

lowered quickly by a hand-wheel operating a screw with a sliding nut. When the top of the table is at its normal height, it may be used for eye operations, dressings, etc. The table is mounted on four rubber-tired casters, two of which are equipped with brakes operated by the foot, by means of which the table can be made stationary if desired. The other mechanical features of the table will be apparent from an examination of the illustrations. Its flexibility and its adaptable height make it serviceable in the entire field of eye, ear, nose and throat work.

215 Pioneer Block.

CASE OF URETHRAL CALCULUS, PROSTATIC DIVISION*

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Urologic literature contains numerous references to urethral calculi, over one hundred reports being recorded, from many of which important lessons can be learned. The most frequent variety of urethral calculus is that of the single impacted stone, of vesical origin, caught behind one of the physiologic narrowings of the urethra or behind a stricture. In the case here reported it is evident that had the strictured area

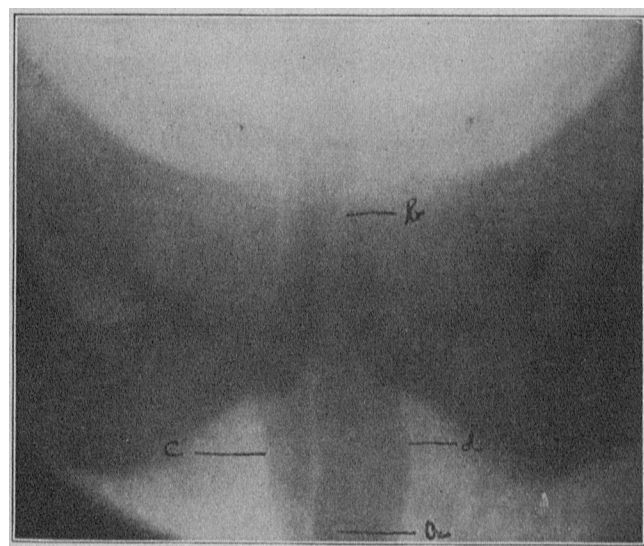


Fig. 1.—Roentgenogram showing calculus in urethra extending from *a* to *b* and from *c* to *d*.

been kept dilated for some time after the prostatectomy, the calculus would not have formed.

The purpose in reporting this case is to demonstrate a roentgenogram taken of the calculus *in situ*.

Patient.—Charles A., aged 61, single, civil engineer, born in Massachusetts, was admitted Jan. 10, 1913. His father died at advanced age, his mother in childbirth. There was no history of cancer or tuberculosis. The patient denied lues, and had never been ill except as will be described. He was addicted to morphin for five years until "cured" one year ago. Emaciation had been recent and gradual. The patient used tobacco moderately, but never alcohol. Appetite and digestion good; bowels constipated.

External urethrotomy for stricture was performed in 1887, internal urethrotomy for stricture in 1892, and perineal section for "enlarged and diseased prostate" in 1906. Following last operation patient had been discharging half of the urine through perineal fistula. Patient was in good health until one year before admission, when he began to ache in region of perineal fistula. Ache was continuous, not influenced by urine passing through fistula or through penile urethra. Ache increased by sitting posture. Patient also

described the "ache" as a "burning pain," and complained of a pain in penis, following course of urethra, gripping in character, not influenced by urination and usually ceasing early in the day. The frequency of urination was from half an hour to two hours, day and night, and equal. Urine caused slight burning when passing through penile urethra and at times contained a few shreds of blood.

Examination.—General: Negative except for emaciation. Pulse regular, good volume, much sclerosis. Reflexes normal.

Local: In midline scar in perineum there is a fistula which does not admit any instrument except a very fine probe. Sound passed into penile urethra cannot be made to enter the bladder. By rectum there is a dense, extremely sensitive immovable mass which fills the prostatic region and extends forward to the bulbomembranous juncture. The rectal wall is not adherent to the mass. Both inguinal regions are free of enlarged lymph-nodes.

Urine: Acid; specific gravity 1.017, no albumin, no sugar. Microscopic examination showed numerous pus cells but no casts.

The x-ray plate was placed beneath the buttocks, with the patient flat on his back and the compression diaphragm just above the pubes at an angle of about 30 degrees. In the roentgenogram (Fig. 1) the calculus extends from *a* to *b* and *c* to *d*.

