The Glands of Littre in Chronic Urethritis.—J. de Keersmaecker (in *Annales des Mal. des Org. Gén.-Urín.*, August, 1896) refers to the part the glands of Littre take in chronic urethritis. The tenacity of a chronic blenorhagia is such that by some it is regarded as incurable. Why the disease gets rapidly well in some, and in others remains for a time apparently cured and yet recurs, requires explanation. Whether the gonococcus persists, it is difficult to say. For the examination of these cases the writer strongly advocates the use of the endoscope, particularly the perfected instrument of Nitze-Oberländer.

By its use it is seen that in the greatest number of persistent cases the disease is confined to the glands and crypts of the canal and to the tissues in their immediate neighbourhood. The whole lining membrane of the urethra, from the meatus to the bladder, is studded by mucous glands or glands of Littre, and by crypts or simple diverticula, both more abundant in the superior wall, where they form *un pointillé serré*. Under physiological conditions the excretory orifice of these glands is invisible by the endoscope. They are rudimentary in the posterior part of the canal, but more developed in the upper wall of the anterior part.

Their situation in point of depth varies. At one time they are found immediately under the epithelium, at another they are more deeply placed in the submucous tissue, extending into the trabeculae of the cavernous body. The ducts leading from them vary in length from a few millimetres to 2 or 3 centimetres, and are directed usually obliquely towards the meatus. Reference is made to the articles published by Neelsen (*Annales des Mal. des Org. Gén.-Urín.*, 1891 and 1894) and by Wasserman and Hallé (ibid., 1894, p. 244), in which the conclusion come to is, that there does not exist a chronic urethritis without implication of these glands, and the author adds also of the lacunae of Morgagni. The lesions in these glands are visible by the endoscope. Areas of infected tissue are seen, less marked farthest from the meatus because farthest removed from the seat of primary infection; a chronic posterior urethritis is less common than is supposed. In simple catarrh the endoscope shows the mucous lining more brightly coloured than is seen in the normal urethra, but pale as infiltration becomes more dense. The glands of Littre and lacunae of Morgagni are little or not affected in simple catarrh. The state of the gland ducts varies with the intensity of the inflammation.

Two types of chronic urethritis may be met with—(1) that in which the gland duct remains permeable; (2) that in which the duct is closed. Such a distinction cannot be made without the endoscope. The author claims that this distinction is important clinically, because in the latter form a particularly chronic condition is likely to result.

If the diseased glands open on the surface of the mucous membrane, their swollen orifice can be perceived even by one not practised in the use of the endoscope. Ordinarily in chronic blenorragic urethritis these glands are hypertrophied, their orifice having the appearance of a small crater with very red swollen edges. Their size makes them liable to be confounded with the lacunae of Morgagni, but their large number distinguishes them. Their redness shows up in the pale mucous membrane, owing to its infiltration and subsequent cicatrisation. The number of inflamed glands in a given area varies; usually there are as many as five to ten in a square centimetre.

In the second form—that in which the orifice of the glands remains closed (encysted)—the endoscopic image is characteristic. The affected patch of mucous membrane appears cadaverous, resembling dead membrane (Oberländer.)

The orifice of the glands or of the crypts is not visible, and if one or two are visible, their colour differs little from the surrounding mucous membrane.
The body of the gland and the lacunæ in the affected area are transformed into little cysts situated immediately under the epithelium and projecting into the canal, or they may appear as little yellowish-grey vesicles about the size of a grain of hemp-seed.

The change which these glands undergoes under treatment the author does not speak of, but he refers to the important point that in this encysted form the discharge may cease and all the objective signs disappear. It is easily seen how these little cysts may remain as irritating bodies embedded in the tissues charged with septic matter.

The use of the endoscope in these cases throws much light on the condition, allows of the proper application of astringents and caustics, and ensures success in treatment.

Hernia and its Treatment.—The Clinical Journal for September contains two articles on hernia and its treatment.

In the issue of 16th September a clinical lecture by Raymond Johnson is given on the subject of "Hernia in Childhood," and in the issue of 2nd September one by Jameson Johnston, on the "Application of Hernial Trusses."

