As to the comparatively bad results in gonorrhea, this agrees with my own opinion, and is indicated by the fact that I state in my paper that I have operated on but a single recent case of gonorrheal abscess. In old gonorrheal cases, however, where the woman has had pus tubes for years, incision and drainage have given good results. I am fully in accord with the view that the gonorrheal cases are least adapted for the drainage operation.

In one point I can not agree with Dr. Cullen. Instead of going in from above, I think it far better to work from below. I never make an incision above Poupart's ligament, unless the abscess distinctly points in the groin. If the subcutaneous tissues are infiltrated, so that you know the abscess is coming out along the round ligament, or just under the skin, then make an incision there, but where the exudate is deep in the broad ligament, it is much more easily and better reached through the vagina. Neither need you fear a hernia afterwards. In almost every case drained above Poupart's ligament a hernia results. So far as I know, I have operated on about sixty of these cases, and I have never injured the ureter, have never had any hemorrhage, nor injured the bowel.

Clinical Report.

SUPPRESSION OF THE SECRETION OF URINE FOR SEVEN AND ONE-HALF DAYS

WITHOUT SEVERE SYMPTOMS OF UREMIC POISONING,
THE PATIENT RECOVERING.

GEORGE SEILER, M.D.

ALMA, WIS.

I. B., a saloon- and store-keeper in the country, aged 48, was taken sick with "lumbago" June 6, 1902. This lasted about three days. On June 9, the patient had an attack of renal colic and passed about 75 to 100 renal calculi the size of a millet seed and some as large as small peas. The urine passed contained a little blood. June 14 he had another attack of renal colic and from this day on the excreting faculty of the kidneys was entirely suppressed for seven and one-half days.

The patient is a very heavy-set man, weighing 250 pounds. His abdominal walls are so thick from fat that palpation of the abdominal organs is very difficult. He was never seriously sick up to last September, when he had his first attack of renal colic after and during which he passed a number of renal calculi of the size of small peas. He was then free from an attack up to the present time.

Previous to the suppression of urine, which occurred June 14, he passed a little less than the daily usual amount of urine and complained of some pain, especially in the right lumbar region on deep pressure and without it. In the afternoon of June 14, he had an attack of colic again for which I gave a hypodermatic injection of morphin, which relieved the pain. I then gave him nitrate of potassium with extract of henbane, $\frac{1}{2}$ -grain doses of calomel and bicarbonate of soda every fifteen minutes followed by sulphate of magnesia. The next morning, as he had not passed a drop of urine, I introduced a soft catheter, but did not get any urine. The same was the case June 16.

Treatment was continued, with the addition of warm wet applications to the lumbar region and later wet packs twice a day. In the evening Dr. Tenney of Alma saw the case with me and suggested tincture of digitalis in 10-drop doses every three hours and Rochelle salts repeated oftener. I had also given a hypodermatic injection of pilocarpin, one-third grain at 6 p. m., which produced a copious sweat lasting fifteen or twenty minutes. June 17 the patient became drowsy and vomited often greenish slimy water with great force; no urine by catheter; bowels moved often.

June 18 and 19 the patient was in almost the same condition but more drowsy and vomiting oftener, no urine secreted, pulse and temperature normal. I kept up the wet pack and pilocarpin injections twice a day and also gave two drops of

croton oil in glycerin. June 20: condition the same, treatment continued. Towards evening patient had a severe spell of pain in the right lumbar region with pains lancinating toward the right testicle and glans penis, probably caused by the stone, which was suspected to blockade one ureter, moving towards the bladder. A hypodermatic injection of morphin and atropin relieved the pain.

On the morning of June 21 his condition was unchanged, save that he was not so drowsy and did not vomit so often; no urine by catheter. Dr. John Lyman of Eau Claire, Wis., who was called in consultation, advised continuation of treatment and $\frac{1}{2}$ -grain doses of calomel every one-half hour continued for forty-eight hours as advised by Senn. As there was some dullness over the region of the right kidney he introduced a trocar at three different places, but only withdrew some blood, no urine. This excluded a hydronephrosis. Any other operation was, of course, out of the question. That evening the patient passed about one-half pint of almost clear straw-colored urine, which showed slight traces of blood under the microscope. The same treatment was continued and the patient passed almost a gallon of urine in the next twenty-four hours, vomited from one to four times a day, his drowsiness disappeared and urine was passed without pain, but the patient suffered a great deal of pain at the point where the trocar was inserted and temperature went up to 100 or 101. The pain diminished in the course of four days.

June 23: patient was very much improved and urinated freely more than a gallon of clear urine without a trace of blood. His bowels were kept open by Rochelle salts; the hypodermatic injections of pilocarpin were discontinued, as was also the calomel, as traces of ptialism appeared. June 26 the patient was able to sit up and improved steadily. July 17: patient passed some gravel about the size of small peas and of irregular form; he has continually a sensation as if needing to pass water and a drawing feeling in his penis and still some deep-seated pain over the right kidney; otherwise he improved steadily and attended to his business.

The principal questions in this remarkable case are: First, what was the cause of the suppression of the secretion of the urine? 2. If there was an obstruction of one ureter—probably the right one where patient complained of the most pain—why did not the other kidney secrete urine? 3. Is it, as some authorities say, possible that if one kidney does not work the other one will in a sympathetic way refuse to work? The greatest wonder is that the patient did not show more profound symptoms of uremic poisoning and that he did not die in coma.

Is there such a case on record? I have heard there is nothing new under the sun, but I thought the case remarkable enough for publication.

Organization of the Medical Profession.—The medical profession has a power for good in the community which is not equaled by that of the clergy or the legal fraternity. Its power is, however, not exerted. It is dissipated by lack of concerted effort, and wasted by internal difference of opinion. . . . Why is it that after a hundred years of practice among the people, the educated and the ignorant alike, our influence is so transient, so feeble, that the most absurd fad, the most hare-brained delusion, the most fantastic fraud that comes along spreads its pernicious poison as rapidly among the people as fire in tow? Where is the educational power over the people of which we boast in our addresses and applaud in our after-dinner speeches? How loyal are the people to us, because of our single-mindedness and devotion to them in their sickness and affliction? How much weight has the opinion of the medical man in a public matter, and with what smiling indifference do not those who make the laws listen to his protests? There is something wrong here. There is manifestly some foolish want of thought in this ridiculous situation. . . . There are doubtless many things to which this state of affairs can be ascribed. One cause, however, stands out as first in importance. It is lack of organization.—Sweeney, in *St. Paul Med. Jour.*