valgus. Some confusion has arisen by certain authors using the term "hallux malleus" as a synonym. The chief characteristic of hallux malleus is pronounced flexion at the metatarso-phalangeal joint and such flexion is combined with adduction of the great toe in some cases of hallux varus; when this is the case it would, perhaps, best be described as "hallux varus et malleus." The congenital hallux malleus observed by Nicoladoni to become complicated in after-life by flat foot may in some cases present a certain degree of hallux varus in the original deformity.

Hallux varus may occur congenitally either alone or as part of the deformity of congenital equino-varus. In the latter condition if treatment is begun at the proper time—i.e., soon after birth—the deformity is always cured. Hallux varus has been noted in cases of congenital absence of the fibula. No case of pure congenital hallux varus has come to my notice, but I should anticipate that persistent careful bandaging would remedy the condition.

Hallux varus in dichotomy of the great toe.—A set of four casts in the museum of the City Orthopaedic Hospital were taken from a patient under the care of the late E. J. Chance. The feet before operation had each six digits, as in Fig. 3 to

FIG. 3.

To the right a cast of a foot with dichotomous hallux, the innermost digit being in a state of hallux varus; to the left a cast of the same foot after amputation of the innermost digit.

the right, the innermost being in the position of hallux varus. In such cases removal of the innermost toe is all that is required, and Chance's case shows that the result is highly satisfactory.

Acquired hallux varus—The records are very scanty on this head and I must confess that I have no personal experience to give. It occurs in some cases of severe genu valgum. In certain paralytic and traumatic cases this deformity would probably arise.

In conclusion I would venture to state my opinion that every case of hallux valgus is curable. The most troublesome cases are those in which a second hammer-toe has been (quite unnecessarily) removed previously to the patient being seen.

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A CASE OF LEPROSY.

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MANY clinical cases of leprosy have been published, but the simple example here recorded is of general interest. The patient was an unmarried Eurasian, aged 27 years. He was born in Singapore but had lived for some time in the Malay Native States. He was a clerk and interpreter in the police-court at Pekan. There was no case of phthisis in the family

as far as was known. One sister suffered from "fits." His father and brother were alive and well. The mother had died in child-bed. The patient had had the ordinary ailments of childhood, but otherwise had been in fairly good health until about Christmas, 1894. He was then treated at Pekan for "simple rheumatic inflammation of the tendon sheaths with some degree of high temperature and glandular swellings." In March, 1896, this illness recurred and was accompanied by a curious bilateral purpuric eruption on the legs fugitive in character. There was again acute inflammation of the tendon sheaths of both feet and of the right hand. He was sent to Singapore, where he was found to be suffering from a peripheral neuritis which was diagnosed as beri-beri. About this time the legs were swollen and he was unable to walk. At the end of June, 1896, he returned to duty. He said that he had squandered his money ever since in the purchase of useless, empiric drugs, but that he had never felt himself again. During the last two years he had had attacks of dysenteric diarrhoea and had been gradually losing heart and strength.

When I saw the patient he complained greatly of weakness and said that his legs often felt useless, especially after walking. He had a rash which came and went. It was on the face, the legs, and the arms. It was not painful and did not itch. About six months previously sores broke out on his fingers, which healed up from time to time of their own accord. Four or five months previously he felt a small lump on the nose. It had given little or no inconvenience and had remained about the same size. He noted that he fumbled in dressing himself and could not button his clothes with ordinary precision. For some time he had had a chronic cold and had snuffled, but he had had no cough. The appetite was indifferent, the teeth were decayed, and the bowels were irregular. On examination he was found to be a tall, thin, sad-looking man with an unnatural aspect. The skin of the face was coarse, with a livid flush on each cheek. The ears were enlarged, projecting, and deformed and were wrinkled and nodular. At the bridge of the nose there was a small broad tubercle. The eyebrows were scanty. The hands were wasted as if from paralysis of the ulnar nerve and the fingers showed clearly some trophic lesions in the skin. They were covered with dry sores, especially on the back of the phalangeal joints. Otherwise the skin here was smooth and glossy as if it had been varnished. There was impairment of sensation in the skin of the fingers and forearms and in places there was anæsthesia. The muscles of the arm and especially those of the forearms were wasted. The interossei muscles were atrophied and doubtless an application of the Roentgen rays would already demonstrate atrophy of the metacarpal bones. The body generally was covered with large patches of brownish pigmentary stains. The chest was ill-developed, but the heart and lungs appeared to be normal. On the outer side of each leg there were patches of anæsthesia with purplish eruptions on the shins. A distinct nodule, among others, of about the size of a split-pea could be felt on the extensor aspect of the right leg. The patient was sent to Singapore where he was seen by Dr. M. F. Simon, in consultation with Dr. J. T. Leask and Dr. W. G. Ellis. They found the bacilli of leprosy in large numbers in the discharge from a sore on the finger and in serum taken from a nodule on the ear.

