

abdominal wall in Mr. Tait's case; for in Sims's case and one by Keen¹ of Philadelphia, where the incision was made away from the median line and directly over the tumour, there was considerable hemorrhage. He also asked whether in the progress of the case the contracting gall-bladder produced much traction on the abdominal wall.

Mr. SPENCER WELLS said that several years ago he was consulted about the removal of gall-stones in a case where the operation was discountenanced, and, as it proved, correctly, because there was thought to be cancer present. At that time he considered that an opening by potassa fusa caustic would be preferable to the knife, and he should still, if such a case presented itself, prefer to adopt the former plan. He congratulated Mr. Tait on the issue of his case, and asked how long the bile continued to flow from the wound.

Mr. BARKER asked whether, as a rule, impaction of a stone in the neck of the gall-bladder was followed by jaundice. In a case he had brought before the Pathological Society where a large stone gradually escaped into the ileum and there produced fatal obstruction, there was no trace of jaundice at any time. The late Dr. Murchison had told him that it was not usual to have jaundice when the calculus was lodged in the cystic duct.

Mr. LAWSON TAIT could not say whether jaundice occurred in such cases. He had always thought the calculi were formed in the gall-bladder and thence passed down the ducts. Mr. Hulke's remarks showed how careful one should be in bibliographical research; and he must confess that he had gathered his knowledge of the history of the operation from Dr. Sims's paper, where the priority of the idea is given to Dr. Jones. There was no amount of hemorrhage in the operation, and he attributed that to his following the rule of making all abdominal incisions in the linea alba. Only the day before he was compelled to depart from this rule and to make a small incision to the side of the median line in order to reach a large hydatid cyst, and the bleeding from the small wound was much greater than that from a long incision he had also made in the median line. In his case no traction was produced by the shrinking gall-bladder. The flow of bile from the wound continued as long as this was open—that is, as long as the antiseptic dressings were left applied.

A Case of Uretero-Uterine Fistula cured by Extirpation of a Kidney.

The following case is recorded by ZWEIFEL, of Erlangen, in the *Archiv für Gynäkologie*, Bd. xv. S. 1. The patient, a sufferer from contracted pelvis, had been five times delivered, each time with difficulty. On the fifth occasion delivery was effected, as in most of the others, by forceps. This was complicated with laceration of the cervix, and led to the establishment of a uretero-uterine fistula. There was constant dribbling of urine through the os, with, at the same time, normal filling and evacuation of the bladder. The diagnosis was established beyond reasonable doubt by catheterization of the ureter, through the bladder. It was found quite easy to catheterize the right ureter after dilatation of the urethra by Simon's speculum. The left ureter could not be catheterized, although the experiment was repeatedly made. On each occasion the right ureter could be catheterized without difficulty. After injecting coloured fluid into the bladder, only a drop could, after a time, be seen at the outer os. Various means to obtain relief having been tried and found ineffectual, there remained only two feasible proposals—viz., either to obliterate the vagina after the formation of an artificial vesico-vaginal fistula, or to remove the entire left kidney. The patient

¹ Am. Journal Med. Sciences, Jan. 1879, p. 134, and April, 1879, p. 575.

and her friends objected to the first method, and preferred to risk the second. This Zweifel performed by the extra-peritoneal method. His incision externally extended from the eleventh rib to close upon the crest of the ilium. The deep incision was then continued along the outer edge of the erector spinal mass, and outside the quadratus lumborum. The latter muscle was, accordingly, not cut into. There was some difficulty in enucleating the kidney from its situation, through want of room for the hand, but this was ultimately effected with the help of a Nélaton's forceps. The ureter and renal vessels were tied separately by passing an aneurism needle, armed with a carbolized silk ligature, between the ureter and the vein. Care was taken not to cut the kidney substance too close to the ligatures, so as to avoid any tendency in them to slip. The wound was sewed up, all except the lower edge, through which the ligatures were taken. Antiseptic precautions of the strictest character were observed throughout the operation and in the after-treatment. The case went to a successful termination, notwithstanding that an abscess formed in the track of one of the deep sutures, into which a small drainage-tube was passed, which became incarcerated in the wound. The patient recovered without any symptoms of injury. There was no cardiac hypertrophy, nor indication of urinary disturbance from the operation. The right kidney appeared quite sufficient for the wants of the economy.

Zweifel proposes, after Heineke, to introduce the term *nephrectomy* for complete removal of the kidney, and *nephrotomy* when the kidney is merely cut down upon for the removal of calculus or other cause.—*Edinburgh Med. Journal*, Nov. 1879.

Tubercle of the Urinary Organs.

Dr. TAPRET terminates an article in the *Archives Générales* for October with the following conclusions: 1. Tubercle of the urinary organs is of more frequent occurrence than is supposed, if we are to judge by the small number of cases that have been published. It appears usually between the ages of sixteen and forty, and is rare in the female. 2. Tubercle may occur primarily in the kidney, bladder, prostate, and urethra, remaining stationed there, or becoming propagated in the course of a longer or shorter time, and after periods of arrest, to the genital organs, or invade the lung. Urinary phthisis is rarely associated at once with other manifestations of the diathesis. 3. When the disease commences by the kidney, its onset is insidious; on the contrary, its invasion of the neck and trigone of the bladder is usually indicated by frequent and painful irritation, hæmaturia, pus in the urine, etc. 4. The symptoms of vesical tubercle are grouped in a variable but regular order, and although some may be wanting, they constitute a characteristic morbid assemblage. 5. Its course, usually chronic, may be precipitated by the rapid or slow invasion of the testis or of the lung, rarely of the peritoneum or meninges. In spite of its periods of quietude, of greater or less length, it leads to consumption, and uræmia may terminate the scene. 6. The diagnosis is based on a thorough appreciation of the value of each symptom, direct exploration being employed only as a means of confirmation, and as rarely as possible. 7. Tubercle of the kidney, bladder, prostate, and urethra presents the same stages of evolution as that of the lungs, peritoneum, meninges, and testis. 8. Its treatment is that of tuberculosis in general, modifying injections being employed in some cases. The most painful symptoms may be assuaged by morphia. 9. The appearance of urinary tuberculosis may put us on the way of other varieties, and furnish valuable indications as to the nature of certain morbid phenomena of the pulmonary and genital organs.—*Med. Times and Gazette*, Nov. 29, 1879.