

appear that whilst surgeons in India are endeavouring to widen the sphere of litholapaxy their brethren in Europe, and even in America, seem inclined to restrict Bigelow's operation to very narrow limits. This divergence in opinion and practice between the East and the West has doubtless been brought about by the increasing favour now being accorded to the operation of supra-pubic cystotomy in its revived form. I have had no practical experience of the "high" operation; but, in common with most surgeons, I recognise the fact that in its latest development it is eminently adapted to the treatment of very large stones, which cannot be disposed of by litholapaxy or by perineal lithotomy. And in dealing with cases of tumours of the bladder and encysted stones, no matter what their size may be, it is doubtless the correct method of surgical procedure. It cannot, however, be said that there exists a universal consensus of opinion amongst practical surgeons at the present day as to where we should draw the boundary-line between litholapaxy and supra-pubic cystotomy. I certainly am not disposed to draw this line at a stone which is hard and much above an ounce, and I feel certain that my brethren in India, with their unrivalled opportunities of treating stone, have no intention of adopting a course of practice which I can only characterise as retrograde.

The size, density, and weight of a stone must be carefully considered when drawing the boundary-line. But the size, density, and weight of a stone are not the only important points of the problem to be solved. The size and the general condition of the bladder and prostate, together with the size or calibre of the urethra, are equally important points for consideration before we can arrive at any safe conclusion as to the method of treatment best adapted to each individual case. Indeed, no operator can tell with anything approaching accuracy the weight of a stone in the bladder when grasped between the blades of a lithotrite. The weight can only be determined after its evacuation from the bladder, and its density can only be learned during the progress of the operation. And, therefore, rules laid down to guide inexperienced surgeons in drawing the boundary-line between litholapaxy and supra-pubic cystotomy based solely on the weight and hardness of a stone must prove valueless and misleading in actual practice. For it often happens that a stone of moderate size lying in an irritable, contracted, and diseased bladder will give the operator much more trouble than a stone weighing upwards of three ounces will do, in a roomy and healthy viscus. Again, there are some cases, happily rare, wherein the bladder continues to contract during the whole course of the operation, grasping with spasmodic effort the lithotrite, impeding its working and ejecting the water thrown in by the aspirator. These are certainly the most difficult cases we meet with in practice, and should the novice in performing litholapaxy be so unfortunate as to come across a case of this kind, it will give him an exaggerated idea of the difficulties to be met with in performing litholapaxy in the ordinary run of cases. It requires all the patience, care, and skill which an experienced hand can command to combat such conditions as these. Indeed, it is a question for consideration whether even an experienced litholapaxist would not better consult the safety and welfare of his patient by having recourse to perineal or supra-pubic lithotomy when brought face to face with a case of this kind, more especially if the stone happens to be at all large. I am, however, of opinion that any uncomplicated stone on which the surgeon can lock a trusty and efficient lithotrite can in most cases be crushed and evacuated from the bladder at one sitting. By an uncomplicated stone I mean one not complicated by an enlarged and diseased prostate, and which lies free in a healthy and roomy bladder. I can, of course, imagine a case in which the surgeon, having locked his lithotrite on a very hard mulberry calculus, weighing between two and a half and four ounces, would fail to break it; and I can also imagine a case in which the surgeon, having broken across a large stone, would still be unable to evacuate it at one sitting owing to the inability or unfitness of the patient to remain sufficiently long under an anæsthetic to permit of the operation being completed at one sitting. But putting aside exceptional cases such as these, I think that, using efficient modern instruments, the surgeon ought to be able to dispose of any uncomplicated stone on which his lithotrite will lock, at one sitting. I would go even further, and say that some stones on which a lithotrite will not in the first instance lock can be reduced in size to the working capabilities of the lithotrite by judicious chipping

of the outer covering of the stone, and that then the operation can be completed at one sitting. In dealing with cases of large, soft, phosphatic stones this chipping process is quite feasible. I shall now endeavour to substantiate these views by relating the histories of some cases from my own practice at the Indore Hospital.

