

Clinical Observations ON LITHOTOMY.

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GENTLEMEN,—The anatomy of the perineum has been made unnecessarily complicated by the arbitrary subdivision of the fasciæ into numerous layers, which do not exist in nature. We meet successively with the skin; subcutaneous tissue and superficial fascia; the muscular fascia; the layer of muscles—namely, erector penis, accelerator urinæ, &c.; the interosseous membrane or ligamentum triangulare. Beyond this lies the pelvic fascia. Remember these two points: first, the triangular ligament does not extend below the urethra; secondly, the vessels of the perineum are very irregular in their course and distribution. The distance between the neck of the bladder and the surface of the perineum depends on the thickness of the subcutaneous strata, varying from two to four inches. The neck of the bladder lies about an inch behind the symphysis pubis, in which spot it is held firmly by its ligaments. It is a fault with many surgeons to cut too much backwards when the knife leaves the groove of the staff and runs between the bladder and rectum. The operation is always an anxious one, because the greater part is performed on structures which are out of sight; but, when difficulties arise, they almost invariably proceed from the fact that the surgeon has missed making a proper opening for the extraction of the stone. In this hospital, where high antiquity gives a traditional interest to its rules, it has never been in my remembrance the custom to draw off the urine just before the operation, and to distend the bladder by the injection of warm water. Such a proceeding is unnecessary and tedious, and is apt to disturb parts. But the rectum is always carefully emptied by means of an injection, and the patient is enjoined to hold his water as much as possible. The position of the patient is that commonly adopted elsewhere.

I do not recommend that the first incision be very deep. When the skin has been divided to the proper extent, the fat and subcutaneous tissue will readily yield to any amount of pressure. By adhering to this rule you often avoid wounding arteries of considerable size, or even a part of the bulb. The point of the forefinger of the left hand should then feel for the staff as it lies under the pubes, and the knife should be made to enter the groove by being pushed obliquely upwards, inwards, and backwards, so as to pass if possible *behind* the bulb and its arteries, being introduced about the middle of the external wound.

The membranous part of the urethra is that usually first opened, and some urine often escapes; but do not hurry the withdrawal of the staff. Press the knife onwards, followed by the left hand, until you can get the forefinger well into the prostate, when in most instances you can dilate to a sufficient extent. I believe the more we dilate and the less we cut the better. In a case which I had the opportunity of examining, the membranous part of the urethra was opened, the prostate partially divided, and the neck of the bladder had the smallest possible incision. In the choice of instruments, every surgeon has his own fancy. I commonly complete the operation with an ordinary knife; but in cases of very deep perineum a beaked knife is to be preferred, and in this case it is perhaps better that, as he presses the instrument through the prostate, the surgeon should depress the handle of the staff with his left hand. The stone is removed either by the forceps or the scoop. It may sometimes be turned out by the finger. There is no need of alarm should a moderate amount of hæmorrhage ensue; indeed patients in whom this occurs seem often to make the most rapid recovery. Death from hæmorrhage is extremely rare. Do not introduce a gutta-percha tube into the bladder through the wound. If the incisions are properly made, the urine will flow through the wound without difficulty. The patient should be put on his left side, a layer of mackintosh under the buttock; the feet should be tied together, the thighs slightly flexed. The diet should be nutritious, and an

opiate should be given at night-time if necessary. Cases for the most part do very well, unless there should be disease of internal organs, and more especially if the kidneys be affected.

It has been asserted that in the London hospitals the mortality from lithotomy is 1 in $4\frac{1}{2}$. Whether such a statement be true or not in the aggregate, it is hard to say. There may be incompetent operators or ill-ventilated or badly-arranged buildings. In St. Bartholomew's Hospital the mortality is about 1 in 10, nearly the same as in the days of Cheselden. I have had six consecutively successful cases, and others of my colleagues could give an equally favourable return.

I directed your attention to the case of a young man in Pitcairn ward, who is convalescent from the lateral operation performed nearly three weeks ago. You may remember that he suffered severe pain in micturition, and was liable to epileptic fits in rapid succession. The stone, when extracted, was found to be composed of oxalate of lime; it was as black and as nodulated, and in size the counterpart of a mulberry. Since the operation the lad has had but one slight epileptic seizure, and that during sleep. He is now so far recovered that I can scarcely persuade him to remain in bed.

As in the male, so in the female, I should say, Dilate, but do not divide more than is absolutely necessary. Those who have not tried will scarcely believe the extent to which the female urethra, the homotype of the membranous and prostatic portions of the urethra in the male, will yield to slow distension.

ON THE TREATMENT OF CONGENITAL CLEFT PALATE.

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IN presenting the subject of the treatment of congenital cleft palate for consideration, I must beg the indulgence of the readers of THE LANCET if I present no new or original thoughts; and if the statements I make or the views I shall advance shall seem to conflict with the opinions of the profession in England, they are, nevertheless, the generally accepted opinions at this time in the Transatlantic States.

I shall not enter into any discussion of the causes of this deformity, nor any extended description of the variety of extent which this malformation assumes. So far as I know, no research has discovered the cause of this arrest of development, nor any means of preventing it. It does not seem to any extent to be entailed or transmitted to offspring. In but few instances which have been brought to my knowledge has there been any evidence that the defective organization was inherited. In some instances it has appeared in several children of the same parents; but in a large majority of cases they are the solitary instances in the family. Neither is there any uniformity in its extent.

If we take the uvula as the starting-point, we sometimes find merely a bifurcation of that organ, and from this very slight defect it is presented with every gradation of extent, into the velum, to the posterior edge of the palatine bone, to the base of the alveolar ridge, and sometimes dividing the maxilla along the line of either or both the nasal passages.

The only evils arising from this deformity worthy of our attention are its influence on deglutition and articulation. These functions of deglutition and articulation being unlike each other in the fact that the former is a natural, while the latter is an acquired or a mechanical function, it will readily be seen that the loss of any of the organs concerned may influence the two in a very different manner. A person suffering from a congenital defect of an organ concerned in a natural function may by repeated efforts acquire such a control over the remaining organs as to experience no real discomfort from his defect. A child born with a defective velum or palate must of necessity find the function of deglutition during all the earlier periods of its life, and especially while it is dependent upon fluids for nourishment, much impaired. To such an extent have these poor unfortunates suffered from this deformity, that there is no doubt that many lives have been sacrificed solely from want of nourishment. But when the deformity is discovered by the nurse, and accommodation made to meet the child's condition, it is very soon able to obtain all the food necessary to its deve-