Operation.—Jan. 30, 1913, under general anesthesia, a median perineal incision was made through the scar, and the calculus (Fig. 2) was grasped with forceps and withdrawn,

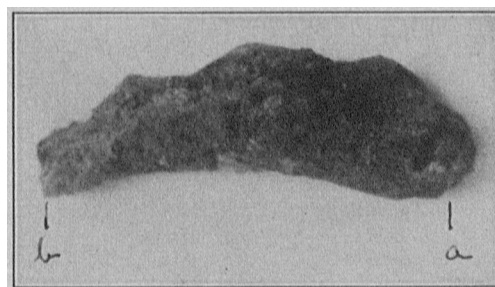


Fig. 2.—Calculus weighing 13.21 gm.

followed by a gush of foul urine. The calculus extended from the bulbomembranous juncture anterior to within the vesical sphincter posterior, the large end (*a*) being anterior (penile). A dense stricture, anterior to site of calculus, was cut and a permanent catheter inserted through the penis into the bladder.

The weight of the calculus was 13.21 gm. Section showed it to consist of a homogeneous mass in layers, without any definite nucleus.

My sincere thanks are due to Dr. W. P. Willard for the privilege of reporting this case, to Dr. H. H. Markel for the roentgenography, and to Dr. A. W. Lee for the photographs of the roentgenogram and calculus.

DOUBLE VULSELLUM CERVIX FORCEPS

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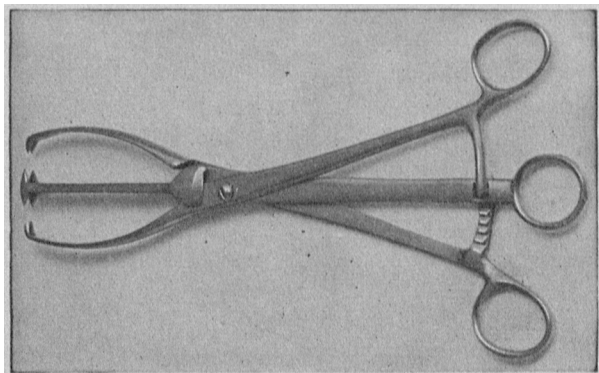
It has been my misfortune to have to repair lateral tears of the cervix of the uterus without proper assistance, and it seemed to me that an instrument should be devised which would be of assistance in approximating the edges of such a tear by drawing the lips down at the same tension, thus making it possible to sew them together while keeping their correct relation with each other. Two pair of tenacula are difficult to hold and require an extra pair of hands; therefore, I have designed an instrument for such use. After placing it on the cervix, one set of teeth gripping each lip, it is possible to hold it off to one side, and place the sutures with the other hand. I have found it particularly useful in a

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* From the Urologic Service of the University of California San Francisco Hospital.

few cases where an immediate repair of a small tear in the cervix after delivery is essential.

The instrument itself can easily be understood by reference to the accompanying illustration. It is heavy enough to be strong, but not bulky. It is nine inches in length, and the space between the outside blade and the central shaft, when the instrument is closed, tapers from half an inch to a quarter of an inch. As is shown in the illustration, the three parts of this instrument are held together by screws, and in some ways are similar in mechanism to the various forms of stomach clamps. Each blade has its own ratchet allowing the adjustment of one set of teeth at a time into each lip of the cervix.



Double vulsellum forceps, made by the E. H. Mahady Company, Boston.

In practice, I have found it easier to grasp the posterior lip first, and then approximate the anterior lip to it and grasp it in the same way.

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ASCARIS LUMBRICOIDES AS A COMPLICATION OF A SURGICAL OPERATION

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The physician who practices medicine in tropical or semi-tropical countries has constantly to bear in mind the omnipresence of intestinal parasites and especially the *Ascaris lumbricoides*.

In Persia it is almost always a safe assumption that every person, whether child or adult, harbors several if not scores of these parasites. It is in fact a custom among some of the more enlightened of the Persians to take a dose of santonin as a matter of routine every few months. A brief history of a gynecologic case in which these worms played a curious part may perhaps not be without interest to others.

