I can make of them here is to add them to Vedeler's and give the result of the two sets of figures combined. They are as follows:—

	Decided flexions.	All cases of flexions.
	Per cent.	Per cent.
234 Nulliparæ (non-dysmenorrhœal) ..	75, or 32	154, or 65·8
115 Nulliparæ (dysmenorrhœal)	41, or 35·6	84, or 73

The figures thus show a slightly greater frequency of flexions of the uterus among patients the subject of dysmenorrhœa. If this be admitted as an established fact, it still does not show that the flexion stands to the dysmenorrhœa in the relation of cause to effect. It may be that both flexion and dysmenorrhœa are the results of causal conditions common to both. For instance, statistics collected by Whitehead,⁵ and others by West,⁶ show that women in whom menstruation does not commence until later than usual—that is, those in whom the development of the uterus is imperfect—are more prone to derangements of health connected with its functions than other women; and a paper by Dr. John Williams was read before the Obstetrical Society of London in 1882 in which it was maintained that in cases of primary dysmenorrhœa (the kind chiefly met with in nulliparæ) the uterus is imperfectly developed. Now, according to Dr. Hewitt (from whom I do not here differ) the uterus in early life is more anteflexed than subsequently, and this anteflexion disappears as the organ enters upon functional activity. Assuming these views to be correct, we have here an explanation of the preponderance of flexion among the dysmenorrhœal—viz., that among such patients an undue proportion of imperfectly developed uteri is present. But to pursue this subject would be to discuss that of dysmenorrhœa, and I wish here to keep to that of flexion. If the inference which I presume Dr. Hewitt would draw from these figures be correct—viz., that the preponderance of flexions among the dysmenorrhœal indicates that the flexion is the cause of the dysmenorrhœa,—I would point out, first, that it does not follow that the dysmenorrhœa is produced by blocking the canal; next, that the proportion of flexions met with in the non-dysmenorrhœal is very large, and the excess of that condition in the dysmenorrhœal very slight. If it be assumed even that in every case of flexion with dysmenorrhœa the flexion was the cause of the dysmenorrhœa, it still results that 47·3 per cent. of decided flexions, and 47·4 per cent. of all flexions, are quite innocent of any connexion with menstrual pain. Taking the more reasonable estimate, that the number of cases in which the flexion stood in a causal relation to the dysmenorrhœa is represented by the excess of flexed uteri among the dysmenorrhœal cases, we find this consists of 7·2 per cent. of all flexions, 3·6 per cent. of marked flexions. If these figures indicate that flexion is a cause of dysmenorrhœa, they also indicate that it is one of the least frequent, and, therefore, least important causes. It will be noticed also that the slight disproportion is larger when flexions of all grades are taken into account than when marked flexions only are regarded, which goes to show that dysmenorrhœa associated with flexion does not increase in frequency proportionately to the sharpness of the bend, as it should do were it mechanically caused by the bending.

Such a large percentage of flexions among the dysmenorrhœal, and such a trifling difference in this respect between them and the dysmenorrhœal, seem to me altogether inconsistent with the view that Dr. Hewitt takes of the importance of the flexed condition—viz., that it is “the most common and most troublesome of the maladies to which the uterus is liable,” and the cause of dysmenorrhœa in the majority of cases.

(To be concluded.)

⁵ On Abortion and Sterility, p. 48.

⁶ On Diseases of Women Fourth edition, p. 27.

A SIMPLE METHOD OF WASHING OUT THE BLADDER.

By G. BUCKSTON BROWNE, M.R.C.S. ENG.

IN the treatment of various diseases of the urinary organs it is often necessary to teach a patient to wash out the bladder. As a rule he is elderly and not very skilful, and consequently the apparatus put into his hands should be of a simple kind. In all the instruments hitherto designed there are taps to turn, and the injecting nozzle has to be constantly connected with the catheter and disconnected; hence they all lack the element of extreme simplicity; moreover, none of these movements can be made without shifting the catheter more or less, and this is very undesirable in a tender and perhaps inflamed bladder.

