

cases have any serious connection with either Thomsen's disease or paramyoclonus multiplex seems to me to be almost out of the question.

If one is to make a definite classification merely on the basis of certain striking clinical symptoms, these cases might equally well or better be brought into a group with tetany. In a number of points they clearly resembled tetany; but, on the other hand, the tonic spasms were almost entirely intention spasms; the myokymia was quite as marked a feature as the tonic spasm; considering their severity, the attacks were remarkably brief for tetany; and much more important than these facts, the Chvostek, Trousseau, and Hoffmann phenomena were absent. Hence, these cases certainly cannot well be classed with tetany.

The variety of classifications adopted by various authors when dealing with the myospasms shows that the manner in which many of these conditions are grouped is largely a question of personal fancy. This can, it seems to me, scarcely fail to continue to be the case until the nature and the manner of causation of the various myospasms become clearer than they are at present.

LITERATURE.

- Kny. *Archiv f. Psychiatrie*, 1887-88, Bd. xix.
 Schultze. *Deutsch. Zeitsch. f. Nervenheilkunde*, 1895, Bd. vi.
 Talma. *Ibid.*, 1892, Bd. ii.
 Walton. *Journal of Nervous and Mental Disease*, 1902.
 Dana. *Ibid.*, 1903.

A CASE OF PAPILLOMA OF THE BLADDER, COMPLICATED WITH PYONEPHROSIS, WITH REMARKS ON THE SURGICAL TREATMENT OF PAPILLOMA.¹

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G. W., aged fifty-seven years, had noticed that for several months his urine had been mixed with blood; but other than a certain amount of weakness following these hemorrhages and a dull pain in the left lumbar region, the patient feels fairly well. Upon questioning, however, he complains of certain vague dyspeptic symptoms and dryness of the mouth. No headache. Sleep is uninterrupted, and examination of the thoracic viscera reveals

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nothing abnormal other than a slight chronic bronchitis. Pulse 80, hard, and rather tense. Some general arteriosclerosis. The urine contained a considerable amount of pus, blood, and renal cells from the pelvis of the kidney.

Cystoscopic examination of the bladder showed a body situated on the left side of the bladder wall in the vicinity of the ureteral orifice, but its exact nature could not be made out on account of the clouded condition caused by the presence of blood.

After several days of preparatory treatment of milk diet and the exhibition of urotropin a transversal suprapubic incision was made, and the bladder opened, and by digital exploration a polypus of soft consistency and distinctly pedunculated was found seated in the floor of the bladder to the left of the middle line. In size it might have been that of a large walnut.

The growth was seized as near its base as possible, and its pedicle was excised along with a certain amount of the surrounding vesical mucosa. Sutures were then inserted, and the resulting wound closed without much loss of blood.

On account of the presence of pus in the urine it was decided to drain the bladder. The suprapubic wound was loosely packed with iodoform gauze, and a permanent catheter was inserted.

The after-course of events was simple. The catheter was removed at the end of the sixth day, and the iodoform gauze packing was changed daily until the eighteenth day, when only a small opening remained through which very little urine was voided, the greater proportion being expelled by the urethra. In four weeks' time the suprapubic opening had completely closed, and the patient was discharged.

The patient was seen three months after the operation, complaining of pain in the left lumbar region, recurrence of the hæmaturia, and chills. The temperature was 38.8° C., and the pulse was weak and irregular at 110. The suprapubic incision was found in excellent condition, firm union having taken place.

The urine contains a large amount of blood and pus. Tongue dry, and digestive disturbances, which had somewhat improved before the patient left the hospital, had returned with greater severity than before.

By palpation an enlarged left kidney could be easily detected, and it was thought that fluctuation could be elicited.

The next day the kidney was exposed by a transverse incision and freely incised, which gave exit to about 500 c.c. of dark-red and very ill-smelling pus. Two large drainage tubes were inserted and the wound packed with iodoform gauze.

Within a day or two the temperature had dropped to normal and the pulse to 90, and was of better quality. The patient also commenced to recover his strength, and was able to take a fair amount of food. From this time on the progress toward recovery

went on uninterruptedly, and he was discharged, with a renal fistula, five weeks later.

