles were found and removed.

The author admits, however, that in many prostatics of advanced age, a degeneration of the vesical walls co-exists, so that the contractility of the bladder is much impaired. Differentiation between obstructive and degenerative factors in a given case ought to be made before operation, though it cannot always be accurate. Evidences of general tendency to sclerosis, as shown by rigid arteries, polyuria, often hæmaturia, extremely hard prostate, feeble flow of urine through catheter, and complete evacuation of the bladder only by pressure upon the hypogastrium, are the symptoms that point to degeneration, and render operative interference unpromising.

Any operation should secure these results: restoration of a low level urethra by removal of prostatic obstacles; temporary drainage of the bladder, and stretching of the prostatic urethra. Since prostatic obstructions present great diversity in size, shape and location, digital contact is the first essential of every accurate radical procedure. A perineal incision will certainly fail in a large percentage of cases to afford the required access to the intravesical obstacle. Suprapubic cystotomy secures minute exploration of the intravesical projections, and thorough drainage of the bladder, yet several instances are recorded in which the removal of salient intravesical growths by this route failed to remedy the prostatic obstruction, owing to the presence of urethral prostatic growths that were not reached. The exploration of the urethral portion of the prostate is quite as important as that of its vesical portion. Especially frequent is a pronounced thickening of

the suburethral prostate whereby the urethra is elongated and the vesical orifice displaced upward. The prostatic urethra should be stretched and explored by the finger, and the discovery of a hard mass or an unduly rigid ring should be the signal for perineal urethrotomy, incision or excision of the resisting tissue and thorough stretching. The author thinks it probable that the combined operation by both suprapubic and perineal incisions will become the rule rather than the exception, since it affords an access to the entire prostate which may convert an utter failure into a complete success.

Thorough enucleation of all circumscribed masses within as well as above the general prostatic surface should be done. Such tumors can be enucleated after incision of the mucous membrane with surprising facility.

The abstract utility of prostatectomy has hitherto been clinically restricted by the fact that so many patients requiring the operation are too feeble to endure it when they reach the surgeon. The hazard of the operation is chiefly due to pre-existing disease of the urinary tract, together with enteeblement of vitality from age and protracted suffering. In very feeble patients perineal prostatectomy alone should be done, since it may be so quickly completed, involves less peril from the anæsthetic, affords temporary relief in all cases, and a radical cure in a fair minority.

Operation should be resorted to earlier in the course of the disease, and not, as heretofore, deferred until the last stage.

Opportunity is still lacking—because the operation is so recent—to determine decisively whether the restoration of voluntary urination is permanently assured by prostatectomy; further experience must show whether new tumors may not frequently develop from the unexcised prostate, causing a recurrence of the original morbid condition.—*Am Jour. Med. Sc.*, November, 1890.

II. Prostatomy and Prostatectomy and the Indications for Their Performance. By Dr. EDMOND VIGNARD (Paris). The author, in a very exhaustive and careful manner, undertakes the task of critically reviewing the present status of operative attacks upon the