

Lectures.

CLINICAL LECTURE.

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LITHOLAPAXY.

GENTLEMEN, — Within ten days we have had two cases of rapid litholapaxy, one of which you saw. After both, the temperature rose from 98° to above 100° F. On the third day it fell to 99° F., and now, three days later, it is normal. This reaction is like that from the effect of a bougie, and the temperature like that of urethral fever. A patient readily recovers from the operation of litholapaxy if we remove from the bladder all the fragments of the stone. In fact, the new method has succeeded beyond expectation.

Small stones are easily ground up, especially if soft, and then come away of themselves. Serious consequences may follow if fragments are left in the bladder. In former times cases that did not admit of lithotripsy had to be cut; likewise those in which, from any reason, lithotripsy was hazardous. A recent number of the London *Lancet* reports a case in which Mr. Smith, of St. Bartholomew, removed four ounces of stone from the bladder of an elderly man, who left the hospital in a week. This is the largest quantity of debris ever removed by litholapaxy.

The operation, of course, is purely mechanical, and any reference to it is chiefly to its mechanics. The principles of litholapaxy and of complete evacuation are pretty well settled and accepted. It is now mainly a question of certain minor details of convenience in the apparatus. I am satisfied that one point which contributes as much as, if not more than, any other to rapid and complete evacuation is the power of regulating and of frequently varying the quantity of water in the bladder. You require just enough water to prevent the *thud* of the slack walls when they are drawn into the eye of the catheter. When you feel that, the bladder must have a little more water to distend it. Too little water crowds the fragments together. When there is too much you may have to chase a single fragment a long time.

The arrangement of hose I show you here is the only one that allows the operator to diminish the quantity of water in the bladder without disturbing the apparatus. If one end of this hose — which is not much larger than a pipe-stem — be kept in a tumbler of water it does not in the least interfere with the convenience of the operator. But, on the other hand, it does enable him, by turning the cocks, to vary from one minute to another, if he please, the amount of water in the bladder. There can be no doubt of the advantage of being able to do so.

Another point relates to the size of the tubes. The smallest tube used in litholapaxy is larger than the largest tube that was used for evacuation in previous operations. But you will find that the largest tubes I use are sometimes not preferred by other surgeons. They are in the habit of using a No. 28 or 29 tube, and these often serve the purpose. The fact is this: a stone after evacuation is found to have been mostly reduced to powder and minute fragments. Large fragments are rather the exception. Now, the fine debris may be evacuated through a 28 or 29 tube, though perhaps not

quite so rapidly as if the tube had a calibre of 30 or 31. It then remains only to crush the larger fragments and repeat the process. I prefer a larger tube, when there is no objection to its introduction, because it not only evacuates the dust more rapidly, but at the same time allows me to remove the large fragments without having to crush them.

I am sure that in the end operators will all use a stand to support the weight of the bulb, because it is very inconvenient to hold it through a long operation. But there should be a device (as in the stand I show you here) for supporting the bulb at different heights, which can be varied during the progress of evacuation.

I also think surgeons will connect the bulb with the evacuating catheter by means of an elastic tube, so that one can be moved without the other. This to me is a *sine qua non*.

RUPTURE OF A TENDON.

You have seen this man in the ward. He came to the hospital with a rupture of the long tendon of the biceps muscle of the arm. It is a rare accident, and is well worth examination. The man fell upon his shoulder and disabled it. More than this he does not know. He has been unable to bend the arm freely, but is now recovering the use of it. There is a noticeable difference between the biceps muscles of the two arms. On the affected side, the outer belly, never long, has contracted into an almost spherical mass. You can see how this arm differs from the other by its curiously irregular outline. Flexion is accomplished chiefly by the brachialis anticus muscle. The biceps here shows one tendon running to the coracoid process, but there is a hollow where the outer belly should be. Just above this depression is a little tendinous mass, which seems to consist of the fibres remaining about the outer tendon. When the man entered he felt pain about the shoulder, and when he contracts the biceps there is very decided pain there now. There can be no doubt as to the character of the lesion. I have had a cast made of the arm. The case is rare. I never happened to see one before.

TUMORS UPON THE STERNUM.

Nine months ago a tumor appeared on the upper segment of this man's sternum. When he works he suffers pain. He is employed in a paper store, and his work is mostly lifting heavy bundles. He has never been sick. While taking down a package of paper from a shelf he struck the sternum. At night it felt a little sore. A tumor soon appeared, and has grown slowly. It is not tender, although he feels it when he first begins to work.

Here is a second case. This man is a stocking knitter, and of sedentary habits. In May or June last he first noticed an inflammatory swelling which extended over a part of the sternum. A second swelling came on later at the top of the bone.

In these two cases we have two exceptional and different tumors of the upper part of the sternum. The inflammatory growth is the more common of the two. Coming on about six months ago, it became tender, was opened, and has been discharging ever since. Within a few weeks the upper swelling appeared on the same patient. It fluctuates a little, but is still firm, and is indolent in progress. It is a case of caries of the sternum with abscess, occurring in a man of weak habit and somewhat run down. Its progress has been

so slow that the character of the lesion might still be doubtful but for the fact that we know that caries of the sternum usually goes on slowly, in this way, producing a diffused or firm swelling. Beyond the removal of the carious portion of the bone, I know nothing to do. It is a case difficult to treat to advantage. When the upper swelling opens both will continue to discharge for a long time.

