the man had sent out his mother upon a trivial errand; he had then locked himself in the room in which she had left him alone—securing the door on the inside,—and during her absence had made the attempt to destroy himself, using a sharp shoemaker's knife. The sequence in which the wounds were made is indeterminable, but the presumption is thought to favour the idea that those in the nape and occiput were first inflicted. Their length suggests that the dominant impulse was the intention to cut off the head rather than to pith the spinal cord. This attempt failing, he stabbed himself repeatedly in the chest, and lastly cut his throat, after which the great loss of blood and the collapse of the left lung rendered him powerless to continue his mad efforts. The apprehension of the occurrence of suffocative oedema has led to the recommendation of tracheotomy by some authorities as a rule of practice in wounds of the larynx. Here, the patient being in hospital and skilled aid being always promptly available, it was deemed sufficient to have the apparatus for placing a tube in the air passages at hand, but at no time did the necessity for recourse to this occur. Death was plainly referable to the acute pulmonary complications.

A man aged twenty-eight, a cobbler, was admitted into Founder ward on April 11th, 1889. He had a swarthy, ex-sanguine complexion; his face was deeply scarred by small-pox, and its expression wandering; his voice was reduced to a husky whisper; his clothes were soaked with blood. Crossing the junction of the occiput with the nape of the neck were three deep, jagged, incised wounds. A jagged, incised wound crossed the front of the throat, extending from the posterior border of the left sterno-mastoid muscle to the middle of the right muscle of this name, partially dividing both these muscles, severing the depressors of the hyoid bone, and cutting through the thyroid cartilage a little below the level of its middle. In the right ala of this cartilage was a triangular defect, a piece having been cut out; whilst in the left ala were two deep cuts intersecting one another at the keel formed by the junction of the alæ. Through the above defect in the right ala the respiratory movements of the glottis were plainly apparent. All bleeding from this large wound had ceased except from the right external jugular vein. In the left front of the chest were four wounds—stabs. Of these, two seemed to be superficial, whilst from the others air issued, proving the pleural sac to have been opened. One of these penetrating wounds was in the third costal interspace, about an inch and a half inside the nipple line, whilst the other was in the fourth space in the nipple line. This side of the chest was hyper-resonant, and respiratory sounds were absent except posteriorly at the base, where they were very faint and accompanied with coarse râles.

The wounds on the chest and on the occiput were washed with a solution of carbolic acid in water (5 per cent.), dusted with iodoform, and closed with compresses of boracic lint. The wound in the neck was similarly cleansed, and lightly covered with a couple of layers of carbolised gauze.

During the next two days nothing worthy of note occurred, except that his general condition scarcely betrayed the receipt of so many and such severe wounds. He sat up in bed, took nourishment freely, swallowing without difficulty, and passed quiet nights. On the 12th he was sleepless, but on the 13th he slept well. On the 14th at 11 P.M., he sprang suddenly from the bed, knocked down the nurse and the male attendant in charge of him, and tried to escape from the ward. This attempt was prevented; he was secured, put again into bed, and hyoscyamine (the fortieth of a grain) hypodermically given, after which he slept during the rest of the night. The injection was repeated twice in the course of the following forty-eight hours. On the 17th the chest wounds were found to be closed, and that in the throat had contracted. On the 18th, at 3 A.M., he again became restless and violent; at 4.30 A.M. he was slightly convulsed and comatose; and at 7 A.M. death occurred.

At the necropsy on the following day, one of the cuts in the nape was found to have penetrated to the occipito-atloid ligament. The stab in the third intercostal space had pierced the upper lobe of the lung to the depth of three-quarters of an inch. The edges of this wound in the lung were glued together by fresh lymph; the lung around the wound was not solidified. There was not any pleuritic effusion. The lower lobe of this (the left) lung was intensely engorged, and its bronchi were filled with muco-purulent fluid. The

right lung was very congested, and it contained several areas plugged with inhaled blood surrounded by excessive engorgement. The laryngeal wound had passed between the false and the true cords. The occurrence of the patches of hæmorrhagic infarction in the right lung only was attributable to the collapse of the left consequent on the opening of the left pleural sac.

The forensic interest of this case is its chief importance, and the justification of its being published.

CROYDON GENERAL HOSPITAL.

REMOVAL OF CALCULUS HAVING A FOREIGN BODY AS NUCLEUS BY SUPRA-PUBIC CYSTOTOMY.

(Under the care of Dr. ADAMS.)

