

different, if allied, composition side by side in one bladder;" and he suggested, in explanation, "that in all probability, after one stone had developed, a slight change in diathesis occurred, and a fresh nucleus of another kind had descended from the kidney and grew also," and he mentioned "that on several occasions, during lithotomy, he had found a large and a very small stone together, and during lithotripsy by the old method the patient would have a distinct attack of renal colic and discharge an entire stone."

East Rudham, Norfolk.

A CASE OF LANDRY'S PARALYSIS.

By W. E. BUCK, M.A., M.D. CANTAB.,

PHYSICIAN TO THE LEICESTER INFIRMARY.

I VENTURE to publish the following scanty notes of a case which I believe to be one of acute ascending paralysis, as first described by Landry in 1869. I desire to direct attention to it as a disease which is by no means easy to diagnose, and which sometimes is rapidly fatal. This paralysis has not, till recently, been noticed in the larger text-books on medicine, and very little is known about its etiology, and absolutely nothing about its pathology. Dr. Bristowe says that no morbid changes have been discovered which can account for the symptoms, and that in many cases the cord has been found apparently in quite a healthy state. These statements are confirmed by most other writers on the subject.

"Dec. 3rd.—Miss R—, aged twenty, seamstress, says she has been feeling poorly for three weeks, and got her feet wet on Dec. 1st. She complains of a feeling of pins and needles, and want of power in the hands and feet. She walks lame, and cannot hold a cup or thread a needle. There is no swelling, redness, or tenderness. She says she does not feel ill.—4th: The patient developed a clicking in the throat last night; she had a good night, but cannot raise herself in bed nor stand this morning. Temperature normal. I was called to see her this evening, and went at 7.45. I found her much altered in appearance; complexion waxy, but not altogether pallid; a tinge of blueness round the lips. She was propped up high in bed. There was a continued rattling of mucus in the trachea, and an inability to speak loudly; there was also a feeling of choking and difficulty in swallowing, although she could swallow small quantities at a time. Bowels open several times. Pulse feeble, and feeling as if it might soon cease. At 9.30 she died without a struggle."

These notes were kindly given to me by Dr. Cox-Hippisley, Miss R—'s medical attendant. When he called me in to see her about an hour before her death she was propped up in bed and answered my questions rationally. She could not move her legs or her fingers, but could move her arms slightly. There was no ankle clonus, but I did not test for other reflexes. Her breathing was feeble and shallow, with a slight rattling of mucus in the trachea and bronchi. There were no other physical signs. Heart sounds normal, but feeble. No trouble as regarded bladder or rectum. Tongue clean; pupils dilated. Temperature normal; pulse normal, but feeble. She died apparently from some pressure or interference with the nuclei of the pneumogastric nerves—in fact, from bulbar paralysis.

I obtained permission to examine the body, and made the necropsy about forty hours after death. The body was exceedingly well nourished and well formed. Heart, lungs, stomach, and liver normal. The kidneys had the capsules thickened and were slightly contracted. The spinal cord was removed and hardened for microscopical examination, but nothing abnormal could be detected. This disease is mainly characterised by negatives in regard both to diagnosis and pathology. It is generally fatal, and may be of very short duration. In this case the patient did her work to within three days of her death, and even went to the theatre on the third evening before she died. The symptoms were in accordance with those usually described, except in one particular—viz., that she did not notice the loss of power first in the lower extremities and then gradually ascending. Dr. Bristowe, however, remarks, in the fifth edition of his "Theory and Practice of Medicine," that in some rare cases the paralysis takes a descending course, beginning above and involving the lower extremities last. This disease is not at all common, and the

literature relating to it is so recent and scanty that I fancy it is not at all well known to the general profession; for these reasons I have thus briefly described this case, in the hope that more attention may be devoted to it.

Leicester.

NOTE ON THE TREATMENT BY SECTION OF HYDROCELE BY THE ANTISEPTIC METHOD.

By EDWARD BELLAMY, F.R.C.S.,

FELLOW OF KING'S COLLEGE, SURGEON TO THE CHARING-CROSS HOSPITAL,
EXAMINER IN SURGERY IN THE VICTORIA UNIVERSITY, MANCHESTER.