In connection with the causes of hernia in childhood, Raymond Johnson alludes to the relation of hernia to phimosis. He believes that the presence of the two conditions is merely accidental, and that the proportion of ruptured children who have a degree of phimosis requiring circumcision is no greater than that of children not so affected. Though circumcision is recommended, if there be phimosis present, he doubts whether this can be regarded as part treatment of the hernia. Of 6,000 out-patients seen by him, no case of femoral hernia in the child was met with.

Very rarely does umbilical hernia persist after the first year or two, and the presence of umbilical hernia since infancy is very exceptional. Treatment by strapping is alone recommended.

Strangulation of umbilical hernia in the child is very rare: one case only has been seen by him.

Speaking of the inguinal variety, reference is made to the fact that in the child the hernia is nearly always reducible, and the reason given is that the omentum takes little or no share in the contents of the sac. In the treatment of this variety in very young children—under six months—the writer refers to the familiar method of a skein of wool made into a truss, and recommends its use. If treatment by this method is commenced immediately, and the hernia kept back for a couple of months, "it is not uncommonly once and for all cured." In children of six months or so, some form of truss is required. He deprecates the use of the ordinary spring truss surrounding the pelvis, and recommends a soft rubber horse-shoe truss, the limbs of which lie over each inguinal canal, and are prolonged into soft rubber bands which take the place of perineal straps. The truss is attached by a flat indiarubber band encircling the pelvis.

If this be constantly worn, and the mother warned to keep up the hernia while the truss is simply dried and the parts dusted with boracic powder, its action is certainly curative.

Speaking generally, all herniæ in children under 12 months are capable of cure by the use of a truss; but after this age a less hopeful view is taken. In children over 2 years an ordinary truss can be employed, but indiarubber should be substituted for leather. In regard to operation in children, the writer says that "under no circumstances should operation be undertaken in children under 2 years in whom the hernia is efficiently retained by a suitable truss."

When the hernia is of unusual size, and the inguinal canal large, radical operation is recommended, even although the child is only a few months old. It is also advised in children over 2 or 3 years where, in spite of a truss being constantly worn, the hernia comes down on its removal.

The following operation the writer finds efficient:—A short incision is made over the inguinal canal, extending down to the external ring, but not into the
Abstracts from Current Medical Literature.

Scrotum. The aponeurosis of the external oblique is exposed and slit up so as to open up the whole length of the inguinal canal. The upper end is defined and separated from the cord. A silk ligature is then applied round the sac as high as possible, and the sac divided below the ligature. The divided end of the sac is secured by another ligature, and left in situ. The aponeurosis of the external oblique and the skin are now brought together, the former by silk, the latter by horse-hair. The dressing should be light. A pad should be worn for five or six weeks and then discarded.

Jameson Johnston (on the Application of Trusses) thinks every medical man ought to know how to measure a truss, and ought also to have a knowledge of the best shape of pad and strength of spring required.

The following are his directions for measurement:—"In ordering a truss send a measurement from the lower part of the hernial orifice up to the anterior superior spine of same side, round pelvis an inch or so below the crest of the ilium to anterior superior spine of opposite side, finishing at upper part of hernial orifice. State kind of hernia, the side, size of ring, strength of spring, age and sex of patient." He recommends a lighter truss to be worn at night.

On the Removal of the Tube in Tracheotomy.—Fasteau, in the Rev. de Chir., June, 1896, writes "On the Removal of the Tube in Tracheotomy." The author refers to several points in the construction of the tube, which might be made to prevent that feeling of suffocation which almost invariably follows its removal.

Firstly, from observation of tubes that had been in use for some time—in one case for three years—he found that one spot on the convex aspect of the tube was not blackened by sulphate of silver like the rest. This black deposit he attributes to contact with the inflamed tissues, whilst the lighter spot corresponds with the lumen of the trachea. For this reason he places the window on the convex part of the tube much further back than is usual, so that the expired air can pass into the trachea. The author believes that with a tube so constructed the patient can accustom himself to respire through the larynx, and in this way facilitate the removal of the tube.

Secondly, he discusses the various measures that have been suggested to intermittently obstruct the orifice of the tube. The use of a valve or an aluminium bowl he regards as inefficient. He found an indiarubber stopper to answer very well.