M. S—, forty-nine years of age, suffering from stone symptoms, was admitted into the Indore Hospital on Dec. 16th, 1884. He suffered from emphysema of the lungs; his heart was weak, and he was very corpulent. His muscular system was very flabby. Urine acid; specific gravity 1014; no albumen. On Dec. 17th he was placed under chloroform, which he took very badly. Equal parts of chloroform and ether were then tried. The largest lithotrite which could be used with safety was a No. 12 fenestrated. The stone was readily seized, but the inspiratory and expiratory efforts were so deep and laboured that the water injected into the bladder was soon expelled, and so the bladder kept continually contracting on the lithotrite, rendering the operation most difficult and tedious. A No. 14 evacuating catheter (English scale) was the largest I was able to employ. The lithotrite was introduced sixteen times, and the operation lasted two hours and thirty-five minutes, although the stone, mixed lithic acid and phosphates, only weighed 272 grains. This will give some idea of the difficulties attending the operation of litholapaxy in this case. Again and again I was obliged to cease working the lithotrite and aspirator in the course of the operation, owing to the frequent spasmodic contractions of the bladder. I have frequently removed stones weighing between two and three ounces with far less difficulty than I experienced in this case.—Dec. 19th: Pulse 120; evening temperature 104°; suffering from an attack of asthma; right testicle swollen; some pain on pressure over bladder.—22nd: Feels burning at time of micturition; condition of testicle unchanged; sounded bladder with Sir H. Thompson's sound, but no fragment of stone could be detected.—26th: Does not sleep well; pain in epigastric region; getting weaker; has difficulty in breathing; had two fits of asthma.—27th: Dyspnoea increasing; pulse rapid and weak; becoming drowsy. Died during the night. No post-mortem examination was obtainable.

I ascribe the fatal issue in the foregoing case to the lengthened administration of chloroform and ether in a patient suffering from emphysema of lungs and weak heart. If I were again to meet with a similar case, I should most certainly perform either perineal lithotomy or supra-pubic cystotomy in preference to litholapaxy, for I consider that litholapaxy is contra-indicated in cases where a contracting bladder keeps on continually grasping the lithotrite and expelling the water injected by the aspirator. We have performed ninety-three litholapaxies in boys, men, and females at the Indore Hospital between May, 1884, and the end of March, 1886, and this case is the only one amongst this large number of litholapaxies which has proved fatal. Indeed, I am disposed to think that, had I used no anæsthetic, and had performed lithotrity instead of litholapaxy in dealing with this stone, the result might have been different from what it was. The history of this case goes to prove how valueless in actual practice are the rules which have been laid down to guide us in drawing the boundary line between litholapaxy and supra-pubic cystotomy, rules which are based solely on the weight and density of a stone.

(To be concluded.)

ON HYSTERICAL AFFECTIONS.

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IN THE LANCET of Sept. 18th is an interesting report by Dr. Suckling of a case of what he terms "paralysis depending on idea." Whether the difference between the cases denominated by this somewhat cumbersome phrase and those of so-called hysteria is fanciful or not need not concern us much at present. Dr. Suckling thinks that there is a difference in the character of the patient, and perhaps he is right. That such cases are "hysterical" in the literal sense of the word no one for a moment supposes. That much-slandered organ, the uterus, has quite sufficient responsibility in carrying out its normal functions without

being saddled with all the ills which we are unable to localise in any of the other organs of the body. The term "hysterical," however, as applied to these cases, is a convenient one, and will probably continue to be used. There is no class of cases which yield such satisfactory results when judiciously treated as these hysterical affections. On the other hand, if not properly managed, there is no class so difficult to benefit in any way. We hear a good deal of the *vis medicatrix nature*, and no doubt physicians gain a good deal of credit which really belongs to nature; but in the cases now under consideration nature is a most hopeless failure, and the physician achieves his greatest triumphs. With regard to the difference in disposition alluded to by Dr. Suckling in patients of this class, some being cheerful, intelligent, and anxious to recover, others just the reverse, the same difference is equally noticeable in patients suffering from other diseases. One thing, however, should not be forgotten, which seems to me to have a decided influence on this point, and that is the length of time the affection has existed. If it has been in progress for months or years, the patient has naturally become depressed and given up all hope of recovery; perhaps she has been under the care of many medical men, and owing to unfavourable circumstances has received no decided benefit. With regard to treatment, if possible it is always better to remove the patient away from her friends, whose injudicious sympathy tends to counteract all beneficial remedies. My own experience is that these cases do better in a hospital than anywhere else, where you have a reliable nurse, who will take an interest in the patient and carry out all your directions. They require so much time and attention that it is almost impossible for a busy practitioner to carry out the treatment effectually. The next step is to gain the confidence of the patient, and not only to impress on her that she will get well, but also to prevail on her to use her utmost efforts in this direction, and to encourage her when we really see that she is making such efforts. The following three cases will serve to illustrate some of the curious phases of this very interesting affection. They came under my notice at the Torbay Hospital. I will state them as briefly as possible.

CASE 1.—Harriett B—, aged forty, unmarried, dress-maker, was admitted into the hospital on Feb. 22nd, 1883. She had always been a very emotional subject. Three years before admission the left breast was removed at the Middlesex Hospital for scirrhus. She had been in bed eleven weeks before admission. She complained of pain in the left thigh and leg; there was no swelling; the muscles were slightly wasted; the left lower limb was completely paralysed, and she could not move it in the bed; there was partial anæsthesia of the whole limb, most marked on the inner side of the thigh; she was anæmic in appearance. She was put on strychnine and iron; the leg was faradised daily, and blistered in a few places with the thermal hammer. In three days she was walking on crutches, a few days later with a stick only, and soon was able to walk without any support at all. She had some difficulty at first in getting up and down stairs, but was made to practise it several times in the day. She gradually improved in health and strength, and was discharged on May 21st, when she could walk several miles a day.

