practising, as a rule, lateral lithotomy by Cheselden's method, as modified by Liston, I have for a long time had grave doubts whether it was really the best way of getting into the bladder, and more especially of extracting a large stone out of it.

These doubts led me to determine to adopt the Transverse Bilateral method in the first favourable case that presented itself, and which was as follows :—

A. G——, sixty-seven years of age, was sent to me at University College Hospital by Mr. Willing, of Great Wakering, Essex. He had suffered from symptoms of stone in the bladder for three years, and had much muco-pus in the urine. The report from the case-book is as follows :—

Aug. 1st.—Mr. Erichsen passed a sound into the bladder, and detected a large stone, apparently two inches or so in length. The patient being in good health otherwise, it was determined to perform lithotomy.

The operation was performed on the 7th of August. The patient having been placed under the influence of chloroform, Mr. Erichsen passed a grooved rectangular staff into the bladder; and the stone being at once felt, he proceeded to perform the operation after the bilateral fashion. A transverse crescentic incision was made in the perineum. The centre of the incision was half an inch above the anus, and each extremity of it about the same distance from the tuber ischii. The dissection was carried down in the line of the superficial incision to the central point of the perineum, so as to separate the bulb from the rectum. The scalpel was then thrust onwards into the groove of the staff, through the membranous urethra, and just in front of the prostate, its blade being directed upwards. The knife was now drawn backwards out of the wound, cutting upwards as it was withdrawn, so as to form a vertical incision in the superficial structure, of about an inch in extent, in the middle line, and communicating with the centre of the crescentic cut originally made. The knife being withdrawn, a lithotome caché was introduced along the groove of the staff; and by the withdrawal of this (the handle of the instrument being at the same time depressed) both lateral lobes of the prostate were divided to the extent of about three quarters of an inch—the distance to which the instrument had been previously adjusted. The lithotomy forceps was then introduced into the bladder, and the stone was at once seized. The withdrawal of the forceps was effected with some little difficulty, owing to the large size of the stone, and to the necessity of changing the direction of its axis in their blades. The calculus on removal was found to be of an oval form, with a long diameter of about two inches and three quarters, and nearly two inches in a transverse direction, and from its surface several irregular nodules projected. It weighed three ounces and one drachm. Its external surface was composed of uric acid. A tube was passed into the wound, and left for about forty hours, the urine coming away freely through it.

Aug. 10th.—The report continues as follows: Pulse 84; the patient going on well. From this time he progressed uninterruptedly (with the exception of a slight attack of diarrhœa, which was easily checked), taking his food well, sleeping well, and suffering no pain whatever.

On the 22nd the urine ceased to flow through the wound, and came entirely by the penis.

The wound granulated healthily, and, occasionally being touched with nitrate of silver, was almost entirely healed when he left the hospital on the 11th of September.

It will be seen by a reference to this case that I performed the operation by Dupuytren's method. This plan, as is well known, is the original "bilateral" operation by means of the "lithotome caché," a most beautiful and ingenious instrument devised expressly for it. Civiale modified this operation by making the external cut perpendicular in the mesial line, but retaining the double section of the prostate; and Sir W. Fergusson has still further modified it by confining the section in ordinary cases to the left lateral lobe of the prostate.

The principle of all these three operations appears to be the same—namely, to reach the neck of the bladder through the mesial line, where it is nearest to the surface. The difference in the details is, however, great, and I think most important.

So far as *external* incision is concerned, Sir W. Fergusson adopts Dupuytren's method—the crescentic transverse; thus getting wide space, enabling the rectum to be fairly separated from the bulb and well depressed, and cutting below or rather behind the arteries of the perineum. In all these respects I think this incision is preferable to the perpendicular external cut of Civiale and Allarton.

In the internal incision—that through the prostate and neck of the bladder—Civiale nearly follows Dupuytren, making the cut equally into both lateral lobes by means of a lithotome caché; whilst Sir William confines his cut, except in certain cases, to the left lateral lobe, and makes it with the scalpel.

To my mind the double cut appears the preferable method, as by it an equal extent of incision can be made in the prostate with less danger of passing beyond its limit. Suppose, for the sake of argument, that to extract a calculus it is desirable to make a cut eight lines long into the prostate. If one lobe only is incised, the cut must go to the full extent in it. If both lobes are cut, only four lines need be divided in each of them; and so proportionately to any extent. As the whole under-surface of the prostate is exposed by the transverse external cut, it is as easy to divide both lobes as one. This may be done with the scalpel, and, in such dexterous hands as those of Sir William Fergusson, with perfect safety; but for a less expert master of our art I think the lithotome caché a safer instrument, as by it the extent of incision can, without possibility of error, be regulated to a hair's breadth.

