28th.—Still very sick; appetite bad; bowels open; expression very vacant. Temperature 98.4°; pulse 114, very feeble, but regular; arm not improved.

29th.—Bowels open very slightly after two enemata of oil. Cheek still drawn to the left; saliva occasionally running from mouth; tongue protruded slightly to the right. Still very sick. To have four grains of calomel on tip of tongue.

30th.—Bowels open very freely. Sick only once since. General aspect very much improved. Appetite better. Arm about the same. Wound looks well; very free discharge; poulticed constantly, and syringed with Condy's fluid and water.

July 1st.—No more sickness; bowels open freely; more power in arm; slept well; takes his food well. Temperature 98.2°; pulse 90, of very much better volume, and regular.

2nd.—Passed a good night. Temperature 98.4°; pulse 94. The arm is gaining power, but is still much colder than the other; sensation is perfect. Wound looks well; discharging freely; treated as before. Bone can no longer be seen at the bottom, being completely covered in.

7th.—Since last note has been gaining power slowly in the arm, but it is becoming more rigid; the flexors are gaining over the extensors of the forearm, and the hand is constantly closed, the fingers being extended by patient only with the greatest difficulty. The right arm is 6° Fahr. colder than the left. The left pupil was noticed to be slightly more dilated than the right for the first time to-day; both act readily to light; face is still drawn to the left as before. Temperature 98.2°; pulse 104, quite regular and of good volume.

14th.—Less rigidity and more power in the right arm; fingers easily extended; noticed to be slightly deaf in the left ear; arms have the same relative temperature as before; very little discharge from wound. Water-dressing applied. Temperature 98.4°. Sleeps and eats well.

20th.—Wound all but healed; patient allowed up; deafness on left side slightly increased; face still drawn to the left side as before; tongue protruded straight. Slowly gaining power in the right arm.

27th.—Wound completely healed. Allowed in the hospital square daily. Has no pain in his head; sleeps and eats well; arm is gaining strength; fingers readily extended. Right arm wasted, being much smaller than the left, and there is still a difference of 6° F. in temperature against the right arm. Speech quite clear; deafness about the same; and the face is still drawn to the left side.

Aug. 12th.—Patient discharged to-day, with the wound in the head completely and soundly healed. Face still drawn to the left side; tongue protruded straight. Left pupil slightly more dilated than the right; both pupils acting freely and readily to the light. Still deaf in left ear, and this deafness is slightly increasing. The left arm is larger than the right, and is warmer by 5.6° F. There is very good use and movement in the right arm and hand, he is able to button his coat with it, and the strength in it is still improving. Speech has perfectly returned, and he swears with great volubility. He seems rather stupid for his age, and his mother does not think him so bright as before the accident. He has had during the last fortnight three most violent, almost maniacal, outbursts of temper.

CHRISTCHURCH (CANTERBURY, NEW ZEALAND) HOSPITAL.

STRICTURE OF THE URETHRA; DILATATION; CURE.

(Under the care of Mr. COURTNEY NEDWILL.)

IN the "Mirror" of Jan. 23rd there is a series of seven cases of stricture of the urethra treated by Mr. C. Nedwill on the immediate dilatation plan. Subjoined is another series of six cases.

Nos. 6 and 7 of the former series have presented themselves for examination since the report. In February a No. 12 bougie was easily passed in No. 6 case, and in July last, without the slightest resistance, the same sized instrument was introduced in No. 7 case, an interval of six months having elapsed since the previous trial.

CASE 8.—R. P.—, aged twenty-eight, labourer, was ad-

mitted into the hospital on Oct. 17th, 1874, with stricture of the urethra, about the beginning of the membranous portion, from which he has been suffering for seven or eight years. Four years ago, he says, an abscess formed in the perineum, leaving a fistula through which urine escaped for two months. A No. 4 bougie only could be introduced through the stricture on his admission, but by the 23rd Sir H. Thompson's dilator was used. On the 29th a No. 12 bougie passed freely, and again on Nov. 24th, and the patient was completely relieved from all his symptoms.

CASE 9.—J. F.—, aged thirty-nine, a cook, was admitted into the hospital on Oct. 27th in a very weak, emaciated condition. Had tried to commit suicide before admission on account of suffering much pain, and having great difficulty in passing water. The urine was loaded with albumen. A stricture of the urethra was detected at the bulb, through which only a No. 3 bougie could be passed into the bladder. Mr. Nedwill gradually dilated every second or third day until a No. 8 was used, but the difficulty in introducing this sized instrument was so great that nothing more was done just then, as there was so much albumen still in the urine. The patient was kept in the hospital till about the 1st of January, 1875, when, finding the albumen had very considerably diminished in quantity, and the stricture had contracted, Mr. Nedwill determined to use Sir H. Thompson's dilator. The patient never had a bad symptom afterwards, and was discharged cured on Jan. 26th, a No. 12 bougie passing easily into the bladder.