CASE 2.—Mary W—, aged twenty-five, formerly a servant, was first seen by me in consultation with Dr. Wills about the middle of February of last year. She had been in bed for five years, and had to be lifted from one bed to another. She was a most pitiable object, emaciated, peevish, unable to stand or walk or feed herself. She could move her legs in bed, but in getting her out of it they gave way under her, and she would have fallen if not supported. I offered to take her into the hospital, telling her that she would get perfectly well. She objected very much, and said she did not want to get well. After much persuasion she consented to come in, and was admitted on Feb. 24th. On admission I ordered her milk and beef-tea at first, as she had taken nothing but slops for some time. She was faradised and rubbed every day. On the third day I ordered her a mutton chop; this she obstinately refused to eat, saying she could not swallow it. On being informed of this by the nurse, I went up into the ward, cut the chop into small pieces, and insisted on her eating it, threatening to apply the battery if she would not do so. After a good deal of trouble she ate the whole of it, with some bread and a cup of milk. After this we had no further trouble about her food and she was put on a liberal diet. On the fifth day she was out of bed, and able to walk a little when supported on each side

by a nurse; a few days later she could walk with crutches in the garden. She gradually gained flesh and strength, and was discharged from the hospital seven weeks from the date of admission, able to walk two or three miles in the day. She then went for a few weeks to a convalescent home in the country, and returned much benefited by the change.

CASE 3.—Mary T—, aged twenty-one. I first saw this patient with Dr. Eales on July 11th of the present year. She had been in bed or on a couch for three years, and was considered by her friends to be suffering from heart disease and consumption. She was very emaciated, and could not stand without being supported; her breathing was rapid and noisy, and she jerked out her words in a spasmodic manner when answering questions, which she rather whispered than spoke. She complained of pain over the region of the heart, which was beating quickly and feebly; the sounds were natural; breathing jerky, but nothing abnormal about the lungs. We recommended her friends to send her into the hospital, and promised that she would get quite well. She was admitted under my care on July 13th. Her weight on admission was 67 lb. She was faradised and rubbed every day, given as much good nourishing food as she could be made to eat, and ordered cod-liver oil and iron. As in the previous case, she was got out of bed, and walked at first with support, and very soon by herself. A small blister was placed over the region of the heart, which removed the pain she complained of. The breathing soon became natural. She rapidly gained flesh, strength, and weight. In a fortnight she was able to take good walks. She was discharged on September 16th, and sent to a convalescent home on the Moor. Her weight on leaving was 80 lb., having gained 13 lb. in rather more than two months.

The above cases are examples of many to be met with in practice. Whatever name we may apply to them—real, ideal, hysterical, or neurotic,—they are all of them very amenable to treatment, are extremely interesting to watch, and amply repay in their satisfactory termination the time and trouble devoted to them.

Torquay.

CASE OF IMPERFORATE HYMEN WITH RETENTION OF MENSTRUAL FLUID.

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MARY F—, aged fourteen, was admitted under my care on April 24th, 1883. In the previous October she began to suffer from pains in the back and thighs, which caused her to stay in bed for one week; after this she got better, but for two or three months past the pains have increased in severity. She never noticed any periodical recurrence of these pains, and her mother attributed them to rheumatism. She had never menstruated. She is a well-developed, healthy-looking girl. I first saw her on the morning of April 24th, but having an appointment in the country, and her case being apparently of no urgency, I did not pay much attention to her symptoms. At 9 P.M. the same evening I was asked to see her. She had been suffering from some amount of pain in the back and thighs all day, but not more than she had previously done. About 8 P.M. she called the nurse's attention to a swelling between her legs, on seeing which the house-surgeon sent for me. On examination I found that the external genitals on the left side were much swollen, blood having extravasated into both the labia majora and minora on that side. So much was this the case that the left side of the labia majora was much thickened, whilst the lower part of the corresponding labia minora was so much altered that it was evidently about to slough. Between these swollen parts on the left and the corresponding parts on the right was a small, bulging, soft, and fluctuating swelling, evidently caused by blood pressing an imperforate hymen forward. The hymen was thick and tough, but in one spot it had partially ruptured, and a small piece of clot protruded through the small aperture where the rupture had occurred. A careful examination proved that the vagina was much distended. The labia majora and minora on the right side appeared perfectly natural, while no