There is one practical point in all these mesial operations of lithotomy—whether Allarton's, Civiale's, or Dupuytren's—which I consider of some little importance. It is the use of the rectangular in preference to the ordinary curved staff. I have now used it several times in Allarton's and Civiale's, and look upon it as possessing three very decided advantages over the curved staff. The first is, that its angle can be placed directly in the membranous part of the urethra, and held there until the knife enters its groove. Thus it becomes an unerring guide to the exact part of the urinary canal that we wish to open. The second advantage is, that it carries the urethra away from, instead of, as the curved staff does, down against the rectum. And the third is, that from the angle onwards the course of the groove is straight and direct, so that the beak of the lithotome or the point of the scalpel is carried on in a straight instead of a curved direction.

Cavendish-place, Jan. 1868.

NOTES ON AN

INTERESTING CASE OF MIDWIFERY.

BY W. H. TAYLER, M.D., M.R.C.S.

ON the 22nd of April, 1865, I was called to attend a woman, aged twenty-nine, in labour with her first child. Finding the pains were very slight I left. I called again in the afternoon, and made an examination, but could not feel the os. I began to suspect there would be some difficulty in the case, but, as the pains were about the same, I went away, telling the nurse to send for me as soon as they became stronger. About eight P.M. I was summoned, and now found the pains were of the right sort. I made an examination, but could neither detect any presentation, nor find the os. I felt about for some time, and at last detected a very small indentation (not an opening) about the size of a pea. This I considered must have formerly been the os, and that I had a case of occlusion of it. I also found the pubes projecting very much inwards, making the antero-post diameter very narrow, and altogether rendering it a case in which I did not feel justified in acting without a second opinion. I therefore sent for my friend, Dr. Stilwell, of Beckenham. He came, and agreed with me as to the nature of it. We also came to the conclusion that nothing remained but to make an artificial os, and overcome the pubic projection by forceps or craniotomy. I informed the husband of the difficulties of the case; he suggested further advice from town, but I told him the confidence we had in each other by reason of our having acted together in several most difficult cases which had occurred in our respective practices, made us feel quite equal to any emergency, and that we declined the assistance of a physician-accoucheur from London.

First, to make an os, I passed one of the blades of a pair of long scissors through the indentation in the uterus, and made several notches round it, which enabled me to introduce the point of the forefinger into the uterus. We then waited to see the effect of the pains. It did not dilate much. Then, by degrees, I introduced the middle finger, and by stretching the edges, somewhat increased the opening. After three hours' work I managed to get two fingers in, and could feel the head presenting. After manipulating for another two hours the opening was sufficiently dilated to render it advisable to rupture the membranes. This being done, the head, after a time, came down as low as the pubic projection would admit; but

here all further progress was stopped. We then applied the forceps, but there was not room enough, and we had to give it up. There was now no help for it but to perforate the cranium. This we did, and after great difficulty succeeded in delivering the woman. There being some placental adhesions, we broke them down, and removed the placenta; and heartily glad we were to complete the case. It was now eight A.M., and we were somewhat fatigued with our anxious night's work.

The most gratifying part of the case was that the patient recovered without a single bad symptom, would insist upon getting up on the seventh day, and was about as usual in a fortnight. Since then her health has been good, the catamenia regular and without pain, and she is now in the third month of pregnancy. She has left the neighbourhood, but will return to it to be under my care for her confinement, and I hope, by inducing labour before the full period, to deliver her of a living child.

Tudor House, Anerley, Dec. 1867.

SOME CONTRIBUTIONS TO THE PATHOLOGY OF FIBROUS TUMOURS.

BY J. H. JAMES, F.R.C.S., &c.,
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THE subject of tumours has, for many years past, so much engaged the attention of the profession, and so many valuable memoirs have been published on the subject—and I may especially mention the last comprehensive and carefully arranged contribution from the pen of Mr. Paget, in Holmes's "System of Surgery,"—that it might almost appear to be a work of supererogation to offer any contribution on the subject, were it not that, in all matters of medical science, there will be parts to be filled in; and there is one class of tumours—I mean fibrous—on which there is some measure of doubt even among the highest authorities. A great number of these have, first and last, come under my care, and I will venture to submit a few, with some observations connected with them, to the consideration of the profession.

There can be little doubt that, although fibrous tumours are generally of a nature non-malignant, yet cases do occasionally present themselves where they are not only malignant, but intensely so; becoming, in their progress, allied to the most intense forms of cancer, although, at their commencement, and it may be through their whole course until they have disintegrated, their pathological characters possessed strong distinctions from cancer. But it is not on this account, simply, that I present the following cases, but rather to show the difficulties and dangers which attend their removal when large, while the necessity for doing so is often but too clear.

