

possible the effects of shock. With this object I always take care that the body and limbs of the child are wrapped in flannel bandages, and during the operation the patient lies upon a large, flat, hot-water tin, covered over with a blanket, which fits on the operating table. If hot fomentations are applied to the lower part of the abdomen and perineum after the operation, the child will usually pass urine in the course of a few hours without any straining or difficulty, and, beyond a slight smarting, with very little pain, usually much less than previously to its performance. In only one of my cases has there been any rise of temperature, and the following morning the patients have all been practically convalescent. It is, however, advisable to keep them in bed till the third or fourth day, when they may sit up in the ward, and at the end of a week they are usually quite fit to leave the hospital. In each instance the operation was performed with Weiss's Nos. 5 and 7 children's lithotrites, and the fragments removed with Nos. 6 or 8 evacuating tubes. In Case 4, as the stone was too large to be crushed with No. 7 lithotrite, it was first broken up with one of Weiss's small lithotrites for adults (about No. 9 size), and the operation was completed with Nos. 5 and 7 lithotrites. This case illustrates the fact that a calculus of considerable size—viz., over an inch in diameter—may be safely crushed in a young child. I believe that in the future lithotripsy will quite supersede lateral lithotomy in children, and also that if a stone is too large to be crushed, it will be an indication for the selection of the supra-pubic operation.

Manchester.

A CASE OF HEMICHOREA FOLLOWED BY PARALYSIS (PARTIAL HEMIPLEGIA) IN A CHILD FOUR YEARS OF AGE.

BY E. A. PIGGOTT, L.R.C.P. & S. EDIN., L.S.A. LOND.

THE following case is of interest not only as occurring in so young a child, but also as exemplifying the embolic theory in the causation of chorea. The partial hemiplegia, I take it, as clearly indicating cerebral breach of structure, in all probability dependent upon capillary embolism. For the early history of the case I am indebted to the parents of the child, at which period she was under the care of another practitioner. The case came under my observation only a short time before the development of the hemiplegic symptoms. M. D—, aged four years, the child of healthy parents, suffered more or less from convulsions during dentition, the commencement of which was delayed until she had attained the age of eighteen months. When she had completed her fourth year she was attacked with influenza, which was generally epidemic at the time (March, 1890). During the interval of time between the subsidence of the convulsions synchronous with dentition and the attack of influenza the child enjoyed perfect health. The attack of influenza was succeeded by marked choreic movements in the left upper extremity, the facial muscles on the left side being the next affected; the disease, assuming a decidedly progressive character, ultimately reached the left lower extremity. The muscular contortions were almost entirely limited to the left side of the body, and were often present during sleep, frequently causing the little patient to awake with a sudden start. Locomotion was also interfered with, the left leg being drawn along the ground in walking. A nourishing diet, consisting of milk, beef-tea, eggs, &c., was ordered, and a mixture containing compound syrup of the hypophosphites, combined with small doses of liquor arsenicalis, together with cod-liver oil, prescribed. Under this treatment there was a marked improvement in the choreic symptoms; the improvement, however, was of brief duration. Decided evidence of hemiplegia soon commenced to manifest itself, paralysis of the left facial muscles, partial ptosis, and considerable photophobia, with loss of power in the left arm to such an extent that there was complete inability to grasp any object, the child using the right hand to endeavour to assist the left, finally being unable to lift the arm at all. The bowels were relieved naturally until this date (Oct. 13th, 1890). On Oct. 15th I was called to see the patient, as the symptoms were alarming. On arrival I found the following condition—viz., pupils unequal, left dilated, right con-

tracted; the conjunctiva of the left eye totally insensitive, with diminished sensibility in right conjunctiva; marked trismus, the jaws being firmly closed. Tonic contraction of the extensor muscles of the left arm and forearm and both legs, the left being the most complete. Temperature in axilla 100°; pulse about 120, weak; respiration normal; child groaning slightly at intervals, and moving the head from side to side. A small quantity of liquid nourishment was administered by forcibly separating the jaws. During the progress of the disease, especially after the paralytic symptoms developed, the child was constantly complaining of pain in the head, and would cry out suddenly, frequently awaking from sleep with a scream—Oct. 16th: The condition to-day nearly approached that of complete coma. Temperature normal; muscular jerkings almost continuous in the left upper extremity, which remained rigidly extended. The fingers were clenched, and the hand drawn back to such an extent that it almost resembled in appearance a complete dislocation at the wrist-joint, both feet being similarly affected, and simulating the condition represented in a case of talipes equino-varus. The bowels were obstinately confined, the urine being passed involuntarily. From this date the patient gradually passed into a state of profound coma, sordes forming upon the lips, with a total inability to take nourishment, death finally releasing the little sufferer on Oct. 23rd. A post-mortem examination was not permissible.

The foregoing case, in a great many of its details, resembles tubercular meningitis. Both parents being young and vigorous, there was no reason for supposing the child directly inherited a tuberculous diathesis; doubtless a tendency to brain mischief existed, owing to the convulsions attendant upon dentition. It is also a question what share, if any, the attack of influenza had in the production of the fatal cerebral symptoms.

Clare, Suffolk.

ATRESIA ANI.

BY JOHN K. MURRAY, M.B. EDIN.

A WELL-DEVELOPED child three weeks old was brought to me in September, 1891. I found a dimple marking the usual site of the anus, and the fæces passed per vaginam. On passing a probe the fistulous communication could not be found. Under ether, administered by my friend, Dr. Batchelor of Queen's Town, I cut down on the normal site of the anus, dividing the tissues in the middle line to the depth of an inch and a half. I could find no rectal cul-de-sac. The depth of the wound precluded further dissection. To get freer access I partially divided the posterior vaginal wall, and having passed a probe into the posterior fornix vaginae I at last succeeded in making it enter the bowel. By inserting my forefinger into the wound I found the point of the probe just a little behind the vaginal wall. I accordingly cut down on it. This was followed by a free gush of fæces. I put a stitch in the site of the recto-vaginal septum and closed the vaginal opening by absorbent wool. A bulbous silk catheter was tied in the rectum. The wound was syringed daily. By the third day no fæces escaped per vaginam. The catheter was removed, and passed into the bowel four times daily. When seen in the early part of March, 1892, it was found that a well-formed anus was present, rather nearer the vagina than in the normal perineum. No fæces have escaped since the third day per vaginam.

In this case the dimple marked the arrested deepening of the epiblastic fold which grows into and becomes continuous with the mesenteron. The high site of the rectal cul-de-sac probably indicates a defect in the development of the mesenteron itself. As regards the operation, the main difficulty was in striking the cul-de-sac, which was not distended by fæces, free egress being afforded by the vagina frequently during the operation. It is recommended by Dieffenbach and Barton¹ that, if possible, the cul-de-sac should be detached from the vagina and stitched to the skin. This may be feasible where the cul-de-sac is blind or where it comes low down, but where the cul-de-sac terminates at its communication high up in the fornix vaginae such a proceeding is difficult, even hazardous. The result in this case shows the tendency of nature to revert to normal channels when such are re-established. The line of

¹ Medical Recorder, vol. vii., p. 357.