of the prostate is undoubtedly controlled by that of the testes. Up to puberty there is no prostate worth mentioning. If castration is performed before puberty the prostate never grows; if after puberty it wastes and disappears, and the same has now been shown to be true of the abnormal development known as enlargement. This rarely begins after an age at which it may be presumed that the testes are no longer functional (Sir H. Thompson and Sir G. Humphry), and it disappears if they are removed. There are now nine cases on record, in which castration has been followed by complete disappearance of the enlargement within a very few weeks, every single case in which any note as to the condition of the prostate has been taken.¹ There can, therefore, be no question that in some way or other the condition of the testes controls that of the prostate both in its normal and enlarged form.

In this relation between the prostate and the testes there is a very close parallel to that which exists between the ovaries and the uterus. Nor is this surprising. The testes in the one sex are the dominant organs in the sexual system, and the ovaries in the other. The influence that each exerts upon the other (secondary) sexual organs is closely similar, and, perhaps, identical; but this must not be taken as showing that any closer homology exists between the prostate and the uterus (or between prostatic enlargement and fibroid disease) than that which exists between the testes and the ovaries. In what way the testes exert this influence upon the prostate so as to cause it to enlarge must remain at present a matter for speculation. The mere induction of sterility—as, for example, by section of the vasa deferentia—although it may be followed by wasting of the testes, does not appear to be sufficient.² The influence, whatever it is, comes from the testes themselves, and it exists so long as the testes are present. (It is to be noted that although enlargement of the prostate rarely commences late in life, presumably because at that time the testes are no longer active, their loss of functional activity does not induce atrophy of an already enlarged gland.) It may be exerted through the agency of the nervous system, or—as there is little or no proof that the nervous system has any direct control over normal and much less over pathological growth—through that of the circulation. Evidence is slowly accumulating that the nutrition of distant parts of the body is in some instances dependent upon the integrity of organs with which at first sight they appear to have no connexion. Affections of the thyroid gland, for example, rendering it deficient in some unknown substance, can produce the most profound structural alterations throughout the body. It is believed, on experimental evidence, that the pancreas may have duties in connexion with general nutrition entirely independent of its secreting action. There is reason to think that the condition of the ovaries has some influence in connexion with molities ossium; there are, at any rate, many cases on record in which the removal of these organs is stated to have been followed by recovery from this otherwise almost universally progressive disease. And though there is as yet no proof that morbid states of the testes (as distinguished from simple atrophy or removal) can induce changes in secondary sexual characters, this is undoubtedly true of the ovaries, as, for instance, the assumption of the male plumage by the females of various birds when the ovary is diseased.

If this suggestion that enlargement of the prostate is dependent upon some change that takes place in the testes during the latter part of their active life should be accepted—and certain facts point strongly in its favour—it is a curious instance of the way in which modern views are sometimes foreshadowed by the speculative theories of a long past date.

Note.—Since the above was written cases have been published by Watson of Boston and Lannois in which unilateral atrophy of the prostate has followed removal of one of the testes. If this can be established by post-mortem examination it may be taken as proof that the agency through which the influence of the testes is exerted upon the prostate is the nervous system and not the circulation.

Wimpole-street, W.

¹ Ramm of Christiania, *Centralblatt für Chirurgie*, No. 35, Sept. 2nd, 1893, and No. 17, April 28th, 1894; Arthur Powell, *Brit. Med. Jour.*, Nov. 15th, 1893; Professor White of Philadelphia, *Brit. Med. Jour.*, June 23rd, 1894; Mansell Moullin, *Brit. Med. Ass.*, Aug. 1894; and the following quoted by Professor White: Haynes of Los Angeles, California, *Buffalo Med. and Surg. Jour.*, March, 1894, and Fremont Smith of St. Augustine, Florida, *New York Academy of Medicine*, 1894.

² Griffiths, *Brit. Med. Jour.*, Sept. 30th, 1893, and Haynes, loc. cit.

A SUCCESSFUL CASE OF ENTERECTOMY WITH THE USE OF MURPHY'S BUTTON.

