the swelling there and then. Accordingly, at midnight, March 28th, chloroform was administered, and a sound passed with some difficulty into the bladder which felt as if it was embedded in plaster-of-Paris. Its cavity was small and contracted, and its walls hard and resisting. An incision two inches in length was made in the skin of the abdomen in the median line, immediately above the pubes and the interval between the recti was opened up. Continuing the incision Mr. Cuff next cut through what appeared to be a mass of thickened and inflamed connective tissue and finally opened up a cavity—or rather a series of cavities like the pores of a sponge—containing blood-stained urine on the surface of which a glistening scum was floating. This collection of connective tissue, which extended as far as could be made out over the front and sides of the bladder, was apparently the result of chronic inflammation and accounted for the feeling of thickening of the walls of the bladder, the distance between the point of the sound and the fingers being about three-quarters of an inch. One of the small cavities in this mass led down to the bladder wall and communicated by a small opening with its interior, the tip of the sound being felt through it by the fingers in the wound. So far, however, no collection of pus had been found to account for the condition of the patient, his temperature, &c.; and as the operator appeared to be cutting well below the superior limits of the swelling the incision was cautiously enlarged in an upward direction. Here a cavity was found containing about three ounces of a most foul-smelling pus. The wound was well syringed out and a flanged drainage-tube inserted into the cavities. The patient, who was somewhat collapsed, was put back to bed, and a catheter, connected with a piece of tubing dipping into a vessel of carbolic acid solution, was passed into the bladder and tied in to ensure proper drainage. The temperature fell almost immediately to 100°, and on recovering from the anæsthetic the patient expressed himself as feeling much better. Next morning the temperature had risen to 101·4°, but the general condition otherwise seemed to be good. The surface of the wound was discharging freely, and smelt of urine. The urine drawn off seemed to be clear. The temperature kept between 99° and 100° until April 3rd, when it fell to normal, but on the 8th (the twelfth day from admission) it rose again to 103°, and a sharp attack of facial erysipelas, starting from a small scratch on the nose, set in. Seven days later the temperature was again normal, and the patient has progressed favourably since. The abdominal wound has healed, but above the pubes there is still a small hard mass to be made out on palpation. A catheter has been passed regularly, and the patient says he is now passing urine with more comfort than he has known for years.

Remarks by Mr. CUFF.—It seems clear that here was a bladder the walls of which were probably pushed out into sacculi from the prolonged straining of micturition, consisting only of mucous membrane, and this softened and ulcerated from the effects of the recurring attacks of inflammation, from which the man suffered. Under the muscular strain put upon such a bladder by the abdominal muscles in lifting a heavy weight, one of these sacculi had given way and permitted of the escape of urine on to the anterior surface of the organ and, fortunately, outside the peritoneal cavity. That little was enabled to so escape—and the widespread areas of sloughing seen in traumatic cases were not present in this case—was due in all probability to the great inflammatory thickening serving to support and strengthen the walls of the bladder and opposing the spread of a fluid in its meshes. This thickening, the result of a long-continued chronic cystitis, finds an analogy in the thickening produced by a chronic urethritis extending through the mucous membrane of the urethra and involving the tissues of the corpus spongiosum. To the good influence of this thickening outside the bladder may be attributed also the absence of shock, it permitting only a very small breakage of the bladder-wall at first, this becoming larger subsequently by erosion from the escaping urine. It is interesting to note that the abscess present had not formed at the spot of rupture, but at a point nearer the peritoneal cavity, and hence nearer to the infecting intestines. The extravasated urine had set up an acute inflammation all around it, but only that portion of the exudation nearest the intestines had been invaded by pus-forming organisms. Pathological rupture of the bladder is one of the rarest forms of rupture to which that viscus is liable. It is due in some cases to the bursting of an ulcerated wall or sacculus; in other cases to the sloughing of the wall from pressure—e.g., by retroverted gravid uterus—or inflammation; the relative numerical proportion of cases of pathological rupture to cases due to traumatism is uncertain. Rivington, quoted by Henry Morris, collected seven cases of rupture associated with ulceration or sacculus, and nine due to pressure by a retroverted gravid uterus, out of a total of 322 cases of rupture from all causes. Of the 7 cases, 3 were intra-peritoneal, 3 extra-peritoneal, and 1 doubtful.

PAISLEY INFIRMARY.

A CASE OF SIMULTANEOUS DISLOCATION OF BOTH ENDS OF THE CLAVICLE WITH FRACTURE OF THE SCAPULA.

(Under the care of Dr. W. F. GIBB.)

THE small number of cases in which simultaneous dislocation of both ends of the clavicle has been met with makes the record of this one exceptionally interesting. It is evident that considerable violence was required to produce the displacement and it is very probable that it was applied in the only direction which renders this displacement possible. In spite of the shape of the joints at each end and the position of the bone, injuries to the shoulder far more frequently result in fracture of the clavicle or in dislocation of the humerus than in displacement of either end of the clavicle, for the ligaments which hold it in position are very strong.

A man, aged sixty-four years, was admitted to the Paisley Infirmary on May 19th, 1896. He had been coming down a plank gangway at a building in the course of construction, when he fell, alighting from a height of about four and a half feet on the point of his left shoulder. He was tall, bony, and about 11½ st. in weight. When seen by Mr. J. A. Graham, junior house surgeon, at 7.15 A.M. he was suffering pretty severely from shock, the accident having occurred at 6 30 A.M. The clavicle at its sternal end was dislocated downwards and forwards, forming a very prominent swelling at the top of the sternum. The rhomboid ligament was evidently torn through. The acromial end of the clavicle was displaced inwards about an inch and a half from its articulation with the acromion, so that the bone lay in an almost antero-posterior direction instead of its usual position; from the acromion inwards, forwards, and downwards. On taking hold of the two ends of the bone it could be lifted and moved backwards and forwards. There was a starred fracture of the infra-spinous fossa of the scapula and a suspicion of fracture of the ribs, though this last could not, on account of the swelling of the tissues around, be made out with certainty. There was considerable embarrassment of respiration from chronic bronchitis. Dr. Gibb confirmed the above diagnosis at his visit at 4 P.M. The patient was put to bed and supported by pillows in a semi-recumbent posture. The arm was placed in a dislocation sling and secured to the body by a bandage. The hand, however, slipped down and the bandage greatly impeded his respiration. The dislocation was not materially affected by the slipping of the hand, his posture appearing to benefit it more than anything. Accordingly, an ordinary sling was substituted and a binder lightly applied round the arm and chest. On May 27th he died from bronchitis. No post-mortem examination was obtainable.

Remarks by Dr. GIBB.—The above case is put on record on account of the rarity of simultaneous dislocation of both ends of the clavicle. In "Heath's Dictionary of Practical Surgery"[1] only four cases are mentioned as having been recorded. In "Ashurst's International Encyclopædia of Surgery"[2] it is stated that "a few cases of this rare form of luxation are said to have occurred." In "Treves's System of Surgery"[3] there occurs: "This accident is one of the curiosities of this part of surgical literature, and is generally produced by extreme violence. The sternal end is thrown forward, the acromial backwards."

[1] Vol. i., p. 313.
[2] Vol. iii., p. 661, 1883.
[3] Vol. i., p. 965, 1895.

INFIRMARY MEDICAL SUPERINTENDENTS' SOCIETY.—The January meeting was held on the 30th ult. at the Infirmary, Plumstead, Mr. Walter Burney (Greenwich) presiding. Mr. W. E. Boulter showed cases of Recurrent Sarcoma, Amputation of Thigh, and Perforating Ulcer.