I have much pleasure in expressing my thanks to the Principal Civil Medical Officer (Dr. Simon) for his kindness in confirming the diagnosis. There were no other cases of leprosy in Pekan at the time. The disease, in fact, is not common in Pahang, where it is usually met with among the poor of the native population. In this case, however, the patient was an intelligent member of the community following a public occupation and leading a more or less healthy life. It is an instance of the mystery which still surrounds the origin of isolated cases of leprosy. The history is of special interest now that the compulsory segregation of lepers is under the consideration of the Government.

It is agreed that leprosy is a contagious disease. All observers, however, who are not influenced by any theory and who have no desire to fit the facts of their cases to any favourite doctrine will, I think, admit that a certain number of cases appear to militate against a very widely received opinion as to the advisability of compulsory segregation. Ample as the reason for legal measures may be in the colonies, they will, I think, allow that under certain circumstances voluntary isolation is a sufficient safeguard. I refer

especially to those periods of latency which may occur during the course of the disease.

In the case given above the patient had given up his occupation and had made no attempt to trifle with his affliction. If any inquisitorial interference with his home had been instituted there would not have been wanting critics to designate it as a grave offence against the public liberty. Doubtless if the disease had been found out earlier he would have been discharged from his office long before. It may be fairly presumed, however, that until the open sores had developed he had not been an immediate source of danger to the crowds in the police courts. After that time the danger from inoculation would have been great. In this particular case the difficulties in diagnosis of the early stages of leprosy were well exemplified. It was at first confounded with an infective form of rheumatism and then with the peripheral neuritis of beri-beri. Later the patient was popularly supposed to be suffering from tertiary syphilis. Like hydrophobia and diphtheria leprosy is most deadly when it forms a focus, and although the bacillus so closely resembles that of tuberculosis the resisting power of man to the bacillus lepræ is probably not as great as that to the tubercle bacillus. In both cases isolation as a preventive measure affords the best and only protection for the public health, and although the hygienic treatment of tuberculosis in sanatoria seems likely to repay at last the persevering quest of modern scientists the cure of the individual leper seems more likely to be brought about by the inoculation of some antitoxin.

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A CASE OF SUPPRESSION OF URINE OF 60 HOURS' DURATION TREATED BY OPERATION.¹

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A MAN, aged 53 years, was admitted into St. George's Hospital on Dec. 3rd, 1899, complaining that he had not felt well for several weeks. During the last week of November he suffered from pain in the left loin and a dragging sensation in the region of the left kidney. Micturition was frequent, his urine appeared natural in colour, and he had never seen any blood. On Dec. 1st he was unable to pass any urine whatever and complained of acute tearing pains in the left groin and lumbar regions with frequent vomiting. He was seen by a physician, under whose directions hot fomentations were applied to the loin and diuretics given internally, but with no good result. The suppression persisted during the next two days. A catheter was passed, but only a little blood-stained mucus was drawn off. No definite tumour could be felt at first, no doubt owing partly to the thickness of the abdominal walls and to their rigidity, but on the 3rd a very definite tumour could be felt which was thought to be a distended kidney, probably hydronephrosis. He had never had any trouble with his urinary tract and apparently his only illness was an attack of congestion of the lungs when he was much younger.

