the bladder, and, after drawing off the urine, about six ounces of warm water were injected, when the bladder could be seen to rise distended nearly to the umbilicus. An incision about two inches long was made in the middle line, with its end well over the pubes, and a dissection between the muscles exposed the bladder, which rose into the wound. The bladder wall was then incised to the extent of half an inch with a sharp-pointed scalpel, this being followed by a gush of the water which had been injected. On introducing the finger, the stone, a small one, was felt, and easily removed. The bladder was then seized, and, by means of a curved needle, silk threads were passed at each end of the incision to hold it forwards. Seven Lembert sutures of fine carbolised silk were then passed through the walls in such a way that the sutures at either end lay well beyond the angles of the wound. After the sutures were tied the bladder was fully distended with water, and it was seen that none escaped. Finally, a small tube was put in at the lower angle of the abdominal wound which was closed with four or five sutures. The parts were dusted with iodoform, and a mercuric wool dressing applied. The peritoneum was not seen throughout the operation. At 8 P.M. the same evening he was quiet and free from pain, and had passed urine naturally through the urethra. The next day (Nov. 6th) he complained of some pain in the chest and cough. He continued to pass urine without difficulty. The temperature that evening, which had hitherto been normal, rose to 101.4° . On the 7th he was found to have acute pneumonia on the left side. He was much troubled with frequent and distressing cough. We now found from his mother, what had not previously been discovered, that he had been absenting himself from school, and, fearing punishment when he got home, he had for two nights previously to his admission into hospital slept out of doors. The wound was dressed, and looked quite quiet; there was no discharge, and it was healing. The tube was removed. Temperature 103.4° . He continued to pass urine naturally. On the 9th the cough and fever were troubling him a great deal. He had much dyspnoea. The wound was dressed and had healed, and the abdominal sutures were removed. The following morning, on awaking from sleep, he had a violent and prolonged fit of coughing, lasting half an hour. On removing the dressing a portion of the skin wound was found gaping. There had been no bladder trouble. On the 12th he began to recover from the attack of pneumonia, and his temperature suddenly fell to below normal. From that date he made an uninterrupted recovery. The portion of the skin wound that had opened healed by granulation. He never had any urinary trouble, and is now well. The boy was shown to the Nottingham Medico-Chirurgical Society just a month from the date of his admission into hospital.

The following points may be noted in connexion with this case. 1. It was one which was most favourable for the success of the particular operation which was performed. Thus the urine was quite healthy, clear, and free from deposit. There was no albumen and no sign of renal disease. The boy's suffering was slight, and the stone small. 2. The operation was put to a severe test by the occurrence of acute pneumonia on the second day. Not only was there pyrexia to contend with, but a frequent and violent cough, which I feared might prove especially disastrous to a wound in this situation. As a matter of fact, although the bladder wound healed without hindrance in spite of this drawback, yet the cough spoiled the brilliancy of the result, for on the night of the fourth day, after the sutures had been removed and the wound healed, the violent fit of coughing which ensued on his waking from sleep was, in all probability, answerable for the tearing open of that portion of the wound that subsequently healed by granulation. I firmly believe that if it had not been for the pneumonia he would have been up and about at the end of a week. 3. The third point I would mention is that no catheter was employed, nor had one to be used subsequently. The calculus was composed of oxalate of lime, with an unusually rough and spiculated surface.

Nottingham.

LIVERPOOL MEDICAL INSTITUTION.—At a meeting of the members of this institution the following resolution was adopted: "That, in the opinion of this meeting, it is desirable that the physicians, surgeons, and medical officers of all non-medical charitable institutions should receive some pecuniary recognition of their services."

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

MENINGITIS AND COMPULSORY EDUCATION.

BY B. LANGRAN, L.R.C.P. ED., L.R.C.S.I., &c.

THE following is a brief account of three cases of meningitis which it has been my misfortune to attend within the past month.

CASE 1.—G. S—, aged eleven years, had been ill for three weeks before I saw her in consultation with the medical man then in attendance. At the time of my visit she was very pale and much emaciated, and complained constantly of her "poor head"; the abdomen was retracted, but there was an entire absence of vomiting, nor was she at any time convulsed. She took her nourishment well whenever it was offered, but asked for nothing. A week afterwards she passed into a semi-comatose condition, in which all her motions were voided involuntarily, but continued to take a considerable quantity of milk. The coma became more profound, yet she lingered on for a fortnight longer, when she passed quietly away. The family history was good, but the child herself had never been robust and was of a very nervous temperament.

