(1) In the first no doubt we do come across a few—very few—instances of genuine atony of the bladder, in my opinion the result of defective early training in control of the bladder, and the habit becoming confirmed is sometimes carried on into manhood. I should like to try the effect of circumcision on all such cases in childhood, as I have no doubt it would prove beneficial in this as in other ways. I have found treatment of little avail in such cases, still less punishment or even pecuniary loss, and for this class invaliding seems to be the remedy.

(2) In this category I include all cases suffering from irritability of the bladder, whether the cause be stricture, neglected gonorrhoea, or a condition of hyperacidity of the urine from whatever cause; bowel trouble, too, such as colitis, often occasions excessive irritability of this organ. In all cases of this kind the cause must be carefully ascertained and removed, when, of course, the incontinence, which was merely a symptom, at once disappears.

(3) In this, the third class, which is by far the most numerous, I think it will generally be found that there is a good deal of heavy drinking going on, and the culprits, having to choose between getting up and relieving their bladders in the ordinary way (being naturally of irregular habits and regardless of decency), commit themselves at the expense of their beds and bedding. A simple but very effective procedure in dealing with such gentry is to have a parade at uncertain times of all bedding, the latter to be ranged up in a conspicuous place in barracks. The lazy ones can then no longer hide their shame, besides which, a man of this sort would think twice before committing himself, when he finds that he has to face the quartermaster’s bill on the one hand and the wholesome chaff of his comrades on the other, the moral effect of which latter is most salutary. A few such parades, carried out systematically, have a wonderful effect in checking epidemics of this nuisance, and I desire to commend a trial to such of my brother officers who may find themselves called upon to deal with an outbreak under similar circumstances.

MOSETIG-MOORHOF’S METHOD OF TREATING BONE CAVITIES.

By Major Robert J. Blackham.

Royal Army Medical Corps.

With reference to Captain F. F. Carroll’s paper on Professor Mosetig-Moorhof’s method of filling bone cavities with iodoform wax in the September issue of this Journal (“Some Notes on Continental Surgical Procedure,” vol. vii., p. 255), the following account of a case in which this new treatment was put into practical application may be of general interest.

E. R., aged 6, the daughter of a sergeant in the Royal Marine Light
Clinical and other Notes

Infantry, was admitted into the Military Families' Hospital of Devonport on April 23rd, 1906, suffering from advanced tubercular disease of the knee-joint. After consultation, it was decided to excise the joint, adopting the procedure of Professor Mosetig-Moohof. The operation was undertaken on April 30th, 1906, with the able assistance of Captain F. F. Carroll, R.A.M.C.

On opening the capsular ligament the joint cavity was found full of tubercular granulation tissue which was almost black in colour. The patella had been invaded by the disease and was removed early in the operation. The tubercular tissue was carefully scraped away, but in the process of clearing out the joint it was found that the head of the tibia was occupied by a large abscess cavity which was discharging, through an opening in the bone, behind and below the joint. The pus, from its point of exit, had tracked its way down the calf and occupied the plane between the gastrocnemius and soleus muscles. The condition of the limb appeared almost hopeless, as if a slice of bone had been removed from the head of the tibia it would have opened up the abscess cavity, while the collection of pus behind the joint was flowing freely into it and bathing the whole of the tissues in tubercular matter. At this stage it was regretted that permission to amputate had not been obtained. We decided, however, to give the limb a chance, and having made a counter-opening through skin and muscular tissue in the calf, we washed out the joint and abscess cavities in the bone and muscle with weak lysol solution. The joint was then irrigated with a 1 per cent. solution of formalin, and an attempt made to dry the walls of the cavity with the contrivance which Captain Carroll refers to in his interesting paper.

Unfortunately, although the arrangement of two bottles and a double rubber bag sounds "very simple" on paper, it is not so easily managed in practice. I had an apparatus made by a local chemist, but it would not work at the crucial moment, and we were obliged to imitate Dr. Silberman's electric heater, with an ordinary Paquelin's cautery. The iodoform-knockenplombe, which had been liquefied by heat, was then slowly poured into the joint. It set in a few minutes and the superficial soft parts were then united.

The incision wound healed up rapidly, leaving a small sinus which discharged serum mixed with iodoform for about two weeks and then closed up. The child rapidly improved in health and put on weight. The limb, however, was useless, as there was only a limited amount of fibrous union between the articular surfaces.

I therefore reopened the joint on August 28 and found that the abscess cavity in the tibia had completely filled up with new bone, that there was no granulation tissue in the joint, and that the ends of the bone were quite healthy. I performed an excision in the ordinary way, and as an additional precaution pegged the ends of the femur and tibia together with ivory pegs.
The operation wound healed by first intention and I removed the pegs in six weeks. The bones united in the most firm and satisfactory way, and the child went out of hospital on November 17th with a perfectly useful limb.

As this appears to have been the first occasion on which Mosetig-Moorhof's method has been used in a military hospital in England the case appears worthy of record. I am of opinion that no other method of treatment would have saved the limb in the condition in which it was found last April.

I am much indebted to Captain Carroll for explaining the technique of the method and assisting in the first operation.

A CASE OF ENTERIC FEVER COMPLICATED WITH AN EMPYEMA, THE EXCITING ORGANISM BEING ONE OF THE BACILLUS COLI, OR TYPHOID INTERMEDIATE GROUP.

By Captain E. C. Hayes.
Royal Army Medical Corps.

PRIVATE T. was admitted into hospital on December 17th, 1905, suffering from a continued pyrexia, malaise, furred tongue, &c. There was also some diarrhoea—about four stools per diem. No enlargement of the spleen could then be detected, nor was there any crop of rose spots. At first Widal's reaction was negative, but about the tenth day a very definite reaction took place, and he was accordingly diagnosed enteric fever. Preventive measures of disinfection were taken both in hospital and barracks. The origin of the disease is most obscure.

It is many months since a case occurred amongst the troops in Colombo, and this man has not been at any other station for the past twelve months. He is a teetotaller, and has been known to have recently visited an hotel at Borella, which is now "out of bounds." Many cases have been reported amongst the civil population in this suburb of Colombo, and it is probable that infection was here contracted. The case has been of a severe type as regards pyrexia, but the clinical symptoms were not very characteristic. Subsequently his spleen became enlarged to a medium extent. There occurred towards the end of the first fortnight definite signs of congestion of the bases of both lungs, and the fever, which seemed about to drop by lysis towards the normal, assumed a higher type. It became much more remittent within a few days, when patches of broncho-pneumonia were detected on percussion and auscultation. His general condition became very low and of an asthenic type. Free expectoration was produced on the administration of stimulating expectorants, alcohol, and local fomentations. The expectoration was of a highly offensive nature, suggesting abscess of the lung. No elastic tissue was identified under the microscope. Remittent fever, high at