

normal and on July 11th the girl was transferred from the infectious block to the general ward, having been up and about for a week and seeming strong and well. There was little, if any, vaginal discharge, but no control over the urine. On the 19th, under ether, the vagina was found to be considerably contracted and its walls were hard and resistant; the urethral floor had disappeared and its upper wall was adherent to the pubes and formed the upper boundary of the urethro-vaginal orifice. The wall of the rectum and the external sphincter were intact. The base of the bladder had almost entirely disappeared; in the hard roof of the irregular vesico-vaginal cavity an offset which admitted the index finger went upwards and to the right behind the pubes. The vagina admitted the forefinger for 2 in., and at the further extremity there were two offsets, one, the orifice of which felt like a dimple, into which a sound passed easily, going upwards and backwards for 1½ in.; and to the left of this a larger but shallower offset. No trace of the cervix uteri could be felt, and neither by vaginal nor rectal examination could anything be found resembling the uterus distinct from the hard walls of the irregular cavity just described. On August 8th, under ether, an attempt was made to close the orifice of the vagina while re-forming the urethra. A V-shaped incision was made with scissors round the orifice about ¾ in. deep except anteriorly, where a short longitudinal incision was made on either side; these short incisions enabled the urethra to be re-formed and the margins were united with silkworm gut sutures. The flap made by the V-shaped incision was then turned inwards, but with great difficulty, on account of the dense cicatricial resistance, and united with two strong wire sutures. On August 11th, three days later, a note was made that the urine still mostly dribbled, but 10 oz. had been passed on one occasion. On the 16th the urine was being passed in quantities of about 6 oz., and in the previous two days was only passed involuntarily on one occasion. One wire suture was removed on the 26th and the patient was allowed to get up on the 30th. On Sept. 3rd the last suture was removed and the parts had all healed satisfactorily, the vagina being completely closed, and a urethra of somewhat above the normal size having been formed. The patient could retain her urine for two hours or so when standing or walking, but if she went longer there was still occasional dribbling, though not to a great extent. On August 29th and 30th, and again from Sept. 29th to Oct. 2nd, the urine was discoloured with menstrual discharge. On Oct. 7th the patient was sent home and she was again seen in the out-patient room on Nov. 18th, well, and with complete control over the bladder.

Mr. Arthur Hands very kindly visited this patient for me in April, 1894, and finding that she had been married at the preceding Christmas he was good enough at my request to send her to see me. On April 24th she appeared well and healthy; she had returned to her work one month after leaving hospital and had continued till the last three weeks, when she left at her husband's request. The periods have appeared regularly every month, lasting three days or so; they are painless; the fluid passes in the urine, which becomes a little red. There are no clots. The patient would not know she was "poorly" if she did not examine her urine. The urine can be retained for three or four hours in the daytime and seven or eight hours at night; it is never passed involuntarily even in sleep. Since her marriage there has been no pain or difficulty in connexion and the sexual feeling is the same in all respects as before her child was born. There is now a thick, soft, fleshy perineum; the index finger passes easily along the canal which was intended for a urethra into a *cul-de-sac* lined with soft mucous membrane, partly divided into two by a septum, in front and above which, between it and the pubes, the examining finger passes into the freely communicating bladder; this anterior part is very tender to examination. Nothing that feels like a sphincter to the bladder can be made out. No opening can be felt in the wall of the posterior part of the *cul-de-sac*. Bimanually the fingers meet behind the pubes and at the sides and nothing definite can be made out. Per rectum, through the anterior wall is felt a firm, tightly fixed body, rounded from side to side with the convexity backwards, extending from immediately above the sphincter ani internus upwards for about 3 in.; nothing further can be made out by bimanual examination with the finger in the rectum.

What happened at the delivery of this girl will never be exactly known, the only certain facts being that there was a

dead child born after a short first labour, that there was complete incontinence of urine from the time the labour was finished, and that on the seventh day the patient was in a gravely septicæmic condition with sloughing vaginitis, the result of urine flowing freely over the raw torn surfaces of the parturient canal. Her recovery from the grave condition she was in when admitted to the hospital is a striking instance of the value of alcohol in treating septicæmic conditions. Sixteen ounces of brandy daily for five days is a large dose for a girl of eighteen years; still, not only did this produce no sign of alcoholism, but it enabled her to take and digest a sufficient quantity of milk and eggs to satisfy our minds that it was acting as a tonic as well as a stimulant. The condition of the parts locally was such as to preclude a thorough cleansing of the surfaces, and we had to be contented with a partial cleansing, followed by repeated douchings.