CASE 2.—M. C—, aged ten years, was first attacked with giddiness followed by convulsions and vomiting, after which she was for a few days comparatively well, complaining only slightly of her head; the convulsions, however, returned, and she cried out constantly of the pain in her head. Gradually becoming worse, she passed into a state of stupor, in which she remained till the time of her death—three weeks from the initial symptom,—the muscles of deglutition being paralysed for twenty-four hours before death. This child previously to her illness had been a strong, healthy, rosy-cheeked little girl, with a good family history.

CASE 3.—E. D—, aged twelve years, complained of malaise and headache on Feb. 28th, and at 4 o'clock A.M. on March 3rd had a violent convulsion followed by vomiting. The convulsive movements recurred every few hours during the day, but ceased that night, when she became semi-comatose. The stupor deepening, she sank rapidly, and died at 2 P.M. on the 5th, six days from the beginning of the illness. In this case the family history was not so good, and the rapidly fatal termination may possibly be in some measure attributed to the poverty and unhealthy surroundings of the child.

The above cases corroborate the generally acknowledged facts—first, that the diagnosis of meningitis in the early stage is usually a matter of great difficulty; and, secondly, that the symptoms presented throughout the disease vary considerably. In the first case there was an entire absence of both vomiting and convulsions, whilst the duration of life for six weeks is also unusual; the second is a more typical case, but in it, as in Case 3, the patient vomited only once. In the latter the constantly recurring convulsions so rapidly passing into coma and death present a great contrast to the first case. In two particulars they all agreed—a well-marked *tache cérébrale* and the peculiar sighing respiration. As regards the treatment adopted, in two cases the heads were blistered, in all three, cold affusions were employed, whilst internally bromide and iodide of potassium, mercury with chalk, calomel, &c., were variously used. Post-mortem examinations were not obtainable, and in no case could I discover tubercular disease of any other organ; yet I am inclined to think that Cases 1 and 3 were of tubercular origin. The patients resided at distances varying from two to six miles from each other, and all three were actively preparing for the School Board examinations, and attending different schools. Further, each of them, during delirium, spoke of school tasks, teachers, &c., from which (in the absence of any other assignable cause) I conclude that educational pressure was in these instances the exciting cause, and I have little doubt that the present compulsory education system is not only highly injurious, but productive of many cases such as I have recorded. That children must all at a certain age attain a certain

standard or the school and teachers suffer loss, is a barbarous regulation, as everyone with any knowledge of children is aware that they differ as much in brain power as they do in personal appearance. Fear of punishment or, if sensitive, dread of disgrace, urge many of them to attempt tasks far beyond their power, and the result is too often utter collapse, either physically or mentally.

Axminster, Devon.

STRICTURE OF THE RECTUM FOLLOWING UPON FISTULA IN ANO.

BY G. R. GILRUTH, F.R.S.E.

MRS. — came under my care in 1876, as she was suffering from a troublesome discharge of pus from the rectum. She had previously been operated on for fistula in ano. An examination revealed the presence of a large abscess situated on the left side of the anus. With the assistance of Dr. Alexander Moir the abscess was opened and a large quantity of pus evacuated. As the opening into the rectum could not be found, the point of the bistoury was pushed through its coats and the sphincters divided by a free incision. Several sinuses were found running deeply in different directions. The case was treated in the usual manner, and the sinuses were syringed out with carbolic lotion for a long time. Some improvement resulted from this treatment. The patient, however, left Edinburgh, and was not again seen till 1888. This time she came to consult me on account of the pain and difficulty she felt in evacuating the bowels. The difficulty had become so great that purgatives had almost always to be taken. On examination, it was found that the sinuses had all healed soundly, and that there was no trace of the fistula. On passing the finger into the rectum, a broad rigid band could be felt corresponding to the left half of the internal sphincter, and behind this point there was a large sac, and into this pouch, the patient said, as Brodie long ago remarked, the fæces seemed always to lodge. The opposite side of the sphincter was soft and yielding. Bougies were used, and gradually increased in size. There was still, however, some difficulty with the stools. On May 25th, 1888, an incision was made through the thickened portion of the gut, and on May 28th the patient had a free natural stool. Up to the present date I believe she continues well.

The interesting points in the case are—first, the healing of the fistula and the sinuses; secondly, in the plastic matter that had been thrown out becoming organised, and going to form the stricture portions of the gut.

Edinburgh.

ON SENSATIONS REFERRED TO THE MOUTH.