Patient.—A Jewish girl, aged 16, married, was admitted to the hospital Nov. 4, 1912, complaining of abdominal pain. General health had been good up to a few months previously when she had a miscarriage at three months. Since that time she had had fever, pain in the lower abdomen, and throughout the time a marked diarrhea, worse at night, when she would have from seven to eight evacuations. Two or three months before admission I examined the patient, made diagnosis of right pyosalpinx and advised operation, to which she would not consent. She was put on a treatment of hot vaginal douches with an ice-bag to the abdomen. Her condition steadily grew worse. At last the patient and her family, fearing death, consented to the operation.

Physical Examination.—On admission: Temperature 100, pulse 120. Heart and thorax, negative. Abdomen distended and held very rigidly over the lower half. From a point a little above the umbilicus on the right side, sloping down to the middle of Poupart's ligament on the left, could be felt a line of marked resistance with great tenderness on pressure. There was apparently some sort of a mass filling up this portion of the abdomen. There was no discharge or external

evidence of infection on vaginal examination. The cervix was small and quite freely movable. There was marked induration behind the uterus and in both fornices. Neither the fundus nor the appendages could be felt. White blood-count 15,400. On account of the history of diarrhea the stools were examined and found full of ascaris eggs. On that account 3 grains of santonin were given before the operation, but up to the time of operation no worms were passed.

Operation.—The abdomen was opened in the mid-line. Peritoneum was found markedly thickened and so firm that it resembled an aponeurosis. As soon as the peritoneum was opened a large quantity of foul-smelling pus escaped. About 2 liters (2 quarts) were evacuated and the abscess cavity explored. The uterus was at the bottom of the cavity, small, and adherent to the intestines. The right tube and ovary were tied up in a mass of adhesions to the right of the cavity. The left tube and ovary were not seen. No attempt was made to free adhesions. The cavity was irrigated with salt solution and the incision closed and drained above. A vaginal drain was not put in as it was feared that too many adhesions would be broken up in an attempt to get behind the uterus.

Postoperative History.—Second Day: Patient doing well, wound draining freely and looking well. Dressings changed.

Third Day: Patient given a water and glycerin enema, which was effectual. Ascaris worms passed with it. Dressings removed from wound and a large ascaris, perhaps 8 inches long, found lying across the wound under the dressings. Wound draining very freely; pus very foul but with no suggestion of a fecal odor.

Fourth Day: Water and glycerin enema again effectual, ten or more worms passing with it. One ascaris again found under the dressings and another in the abscess cavity when one of the drains was pulled out. Still no suggestion of fecal odor to the pus.

Fifth Day: One ascaris found under dressings. An occasional sound heard as of gas bubbling through the wound but no fecal material in the pus.

Seventh Day: Two ascaris worms removed from the abscess cavity. Five grains santonin given with Epsom salts; two grains santonin passed through unchanged with stools. No worms with stools. At night a third worm was found in the cavity.

Eighth Day: Wound much cleaner in appearance and beginning to granulate up. No worms.

Ninth Day: Considerable pus but no worms.

Tenth Day: One worm found under dressings. No fecal matter.

Eleventh Day: Pus less.

Twelfth Day: Pus again increased; one small worm found in the incision.

Sixteenth Day: No more worms; still a great deal of drainage; wound slowly filling up.

Twenty-Second Day: Patient's temperature 102; complained of pain in right side of abdomen. No cause for the fever found.

Twenty-Sixth Day: Fever has gradually cleared up; pus, which was more abundant for a few days, has become less.

Twenty-Eighth Day: Patient goes home. Wound still draining profusely and large abscess cavity still present. Family unwilling that she should remain longer.

Four Weeks Later: Patient in same general condition. Since going home developed a cough and had a great deal of diarrhea. Wound not improved. Five grains santonin again given with calomel and castor oil. Patient completely prostrated by the treatment. For about a week, no worms appeared in stools; one appeared in the wound the day after the santonin.

Two Months After Operation: Wound still unhealed. Profuse purulent exudate present; granulation tissue very sluggish. Diarrhea better; cough very troublesome. Patient developing an extremely edematous and painful phlegmasia alba dolens of the left leg.

The patient died about two months after the operation.

Remarks.—At no time was there any evidence of a fecal fistula. There was no fecal odor to the pus nor, in spite of