CASE 10.—G. S.—, farmer, aged forty, admitted on Dec. 5th, 1874, with stricture of fifteen years' standing, about two inches from the orifice of the urethra. A No. 3 bougie only could be passed on admission, but in a few days Richardson's dilator was used. A No. 12 catheter was left in the bladder, and the man had never a bad symptom afterwards. At the end of March last a No. 12 was passed with ease, and again about Aug. 26th, 1875.

CASE 11.—W. G.—, aged twenty-three, applied for relief of retention of urine on the 15th January, 1875. For two years past he had had great difficulty in urinating, and his health was becoming seriously affected. A warm bath and the sedative solution of opium were ordered, and afterwards, notwithstanding the most patient attempts, no instrument could be got through the stricture beyond the bulb. During the night the patient had repeated doses of opium and several baths, but failing on the following day to reach the bladder, Mr. Nedwill sent the patient into hospital with the object of aspirating the bladder, which he did, and drew off two quarts of offensive urine. Next evening fresh attempts were made to pass a bougie, but in vain, so that the aspirator was used again. After using several No. 1 catgut bougies, Mr. Nedwill cut the end off a very small No. 1, and passed right down to the point of it a fine wire. With this bougie he managed, after nearly half an hour's steady pressure, to get it engaged so much in the stricture as to give to the hand the sensation of its being stuck in wax. It was left in for fifteen minutes, and then, after steady continuous pressure, kept up for about twenty minutes, Mr. Nedwill had the satisfaction of feeling it pass into the bladder. Without this wire it is certain no bougie ever yet made could have been passed; the wire gave it just enough rigidity to allow of a continued pressure being kept up. This bougie was tied in the bladder for twelve hours, and on its withdrawal a No. 3 went in easily. In a few days Sir H. Thompson's dilator was used. From this date until August 26th, 1875, a No. 12 bougie had been passed on several occasions without difficulty. It should be mentioned, that for several weeks after the operation this man was in a very critical condition. He passed during this time large quantities of blood and pus, and although the stricture is now apparently quite cured, the patient still suffers from an irritable bladder.

CASE 12.—R. T.—, a sailor, aged thirty-two, admitted on April 28th, 1875, with stricture of urethra. Has had difficulty in passing water for nine years, with occasional attacks of complete retention. A caustic bougie, which was said to have been followed by temporary relief, had been used some time before. He soon relapsed, however, and on admission, as no instrument could be passed, and as the bladder was very considerably distended, the bladder was aspirated above the pubes, and three pints of urine drawn off. The next day he passed urine in a very small stream, almost guttatim. For three weeks Mr. Nedwill was unable,

in spite of repeated attempts, to get an instrument through the stricture, which was about the junction of the bulbous and membranous portions; and during this time he had a hot bath night and morning, which enabled him to pass his urine with somewhat less difficulty. At length a No. 1 elastic bougie was introduced into the bladder, and on its withdrawal after twenty-four hours a No. 3 was passed with ease. A severe shivering fit, however, coming on, no more instruments were passed for a week. On several occasions afterwards Mr. Nedwill failed in getting through the stricture, and rigors followed these attempts so frequently that the patient was put under chloroform, and Sir H. Thompson's dilator was forced through the stricture, the finger being kept in the rectum to guide the instrument. A No. 12 silver catheter was passed, but had to be taken out a few hours afterwards on account of rigor. Next day the patient looked very ill, temperature 104° , and complained of a feeling as if he "had been hammered all over." Quinine in ten-grain doses was administered night and morning, and the man made a good recovery. Discharged July 10th. Since discharge a No. 12 catheter has been passed.

CASE 13.—W. J—, aged thirty-three, a sailor, admitted on June 11th, 1875, with hæmaturia and history of stricture. A No. 4 bougie was held firmly in front of the bulbous portion of the urethra. After a fortnight's residence in the hospital, as there was no albumen in the urine, a No. 4 bougie was used with difficulty. This, however, was followed by rigor and constitutional disturbance. Quinine having been given for some days, Sir H. Thompson's dilator was passed through the stricture; but on its withdrawal a No. 10 catheter only could be introduced. Rigor, very high temperature, and a sharp attack of orchitis followed. Quinine was administered freely, commencing with a ten-grain dose, followed by two grains and a half every four hours. A few days before the patient's discharge—convalescent on the 5th of August—a No. 12 bougie was passed easily. Again a severe rigor followed, but no further ill effects.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

At the ordinary meeting of this Society, held on the 16th inst., the President, Mr. G. Pollock, in the chair, a very large number of specimens (many of them of great interest) were shown. Among them we may specially indicate a remarkable case of Embolism of the Pulmonary Artery, shown by Dr. Fagge; a specimen of Tubercular Lupus of the Tongue and Palate, by Mr. Fairlie Clarke; and two interesting examples of Congenital Malformation of the Œsophagus, due to the arrest in development of the anterior part of the alimentary canal, the pharyngeal portion not becoming blended with the lower end of the tube; the case formed thus a parallel to the more frequently occurring condition of atresia ani.