BY J. HILTON THOMPSON, M.D. VICT.,

LATE SENIOR RESIDENT MEDICAL OFFICER TO THE CHILDREN'S HOSPITAL, PENDLEBURY.

THE following case appears to be similar in some respects to those described by Dr. W. B. Hadden in THE LANCET of Jan. 25th, 1890.

Mrs. B—, a lady forty-nine years of age, noticed about five months ago tingling sensations in the tongue, the mouth at the same time feeling hot and dry. The tingling increased in intensity, until the tongue felt as though the ends of numerous small wires were being pressed against it. This sensation was more marked in the posterior two-thirds of the organ. The sensation of heat also became more marked, until the tip of the tongue, palate, and gums seemed to burn. These sensations were worse at night, and interfered materially with the patient's sleep, she also stated that she frequently suffered from a feeling of distension in the epigastric region, also from scalding eructations, occasional palpitation, and pain between the scapulæ. On examination I found the patient anæmic and depressed. The thoracic organs were apparently normal; the liver was not enlarged, but there was slight pain on pressure over it; the stomach was dilated, but not painful on pressure; the tongue small, dry, and covered with a thin white fur, through which large and congested papillæ projected at the sides and tip; bowels constipated; kidneys normal; old laceration of perineum and cervix. The patient had no teeth in the upper jaw, but wore artificial ones attached to a suction plate; this, however, did

not appear to have anything to do with the symptoms complained of, for they continued after the plate was removed; sense of taste less acute than normal, but not markedly affected. Supposing the condition of the mouth to be secondary to a disordered state of the digestive organs, I prescribed in the first place terebene purus, hoping that it would relieve distension and arrest the cultivation of organisms. The bowels were regulated by means of podophyllin and small doses of calomel. At the end of a week the patient had improved, the above treatment was stopped, and a mixture of liquor pepsi porci, with hydrochloric acid, ordered; massage over the liver performed every day; diet limited to starches and milk. The patient improved rapidly, and now the pricking and burning sensations have quite disappeared.

In this case there was nothing in the condition of the mouth or tongue to account for the symptoms; but the fact of the sensations diminishing in intensity, and finally disappearing as the condition of the digestive system improved, make it probable that the sensations complained of were the result of an irritant acting on the nerve endings in the stomach, and that the resulting sensations were referred not to the seat of the irritation, but to the tongue. When it is remembered how closely united are the origins of the vagus and glossopharyngeal nerves in the medulla, and how intimately connected in the first part of their course, we would appear to have a reflex tract that would at least account for sensations of pain in the posterior part of the tongue; moreover, we know that irritation of the fibres of the glossopharyngeal in the posterior third of the organ produces nausea and vomiting (Volkman), this is the result of a reflex from tongue to stomach, consequently a return reflex from stomach to tongue is all the more probable.

Brooks's Bar, Manchester.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

THE LONDON HOSPITAL.

CASES OF OPERATION FOR DISEASE OF THE HIP JOINT IN WHICH THE UPPER EPIPHYSIS WAS SEPARATED;
REMARKS.

(Under the care of Mr. RIVINGTON.)

THESE cases of separation of the upper epiphysis of the femur are an interesting contribution to the subject of diseases of the hip-joint, and illustrate a condition for which early operation is desirable. It is not possible to give the average percentage of hip-joint disease in which this separation may be expected, but the Committee of the Clinical Society on diseases of that joint found that necrosis occurred in nearly 60 per cent. of the specimens examined. The case of simultaneous excision of both hip-joints is especially interesting; there are few on record.

CASE 1. *Excision of the hip-joint; recovery with a serviceable limb; remarks.*—Wm. H. J—, aged fifteen, clerk, was admitted under the care of Dr. Gilbert Smith. He had enjoyed fairly good health all his life, but had suffered from bronchitis. Since leaving school, two years before, he had been an under clerk. The present illness commenced on Nov. 22nd, 1888, when he experienced severe pain round the right hip-joint, for which he could not assign any cause. He was treated by a doctor outside with blisters, but, getting rapidly worse, he came to the hospital and was taken in as a case of "rheumatism." He was transferred from the medical to the surgical wards on Dec. 8th. All the movements of the joint were performed with perfect ease, but just above and behind the great trochanter there was a tender swelling. Aspiration at this spot detected pus, and through a free incision a large quantity was evacuated. The resulting cavity was well washed out with carbolic lotion, a drainage-tube was inserted, and the wound was dressed with iodoform and wood wool. Extension