After the recovery of the girl the injury was found to be too extensive to hope to restore the bladder, and as the urethral floor was also wanting some method had to be devised by which, if possible, a new sphincter could be provided. There seemed to be no way of testing the natural condition, nor did it appear to be worth while troubling too much about this since it was not clear whether any—or, if any, how much—of the uterus was left. The best way appeared on consideration to be that which was carried out with complete and permanent success—to split flaps by a V-shaped incision round the vulvar orifice, extending forwards as far as the level of the urethral floor, with two incisions at this level at right angles to the rest of the incision; by then bringing the raw surfaces together it was hoped to restore the muscular wall of the urethra at least sufficiently to get some power of retaining urine. The measure of success obtained was most gratifying. After the vulva was thus closed the uterus, as has often happened after colpocleisis for extensive vesico-vaginal fistula, gave evidence of its being still present by menstruation recommencing and continuing regularly. Since leaving the hospital the patient's general health has continued perfect and her marriage appears to have afforded complete satisfaction to herself and her husband, the repaired urethra having added to its functions without difficulty and with perfect success. The total absence of any irritation of the lining membrane of the bladder, or rather the new urine reservoir, and of any phosphatic deposit or subjective discomfort are notable facts, as also is the comfort with which the menstrual function is carried on under the new conditions. *A priori* some troublesome symptoms relating to these functions might be expected, and as a matter of experience in some of the cases in which the vagina has been thrown into the bladder vesical catarrh, metritis, pyelonephritis, or phosphatic calculi have been observed, but in the majority of subjects, as in the present instance, the different functions are continued in comfort.

Birmingham.

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.

LONDON LOCK HOSPITAL.

A CASE OF ACUTE PEMPHIGUS; RECOVERY.

(Under the care of Mr. BUXTON SHILLITOE.)

It is very probable that several distinct forms of bullous disease of the skin are classed together under the name of pemphigus. It is at all events certain that in a large number of cases of bullous dermatitis a very definite micro-organism has been repeatedly found, while it is apparently not discoverable in all. When constitutional symptoms appear they are probably to be attributed to the absorption of toxins from a secondary streptococcic infection of the serum of the bullæ. We are not told in the record of the

case below in what doses the arsenic was administered, and therefore it is difficult to be sure that this was an instance of pemphigus in which arsenic failed. The diagnosis of a bullous syphilide from pemphigus is sometimes very difficult, but on the whole a true pemphigus is more liable to be mistaken for a syphilide than for the reverse error to occur. For the notes of the case we are indebted to Mr. C. F. Marshall, resident medical officer.

The following case was sent to the Lock Hospital as there was a suspicion of its being syphilitic in origin. The patient, a girl aged nineteen years, had no other signs of syphilis and the progress of the case without any specific treatment shows that it was not a bullous syphilide. The rash appeared on Jan. 1st in the form of clear blebs on a slightly reddened base, first on the hips and arms; afterwards it spread over the whole of the lower limbs, the greater part of the back, neck, forearms, and slightly on the chest and chin. The front of the abdomen, the palms of the hands, the soles of the feet, and the mucous membrane of the mouth were free. The bullæ varied in size from that of a pea to that of a walnut; they contained clear fluid at first but in a few days this became purulent and in some cases slightly hæmorrhagic. They soon coalesced when close together, forming large areas of sodden epithelium with sero-purulent discharge, but at no time were there any constitutional symptoms. The progress of the case is briefly as follows. By the 25th most of the bullæ had burst and coalesced; a few fresh ones were appearing from day to day; some were clear and others were purulent from the first when appearing on parts already affected. By Feb. 2nd the bullæ were nearly all healed, leaving a brownish-red staining of the skin. Some fresh pustules had appeared on the inner side of the thighs. The stains were mostly confluent on the back and limbs and were discrete on the neck. On the 24th the patient was sent away to the country. Only a few small blebs had appeared from time to time. Her general health was good. On March 11th there was a recurrence of fresh bullæ and pustules on the thighs, arms, and chin. These increased on the lower limbs till the condition was nearly as bad as at first. By the 23rd the skin was quite clear again except for fresh staining. On the 29th some fresh pustules appeared on the thighs, forearms, and face. On April 6th she was sent to the seaside, but a few days later, the 10th, she had another relapse. Clear bullæ appeared as at first, involving the whole of both upper and lower limbs, and slightly affecting the shoulders and chin. By May 2nd the skin was quite clear again and the general health was much improved. On the 15th a few small pustules appeared about the wrists and ankles. The stains of the old rash were fading. By June 1st she was well and no subsequent relapse has occurred. With regard to treatment arsenic was given internally nearly all through the illness, but it did not seem to have much effect. Locally the most satisfactory result was obtained from iodine baths (about 1 in 5000), which were given daily while the eruption was active. During the last severe relapse (April 10th) the local treatment consisted of liquor carbonis detergens, which acted equally well.

