

nutrition, although even then marked improvement may occur. In early stages, however, there may be no appreciable change for months or even years, especially where there is no continuous excitement. There are, too, eccentric people outside asylums, whose behaviour certainly suggests that they have travelled a few steps on the road, and there halted.

Cases showing transitions between typical general paralysis and typical cord disease are by no means rare both in and out of asylums. For illustrations I would refer to Dr. Handford's article, and also to one by Dr. Bristowe.<sup>4</sup> Such cases are often of long duration, and the mental symptoms may be very slight, there being only apathy and self-complacency, and, later on, emotional dementia in a mild degree. Affinities may also be traced between general paralysis and some cases of acute mania or melancholia, having a fatal termination. Where there is much excitement, as Dr. Mickle remarks,<sup>5</sup> somatic signs may be temporarily masked, only showing on its subsidence. But there may be death from exhaustion before this occurs. The connexion between syphilis and general paralysis was discussed by Dr. Savage at the Washington Congress in 1887, and in his address<sup>6</sup> are details of many cases of general paralysis in syphilitic subjects, either following the usual course or combined with more localised and specific lesions. Between simple general paralysis and senile paralysis and insanity the boundary is even more indefinite—I might say non-existent.<sup>7</sup> General paralysis is, in fact, often a localised premature senility, setting in without any definite exciting cause, and, it may be, without any signs of initial overaction. I need hardly say that the prognosis in such cases is extremely bad. It would not be difficult to trace analogies between general paralysis and other forms of brain and cord disease, besides those referred to, even where at first sight very little resemblance can be seen. But I do not want to weaken my argument by speculation that may be termed fanciful.

For some time past teachers of general pathology have insisted more and more that the processes we call growth, inflammation, degeneration, &c., are not only closely allied, but absolutely inseparable. The repair of a fractured bone, for instance, is now described in language very different from that of ten years ago. In accounts of named diseases, however, one finds that far more space is devoted to differential diagnosis than to consideration of affinities, even in regard to those due less to specific irritants than to general causes and innate tendencies. But, to quote Mr. Jonathan Hutchinson,<sup>8</sup> "Pathology knows no Melchisedecs, and if we would rightly understand the nature and origin of the various and often very peculiar maladies which come under our observation, we shall succeed better by seeking for relationships than for differences. In all probability no malady is really isolated." I may point out that in trying to follow this advice, it is of first importance to ignore *pro tem.* those non-essential or remote effects which are often, in disorder of a highly specialised tissue, out of all proportion to the pathological basis.

To sum up, I submit that acute disorders of the central nervous system, not essentially different from one another, may be induced by a variety of causes, toxic and otherwise, acting singly or in combination; and in subjects so predisposed by age, sex, general constitution, &c., these are apt to be associated with progressive and general degeneration. The latter may also occur as a primary change. The term "general paralysis" may be conveniently used to denote the condition it literally signifies, but not to imply that there is an isolated and specific disease so named. Recovery or indefinitely prolonged arrest in "early general paralysis" is unlikely, but there is no reason for an arbitrary denial of its possibility. I know only too well that the controversy is an ancient one, and that little originality can be claimed for much that I have written. The problem is, however, one that alters as our knowledge of general pathology increases, and is really one of practical and universal importance, but is yet one that has hitherto been chiefly discussed in publications seldom seen by many practitioners. I trust these considerations may furnish some apology for my contribution.

Portsmouth.

<sup>4</sup> Brit. Med. Jour., Jan. 1st, 1887.

<sup>5</sup> General Paralysis of the Insane, second edition.

<sup>6</sup> American Journal of Insanity, Oct. 1887, and Jan. 1885.

<sup>7</sup> Vide Dr. Savage's Presidential Address, Med. Psych. Assoc., 1886.

<sup>8</sup> Harveian Lectures, Dec. 1887.

## A CASE OF SUPPRESSION OF URINE TREATED BY REMOVAL OF AN IMPACTED CALCULUS FROM THE URETER BY OPERATION.

BY F. W. KIRKHAM.

