

clapsing before its effect is distinctly perceptible. 2. The effect, when obtained, is somewhat permanent, so that if the drug be withheld the pulse does not attain its previous rate for two or three days. Both of these are in contrast to its action on the temperature, which is never prolonged beyond thirty-six hours, by even the largest antipyretic dose. 3. Its action is not limited to typhoid fever. I have obtained similar results in the last stages of phthisis, in croupous and broncho pneumonia, and in surgical cases with hectic. I venture to think that the recognition of this use of quinine is a point of great importance, and that by it alone many lives might be saved. The difficulty of meeting the emergency of heart failure in fevers is testified to by the number of drugs that have at various times been recommended for it. I have given the great majority of these a more or less extended trial, without ever being able to satisfy myself that I obtained any result, except, perhaps, from digitalis. Digitalis, however, had nothing like the effect of quinine, while it appears to have, in doses sufficient to reduce the pulse-rate, dangers peculiar to itself.

Most works on therapeutics seem to imply that quinine is a cardiac depressant. What is the influence of this teaching on practice? A case of typhoid fever is being treated with small doses of quinine, two or three grains every few hours (a common routine treatment). Later on, in the usual course of events the pulse becomes weaker and more frequent. The drug is then probably withdrawn on the supposition that it is weakening the heart's action, whereas this is the very time that the dose should be doubled or even more largely increased. All this has, at any rate, frequently happened to myself.

Aberdeen.

## VERY SEVERE PAIN IN ANTERIOR EXTREMITY OF URETHRA.

SUPRA-PUBIC CYSTOTOMY; FORCIBLE DILATATION OF CONTRACTED PROSTATIC URETHRA; RECOVERY.

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J. W. P.—, aged forty-two, builder's foreman. His mother died from consumption, and his six brothers and sisters from various diseases—two from inflammation of the lungs, one from abscess in the side, one from blood poisoning, and two from convulsions in infancy. He was a married man, and had always been stout and vigorous till the onset of his present symptoms. These developed about the middle of 1888, and consisted of almost unbearable pain in a position corresponding to the floor of the anterior extremity of the penile urethra. This pain was so violent and constant as to make it impossible for him to continue his occupation. He was unable to eat his meals and he lost flesh rapidly. He stated that he was for some time an out-patient in St. Peter's Hospital, where nothing was found, and his pain was not relieved. I saw him at the out-patient department of Guy's Hospital, and admitted him into the hospital under the care of a colleague. When under observation, it was seen that though the man complained of constant pain, he was subject to violent exacerbations lasting from a few minutes to three or four hours. During these attacks he appeared to be in the greatest agony. Though the pain was increased by his getting about, yet he had severe attacks when kept perfectly at rest. The right testicle was undescended. Nothing could be made out by examination with the cystoscope, sound, finger, &c., either at this time or on subsequent occasions. His weight was about 8 st., and he appeared wasted and distressed. His usual weight was about 10 st. His urine was acid, sp. gr. 1008, and contained no blood or pus. Some crystals of triple phosphate were present. He was treated with various drugs, dieted, and kept in bed for some time, and apparently with some benefit. He left the hospital on Sept. 1st.

He was readmitted under my care on Sept. 22nd, having spent three weeks at a convalescent home. He asserted that it was impossible to continue life in his present condition. Considering that the cause of the pain might be some condition of the prostate not apparent by the cystoscope, sound, or finger, in the rectum, I determined to open the bladder above the symphysis, and examine it bimanually. I may say that I had carefully examined the position of the

kidneys and ureter, and made him take violent exercise of a varied nature, to find if possible any complaint of pain elsewhere than in the end of the penis, or any alteration in the urine, without any success. Therefore, on Oct. 22nd, I opened the bladder above the symphysis, and found its interior healthy, as we had previously found it on examining it with the cystoscope. On attempting to introduce the tip of the little finger into the prostatic urethra, the greatest resistance was felt, and it was only after using much force, both with the finger and with instruments, that it was possible to dilate up this portion of the urethra. Nothing abnormal could be detected in the prostate except that its right lobe was smaller than the left. Hardly daring to hope that this dilatation of the prostatic urethra would be of any service to the patient, I introduced a drainage-tube and closed the wound. On Nov. 1st the drainage-tube was removed, and he passed urine through the urethra. (The reason I took the unusual course of introducing a drainage-tube into a healthy bladder was that I wanted to keep the prostatic urethra at rest for a few days.) He was delighted to find that he had lost the pain since the operation. He left the hospital on Nov. 8th, with the object of spending some weeks at the sea-side. I saw him about the beginning of this year, and found him looking strong and in much better condition. At times he said he felt a very slight pain in the position of his old trouble, but it did not seem to cause him any concern.