Eighteen months after the last operation we saw the patient in excellent health, but still discharging a certain amount of urine, and some pus by the fistula from the kidney. But on account of his excellent condition and the absence of all symptoms pointing to uræmic poisoning, we have thought it best to desist from doing a secondary nephrectomy, which can always be resorted to should the indications point that way.

In considering the history of this case it would appear to us that in all probability there was a relationship between the papilloma and the suppurative renal process, inasmuch as the vesical neoplasm probably obstructed the ureter, causing a retention, and the kidney thus weakened easily became a prey to secondary infection.

Microscopic examination of the neoplasm showed the ordinary picture of papilloma without any evidence of malignant transformation.

I would like now to discuss briefly the surgical treatment of papilloma of the bladder in a general way, and, although I have nothing novel to offer, I can at least describe those methods which at my hands have proven the most satisfactory.

Small pedunculated papilloma in the female may occasionally be successfully removed without much difficulty through the dilated urethra; but this manner of operating I believe to be unsurgical, for the simple reason that one is working in the dark, and if the urethra is dilated to the extent requisite for giving a large enough operative field, permanent incontinence of urine is the usual inevitable result, and for this reason I believe that the suprapubic incision is the proper one to select, as I have already pointed out in a paper entitled "*Chirurgische Behandlung des erworbenen unwillkürlichen Harnabganges bei Frauen*," and published in the *Monatsschrift für Geburtshülfe und Gynäkologie*, Band xix., Heft 4.

Other intravesical operative procedures applied to the male have been described from time to time, such as Chismore's aspiration with a metallic catheter, etc., but all such methods are defective, inasmuch as the operation is performed entirely in the dark. On the other hand, Nitze's cystoscopic technique is certainly a vast improvement over the older manœuvres, and, although this distinguished *confrère* has published thirty-one cases in which he obtained excellent results, it would appear that this ingenious invention has not found many supporters.

The reasons why Nitze's method has not been adopted in general is because the removal of a large papilloma requires a number of sittings, and when one is dealing with a patient already in a weakened condition, the *séances* can only be undertaken at considerable intervals. For most surgeons this is enough to deter them from undertaking the removal of a papilloma by this method, and, on

the other hand, I believe that the majority of patients would prefer to take a little ether and have the neoplasm removed at once and for all than to be continually tampered with.

I would also point out that Nitze himself admits that accidents may occur during or after the execution of these intravesical operations, such as severe hemorrhage or cystitis, irritation of the kidney or its pelvis, as well as febrile disturbances, which simply mean a septic condition; and, last of all, but by no means the least important, prostatitis or epididymitis has been known to supervene. On another occasion Nitze says that severe hemorrhage from the growth, severe cystitis, a small bladder, etc., will render the intravesical operation impossible, and if the neoplasm is of large size, or when there are several growths, the execution of the operation is extremely difficult.

Now, if such an expert as Nitze himself is in these matters admits such difficulties in the operation, it is quite natural that the average operating surgeon will select another technique on which he can rely with practically perfect security. It is evident that many of the present defects in Nitze's method may be removed by the improvement in the instruments, so that the future of this procedure may be increased, but for the present it would appear that its application is extremely limited.

In opposition to intravesical operations we have three techniques by which the tumor may be exposed and removed. The first and oldest of these is Thompson's median perineal incision, which at the present time has lost its diagnostic value on account of the general use of the cystoscope, while its therapeutic importance for the removal of papilloma is practically *nil*, but its applicability for the removal of calculi may be still reserved for certain cases. This procedure may give satisfactory results to a few picked operators, but it is to be doubted whether it will ever be generally employed, because, on the one hand, there is always considerable danger of accidentally wounding the bladder, and, secondly, one never can be sure that he has completely removed the growth. The demands of modern surgery that the field of operation should be freely exposed will certainly place this method in the background, more especially so when one recollects the great possibility of hemorrhage during the operation and the very great difficulty one would meet with in controlling it through the perineal incision.