On his admission to the hospital, when I saw him on the evening of Dec. 3rd, 60 hours from the onset of the total suppression of urine, he appeared to be healthy. He was a somewhat stout man. His expression was anxious and he was restless. There was marked perspiration, especially of the hands, and the tongue was fairly moist. The pulse was rapid (124) and intermittent, dropping a beat about every seventh beat, and the respirations were 24. He complained of considerable pain and tenderness over the region of the left kidney. There was marked resistance of the abdominal walls on the left side, but by careful palpation a large rounded swelling could be felt, about as large as a coconut, soft, though no actual fluctuation could be made out. The manipulation appeared to cause much pain, so it was not continued. A catheter was now passed, but only a little blood-stained mucus was removed; I therefore recommended an exploratory operation by a lumbar incision and draining the supposed hydronephrosis.

Gas and ether were given and an oblique incision six inches long was made in the left lumbar region. Upon opening the swelling it was found not to contain urine, but blood-clot and serum to the quantity of rather more than a pint, which was situated between the perinephritic fat and the kidney, and on incising the capsule blood was found between the capsule and the cortex. The capsule being stripped off the kidney over a considerable area the kidney appeared to be larger than normal, and on incision it was much congested and bled very slightly. The pelvis of the kidney was full of blood-clot. No calculus was felt. A sound was carefully passed into the upper part of the ureter but nothing was felt. The pelvis of the kidney and the space outside the kidney were freely irrigated with warm water at a temperature of 102° F. A large-sized drainage-tube was passed into the pelvis of the kidney and the wound was sewn up with silkworm-gut sutures and dressed with cyanide gauze and wool. Two hours later the dressings had to be changed as it was found that urine was being freely secreted and passing from the drainage-tube. During the night the drainage-tube slipped out of the pelvis of the kidney and I did not think it necessary to replace it.

Thirty-six hours later practically all the urine was passed by the urethra. The first urine passed contained blood but not in any great quantity, the following day it was only slightly turbid, and before the end of the week there was no blood. The urine was pale in colour, of a specific gravity of 1015, it was faintly acid, and there was no albumin. The quantity passed in 24 hours was 65 ounces, and the quantity increased daily during the next fortnight till it reached 100 ounces in the 24 hours and the following week it gradually diminished to 70 ounces. The intermittent condition of the pulse disappeared during the patient's stay in the hospital. The stitches were removed on the sixth day and on the sixteenth day he was allowed to get up. He left the hospital just three weeks after admission, quite well.

This case is one of considerable interest—firstly, as to the cause of suppression; secondly, as to the question of operation in similar cases; and, thirdly, with regard to the question which has recently arisen regarding the insurance of the lives of patients after operation.

As to the cause of suppression of urine it may be placed under two heads (1) obstructive suppression due to some mechanical cause, and (2) non-obstructive suppression due to a pathological cause. It is difficult to know in which class to place this case. In obstructive suppression the usual cause is an impacted calculus either in the pelvis of the kidney or in some part of the ureter, the other kidney not being functionally active or being so diseased that it is unable to carry on the increased amount of work. I can recall a case very much resembling the above. Some years ago I was called to see a case of total suppression of urine, but when I saw the sufferer operative interference was out of question, the patient being already moribund. At the post-mortem examination the capsule of the kidney was completely stripped off up to the hilum and contained a pint of blood-clot, the kidney was enlarged, and on cutting into the pelvis of the kidney a scale-like piece of calculus was blocking up the ureter. The very slightest manipulation would have displaced it. The opposite kidney was totally obliterated and its place was taken by a large branched calculus covered by only the capsule. It is quite possible that the present case was of a similar nature and that the irrigation displaced the calculus thereby allowing the free passage by the ureter. Of course, it is quite possible that the suppression was due to kinking or pressure of the ureter by the blood surrounding the kidney. Of likely causes of non-obstructive suppression the only one is congestion of the kidney. The patient admitted that he had been dieting himself with the view of reducing his weight—in other words, he had been "Banting"—and in a patient over 50 years of age this might easily have caused marked congestion and thereby suppression.

As to the question of operation in these cases I am of opinion that if one is certain of the diagnosis the sooner the kidney is explored the better. There is a difficulty in many cases of ascertaining which kidney is affected. Laparotomy and the examination of both kidneys have been recommended followed by a lumbar incision and the removal of the stone, but there are many cases recorded which have been operated upon and in which no stone has been found. Some authors place the number as high as one case in every five where no stone is found but after the operation all the symptoms of stone disappear. Is not this due to

¹ A paper read before the Harveian Society of London on Feb. 15th, 1900.