Separate Acromion Process Simulating Fracture,—In an exhaustive series of articles in the Edinburgh Medical Journal, Prof. Struthers has discussed the above subject. The point in question was whether the occurrence of a separate acromion process, as found in dissected and other specimens, was due to true fracture of that process, or to separation of the epiphysis delayed in its union to the shaft, or permanently ununited.

The following are briefly his conclusions:—

(1) That fracture of the acromion process is in all probability a much more frequent occurrence than is generally supposed. That it is liable to be overlooked from the absence generally of displacement, but that it may be detected on careful manipulation by the movement of the fragment and by crepitus, and that this conclusion is fully established by the researches of Mr. Arbuthnot Lane.

(2) That fracture may occur at any part—in front of the clavicular facet, opposite the facet, or behind the facet. Just behind the facet is the most frequent site.

(3) That this post-clavicular line is the weak point of the acromion, and for two reasons—(a) the acromion is thick behind, supported and strengthened by the sub-acromial beam of the spine, and becomes thinner just behind the clavicular facet; (b) and more especially as the acromion in front of this is bound to be supported by the clavicle. Forces, therefore, tell mostly on this part of the acromion.
Diseases of the Ear.

(4) That the alleged relation between rheumatoid arthritis of the shoulder-joint and separate acromion is founded on misapprehension.

(5) In regard to non-union or separation of the epiphysis theory, the place of junction of the epiphysis corresponds to the post-clavicular line. Though this is so, it is not admitted to be the cause of weakness, since, after union is completed (between twenty-second and twenty-fifth year), there is no difference in the internal structure, and no special thinness exactly at the line of union. The correspondence of the two lines is incidental, but introduces the element of doubt when separation occurs, as it usually does, at this post-clavicular line. After giving the arguments both in favour of and against the epiphysis theory, Prof. Struthers sums up thus:—“The epiphysis theory is attractive to the anatomical mind, . . . but when critically examined has to be abandoned for the fracture theory.” The post-clavicular line, as the most frequent seat of fracture, gives a family likeness to the great majority of specimens, is none the less anatomical, and appears to be the true interpretation.

DISEASES OF THE EAR.

BY DR. WALKER DOWNIE.

Foreign Bodies in the Ear.—Already during the present year attention has been drawn in these abstracts to cases where serious consequences have followed attempts at removal of foreign bodies from the ear. Every aurist, while condemning for this purpose the routine use of instruments other than the syringe, sympathises with the inexperienced man who, seeing a foreign body in the meatus, apparently within easy reach of forceps, attempts its removal by such instruments. In place of extracting the body he invariably pushes it further inwards, and in his determination to get hold of it not infrequently does serious damage. Bearing on this subject there is an interesting summary of the literature of the extraction of foreign bodies from the ear by Preobraschensky in the Epitome of Current Medical Literature, in which statistics of 200 cases are given. The principal conclusions may be quoted as they there appear:—

1. An unskilled person should never attempt the instrumental extraction of a foreign body.
2. Foreign bodies reach the middle ear almost solely as the result of clumsy attempts at removal.
3. The foreign body usually does less harm to the ear than its extraction by an unpractised hand.
4. The changes produced by the presence of a foreign body in the ear cannot be estimated by the length of time during which it has remained there.
5. The injection of warm water is an infallible means of securing the evacuation of any foreign body from the ear; irrigation with alcohol may be further necessary to prevent swelling of the intruder.
6. There is no indication to expedite the removal of foreign bodies which are giving rise to no troublesome symptoms.
7. In inflammatory processes caused by necrosis from unskilled attempts at extraction expectant treatment suffices as long as no dangerous symptoms are present.

With regard to living objects, insects are easily killed by water or oil, and may then be removed by injection. Larvae, on the other hand, are only rendered more lively by water, and they tend to cling to the walls. They may be killed by turpentine or ether, which, however, may cause inflammation, and the author thinks they are better removed by pincers.—(British Medical Journal, 10th October, 1896.)

Neoplasms of the Ear.—Dr. Dench reports five cases, namely:—
(1) Sarcoma above the tragus; (2) large exostosis; (3) ulcerating papilloma; (4) fibro-sarcoma of the middle ear; and (5) round-celled sarcoma.