THE few remarks I make are based upon the results of a considerable number of cases I have treated, both in hospital and in private practice, in the early and later stages of hydrocele, by which latter I mean those which have been repeatedly tapped and in most instances injected. It is hardly necessary to take up space by instancing the individual cases. It is certainly time that the old-fashioned method of tapping and the supposed radical cure by continuous injection was done away with, as painful, dilatory, and generally useless. I claim no originality whatever in this treatment. I desire to call the attention of practitioners to the fact that they should invariably adopt the method of free incision with strict antiseptic precautions, and I cannot understand why it is not more universally carried out. Every surgeon knows of the method, but, as far as I see, contents himself with adhering to the usual proceedings. There is no danger in it. An anæsthetic can be given if necessary, the healing is rapid, the cure almost certain, if not absolutely so. The operation is as follows. The diagnosis of course being established, the scrotum should be shaved, and (if the surgeon thinks necessary) the spray used, the tumour is firmly grasped so as to render the parts as tense as possible. A clean sweep through all the scrotal tissues is then made with the bistoury from the cord to the base, and the fluid escapes. Every bleeding vessel, however small, must be twisted or tied most scrupulously, and the interior of the sac carefully examined for any vessel which may have been wounded or have given way. The cavity should then, not too tensely, be stuffed with either lint soaked in 1 in 40 carbolic oil or gauze, and the upper part of the edges of the wound stitched together, including all tissues—I do not see any advantage in stitching the cut edges of the sac to the sides of the wound,—a small tag of the contents being left out of the most dependent part on the contingency of drainage, a pad of salicylic wool placed over all, and the scrotum supported by a cushion between the thighs. In a couple of days the parts may be dressed (under spray, if thought desirable) and the contents of the sac withdrawn. As a rule considerable contraction of the walls of the sac will have set in, but it is advisable to still introduce the antiseptic material so long as any appreciable cavity exists, and this is generally for about a week in very favourable cases, when it will be found impossible to pass anything into it, and merely the lips of the original wound are left to close. Tubal drainage is, I venture to think, unnecessary. I have not yet met with any untoward constitutional symptoms by adopting this method, which is equally applicable to encysted hydrocele of the cord.

Wimpole-street, W.

A REMARKABLE CASE.

By JAMES H. AVELING, M.D.,

SENIOR PHYSICIAN TO THE CHELSEA HOSPITAL FOR WOMEN.

THE patient whose case is here briefly narrated is a married lady aged thirty-eight, with a family. She is very intelligent, and has no history of hysteria or other nervous disorders. In October, 1884, one of her children struck her left eye with the back of his head. Six weeks after she felt something wrong with the eye. She also had noises in the ears, and tenderness of the nose, and pain at the back of the head when she stooped or had the bowels moved. Her speech also was affected. She hesitated and stammered when she spoke. These symptoms lasted and gradually got

worse from December, 1884, to March, 1885, when she had three blisters on the back of her neck. The pain in the head now became constant, and caused sickness. During these three months the patient, besides her own medical man, had the advantage of receiving the advice of the following eminent members of our profession:—Mr. McHardy, Mr. Couper, Mr. Hulke, Dr. Morell Mackenzie, Mr. Power, Mr. Cumberbatch, and Dr. Ferrier.

On March 22nd the patient spoke to her medical attendant, Mr. Robert Mathews, of other symptoms which she had felt for a long time, but which she had not mentioned because she thought they could not have anything to do with her head troubles. She then described herself as having a constant feeling of weight in the pelvis, as if something were coming down, and that she could only pass a small quantity of water at a time with great effort. This statement induced Mr. Mathews to make an examination, when he found "extreme anteversion of the uterus, with a full bladder, the fundus of the uterus resting on, and making as it were a bed for itself in, the bladder." He replaced the uterus, emptied the bladder, and, to his surprise, all the head symptoms disappeared. The relief, however, was only temporary, for the symptoms returned when the uterus fell forwards into its abnormal position. At the suggestion of her husband, she tried the plan of lying with her hips raised on a high pillow, and when in this posture the head symptoms were relieved.

In April Mr. Mathews asked me to see the case, with the view of mechanically rectifying the position of the uterus. I found laceration of the perineum and os uteri, the latter being sufficiently patulous to admit the tip of the index finger. The uterus was large and congested, low down in the pelvis, and acutely anteverted, its fundus pressing on the neck of the bladder.

April 20th.—The patient having come to London I replaced the uterus and retained it in position by one of Dr. Graily Hewitt's cradle pessaries. When I visited her the next day I found all the head symptoms gone. Eye, ear, nose, and head were perfectly well and the speech free from hesitation or stammering. The only trouble left was vesical, and this was due to the pessary which did not quite fit. After trying one of Thomas's anteversion pessaries without success, I introduced a smaller cradle pessary, and no further trouble with the bladder has been experienced.

The patient returned home, and on June 3rd I heard from her. She wrote, "I am quite comfortable and perfectly free from any kind of pain."