I felt that this case deserved to be put on record because of the obscurity of the causation and pathology of the condition of the prostatic urethra, of the apparent causal connexion of the prostatic stenosis with the local penile pain, and of the happy termination, almost accidentally arrived at, of a complaint which would not only have considerably abbreviated the course of the man's life, but would also have rendered it exquisitely miserable, if in all human probability the intensity of his misery did not lead him to terminate his existence. I trust that this communication may lead others to publish accounts of some similar cases they may have observed, which may help to throw light upon this condition, apparently a very rare one. Should the pain recur in this case I will dilate the prostatic urethra forcibly and extensively with a suitable lithotrite.

I regret to say that after a time the local pain returned, but with less severity than before. Forcible dilatation of the prostatic urethra relieved this pain, though it did not remove it. No further light has been thrown upon the condition since the first operation.

St. Thomas's street, S.E.

## Clinical Notes:

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### HÆMATURIA IN EAST CENTRAL AFRICA.

By R. F. CASTLE, M.B., B.C. CAMB.,

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HÆMATURIA is certainly one of the commonest causes of complaint both amongst the natives and the Europeans resident in Zanzibar and on the adjacent mainland. The hæmaturia may be roughly divided into two great classes—one dependent on the presence of a parasite, the other not. The *parasitic* form is due to the presence of the trematode *bilharzia hæmatobia* in the body, and the ova can invariably be seen in the urine, although the latter may appear to be free from blood. The persons who suffer from this disease are very numerous, are usually of the male sex, and are almost invariably under the age of thirty; after that age the symptoms seem to disappear. All the cases which came under my observation were directly traceable to the patients drinking water from one of two small rivers which drain part of the Usambara district. In both these rivers I have found the free-swimming embryo. In other parts of the same district where water was scarce and the natives derived their whole supply from mud-holes the disease was apparently unknown. The Europeans living in this district are in the habit of boiling and filtering their water before using it; consequently none suffer from the disease. Again, a native will drink three or four times as much water in the day as a European will, a small

boy taking, as a matter of course, a quart bottle of water to bed with him and finishing it before the morning. Therefore a native always runs a greater risk than the European does. The only treatment which I found to be of any use was small doses of buchu and opium freely diluted. This seemed to allay the irritability of the bladder (which was the prominent symptom) better than anything else. The *non-parasitic* form of hæmaturia was always associated with a high temperature. The usual course of a typical case was as follows: First, a rise in temperature ranging from 103° to 105°; this would last for about two hours, by which time the patient had probably gone to bed. Secondly, a severe rigor, lasting perhaps twenty minutes; about an hour after the rigor the temperature falls to about 102° (probably influenced by antipyretics). Thirdly, a feeling of faintness comes on, marked by great pallor; the first quantity of urine which is passed after this will be absolutely black, and is found to contain a large quantity of grumous material, composed of disintegrated blood-cells. At this stage of the disease no actual blood-cells can be discovered by the microscope; but as the patient recovers, and the amount of blood passed is less in quantity, it becomes more like real blood in its appearance, and cells more or less altered can be readily made out. The hæmorrhage usually continues for about three days under treatment; perhaps it would last longer if not treated, but naturally one did not care to try. And then follows, fourthly, the stage of convalescence; the hæmorrhage has ceased, but there is still a temperature of about 102°, which may persist for a month or until the death of the patient. Probably the system, weakened by the great loss of blood, is unable to resist the malarial poison as it otherwise would; for an African fever is generally sudden both in its onset and in its retrocession; the man who has been moaning with pain and delirium, with temperature 106° one day, will in two days' time be out stalking antelopes. This, however, is not the case after an attack of hæmaturia; recovery is then always very slow and tedious. This disease is common amongst the Europeans, but rare amongst the natives, although they are frequently attacked by ordinary malarial fever. I have heard of another form of hæmaturia in this district (hæmoglobinuria), but as I have not had a case under my care I give no description of it.

Darfield, near Barnsley, Yorks.