CASE 1.—On Dec. 20th, 1862, I was desired to see a lady in the northern division of the county, aged forty. She had a tumour in the right thigh, the middle of which it occupied, and extended upwards nearly to Poupart's ligament, apparently throwing out a prolongation in that direction. It was slightly movable and somewhat irregular on the surface. She was under the care of an excellent surgeon, and, after a careful examination, we agreed that it should be removed; the character being that of a fibrous tumour. This was effected with much dexterity by the surgeon, assisted by my son and myself. From its close proximity to the artery, this required much care. Its base was imbedded in muscular structure. The capsule was not so strongly marked as in many other cases, but the surrounding adipose substance was dense. At its base it was connected with muscular structure, which was partly removed with it, also with the inter-muscular fascia. The prolongation towards Poupart's ligament proved to be a gland, partaking very much of the same appearance as the tumour, and connected with it by dense cellular substance. In the course of the operation, the artery was necessarily bared. The section of the tumour was mostly white and fibrous, with a portion of the centre less solid and of a chocolate colour. The surface was granulated.

March 19th, 1863.—I received a bad account: a quantity of little tubercles in the cicatrix.

June 10th.—Being in the neighbourhood, I saw her. Her state was most singular. The abdomen was covered with small tumours, movable under the skin; and there were several elsewhere, one being on the upper part of the spine, which had produced absorption of the bone, and caused paralysis of the left arm. Part of the wound never healed, and had the character of a decided cancerous ulcer.

She died at the end of June.

The preparation is in the museum. There can be no question as to the extreme malignancy of this disease, which, however, never appeared until subsequent to the operation.

CASE 2.—J. S——, aged twenty-six, not of an unhealthy appearance, was admitted May 8th, 1851. There was a tumour extending from the upper part of the ear to considerably below the angle of the jaw, about the size of an orange. It was firm, a little uneven, and movable in a slight degree. It had not increased very rapidly until recently, for the duration was eleven years. It was clear that, if it could not be removed, it must destroy life by pressure on important parts, or by breaking up and ulcerating. After an anxious consultation with my colleagues, it was determined to attempt its removal, however difficult. This was done on the 14th May. The operation consisted in making crucial incisions (the first coinciding with the direction of the artery) and dissecting back flaps, and separating the tumour above and posteriorly, where the ground was safe; but when I came to the anterior and lower portion below the angle of the jaw, where it actually sank to the vertebral column, as found in the course of the operation, the difficulty was extreme, as may be easily understood by the situation. It was not only imbedded amongst arteries and nerves of the greatest importance, but was also connected with the muscular fibres of the digastricus, stylo-hyoideus, and sterno-cleido-mastoideus. By using my knife as little as possible and my nails whenever they would serve, I had in a great measure succeeded in separating its anterior and deep part, when I sprang an artery, which bled violently. All attempts to seize its mouth, even when the carotid was compressed, were vain. With the kind assistance of my colleagues, Mr. De la Garde and Mr. Edye, I tied the common carotid; this happily stopped the hæmorrhage. I then cut away all the tumour which had been cleared, which gave me greater facility, and also disclosed its character, which was then supposed to be malignant. Feeling that it would be highly dangerous to follow it down to the transverse processes with the knife, which might risk wounding the carotid again, or other important arteries or nerves, I passed a double ligature close to the transverse process to which it adhered.—9 P.M.: No hæmorrhage. Sleepy. Complains of much dragging and soreness of the throat; no other bad symptoms.

May 15th.—The drowsiness has passed off, and no ill consequence is imputable to the ligature of the carotid. He has extreme difficulty in swallowing from soreness and phlegm in the throat. Considerable tumefaction; little fever.

16th.—Difficulty of swallowing relieved. In all respects going on well.

June 5th.—Nothing could have done better than this case up to the present time. The wound had healed with the exception of a small portion under the angle of the jaw, where the root of the tumour was tied, and this discharged quite healthy pus; and also a small portion where the ligature of the carotid remained, which we all thought would safely separate. Without, however, any particular cause, hæmorrhage took place early in the morning, and, on the house-surgeon being called, was suppressed; but he had lost a large quantity of blood. It did not flow *per saltum*, and was not abated by pressure below; consequently, there could be little doubt of its being a refluent hæmorrhage. The day before he had noticed a pulsation in the temporal.

8th.—9 A.M.: Early on the 6th there was a recurrence of the hæmorrhage—half a pound supposed—but stopped by light pressure; not at all controlled by pressure on the carotid below. A compress moistened with collodion was laid on the part, and secured by straps of adhesive plaster. There has been no recurrence of the hæmorrhage since, and everything appears favourable.

14th.—No recurrence of the hæmorrhage. The collodion compress not separated.

21st.—Everything going on well. Made out-patient.

In the middle of August he had an attack of peritoneal inflammation, but recovered.

September 13th.—There is no vestige whatever of the tumour, but all is sound and healthy.

May, 1852.—This man has gone to Jersey.

November, 1858.—I heard of this man being alive; so he could not have had malignant disease, and, indeed, the length of time (eleven years) before the operation goes to the same point.