Bacteriological examination.—This was carried out by Dr. Bulloch at the British Institute of Preventive Medicine and we are indebted to him for the following notes:—Examination of fluid from the clear bullæ showed the presence of a diplococcus agreeing in almost every particular with the diplococcus first found by Demme in cases of pemphigus, and also found by Dr. Bulloch in other cases of acute pemphigus. Fluid from the bullæ which marked the relapse of April 10th was also examined, but the diplococcus was not present in this, only streptococci and staphylococci.

Remarks by Mr. BUXTON SHILLITOE.—This case is remarkable chiefly on account of recovery after such a severe attack of pemphigus and also for the total absence of constitutional symptoms. It is also of interest that a diplococcus was found by Dr. Bulloch agreeing with that found by Demme in similar cases. A further point is the fact that a month before the appearance of the rash superficial whitlows formed on several of the fingers. This is of interest in that Mr. George Pernet¹ collected several cases of pemphigus in butchers all of which were preceded by whitlows, suggesting the possibility of the poison being contained in the meat. In the present case there was no distinct history of contamination from meat except that the patient frequently did cooking. With

regard to treatment I should like to draw attention to the benefit derived from local antiseptic treatment of the skin both by iodine and by liquor carbonis detergens, and to the apparent failure of arsenic to modify the course of the disease. I am much indebted to Dr. Bulloch for making the bacteriological examination and also to Dr. Roberts of the Folkestone Hospital for notes of the case during the relapse.

LIVERPOOL ROYAL INFIRMARY.

TWO CASES OF OMENTAL UMBILICAL HERNIA ATTENDED BY SLOUGHING.

(Under the care of Mr. RUSHTON PARKER.)

SLOUGHING of the skin over an umbilical hernia is a rare occurrence and even for that reason Mr. Rushton Parker's two cases deserve to be recorded, but there are other points of interest about them. In the first case the ulcer left after the separation of the slough healed rapidly with very little treatment. In the second the connexion between the interference with the circulation in the hernia and the two confinements is interesting, though easily explicable by the increased abdominal pressure. Mr. Parker's explanation of the manner in which the sloughing was brought about appears to be extremely probable.

CASE 1.—A woman, aged thirty-nine years, was admitted into the Liverpool Royal Infirmary on July 5th, 1880, having an umbilical hernia which was 2 or 3 inches in diameter and over which a small piece of skin had sloughed. After separation there was exposed œdematous and juicy connective tissue of a pale greenish colour, suggesting bile-staining. An offer of herniotomy was made to the patient for the purpose of curing the rupture, but this she declined. The exposed tissues healed without difficulty or complication under some antiseptic dressing. The rupture had given her no inconvenience until the slough appeared, and when the aperture closed over her purpose was served and she left the hospital after a few weeks. The contents of the sac were apparently omentum, but were never seen.

CASE 2.—A woman, aged forty-two years, was sent to Mr. Rushton Parker's ward at the Liverpool Royal Infirmary on the night of May 1st, 1891, by Dr. Henry Briggs, who informed Mr. Parker that he had found her in a feverish condition with an umbilical hernia in a state of acute inflammation, with sloughing of the skin over the sac, which evidently required operative treatment without delay. Mr. Parker therefore went up to the ward about midnight and learnt that the hernia was an old one; that the patient had been confined eighteen months previously, after which the hernia had become discoloured and had remained so; that three weeks before admission she had also been confined; and that the hernia had become acutely inflamed. An operation was performed at once under chloroform, the hernia being of about the size of a man's fist, surrounded by an acutely inflamed area and having a black skin slough in its centre somewhat larger than a crown piece. The sac was laid open and was found to contain extremely foetid pus and gangrenous omentum. The skin slough was cut away and the interior was well washed with a 1 in 1000 solution of perchloride of mercury. The neck of the sac appearing to be free from contamination the omentum was pulled out and transfixed with two large pins, behind which it was tightly tied with a piece of strong bandage soaked in the sublimate solution of the strength above mentioned. All the gangrenous portion was cut away and with it the anterior portion of the sac, which was also gangrenous. The wound was left open and filled with cyanide gauze. Some more sloughs separated in the course of about ten days and healing was gradually accomplished without local incident or complication by the last day of June, two months after admission, the site of the former hernia being well depressed. The temperature at the time of the operation was over 102° F., but fell during the early morning to normal and remained so for three weeks except for a rise of a single degree on the fourth day. Then the temperature rose to 100° but fell to normal for a day and a half, then rising again to 100°. In the middle of the fourth week there was an evening rise to nearly 105°, but the temperature fell a degree each evening and at the end of the fourth week the normal was again reached and so remained during the fifth week. The temperature in the morning was 3° or 4° lower than in the evening during this rise. The sixth week commenced with

¹ British Journal of Dermatology, 1896.