In February of this year Dr. Wm. Job Collins published in THE LANCET a description of a two-way tap, furnished with two stopcocks, and intended to be fixed to an ordinary Higginson's enema syringe. This excellent contrivance at once suggested to my mind the following arrangement, in which all stopcocks are done away with, and by which washing out the bladder is made as uncomplicated as possible. The accompanying figure will for the most part

explain itself. ABCD is simply a bifurcated brass tube without valve or stopcock. The end, D, is fixed to a Higginson's syringe. At A and B are discs to support (in self-use) the left thumb and second finger, the left forefinger being free to alternately close and leave open the orifice of the efferent tube at C. The jug, E, contains any bladder wash prescribed by the surgeon, and the enema apparatus is filled with it in the usual way, so that all air is expelled. The catheter is then passed, and when urine ceases to flow the nozzle is introduced into the end of the catheter. The left forefinger is firmly applied to the orifice at C, and two ounces of injection are gently introduced into the bladder

GLASGOW MEDICO-CHIRURGICAL SOCIETY.—At the first meeting of this Society, held in the Faculty Hall on the 3rd inst., the following gentlemen were elected office-bearers for the present session:—President: Dr. G. H. B. Macleod. Vice-Presidents: Drs. Hugh Thomson and David Taylor (Paisley). Council: Drs. D. Maclean, J. C. Woodburn, William Whitelaw (Kirkintilloch), W. A. Wilson (Greenock), R. Cowan, J. A. Lothian, William Patrick, and M. Thomas. Secretaries: Drs. W. L. Reid and J. W. Anderson. Treasurer: Dr. Hugh Thomson.

by squeezing the ball in the right hand. The left forefinger is then raised and the fluid issues from the bladder, while the right hand relaxes its pressure and allows the bulb to draw up a fresh supply of fluid. This process can be repeated as often as is desired, without trouble to the patient or disturbance of the catheter. In practice, I have found this simple apparatus prove of great service to patients suffering from atony of the bladder or prostatic disease, when washing out the bladder has been indicated. The brass nozzle is made by Messrs. Weiss and Son.

Wimpole-street, W.

A NOTE ON PREPUCE GRAFTING.

By CHAUNCY PUZEY,

SURGEON, NORTHERN HOSPITAL, LIVERPOOL.

THE article by Mr. Clement Lucas, which appeared under the head of "Prepuce Grafting," in THE LANCET of Oct. 4th, reminds me of a case bearing upon this subject which was under my care about a year and a half ago in the Northern Hospital, Liverpool.

A sailor, about thirty-five years of age, sustained a severe crush of the soft parts of his left foot, owing to a spar falling upon it and rolling about on it during a heavy gale at sea. The injury was aggravated by want of attention and exposure to cold and wet for several days, so that when the ship arrived at Liverpool and the man was brought to hospital, the integuments of the foot, from the toes to the flexure of the ankle anteriorly, and as far as the os calcis on the plantar aspect, were sloughing, and soon came away, leaving a large granulating surface all round the foot (with the exception of that part occupied by the fifth metatarsal bone, which part had escaped injury, and was covered with sound skin) and from the bases of the toes to the lines before-mentioned, the sheaths of several of the extensor tendons being exposed on the dorsal surface of the foot, and a considerable portion of the plantar fascia having sloughed away. This looked a case which would take months in healing, and in which even then a tender foot, crippled by tight cicatrices, must result—a typical case for extensive skin grafting. Therefore, as soon as the wound was in a clean and favourable condition, I obtained the patient's sanction to the removal of as much skin as might be required from a part where there was plenty—namely, his scrotum. This having been cleansed by the continuous application of carbolic fomentations for a couple of days, I removed two folds of this skin, each about the size of a crown-piece, but oval rather than circular, having previously passed two or three long and thick catgut threads through the folds, near the line of section. One of these pieces was then spread out on the dorsal, the other on the plantar surface of the foot, the catgut being used for tying down the transplants and preventing their tendency to roll up. Carbolic dressings were used, but when they were removed after forty-eight hours, the transplants looked dark and sodden, their cuticle was separating, and the wound had a bad odour. Frequent cleansing, and gauze and oakum dressings, soon improved affairs, but the transplants looked as if they were softening down and would soon disappear. A boy having been found who required circumcision, his prepuce was divided into half a dozen pieces, and these were laid upon the wound in various places between the scrotal transplants and the healing edges of the sore. These preputial grafts adhered at once, and the condition of the sore rapidly improved; moreover, in the site of the scrotal transplants, which we thought had failed, new skin rapidly appeared, and in the course of a few weeks the whole of the large granulating surface was completely healed, partly by cicatrization, but to a great extent covered with healthy skin. Weeks instead of months had sufficed for the restoration of a perfectly useful though rather disfigured foot.