Upper Wimpole-street, Cavendish-square, W.

TWO CASES OF TRAUMATIC GANGRENE OF THE LEG; AMPUTATION.

BY D. CHARLES DAVIDSON, I.M.D.,
ACTING HEALTH OFFICER, BOMBAY.

WHILE stationed at Belgaum in 1878, Dr. Peters, civil surgeon, asked me to see with him, in the Civil Hospital, a case of fracture of the tibia and fibula, complicated with wound of the soft parts, but not constituting a compound fracture, in which gangrene had supervened. We found the man in a high state of fever; the foot, and a considerable portion of the leg, which had been fractured at the lower margin of the middle third, black, covered with phlyctenæ, and emitting an offensive odour. The gangrene was rapidly spreading; the thigh very much swollen, and deeply infiltrated.

As Dr. Peters was leaving the station, and as the case would thus have come under my care in a few days, he kindly asked me to operate. The leg was amputated immediately above the knee-joint, the obtaining of good flaps being sacrificed to a wish to remove as small a portion of the femur as possible, and thus afford the patient the best chance of recovery. The man bore the operation fairly well, lost little blood, and passed a tolerably good night, with the exception of infiltration of the thigh with pus, which had to be evacuated by means of free incisions. The patient went on gaining strength without a bad symptom. The flaps, however, sloughed, and a portion of the femur had subsequently to be removed. The man did well.

In February of last year, while in charge of the Surat Civil Hospital, a police sepoy was admitted under my care,

complaining of a badly swollen foot. He stated that on the day previous to his admission into hospital he had been attached to a shooting party, and had injured his foot with a thorn in getting through a prickly pear hedge. On examination the foot was found swollen, hot, and tender; but no foreign body could be detected. The man was feverish, with hot dry skin and considerable thirst. He was put to bed and warm moist applications applied. I visited him some time afterwards, and found the swelling increased, the skin of a mottled hue, circulation much impeded, and sensation nearly gone. A free incision was made, a quantity of watery serum evacuated, large poultices applied, and the whole wrapped up in a layer of cotton-wool. I saw him again in the evening, and found the part up to the middle of the leg cold, pulseless, and entirely without sensation, and the greater portion of the foot black and covered with phlyctenæ. As mortification was rapidly spreading, amputation was decided upon, with the kind assistance of Dr. Jones, of the 10th Regiment, Native Infantry, who concurred with me as to its necessity. The leg was amputated immediately above the knee-joint. The man bore the operation well, the pulse keeping up, and little blood being lost. He, however, died on the following morning, about twelve hours after the operation.

Bombay.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. BARTHOLOMEW'S HOSPITAL.

DISEASE OF THE KNEE-JOINTS (OSTEO-ARTHRITIS) WITH
VARIOUS NERVOUS SYMPTOMS; REMARKS.

(Under the care of Mr. MORRANT BAKER.)

OUR readers will recollect the discussion on joint disease in connexion with locomotor ataxy which was opened by Mr. Morrant Baker on November 14th of last year at the Clinical Society. The following case forms an important addition to the literature on the subject. It is difficult to give the relationship between the disease of the joint and the neurotic changes which had probably commenced before the injury to which the joint had been exposed. No nerve symptoms appear to have been noticed by the patient.

For the notes of the following case we are indebted to Mr. J. N. Vogan, late house-surgeon.

J. R—, a man aged forty-two, was admitted into Darker ward, under the care of Mr. Baker, on Feb. 15th, 1885, suffering from disease of both knee-joints. Patient looks a fairly healthy man, and is well-nourished. He states that up to within three years and a half ago he was quite well, with the exception of a few rheumatic pains in damp weather. Then, while he was at work, he slipped off a step, fell, and twisted his leg under him, severely spraining it. It swelled up very soon after the accident, and caused him much pain. He was admitted into the Northampton Hospital for it, and was under treatment there for five weeks. It was painted and strapped. It got a little better, but it has never been right since. When in the Northampton Hospital his right knee became enlarged and painful, but it was not treated. Since then both knees have been getting gradually worse. After a day's work they become much enlarged and very painful, so that lately he has been unable to continue his work regularly. A fortnight ago he walked up to London to seek advice. He walked about eight miles a day, and at the end of each day his knees were very painful indeed, keeping him awake at night. When he arrived in town he came to this hospital, and was admitted. When young he was in the army. He left twelve years ago. He had gonorrhœa when twenty years of age. Thirteen years ago he had rheumatic fever very severely. He was laid up with it for thirteen weeks in the Bermuda Hospital. He says he was much reduced in health afterwards. The family history is good. His father lived to seventy-two,