THIS case is one in which a calculus of the bladder formed around a foreign body as the nucleus, and is a good example of what in the male is a comparatively rare mode of formation of stone. Symptoms resembling those produced by a calculus had commenced four years before the date of admission, were relieved by catheterism, and recommenced after an accident to a catheter, the broken part of which was supposed to have been removed. However, on section of the stone after removal the central part was occupied by the bulbous end of a black elastic catheter, the remainder of the concretion consisting of the phosphate of lime and phosphate of magnesia and ammonia which generally constitute the calculous mass deposited on substances introduced into the bladder. Foreign bodies forming a nucleus for stone are not often met with in the male bladder, although they are not infrequent in the female. In the former instance they may be introduced through the urethra, and are usually a portion of bougie or catheter. Of these the museums of most hospitals have specimens. In that of the Royal College of Surgeons there are three of contorted bougies encrusted with phosphates. There is also one in which a brass pin forms the nucleus, another in which a pea occupies the centre, and two in which the phosphatic concretion was deposited upon a mass of margarate and oleate of lime. In these instances the nucleus resulted from the use of solutions of soap for irrigation of the bladder. In this museum, also, there is a stone of more than usual interest, thus described in the catalogue: "A slender piece of steel as the nucleus of a large oval calculus, consisting almost entirely of uric acid. The tendency to the deposit of uric acid must have been exceedingly strong in this individual, since it has not only prevented the deposition of phosphates, but has established and maintained during the whole of the period required for the growth of the calculus a diathesis of a totally opposite character." Foreign bodies introduced from without, usually by a process of ulceration, are of various kinds—lime, pieces of clothing, ligatures, bullets (of which Dixon collected fifteen examples), &c. Various things may pass from the rectum into the bladder. In one of the cases recorded by Surgeon-Major Keegan the nucleus was a long piece of "tilli" stalk, which had entered in this way by a process of ulceration.

H. H—, aged fifty-five years, was admitted on Feb. 28th, 1889, for supposed malignant disease of the bladder. The symptoms dated from four years ago, when he began to notice unusual frequency of micturition, which became more and more painful until two years previously, when he was an in-patient, and was repeatedly, but unsuccessfully, sounded for stone, and finally discharged, passing a catheter for himself. This he continued to do until (he says) the end of the catheter came off in his bladder, and he was re-admitted to the hospital, and the fragment removed by "aspiration" through the urethra. Since this time he had never been well, and had been getting progressively and steadily worse as regards his difficulty of micturition and the pain accompanying the act.

Condition on admission.—Aspect pinched and worn-looking; sallow complexion and eruption of acne rosacea round the nose. Voids his urine every fifteen or twenty minutes, with the most extreme tenesmus, the pain causing him to groan aloud, and being almost continuous. Bowels usually act at the same time loosely, and the motions are very offensive. Urine brownish, smoky-looking; strongly ammoniacal, and alkaline; fetid; sp. gr. 1022; contains much viscid muco-pus and some triple phosphate, which,

after standing for twelve hours, reaches two-thirds of the way up the specimen glass. Limbs feel clammy, and body surface cold.

On passing the catheter after a severe tenesmus, five ounces of fetid residual urine were withdrawn. The bladder was then thoroughly washed out with Thompson's fluid, a morphia suppository given, and a medicine ordered consisting of salicylate of soda, tincture of belladonna, and infusion of buchu. He took milk and farinaceous food.

March 1st.—Had about two hours and a half's rest after washing out the bladder last night, after which the tenesmus &c. returned. Urine yellow; deposit only equal to one-third of specimen; sp. gr. 1020; ammoniacal. Bladder to be washed out night and morning.

3rd.—Much better; slept quietly for three hours after irrigation last night. He still has great tenesmus, and has to pass urine every three-quarters of an hour, except for a time after the use of a catheter. Urine alkaline; faint smell, but not ammoniacal; mucus much less in amount, and flocculent instead of ropy; pale yellow; urea 1·2 per cent. The diarrhoea has ceased. His careworn expression has nearly left him. He still complains of pain in the hypogastric region. The pain and tenesmus in the bladder are worst just when it is emptied by the catheter, but after the washing out is completed he has from two to four hours of comparative comfort.

13th.—Chloroform was given, and a stone felt by Dr. Adams; it measures about two inches in diameter. Condition generally is much improved.

16th.—Chloroform again given. Bladder washed out and distended with twelve ounces of boric lotion; rectal bag introduced and filled with water (nine ounces). The bladder can now be easily distinguished above the pubes. A three-inch incision was made in the linea alba, reaching well down on to the symphysis, and was deepened until the bladder was exposed, looking pale and somewhat glistening. This was fixed with a hook and opened, when the finger at once felt the stone, and scarcely any difficulty was experienced in seizing it with forceps and removing it. Several small fragments were felt and removed; and on exploring the base of the bladder with the finger, a bar was felt to extend across, leaving a shallow pouch behind, in which the stone had rested. The bladder was thoroughly washed out with a Higginson's syringe and boric lotion, a No. 15 drainage-tube inserted, and the upper part of the wound brought together with three silver stitches, which passed through the aponeurosis. A morphia suppository was then administered and the wound dressed. The stone weighed two ounces and thirty grains, and consisted of mixed phosphates or "fusible calculus." It was smooth and convex on one side, where it rested in contact with the bladder, rough and tuberculated and flatter on the other. Its nucleus was seen to be some foreign body. Around this the mixed phosphates were deposited in laminae.