Koch collected thirty cases operated on by Thompson's method, and in only two was the complete removal of the neoplasm a certainty. In five no recurrence had taken place after the first year, while in seven no symptoms returned for two and one-half years; five patients died during the first few weeks following the operation, death being partially due to exhaustion resulting from the severe hemorrhage during the operation, and partly from some intercurrent affection. In more than six of the cases no opinion

could be formulated on account of the short lapse of time since the operation, while in three cases a recurrence took place for the simple reason that the neoplasm was only partially removed. In one case there were three recurrences due to an incomplete removal of the growth. It would seem from these cases that an entire extirpation of the neoplasm is not possible to attain excepting in a few instances unless the tumor grows near the urethral opening of the bladder or in the pars prostatica, under which circumstances König is of the opinion that the perineal incision is more advantageous than the suprapubic opening.

Colpocystotomy for the removal of papilloma in the female bladder has only a limited field of usefulness. The operation is impossible when the vagina is small and also when the tumor grows from the anterior wall of the bladder. Then, again, large-sized growths can only be removed by this route with difficulty, and then only by resorting to morcellation.

Suprapubic cystotomy is in all probability the method now generally employed for the removal of papillomata or other vesical growths. Combined with Trendelenburg's position it fulfils all the requirements for the complete exposure of vesical neoplasms, because a complete view of the entire cavity of the bladder may be obtained, and all parts are accessible to operative manipulations. There is no doubt in my mind that by this route the greatest convenience and security are to be obtained, and as far as hemorrhage is concerned, there is no other technique which gives such absolute security as this one.

The defective points in the operation are, first, the danger of opening the peritoneum, and, secondly, urinary infiltration of the pelvic cellular tissue; but the progress of surgery has practically done away with the first danger, so that should the peritoneum be opened it can be immediately closed, and no ill result is apt to accrue. The dangers of infiltration of urine can be, I believe, easily avoided by proper drainage.

It would also seem to me, from a very large experience, that the transverse suprapubic incision is far more preferable than the median one, and in corpulent patients it certainly gives a far more extensive field of operation.

To render the bladder more ready of access, the injection of air is, to my mind, better than sterile liquid, because, when the latter runs out through the abdominal wound, it inundates the entire field of operation, and if the bladder is infected, the liquid carries the agents of infection with it, which may infect the cellular tissue. Petersen's rectal bag should never be employed, being both useless and dangerous.

The removal of the papilloma, whether pedunculated or not, should include the removal of a certain amount of mucous membrane around the base of the growth, followed by a careful suturing

of the remaining defect. Some surgeons are satisfied by simply ligating the pedicle, cutting off the growth, and then applying the thermocautery to the stump; but this procedure is not safe, because one can never tell whether the growth has commenced to undergo malignant transformation, and in its removal it is more prudent to assume the possibility of malignancy.

Regarding the dangers of purulent infection of the prevesical cellular tissue, I believe with Kraske, that the use of the permanent catheter is not alone sufficient, and that unless the bladder is free from cystitis it is all-important to obtain free drainage. If, however, the urine is apparently aseptic the bladder and the abdominal wound should be closed by a careful suturing, and the bladder drained by the use of the permanent catheter.

To effect a perfect drainage of the wound, the use of iodoform gauze loosely packed in and changed daily is, to my mind, the proper way, and secondary union will follow quickly. The resulting cicatrix is firm, and urinary infiltration is avoided. This manner of drainage is to be recommended in cases of purulent cystitis and, in fact, after all operations where bladder drainage is required for a short time following an operation. Combined with this, the use of a permanent catheter should be resorted to as long as the patient can comfortably bear it and its presence in the urethra gives rise to no untoward symptoms.

SOME UNSETTLED AND IMPORTANT PROBLEMS IN THE TREATMENT OF ACUTE LOBAR PNEUMONIA.¹

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To the practitioner of medicine there is no subject of greater interest than the treatment of pneumonia. This interest proceeds from the facts: 1. That pneumonia is met with frequently in all climates and seasons, everywhere, in hospitals, and in private practice. 2. It is a very fatal disease, of rapid course, and of markedly infectious type at times. 3. It has been the subject of a great number of books, papers, discussions from the ablest and most experienced physicians in the past and at the present time. 4. While there is a consensus of good medical judgment as to the efficient cause of pneumonia, as to many accidental and co-operating causes, as to certain indications of treatment, and as to usual causes of death due to it, there still remains much that is undetermined in its treatment, and about which many "good men and true" hold divers opinions.

¹ Read before the American Climatological Association, June 4, 1904.