By PAUL SWAIN, F.R.C.S. ENG.,

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ATTENTION has recently been drawn in THE LANCET¹ to the use of Murphy's button in intestinal resections. The following case I venture to report at some length, as the use of the button by English surgeons has not hitherto, so far as I am aware, been extensive. In October, 1889, I was asked by Messrs. Chubb and Vinter of Torpoint to see a lad who had received a severe injury by falling under the prow of the steam ferry. The principal lesion was abdominal, and resulted in acute peritonitis, from which the boy recovered after a prolonged illness. I saw him some little time afterwards, when he was suffering from fecal impaction, and it was only after many days' use of injections and other remedies that his bowels were "cleared out." In the middle of September of this year I was again asked to see him, and the following history was obtained. His age was fifteen. Ever since the accident he had suffered from periodical attacks of violent abdominal pain, accompanied with great distension and violent vomiting, which on occasions had become fecal. The attacks commenced after some constipation and terminated in violent diarrhoea. Their frequency had of late increased, recurring sometimes twice a week. When I saw him he had just passed through one of these attacks. His abdomen was much distended but not tender. There was dulness on percussion over the cæcum and ascending colon. The countenance was pinched and anxious. My diagnosis was that, as the result of the peritonitis, he had some constricting band, and my advice was that an operation should be performed for his relief. He was consequently admitted into the Private Home for Patients at Plymouth, and on Sept. 27th I opened his abdomen. On passing my hand down into the right iliac fossa I found collapsed bowel and a broad band descending into the pelvis. The small intestine above this was enormously dilated, the circumference of the bowel being in some parts from twelve to fifteen inches. The constricting band was divided, but the intestines were glued together to such an extent that I had very considerable difficulty in separating the adhesions, as many as twenty pressure forceps being on at once. When I was able to draw out the part it was found that a dense stricture existed, through which it was nearly impossible to pass on the contents of the upper bowel. During the attempt to do so a small leak was detected at the point of stricture. It was at once decided to remove the constricted portion of the bowel. An elastic ligature was placed above and below this point and about five inches of gut were removed. The contents of the upper bowel were emptied as far as possible; it contained a large number of cherry and plum stones. The intestine was reunited with Murphy's button. A description of the method is fully given in the article alluded to above. The actual excision of the stricture and the reunion of the gut did not occupy ten minutes. During the night the patient was sick several times, and about midnight he became rather collapsed. He was fed per rectum every four hours with beef-tea and brandy. On Sept. 28th he was very quiet and was not in pain. The temperature was 98.4° F. in the morning and 99° in the evening. He was fed by the mouth every hour with small quantities of peptonised milk-and-water (equal parts), with an occasional nutrient enema. On the 29th he was comfortable. He passed flatus freely by the rectum. The temperature was 99.6° in the morning and 99° in the evening. The milk-and-water was continued in increased quantity. On the 30th he passed a dark liquid motion on three occasions. On Oct. 1st the bowels were opened; the resulting evacuation contained three orange pips. On the 2nd he passed an offensive motion containing milk curds and orange pips. On the 4th the silk-worm gut sutures were removed; the abdominal wound had healed. On the 6th there had been no motion for three days. A large quantity of feces was felt in the rectum. A simple enema produced a hard, lumpy evacuation. On the 7th he passed a loose motion containing a cherry stone, and another containing a plum stone on the following day after an injection. On the 10th, after an enema, he passed a large motion containing the button, nine

¹ THE LANCET, Sept. 15th, 1894.

plum stones, and three cherry stones. The button was coated with faeces and the tube was blocked by a cherry stone. On the 11th the patient was quite convalescent. He was allowed to get up and take fish and chicken.

Remarks.—The above case is in itself a very interesting one, but its importance principally consists as a record of the successful use of Murphy's button. The great objection to all intestinal resection is the length of time spent in securely suturing the ends of the gut. I was surprised at the facility with which the operation was performed. I was only familiar with the use of the button from the description I had read; and yet I found the reunion of the gut a very easy process. The adaptation of the serous surfaces was so perfect that it was with entire confidence that I returned the bowel into the abdominal cavity. Another point worthy of notice is this: the disparity in the circumference of the bowel above and below the stricture was so great that by the ordinary method of suture very considerable difficulty would have been experienced; but with the button all trouble of this kind was removed.

The Crescent, Plymouth.

YAWS IN BORNEO, NOT CONNECTED WITH SYPHILIS.

BY SURGEON-CAPTAIN F. SMITH, A.M.S.

