

isted in the neighbourhood of the stricture rendered it impossible to get an instrument with the sharp curve of a sound into the bladder. Examination by the rectum discovered a prostatic tumour, about the size of a walnut, situated posterior and slightly to the left of the urethra,—in fact, directly in the way of the lateral incision. From the hardness of the tumour, I thought it might be a prostatic calculus. Examination of the urine showed it to be free from albumen and tube-casts; but pus and oxalate crystals existed in abundance. The patient also drew my attention to a very profuse purpuric rash which covered his legs, and I found that his gums were spongy.

His sufferings were very great; he had not been able to work for many months; the stricture had existed for twelve years, and the fistula—which consisted of two tracks leading from behind the triangular ligament forward to the posterior edge of the scrotum—and purpura had existed many months. Altogether the conditions were nearly as unfavourable as it is well possible to imagine. Crushing was utterly out of the question, and I resolved to cut. But there was before my eyes the fear of hæmorrhage owing to the purpura. He therefore went back to the country, continued the appropriate treatment employed by Mr. Hirst, and returned in about a month, somewhat improved in health.

On the morning of March 2nd, when I had resolved to operate, he presented, however, a fresh crop of purpuric rash, a circumstance which very nearly prevented me from proceeding; but with the kind co-operation of Messrs. Hirst, Hollings, G. F. Naylor, and other friends, I accomplished the following operation:—

Having passed a small curved staff into the bladder, I passed a probe down that fistulous track nearer the middle line, and, slitting up its posterior third, my knife entered the staff as if for perineal section, divided the stricture, was then turned as for the lateral incision, and passed on to the prostate. Here I found a little difficulty in keeping the knife in the groove of the staff; but with care I passed the knife into the bladder, cutting through an abnormally resisting structure. Following with my left forefinger, I at once recognised this structure as a very large instance of the prostatic myoma described by Thompson and Virchow, and by the removal of which, in certain cases, Sir William Fergusson has recently added something new to the operation of lithotomy, and not a little to his already immense reputation for skill and daring in operative surgery. My finger next recognised that, instead of two stones, the bladder was occupied by one large calculus of an oblong ovoid shape, and with a circular constriction in the middle, which had conveyed to me the false impression of the presence of two calculi. Had I been able to introduce a sound into the bladder, I might have avoided this mistake. The calculus proved to be a mulberry specimen, weighing five hundred grains. Introducing a probe-pointed bistoury along my finger, I extended the lateral incision through the tumour to an extent which I thought needful for the extraction of the stone, and the result was that I either completely or almost completely bisected the tumour, which was very resisting, and projected a good deal into the bladder. The removal of the stone was not difficult, but needed a little dragging. After its removal, examination of the wound showed me that the segments of the tumour had been partially dislodged—that it was capsulated, and might be removed. I was strongly inclined to attempt its removal; but, having waited a few minutes, and found that there was no bleeding, I hesitated to run further risk, and, remarking that the section of the tumour might lead to its atrophy, I desisted from further interference with it. I think that the result justified my discretion, because oozing of blood went on for three days, when it was checked by a few doses of turpentine. Had I torn across a small artery in the removal of the tumour in a position where I could not have reached it, the result might have been fatal. It is, however, as Sir William Fergusson has written to me on the subject, all well that ends well, and the patient went home on the seventeenth day with the wound all but healed, the fistulous tracks closed, and No. 9 catheter could be passed easily into his bladder.

With reference to the tumour, Sir William writes that he would probably have removed it, and he would, of course, have been justified in so doing. But, for my part, this was a point which was decided mainly on selfish grounds. I did not dare to run the risk of any further complication—a risk

which would have been nothing to the Professor of Surgery at King's College. Sir William has given me his opinion that the tumour will probably not atrophy, against my own hope that it might, as similar growths sometimes do in the uterus after an incision.

Wakefield, March, 1870.

ON A CASE OF MALIGNANT SCARLET FEVER.

DEATH IN FORTY HOURS.

By J. J. THOMPSON, F.R.C.S.I.,

SURGEON 2ND BATT. 9TH REGIMENT.

THE interesting lecture on Scarlet Fever delivered by Sir Wm. Jenner at University College Hospital, and published in THE LANCET of January 8th last, induces me to send for publication a case which occurred in this garrison lately, as it was very similar to some of the cases alluded to by that physician in his lecture.

The case which has come under my observation is remarkable, as showing how rapidly fatal the malignant form of scarlet fever may prove in a young and otherwise healthy man. Such was the intensity of the blood-poison in this instance that the man seemed suddenly struck down by it, and the case was evidently hopeless from the first. As has been so often noticed by other observers, the urgency of the local throat affection was by no means proportionate to the virulence of the constitutional phenomena.

On Thursday evening, Feb. 10th, 1870, at six o'clock, a young recruit from the dépôt brigade of Foot Guards, in garrison at Warley, reported himself sick, and was at once admitted to hospital. He had been quartered at Warley since December last, and had the appearance as well as the character of being a strong and healthy man. He attended his usual drill the same afternoon (Thursday), and it was merely remarked by the drill corporal that he was not as smart as usual. There is no history of contagion, and the period of incubation must be conjectural.

On admission, he complained of his throat being very sore and of a general feeling of illness. When seen directly afterwards, he was lying on his back, low in the bed; his face was congested; eyes suffused; pulse small and frequent; and his tongue was covered with a dirty, creamy coat.

Next morning (Friday) the constitutional symptoms were of a marked asthenic character; pulse 120, feeble and quick; tongue dry and brown in centre; face of a dusky leaden hue, and the abdomen and chest were covered with a dusky red efflorescence; the fauces, uvula, and tonsils were livid and swollen. Towards the evening he became worse, and during the night delirium, not of a violent character, was incessant, and he died at ten o'clock on Saturday morning, about forty hours from the time of his admission.

Wine and beef-tea were freely given from the first, as well as chlorate of potash and diffusible stimulants.

Warley Barracks, Essex, Feb. 1870.

PRIMARY AMPUTATION OF SHOULDER-JOINT SUCCESSFULLY PERFORMED AT THE PATIENT'S HOME; RECOVERY.

By C. E. SAUNDERS, M.D.

At a time when the relative merits of hospital and home practice, as affecting capital operations, are under discussion, the following case of primary amputation may prove of some interest. Occurring, as it did, in a house the general arrangements of which were none too well regulated; nursed by zealous, it is true, but by no means skilled, hands; while it had, on the favourable side of the question, the all-important advantages of pure air, quiet, and, to a patient of such tender years, familiar surroundings, it offers, I think, a fair case for comparison.

On August 12th, 1869, I was summoned to attend H.