Mr. Marcus Beck and Dr. Coupland were nominated auditors.

The following gentlemen were elected members of the Society:—W. M. Ord, M.D., H. Royes Bell, F.R.C.S., H. Hugh Clutton, F.R. Cross, J. P. Irvine, M.D., J. B. Jessett, F.R.C.S., E. E. Noel, M.D., and H. A. Lediard, M.D.

Mr. MAUNDER exhibited a specimen of Cancer of the Male Breast, which had been removed from a patient forty-two years of age. It commenced with soreness and ulceration of the left nipple, and on removal the tumour, which appeared to be scirrhus (but it had not been examined microscopically), was of the size of a Tangerine orange. The patient also was present, and, although eighteen months had elapsed, it could be seen there was no recurrence in the scar. An enlarged gland in the axilla existed at the time of operation. The specimen was referred to the Morbid Growth Committee.

Dr. GOODHART showed a recent specimen of Insular

Sclerosis of the Brain and Spinal Cord, taken from a female patient who had for some time past shown the characteristic symptoms of the disease—viz., spasmodic movements of the limbs and head, increased by effort, nystagmus, staccato speech, without impairment of sensibility, electromotility, &c. Two days before death, which took place from pneumonia, there was paralysis of the palate. The white matter of the brain and cord presented numerous patches of sclerosis.

Dr. COUPLAND brought forward a recent specimen of Ulcerative Endocarditis, which presented a good example of so-called aneurism of the mitral valve. The left side of the heart was dilated and hypertrophied, and projecting upwards into the auricle was a pouch, the size of a bean, formed by a protrusion of the auricular surface of the anterior mitral cusp. The ventricular surface of the cusp showed an ulcerated hole near to the attached border of the valve, large enough to admit the tip of the little finger, leading into the aneurism, which was filled with fibrine. The remainder of the valve was quite natural, but the aortic valves were thickly covered by vegetations, the central cusp being widely perforated. There were two infarctions of old date in the spleen, one of great size. The specimen was obtained from a male patient, forty years of age, who had been six days in hospital. The symptoms, which were chiefly those of præcordial pain and cardiac dyspnoea, were of five weeks' duration. There was no history of rheumatism. Dr. Coupland remarked upon the formation of aneurism of the mitral valve from ulceration on the ventricular surface, and inquired whether in most cases this was not secondary to the disease of aortic valves.—Dr. HILTON FAGGE pointed out the effects of friction on the endocardium as productive of local endocarditis, a fact first observed by Dr. Hodgkin, and insisted on by Dr. Moxon, whose years ago showed specimens in favour of this view. Did the vegetations on the aortic valve in the present case come in contact with the mitral at the seat of ulceration?—Dr. COUPLAND said that it was just this question of friction from the aortic vegetations on the mitral valve that he wished to raise when he asked whether the lesion on the latter could be considered secondary to the aortic disease. That such was the *modus operandi* in the present case was very likely, seeing that there were two erosions on the mitral valve, above the large ulceration, which would have come in contact with the aortic vegetations. But these vegetations were not long enough to reach the site of the aneurism, although the existence of the splenic infarction was presumptive evidence in favour of their having done so at an earlier period.

Dr. CRISP exhibited a specimen of United Fracture of the Humerus from a Gorilla, remarking that it was of interest as showing how completely union had taken place. He also showed several specimens of Rickets in Pheasants which had been reared under hens, and thus under artificial conditions. The long bones were greatly distorted and wanting in ossific material, their ends being enlarged. The skull and spine were not much affected.

Dr. FAGGE showed an interesting specimen of Embolism of the Pulmonary Artery obtained from a patient who had died of enteric fever under the care of Dr. Mumford. Death occurred in the fourth week of the disease, with symptoms of dyspnoea, following an attempt to get out of bed. The ulcers in the intestines were in process of cicatrization, some presenting adherent sloughs. The lungs were engorged. The valves of the heart were healthy, and the organ contained gelatinous decolourised clot. The base of the pulmonary artery was filled by loose black coagulum, but lying across the vessel at its bifurcation was a clot which at first seemed as if it were made up of four distinct cords twisted on one another. It was really a long cylindrical clot folded upon itself; it bore no marks of the valves upon its surface. The cava, iliac, and femoral veins were empty. Dr. Fagge supposed that the long clot in question came from one of the femoral veins, had become detached and washed off into the pulmonary artery, and then folded up across the main division of the vessel. There had been no signs of thrombosis in the leg, so that it was probable the detachment had occurred close upon the formation of the clot.—Dr. CRISP thought the view held by Dr. Fagge should be received with caution.

Dr. FAGGE showed two specimens of curious Pouches from the Ileum, which he proposed to call "distension diverticula." The first was obtained from the body of a