17th.—All the urine has come through the tube. The wound has been dressed twice, and the patient has been lying on either side alternately. He has had a very comfortable night, and complains only of a little smarting in the wound.

18th.—A smaller drainage-tube was substituted for the one in the bladder, and connected with another which conducted the urine into a bottle in the bed. In this way the man was kept quite dry.

19th.—Wound looking as well as could be wished, union being already nearly completed above, and the lower part beginning to granulate. Has passed thirty-nine ounces of urine, which is healthy and contains only a trace of albumen. Pulse and temperature normal.

22nd.—Drainage-tube taken out.

24th.—A Jacques' catheter was passed per urethram, and left in, as his back was slightly sore from the constant wet. He is otherwise as well as can be wished. Stitches taken out, and wound brought together with strapping.

On the 25th the bladder wound had closed. On the 26th the catheter was left out, but ordered to be passed night and morning. The man left the hospital in April.

CENTRAL LONDON DISTRICT SCHOOL, HANWELL.—The assent of the Local Government Board has been given to the appointment of Mr. Sydney Stephenson to take exclusive charge of the ophthalmic cases in the Central London District Schools at Hanwell. The appointment has been made for one year, at a salary of £500. Mr. Stephenson had charge of a similar outbreak in the schools which belong to the parish of Lambeth, at Norwood.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

*Laparotomy for Gangrene of Vermiform Appendix.—
Tracheotomy for Foreign Body in Bronchus.*

THE last ordinary meeting of this Society for the present session was held on June 11th, the President, Sir Edward Sieveking, in the chair.

Sir DYCE DUCKWORTH and Mr. JOHN LANGTON read a paper on removal by operation of a Gangrenous Vermiform Appendix containing a faecal concretion; secondary laparotomy through the linea alba was performed for suppurative peritonitis, and recovery ensued. The case was that of a boy who exhibited all the symptoms of acute suppuration in the neighbourhood of the caecum. Operative measures were at once adopted, and revealed a gangrenous condition of the appendix caeci, which was removed together with its contained faecal concretion. Some days later a median laparotomy was performed in consequence of symptoms pointing to a fresh suppurative peritonitis on the left side. A collection of some ounces of pus was found in a large cavity bounded by agglutinated intestines. The abscess sac, which extended deeply into the pelvic cavity, was drained, and the patient made a complete though somewhat tardy recovery. The authors, in bringing this case forward, laid stress on the importance of early operative interference when suppuration in the neighbourhood of the caecum was supposed to exist, and all the more so in cases of young adults, as the cause was so often due to the presence of some foreign substance in the appendix. They also advocated the value of making the incision in the right semilunaris, as being more directly situated over the seat of the lesion than one made in the middle line.—Mr. TREVES had read a paper before the Society some time ago on this subject, in which he stated his belief that in the relapsing form of typhlitis the vermiform appendix was always at fault. Operations for this condition might be done at three periods: in the early stage of the trouble; or when suppuration was evident; or when no symptoms existed at the time, but there had been a second or third attack of typhlitis, and there was reason to suspect a third or fourth. In America, operation during the first stage had met with much more favour, and the abdomen had been opened by some surgeons in almost every case; probably in many of these instances recovery would have ensued without operation. One complication that might be met with in the early stage should be borne in mind: pus might spread along the back of the colon, and this would probably happen in cases where the vermiform appendix was abnormally placed. He was in the habit of using the freest possible drainage, employing a tube three-quarters of an inch in diameter; this was necessary, as the wall of the abscess sac was usually irregular, being formed only of intestine. He had removed many appendices during a "lucid interval" between two attacks. In more than one case, after a fourth or fifth attack, the appendix had been removed and no subsequent trouble had taken place. It was dangerous to cut directly down on the appendix, as the caecum might be adherent to the parietes and might be inadvertently opened. Mr. Treves concluded by emphasising the importance of carefully suturing the vermiform appendix, and by alluding to two cases in which, on account of adhesions, removal of the appendix was a surgical impossibility.—Mr. BENNETT said that where pus was present, or a strong suspicion of it, no doubt operation was needed. He asked where was the best place for the incision, and when the appendix should be dealt with. He had operated on two early cases of suppurative typhlitis; in both there was induration of the parietes up to the semilunar line. He had seen cases in which the suppuration was isolated, opened into the general peritoneal sac from a median incision; he therefore made his incision near the anterior superior spine of the ilium, opened the abscess, and drained thoroughly. One of his cases had healed; the other was on the way to do so. If one went away from the centre of suppuration, there was a danger of unnecessarily opening the general peritoneal sac. Where the gangrenous appendix lay exposed and the general peritoneal cavity was opened, then the former should be removed; but if the appendix was perforated into a loculus and the case was an early one, he thought it better to leave the appendix at least for a