In the other case we have a strong man and a different growth. The tumor is nine months old. Instead of being diffused it is circumscribed and abrupt. It is lobulated, non-fluctuating, hard in consistence, with a sharply defined base. It followed a blow. I think it is not an inflammatory tumor. It is a rarer form of growth, and simulates an enchondroma. It is about as large as a horse-chestnut. There seems to be a crater in the bone where it escaped from the diploe. As to a definite diagnosis, if the growth be inflammatory a few weeks will develop characteristic symptoms in that direction. If it be a neoplasm, other symptoms will declare themselves in an opposite direction. In a word, we cannot now make a positive diagnosis, and must wait. But if it be an enchondroma any operation would be merely palliative.

Original Articles.

CASE OF MULTIPLE MELANO-SARCOMA OF THE SKIN.

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Mr. —, aged twenty-two years and nine months, first came under my care December 17, 1874, when the following history was obtained:—

He had always been healthy as a child with the exception of a few convulsions. His parents are Americans, living, and in perfect health; he resided within thirty miles of New York. Eight years ago he was operated on for a ranula, which had existed since infancy; the ranula still persists, and fills up and discharges from time to time. Six years ago, while watching a barrel in the process of being hooped, something struck him in the outer side of the right eyeball, inflicting a bruise on the sclerotic. No treatment was adopted, other than keeping the eye closed, and very little inflammation followed. Shortly after this a minute black speck appeared on the site of the bruise, which has steadily increased in size. This is now seen as a bluish-black tumor one fifth by one third inch in diameter, slightly elevated, and with dilated veins running to it. Two and a half years ago the first lesion appeared in the skin, just in front of the lobe of the right ear, which enlarged up to the size of half a walnut, and has again diminished in size, until now it is that of a large split pea, movable with the skin; this tumor has never been colored on the surface, but is of the natural hue of the skin. A year later, that is, a year and a half ago, he noticed a tumor on the left side of the chest, in front; this was discolored, bluish-black from the first, and has since disappeared, as have certain other tumors.

About nine or ten months ago one appeared beneath the left arm, which has flattened and remains, of a dark color. The next tumor was situated on the right temple, the size of a large walnut, which was removed

by Dr. George K. Smith, of Brooklyn, June 30, 1874; another small one had been previously removed, June 19th, from the cellular tissues just below the lower lid of the left eye. Dr. Sherwell, of Brooklyn, who saw the case and examined these specimens, reports that there was no discoloration of the skin over this latter tumor, nor any undue signs of vessels in the neighborhood, or any hyperæmia. The wound bled pretty freely, but not more than natural. The tumor itself was friable in structure and almost black in color. Microscopically a great excess of pigment matter was found, and many large cells with two or even three nuclei, rendered much more distinct by acetic acid. The tumor removed June 30th had the same consistency and color, and presented the same microscopical appearances.

At this time the fundus of the eye was examined by Dr. Matthewson, of Brooklyn, without finding any morbid appearance or deposit, even in the right eye, originally affected by the first tumor of the sclerotic. The larynx and back of the tongue were examined by Dr. Sherwell and found normal.

During the last nine months the development of the tumors has been pretty rapid, new ones being discovered almost daily up to the present time, while others disappear occasionally. During the past few months the general surface of the skin has been very decidedly darkening, especially that of the face, which now presents much the appearance of that seen in Addison's disease.

The condition of the disease when first seen was thus recorded: The whole surface, from head to foot, is more or less covered with a development of subcutaneous tumors of various sizes and shapes, varying from that of a very small split pea, to an inch and even two inches in diameter. Most of the masses are circular, and occasionally a long one is observed, as on the right forearm, where there is one two inches long by three quarters of an inch wide. Some of the lumps appear to be made up of several tumors closely set together. Most of the tumors are distinctly raised above the skin, to various heights, some being round on top, others quite flat; even those of an inch or more in transverse diameter may be elevated only a quarter of an inch or so above the level, and be quite flat on top. These appear to be such as have reached their height of development and are undergoing absorption.

All of the tumors are decidedly hard and firm to the feel. Some of them are colored, of various shades, from a greenish-brown to a deep blue-black, but most of the tumors externally appear of the color of the skin. Over these latter the skin is quite freely moveable, but over those of a dark color, which are really those undergoing atrophy and flattening, the skin is thick, hard, and united with the tumors.

It is impossible to give the exact number of the separate masses, so many smaller ones are deeply imbedded beneath the skin, and can be found only by palpation. When stripped the body appears to be very thickly sprinkled with them; last week his brother counted one hundred and fifty by the eye.

As previously remarked, some of the tumors are now disappearing. After having attained a certain size, or rather height, as apparently subcutaneous tumors, covered with skin of a normal color, they become first of a purplish color, which deepens until of a deep black. While this is going on the tumors seem to flatten, then absorption appears to take place, the surface sinking