ON May 24th, 1888, I was called to a case of suppression of urine. The patient was a farmer, fifty-eight years of age. Six years previously he had suffered from renal colic of the right side. After this attack he passed a small calculus. About a year after this he again suffered in a similar manner, the pain being felt most acutely on the right side. The attack lasted about twenty-four hours, when the pain suddenly ceased. On the day I first saw him (May 24th) he was attacked, early in the morning, with severe pain running downwards from the left loin to the testicle. The pain commenced about 8 A.M. He had micturated about half an hour before the pain commenced, but from the onset of the pain no more urine was passed. The pain, which was very severe, lasted for about an hour, when it gradually became less acute, and finally ceased; and, from his experience of the former attack, he thought that the stone had passed into the bladder. Being then quite easy and free from pain, he went about his daily duties as usual, but was very much surprised to find, on attempting to micturate before retiring to rest, that he was wholly unable to void any urine, nor did he feel a desire to do so. Being somewhat alarmed at this, he sent for me, and I first saw him at 10 o'clock in the evening. He then appeared perfectly free from pain, but was very anxious about the suppression of urine. I passed a catheter into the bladder, but found it empty. I ordered a hot bath, and prescribed fifteen minims of tincture of opium to be taken every four hours. On the next day I found that he had still passed no urine, and he continued in this state, passing no urine and suffering no pain or inconvenience, till the 27th, when he commenced to complain of feeling weary and weak. During this period I administered hypodermic injections of pilocarpine every day, which produced profuse diaphoresis. He continued to take a fair amount of light food with evident relish, and his bowels were relieved on the 26th and 27th, the motions being firm. On the 30th his appetite failed, and he complained of headache and drowsiness with a feeling of great prostration and of muscular twitchings, and he voluntarily took to his bed, which up to that time he had not done.

After considering the previous history of the case, I concluded that the right ureter had been obstructed by the former attack, that the right kidney was thus rendered useless, and that the left ureter was now also blocked by the recent impaction in it of a calculus. Despairing of his recovery, I told my patient of the opinion I had formed of his case, and felt compelled to give a very gloomy prognosis. I then requested him to allow me to cut down upon the ureter, in the hope that, if I should not be fortunate enough to be able to remove the calculus, I might possibly save his life by making an incision into the pelvis of the kidney to procure an outlet for the urine. This he readily gave me his permission to do, and accordingly at 1 P.M. on May 30th ether was administered, and an incision was made from the tip of the last rib towards the anterior superior iliac spine. The integuments, muscles, and fascia were carefully divided, and the kidney at length exposed. After carefully exploring the kidney, and finding no stone therein, the exploration was continued downwards along the ureter, in which a stone was distinctly felt about half an inch above where the ureter crosses the commencement of the external iliac artery. There was a little difficulty in reaching the ureter easily in this part of its course, but after slightly enlarging the wound I ultimately succeeded in cutting into and extracting from the ureter a calculus about the size of a large date-stone. A little urine escaped from the incision, but the amount was, as far as I could judge, very small. The hæmorrhage also was slight. A large drainage tube was introduced into the wound, the edges of which were held together by sutures, and a thick layer of iodoform wool was retained over it by a bandage. Half an hour after the operation an ounce and a half of urine was passed naturally;

afterwards at frequent intervals small quantities were passed, and during the first twenty-four hours after the operation twenty-six ounces of blood-stained urine were voided. On June 1st forty ounces were passed, and it ceased to be blood-stained. From this date he progressed most satisfactorily, and by July 10th the wound had quite healed, and he was enabled to resume his occupation.

Downham Market.

#### NOTES OF

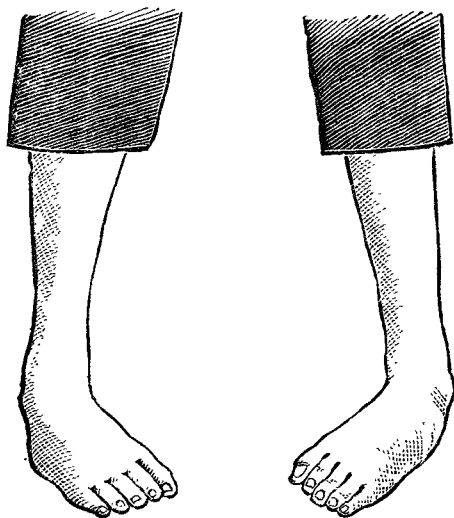
### TWO CASES OF EXCISION OF THE ASTRAGALUS IN CLUB-FOOT.