HAVING recently met with cases of frambœsia in North Borneo which are not mentioned by some of the latest writers on the geographical distribution of the disease, it appeared to me desirable to report them, especially as they seem to throw some light on the question of the relation of yaws to syphilis. While travelling on foot through the jungle I came across a hut belonging to a man of the Dusun tribe. This house stands alone, miles from any other habitation, and the inhabitants have so little intercourse with coast people that they were quite alarmed when told that it was proposed to make a road which would pass their dwelling. The head of the house said, "In that case we must seek a home further away in the woods." The family consisted of father, mother, five children (one at the breast) and a son-in-law. Children Nos. 3 and 4 presented a shocking appearance. At first sight they certainly looked as if they were suffering from severe constitutional syphilis of an uncommon type, but a closer inspection quickly dispelled the idea. My companion, who has lived long in the country and is not a medical man, informed me that the disease was known to him as soft cancer. The best description I can give of the sores is that they were exactly like enormous condylomata, some of them with ulcerating surfaces, others more or less scabbed. A few tubercles had broken down and left ulcers. On one child (eight years of age) the face and neck were affected, and, more sparsely, the arms and legs. The other child (five years of age) was covered with tubercles, more particularly about the genitals and buttocks, where some of them were as big as walnuts and presented a mass of such density that the skin was hidden and the vulvar opening, the gluteal folds, and cleft between the buttocks could not be made out. The mouth was so surrounded that the child ate with difficulty. This condition of affairs was aggravated by the filthy condition in which the sufferers were kept. The next in age, a boy, was said to have recently had the disease, but was a healthy-looking, robust lad when we saw him. He bore scars around the mouth and on various parts of the body. The eldest daughter and the youngest were healthy, as were the father, mother, and son-in-law. The parents were not much concerned about the sickness; they said it was a common disease and would get well of itself, and the children be as strong as their brother who had got over it. I had no opportunity of seeing them again. The Dusuns are familiar with yaws, but syphilis is practically unknown among them. In this instance the father and mother were in good health and there were healthy children older and younger than those affected. Both the father and mother stated that there had been no miscarriages; all the children were alive at the time we visited the place, and they show a regular sequence in point of age (two, five, eight, eleven, and fourteen years). Lactation is prolonged among these people. There were no signs of syphilis to be found in the eyes or teeth of any of the family. The diseased children had no sores inside the mouth or on the hairy scalp, and

no evidence of bone affections or periostitis—nothing but the eruption. It is not likely that syphilis would present exactly the same appearances in three children, and in two of them at one time. Syphilis severe enough to have produced such a condition as was present in these cases would have caused serious constitutional disturbance, but the two Dusun children sprang up when we approached; they took a lively interest in us and in some biscuits which we gave them, and they moved about briskly, though their gait was interfered with by their sores. The Dusuns have no idea of the cause of yaws, but they know it to be contagious. These cases do not absolutely prove anything, but I think they may help to elucidate matters. I am sure that no unbiassed person who saw this family as I did could doubt that yaws and syphilis are totally distinct diseases. I have not met with the disease in Malaya—that is, British Malaya—but should imagine that cases will be found in the interior, inasmuch as the disease is said to be prevalent in the neighbouring Dutch possessions, as Java, Sumatra, &c.

Singapore, Malaya.

Clinical Notes : MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

CURIOUS FETAL DEFORMITY.

BY L. E. STEVENSON, M.B., B.C. CANTAB.

ON Oct. 11th of this year I was called to attend a woman, aged twenty-six, multipara. The previous labours, four in number, had been normal. The patient's abdomen was of unusual size, and I found a large bag of membranes protruding through the os during the pains. This I ruptured, and an enormous quantity of liquor amnii flowed away. I could feel the head presenting very high up. There was long delay at the brim, and when the os was sufficiently dilated I applied the forceps, but they slipped off twice. After waiting an hour the head advanced and was then discovered to be hydrocephalic. I at length succeeded in extracting the fœtus with the forceps without perforating the head. The fœtus was a male and only lived three or four minutes. On further examination later I found the vertebral column so bent and twisted on itself that the anal aperture, though in the median line, was only two inches distant from the base of the skull posteriorly, the pelvis being so tilted that the legs appeared to be growing from the child's back. The umbilical insertion of the cord was greatly dilated, measuring an inch by an inch and a half, there being a corresponding deficiency of the abdominal wall. The anterior parts of the neck were filled in, almost to the level of the chin, by fatty subcutaneous tissue. All the limbs were normal, with the exception of the right leg, the foot of which showed well-marked congenital talipes varus.

Temple Sowerby, Penrith.

CASE OF CONGENITAL HYDRONEPHROSIS TREATED SUCCESSFULLY BY A NOVEL METHOD.

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A BOY fourteen years old, small for his age, being about 4 ft. 6 in. in height, was first attacked by hydronephrosis on the left side in 1885. There was considerable distension of the abdomen, the tumour subsiding spontaneously at the end of four or five weeks. After this he had four or five attacks, each lasting about three or four weeks and then disappearing suddenly. In September, 1893, as he was very much distended, he was tapped by Dr. Freeman of Kimpton, and eighty-four ounces of fluid were drawn off. This quantity did not represent the whole of the fluid contents of the tumour. The abdomen being again enormously distended, on October 11th, 1893, he was tapped by Mr. Bernard Scott of Bournemouth, who drew off two gallons of fluid. Before he was tapped his abdomen measured