


cyst of the liver. Only one of these twelve cases (that of Bergmann) was, like the author's, a veritable hydrops renis cysticus. Concerning the etiology of such cystic kidneys there are great differences of opinion among pathologists.—*Deutsch. Med. Wochenschrift*, January 19, 1888.

C. J. COLLES (New York).

VI. Subpubic Cystotomy. By Dr. C. LANGENBUCH, (Berlin). Of all the older ways of opening the bladder, but two now meet with favor, viz., median perineal section, and the suprapubic operation. First, he sketches briefly the objection to each of these, respectively, the reasons why neither has gained universal preference. In the former these cluster around the operation, in the latter about the after-treatment. The latter would now be esteemed the finer operation, but for dangers which essentially depend on uncertainties in the free discharge of urine. L's present effort aims to demonstrate a new way by which this possibly may be remedied. Some much wider and less easily obstructable discharge than by a catheter is demanded, and also the possibility of more or less continuous irrigation of the bladder without endangering the suturing—and all of this possibly without recourse to the urethra.

For this purpose, he proposes to enter between the lower border of the symphysis and the root of the penis. In reality, he constructs an entirely new entrance to the bladder, for many cases alone sufficient, for others as a pre-operation for suprapubic cystotomy. From special dissections, and with the aid of four colored illustrations from Henle, he first describes the respective local anatomy.

With the subject in lithotomy position he makes a -shaped incision over the root of the penis and the rami of the pubic arch, then frees the lateral and upper parts of the root of the penis, with a knife cuts the attachments of the suspensory ligament to the symphysic surface, and with scissors the laterally attached, sail-like, ligamentous lamellæ from the albuginea. This allows the shaft of the penis to sink down. Of course, the direct attachments of the cavernous bodies to the bones are not touched.

The second step consists in freeing the firm lateral attachments of the transverse pelvic ligament. By holding scrupulously to the bone neither the aa. pudendæ nor the cavernous bodies of the penis can be injured. Here at the diaphragma urogenitale he recommends setting the knife in at the apex of the arch. First divide the arcuate pelvic ligament taking special care not to injure the vena dorsalis, nor to allow the scalpel-point by going deeper to touch the venous plexus about the neck of the bladder. Now with an elevator work a way in between arcuate ligament and bone. As soon as possible have recourse to dilating instruments, as a needle-holder and glove-stretcher. The now depressed, cord-like, transverse pelvic ligament may, if absolutely necessary, be drawn up, isolated and incised, just between the median dorsal vein and the lateral arteries and nerves.

Even a hæmorrhage could, he thinks, be more easily controlled than during a perineal operation. The vertical diameter of this opening to the bladder amounts to 4.5 cm.

The venous labyrinth of Santorini is bilateral, with anastomosing twigs. By care and working with blunt instruments, this can be pushed to each side unharmed. A segment of the bladder now presents, and can be made more accessible by filling the viscus and pressing down on the abdomen. This anterior and lower part of the bladder is partially fastened to the symphysis by the tendinous arc of pelvic fascia. This prevents the in-rolling of the wound edges, so troublesome in the suprapubic incision. Before entering the bladder, introduce a catheter, and control with the left fingers, then incise about 1 cm above the beginning of the urethra. The knife-edge should be directed upwards to avoid prostate and base of bladder. The wall here is rather thick. After fluid begins to run out, dilate bluntly. The access is not so large as by the suprapubic. If needs be, some of the bony arch may be chiselled away. For drainage he introduces two firm rubber tubes size of the little finger. The afferent is left on sewing up in the upper part of the wound. The efferent only has side openings; by means of dressing-forceps it is pushed down and out through the soft parts beside the urethra—appearing, on cutting the skin over its point, about 2 cm., in front of the anus to the right. In this way a discharge from the dependent part of the bladder is secured.

By comparing with other vesical operations, with tracheotomy etc., he concludes that there is very little fear of purulent phlebitis from veins about the field of operation. Nor from the physiology and an observed accident case does he think any lasting harm would follow closure of the median dorsal vein.

The operation is scarcely applicable in children, but would avoid a vesico-vaginal fistula in females.

He sums up the advantages as :

1. The securing of an entrance to the bladder, wide enough to extract the concretions, in most cases of calculus, *i. e.*, to break up and then to remove them. Further the direct exposure of the trigonum Lieutaudi, a very common seat of vesical tumor, or hypertrophy of prostate.

2. The avoidance of injury to delicate parts—vessels, nerves, erectile bodies, urethra, muscles of urinating and erection, the prostate, seminal ducts, rectum and peritoneum.

3. A permanent urine-outlet from the lowest point of the bladder, satisfying all demands, also sufficient drainage to avoid suppurative cellulitis.

4. Avoidance of the so untrustworthy bladder suture with all its even life endangering accidents.

5. The doing away with a permanent catheter, and consequent urethral irritation, and also with repeated catheterization.

6. The possibility of primary wound-union.

Inasmuch as this method does not secure as free entrance as the suprapubic operation it may in special cases, be necessary to add the latter, and thus gain the advantage of both. He thinks it is not as easy as the simple suprapubic, but easier than the perineal methods.

His whole paper represents a suggestion and an incentive, and not an actually applied procedure.—*Lie Sectio alta subpubica*, Berlin: Hirschwald, 1888.

WM. BROWNING (Brooklyn).

VII. Case of Extroversion of the Bladder Treated by Preliminary Division of the Sacro-Iliac Synchondroses, (Trendelenberg's Operation). By MR. G. H. MAKINS, (London).