By J. CRAWFORD RENTON, M.D.,

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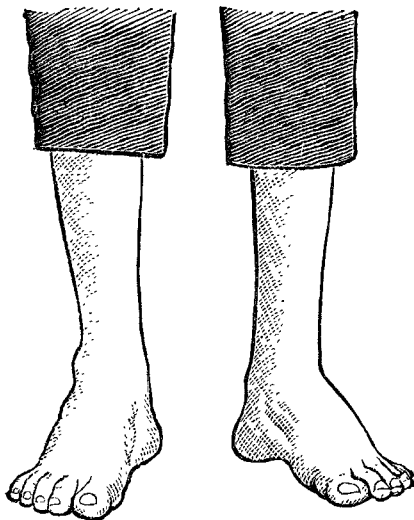
D. R—, aged seven, was admitted to the Training Home for Nurses on Nov. 28th, 1886, suffering from relapsed double talipes equino-varus of a severe form, as is well illustrated in Fig. 1. I had previously operated on the child when an infant, and the result at that time appeared quite satisfactory. The case now presented features so severe

FIG. 1.



that it was quite evident some radical operation must be attempted. The left foot being the worse, I decided to remove the astragalus from it, and this I did on Nov. 24th, 1886, assisted by Drs. Beatson and Somerville, using a single incision from the external malleolus downwards and forwards, as is advised by Professor Lund. The foot was

FIG. 2.



placed in a box-splint, and progressed favourably, the deformity being corrected. As the right foot was not so deformed as the left, I performed Phelps' operation on it, dividing all the resisting structures in the sole of the foot from without inwards, skin included. The foot could now be easily put at a right angle with the leg, and healed

without any trouble and with a single dressing. It is now two years since the feet were operated on, and the boy continues to keep well and is able to run and play the same as his companions. Fig 2 shows the present condition of his feet.

S. M—, aged two years and a half, was admitted to the Western Infirmary in August, 1887, with severe double talipes equino-varus. Several operations had been performed in this case, but without good result, and the deformity was greater than in Fig. 1, so that I determined to excise the astragalus from both feet. This I did, leaving an interval of ten days between the two operations. The feet were placed in rectangular tin splints, and healed without any trouble. Fig. 3 represents the child's feet eighteen months after operation.

Recently I have used Mr. Lund's astragalus hooks, and find them most serviceable in effecting easy excision of the bone.

The above cases show no tendency to relapse, and may now be regarded as tributes to the value of the operation of excision of the astragalus in severe club-foot.

Glasgow.

FIG. 3.



### Clinical Notes:

#### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### A CASE OF SCLEREMA NEONATORUM SUCCESSFULLY TREATED BY MERCURIAL INUNCTION.

By ANGEL MONEY, M.D.

A FEMALE CHILD aged five weeks was brought to me on Nov. 6th, 1888. She was under the care of Dr. Scott of Bath. At birth there was noticed a patch of hard skin on the right shoulder about the posterior axillary fold, and another in the skin of the left parotid region. The skin was hardened all over the back of the body, including the buttocks, shoulders, legs, and neck, and there was a pentagonal area of the same induration, and about an area an inch square in the left parotid region. The thin skin on the front of the face, neck, trunk, and limbs was supple and soft. The induration was of the most marked kind, and suggested calcification—myositis ossificans; but the skin was the part affected. The muscles were splendidly developed, free movement being permitted in most directions. The palms and soles were not affected. The plantar reflexes were perfect, and the knee-jerks were readily obtained. The knee-jerks are usually more ready during the first months of life than at any other period of (healthy) existence. The induration was quite symmetrical. The liver could not be felt below the costal margin, but the spleen extended three fingers' breadth below it on the left side of the abdomen. There was much sweating about the head; the urine was pale and clear, and did not stain or stiffen the napkin. The temperature was 99.2° in the rectum. The cry was lusty; the pulse and heart sound, and beating 100 times in the minute. There was no facial irritability, no cranio-tabes, and no jaundice; but much dark-brown hair existed on the scalp and on the back. The infant had been four weeks solely at the breast, and one week on lime-water and milk. I prescribed frictions over the indurated area with sweet oil, plenty of warmth, and careful feeding with fresh cow's milk and barley-water, together with inunction of blue ointment every day into the skin of the abdomen. From this time onward there commenced a rapid recovery; whereas prior to the prescription of blue ointment the induration had steadily advanced, notwithstanding frictions and warmth. It was the size of the spleen that induced me to prescribe the blue ointment, and the consideration enforced by some, but not by myself, that congenital syphilis produces a hairy scalp. The child was the first of the family, and had been preceded by no miscarriages. Careful questions and an inspection of