No doubt the prepuce affords much better material than the scrotum, and for large grafts it is difficult to imagine anything better than the prepuce of a healthy infant—thin, soft, elastic, free from fat, and thus readily adapted to any surface. Unfortunately, in these days of children's hospitals, the supply of material in general hospitals is somewhat limited, but in the case of a male patient, his own scrotum presents generally an abundant supply, though the material is not of so suitable a quality. As Mr. Lucas observes, the principal objection to preputial grafts is

purely sentimental; still this objection has no doubt hitherto stood in the way of utilising a material which, in these days of conservative surgery, is too valuable to be wasted.

Liverpool.

CASE OF SPORADIC TYPHUS, WITH HIGH TEMPERATURE, COMPLICATED WITH ULCERATIVE ENDOCARDITIS;

POST-MORTEM EXAMINATION.

By AUGUSTUS H. COOK, L.R.C.P., M.R.C.S.,
MEDICAL OFFICER TO THE HAMPSTEAD INFIRMARY.

FANNY W—, aged twenty-three, married, was admitted to the infirmary in the evening of April 26th of the present year, with the following history, ascertained from her husband. The illness commenced on Tuesday, April 22nd, four days before admission. She was perfectly well in the morning, and did her washing as usual; but before dinner she felt so weak that she had to lie down, and complained of feeling very ill. She vomited and retched from the time of the seizure till the end of the week, and complained of severe headache. Her skin was burning hot, and her feet very cold, "like ice." She refused all solid food. She was cheerful and perfectly sensible. During the whole time the pain in the head was very severe ("awful"). She bore the journey to the infirmary well, expressing a wish to go. When she was an infant all her family had typhus, at Wootten-under-Edge, Gloucestershire, her case being the worst; she had typhoid fever when older, and rheumatic fever severely at the age of twelve, but she did not know of any heart disease being left in consequence; she was otherwise strong and healthy. The patient was confined four months ago, natural labour; but has never been so strong since. Her father and mother are still living, aged forty-three and fifty respectively; both are strong and healthy. Two brothers died young ("of vaccination"); two brothers are still living, both healthy; three sisters, all healthy; her baby, aged four months, is healthy; no other illnesses known. She was in the habit of leaving the unwashed napkins under the bed in which she and her husband slept, for days together, and the smell was very bad at times, especially just before her illness, when the soiled napkins had lain beneath the bed for three or four days—so much so that her husband complained about it. On admission she stated that she had been ill for nearly a week, and that the doctor thought it was a bad cold. She did not appear very ill, but the temperature was 103.8° F.—27th: At about 6 A.M. the patient became unconscious, and when first seen by Dr. Paddle and myself at 11 A.M. she was in the same state. On shouting she opened her eyes, but showed no other sign of consciousness. Temperature 103.6°; pulse 120; pupils unequal, the left dilated. No signs of any rash, with the exception of a few light-brown stains about the flanks and abdomen. There was a little tenacious and frothy mucus streaked with blood, but careful examination failed to detect any sign of pneumonia. A soft blowing murmur replaced the first sound at the apex. The urine was drawn off by catheter.—28th: Temperature fallen to 102.8°; pulse 120. Patient very delirious, but able to converse with her husband a little. Bowels, which had been confined throughout, opened by enema. Beef-tea, milk, eggs, &c., taken freely. Incontinence of urine.—29th: Morning temperature, 104°; pulse 150. Prostration extreme; patient still delirious. Temperature at 6 P.M., 106°; 108° at 9 P.M. The patient died at 11.

Autopsy, forty hours after death (at which I was assisted by Dr. Paddle).—The body was fairly well nourished; no eruption, but marked lividity along the back; rigor mortis still present. A dark clot was found on the surface of the brain, over the posterior half of the left hemisphere, about four inches long by one and a half inches wide; it was quite superficial; the vein under the clot was empty. All the superficial veins were gorged with blood, and the membranes were congested but free from opacity, flakes of lymph, or any other signs of inflammation; there was little or no effusion into the subarachnoid space or ventricles. The brain, on section, was found to be greatly congested. There were hæmorrhages into the following parts—namely, (1) into the anterior and outer part of the right frontal lobe, about the size of a pea (the centre of this clot was of a yellowish colour); (2) in the posterior part of the same hemisphere