#### TREATMENT OF ULCERATED SCARLET FEVER AND DIPHTHERITIC THROATS BY IRRIGATION.

BY N. S. MANNING, F.R.C.S.,

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I HAVE used the following method of treatment in the ulcerated throats of scarlet fever and diphtheria in the Birmingham City Hospital for about two years and a half. The appliances necessary are a small indiarubber bag syringe, 4 or 6 oz., according to the size of the patient, two small basins, and a towel. The medicament used is boric acid dissolved in hot water (about 105° F.). In order to facilitate the solution of the boric acid, I have a saturated solution in glycerine, prepared by Messrs. P. Harris and Co., Edmund-street, Birmingham, of which the following are the proportions: Powdered boric acid, four parts; glycerine (sp. gr. 1260), three parts. The glycerine should be heated by steam, and the boric acid (best quality, carefully powdered) stirred in till the solution is perfect. Of this solution, a large tablespoonful is dissolved in about a pint of hot water. The method of procedure is as follows:—Place the patient sitting up, or, if too weak to sit up, place him on his side with his face over the edge of the pillow. Apply the towel round his neck to keep him dry if any water accidentally gets spilled; withdraw the nozzle from the syringe before filling it, and fill with the solution; replace the nozzle, and direct the patient to open his mouth; then put it into the mouth well over the back of the tongue, and forcibly empty the syringe; at the same time receive the water which rushes out of the mouth and nose into the empty basin. In this way the mouth, fauces, pharynx, and in some cases the posterior and anterior nares, are irrigated. The operation is repeated till the parts are washed quite clean. In cases of purulent discharge from the nose or nasal diphtheria, the same procedure is applied to the nostrils. The irrigation may be performed every two or four hours as circumstances require. In this hospital during

two years over 1500 cases of ulcerated scarlet fever and diphtheritic throats have been treated by this method. From this experience I can recommend it as superior to any other I have ever tried. I believe its efficacy is due to the fact that it is founded on the rational principle of washing away all septic discharges with a non-irritating, non-poisonous fluid. It is not in any way disagreeable to patients; on the contrary, when the mouth is dry or foul, it is most comforting. The solution is rendered sweet by the glycerine, so that only a small percentage of even very young children offer any objection to it. Occasionally children swallow some, but without any subsequent ill effects. It should be borne in mind that, in order to prevent any septic matter being sucked into the syringe, the nozzle should always be withdrawn when filling.

Birmingham.

#### A CASE OF AINHUM.

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THIS complaint is commonly met with amongst the natives (Kaffirs) of South Africa, especially in Northern Transvaal, and is usually limited to the little toe; both feet are, however, generally attacked, though not simultaneously. The toe at its junction with the foot has the appearance of being gradually cut off by means of the continuous pressure of a ligature tied round the toe at that spot. The following is an example, extracted from my note-book, of the usual history attached to such cases.

Tozini, aged thirty-four, married. The little toe of his left foot is already gone. About a year ago the dorsum and outer side of his right foot swelled up to a considerable extent and gave him much pain of a burning character, the pain running down into the little toe. The swelling gradually subsided, leaving a small pustule on the inner and dorsal aspect of the metatarso-phalangeal joint of the little toe. This pustule, on evacuating the matter, assumed the appearance of a crack, which slowly extended round the toe, eating deeper and deeper through the tissues; all feeling gradually left the toe, though the foot remained very painful until the toe dropped off (or in some cases gets accidentally knocked off). The wound quickly healed and gave no more discomfort. The complaint appears to be one of nerve origin, and differs entirely from the "mutilans" form of leprosy. The only cure consists in amputating the toe.

Pretoria, S.A. Republic.

### 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.

#### MIDDLESEX HOSPITAL.

CASES OF INJURIES OF PERIPHERAL NERVES (*continued*).  
(Under the care of MR. HULKE.)

WE continue below the interesting series of injuries to peripheral nerves which we commenced at page 877 of our last issue. The cases already brought forward include two of wound of the ulnar nerve, one of recovery of function after immediate suture of median, and one of division of the sciatic nerve within its sheath followed by very incomplete recovery of function.

In Case 5 the presence of small sensitive islands in the palm was singular, in presence of the fact that the divided ends of both median and ulnar nerves were separated by not inconsiderable intervals. The relatively early return of sensibility in the palmar distribution of the median nerve after suture, although the ends of this could not be brought into contact, imperfect as it was, and transitory as it proved in some branches, is a remarkable circumstance. In Case 6, the position of the smaller and posterior of the two scars in