

closed preparatory to introduction into the bladder, which is effected by sliding the extremity *A*, of the probe-pointed blade in the groove of a director. This lithotome consists of scissors curved on their flat, the blades of which cross, and are held together by a screw. When opened they cut outwardly; when shut each cutting edge is protected by the rounded back of its fellow blade, and thus cannot wound the parts. One blade is longer than the other, and terminates in a probe-point. There is a graduated scale on one branch, which indicates the extent of separation of the blades, and a slide which can be fixed by a screw. A spring is attached to the inside of the handles, *E*, Fig. 1. On pressing the handles together, the blades separate and present externally their cutting edges. The extremity of each handle is furnished with a hook, *F*, which can be used, when necessary, as a suspensory of the bladder in the hypogastric operation for lithotomy. Fig. 2 represents the instrument of a natural size, with the blades separated, as when used for incising the parts. *A* is the probe-pointed blade; *B*, the joint; *C*, slide which regulates the extent of separation of the blades. Fig. 3 represents the handles, natural size. *E* is the spring which separates the handles and closes the blades of the lithotome; *F*, *F*, hooks which terminate the handles, and can be used to raise up the anterior parietes of the bladder in hypogastric lithotomy.

We are further indebted to M. Amussat for a description, with figures, of an "*irrigateur vesical*," which he exhibited to the Surgical Society of Paris, Aug. 5, 1868, and a description of which, with figures, we will lay before our readers in our next No.

49. *Ectopia Vesicæ*.—M. GRANDJEAN, in a thesis on this subject, relates a successful case, the first in France—a male child, fourteen months old, operated on by M. Michel. The conclusions are, that the vesical papillæ of the ureters should never be incised. The operation by superimposed flaps—the one abdominal, the other lateral—is preferable. The union of the autoplasic flaps should rather be by their surfaces than by their borders. The operation should be performed at the end of the first year, or as soon after as possible. The thesis gives a complete bibliography.—*Brit. Med. Journal*, Feb. 27, 1869, from *Gazette Med. de Strasbourg*, Dec. 25, 1868.

50. *Puncture of Colon for Relief of Tympanitis and Fecal Obstruction*.—Dr. T. CLIFFORD ALLNUTT, Physician to the Leeds Infirmary, sends us the following interesting note:—

"It is about two years since my colleague, Mr. Wheelhouse, was kind enough, at my request, to tap the distended pericardium of a patient who was in imminent danger of death, and with perfect success. I have now to thank Mr. Teale for a like interference.

"——, aged 40, labourer, was admitted into the Leeds Infirmary on Jan. 4th. He was admitted as suffering from 'obstruction of the bowels.' On investigation, Mr. Bradley found that although the bowel symptoms were more prominent, yet the patient was suffering also from double pneumonia. He told me that he was led to examine the lungs because he had seen obstruction of the bowels more than once in connection with pneumonia. I was also aware of this coexistence of paralyzed bowel with pneumonia, and have explained it by supposing that irritation from the inflamed structures reaches, and finally exhausts, the colon. I have certainly seen it in several well-marked cases, when it has proved a very distressing and unmanageable symptom. My explanation seemed certainly to be true in a somewhat similar case of bowel paralysis attended by Sir William Jenner, Dr. Beaumont of Knaresborough, Mr. Bainbridge of Harrogate, and myself,¹ where paralysis of the bowel was set up by inflammation near it, and such paralysis, we know, often occurs in peritonitis. In such cases of simple paralysis, or of fecal accumulation with distension, I think the mode of treatment I am about to propose may turn out to be of great importance. In the present case Mr. Bradley administered subcutaneous injections of morphia, and full enemata both with and without turpentine and castor oil. No relief was obtained. No feces had now passed from the bowel for at least five days,

¹ Vide *Lancet*, July 18, 1868.

and no wind had passed for about two days. The abdomen was enormously distended, and caused intense suffering; the pulse was small and quick, the extremities cold, and the countenance very anxious. In the evening Mr. Bradley requested me to see the patient. His state remained the same. I advised an injection of a quart or more of warm gruel to be slowly administered with a long tube, this to be followed by an injection of half a pint of olive-oil in the hope that the oil might rise through the gruel and reach the obstruction. Belladonna liniment was also to be applied all over the abdomen, and the subcutaneous injections to be continued. About three pints of fluid were got into the bowel, but no feculent discharge followed; the liniment gave some relief. Next morning I found the patient in great suffering; he had not passed any wind, and he had spent a wretched night. He now had also a decided hiccough, and the abdomen was enormously distended. There neither was, nor had been, much vomiting. The previous evening I had been much tempted to puncture the abdomen with a fine trocar, and in the morning the desire strongly returned. Somewhat later in the day I was with Mr. Teale, and after laying the case before him, I asked him if he would operate for me. He agreed to do so, and we visited the infirmary at once. We found the patient in great distress; he was tossing restlessly about in bed, complaining of the distension of his abdomen, and the breathing was seriously impeded. Mr. Teale plunged an exploring trocar (No. 1, Weiss) into the distended transverse colon. On withdrawing the trocar air rushed through the canula with a hissing noise and the abdomen slowly fell. The air was highly offensive. When the current grew weaker, Mr. Teale made a second puncture into the descending colon, which was greatly swollen; the result was the same. The body had now fallen much, and had become quite soft; the patient expressed the greatest relief, and thanked us warmly. His countenance became placid, the breathing comparatively easy, and he soon sank into sleep. I ordered the morphia to be continued, and poultices to be kept on the body. On my visit next day I found our treatment had been remarkably successful. Not only had the relief continued, and the poor man slept comfortably; but the bowels had recovered their activity. He had passed a great quantity of wind to his great comfort, and many stools; some of these stools were seen by Mr. Bradley, who reports that they were copious and feculent. So far, then, the operation seemed to have been eminently successful. Unfortunately the pneumonia had not stayed its course, and the whole of one lung behind was now consolidated, and more than half of the other. He sank from the lung mischief in about two days more—the abdomen becoming again somewhat distended before death. At the autopsy, almost the whole of the left lung was found in a state of ‘hepatization,’ and a large part of the right lung also. The other organs were healthy; in particular there was no trace of peritonitis, nor had any air escaped into the peritoneal cavity. No traces of the punctures could be detected except upon the outside of the body. I need not stay to point out how often patients beg for relief from a distended abdomen, nor, I think, to show that the simple and painless operation which we practised proved to be quite without danger, and gave great and immediate relief, not only by emptying the bowel of wind, but by enabling it to contract upon, and to repel, the feces which obstructed it. The operation is one which any physician may have recourse to in a moment, and if he has not a fine trocar at hand he may use the needle of the morphia syringe. I may add, that the autopsy did not seem to support my view of the causation of the bowel paralysis. There was no appearance of inflammation on the under side of the diaphragm, nor was the surface of the bowel injected with blood.”—*The Practitioner*, Feb. 1869.

OPHTHALMOLOGY.

51. *Interesting Case of Defective Vision.*—Major TENNANT, R. E., communicated to the Royal Astronomical Society the following particulars of certain defects in his own vision, and of the means by which they were corrected. This