would probably not be of much avail. It had been suggested to use a fine needle with a broken point, preferably roughened, to insert it at one side of a patch and break up the supplying blood-vessels. The vessels would immediately contract, and there would be no scar.

Dr. Moloney said that he and Dr. Le Fevre had not seen such a case before. Its chief feature was the presence of patches containing congeries of enlarged capillaries. This character, which was much more obvious in day-light, led them to class the case as one of diffuse nævus. All sorts of applications had been tried. Dr. Syme's suggestion had been taken into consideration, but it was determined not to adopt it till all other measures had failed.

The following paper was then read by the Hon. Secretary :

A CASE OF SUPRA-PUBIC LITHOTOMY—RECOVERY.

Reported by S. Zichy-Woinarski, M.B., &c.

Honorary Physician to the Ballarat Hospital.

W. P., aged 64 years, mining engine-driver, consulted me with the following history :—Had been suffering off and on for the last 25 years with "sand and gravel," and more or less painful micturition, but up to 16 years ago took very little notice of it. He then, owing to severe paroxysmal lumbar pains, consulted a local medical man, and was treated for lumbago; he has been more or less constantly under medical care since then, till he came under my care, with the exception of two years just prior to my seeing him.

Seven years ago, he noticed specially his frequent calls to micturate, being also disturbed at night three or four times, but being easier at night than when getting about. Within the last eighteen months micturition has become extremely painful and frequent, being called on to relieve his bladder every 20 or 40 minutes; has at various periods passed blood, and has noticed the urine dark in colour. Pains were most marked towards the end of micturition, and were referred to the end of the penis.

Last Christmas, whilst micturating, he passed, per urethram, the small stone shown, but never knew of it passing till he heard it drop in the chamber.

Such were his symptoms when he consulted me. Physically, he looked very worn, and was apparently suffering great pain. The urine was offensive, alkaline, and gave evidence of a good deal of

cystitis. A.C.E. was administered (as owing to the great pain and urethral tenderness, he could allow no instrument to be used), and a rough large stone was detected, a No. 10 beaked sound being used.

At a consultation held, it was determined to perform the high operation, owing to the size of the stone and the general condition of the patient; he was prepared for operation by the washing out of the bladder with a quinine solution, containing small quantities of liq. opii. sed., and the internal free administration of buchu and inf. triticis repentis, frequent hot hip baths, and suppositories.

On the 9th October, assisted by Dr. Radcliffe, I performed the supra-pubic operation on him, Dr. Salmon administering A. C. E.

For distending the rectum and pushing the fundus of the bladder forwards, I found an excellent means in an ordinary six ounce india-rubber enema syringe, which I introduced, collapsed and well-oiled, by means of a little manœuvring into the rectum, where it at once filled out, and answered admirably, the bone nozzle projecting through the anus.

Prior to introducing this, I had filled the bladder by means of a double channel silver catheter, with boracic acid solution, leaving the catheter in, and tying the penis. The extent of humoral dullness over the region of the up-pressed bladder was easily noted.

An incision $3\frac{1}{2}$ inches long was made over the symphysis pubis, extending upwards vertically, the lower part of the incision reaching just below the symphysis; there was a good deal of subcutaneous fat. Then by repeated cuts, deeper at the lower and shallower at the upper end of the incision, the abdominal muscles were cut through, and the bladder was felt at the bottom of the incision. The wound was then enlarged by nicking with the knife, and some slight venous hæmorrhage was encountered in clearing away the supra-vesical fat. The bladder was then raised by an ordinary tenaculum, hooked to the edges of the wound and opened, and the forefinger passed in. The stone was felt just behind the prostate, seized, and extracted by a lithotomy forceps. I then passed in a full sized drainage tube, diameter $\frac{1}{3}$ inch, and stitched it to the edges of the wound, and two stitches were inserted to bring the wound partly together. No stitches were applied to the bladder. I forgot to mention, that when the bladder was raised by the tenaculum, the catheter was withdrawn. An india-rubber soft No. 10 catheter was passed into the bladder, and tied in, and patient put to bed on his side.

The large tube from the bladder in front was immersed at its terminal end into a basin of water.

The subsequent history of the case was very satisfactory, some sloughing however took place around the edges of the wound, and slightly subcutaneously; this I attribute to fixing the drainage tube to the upper, instead of the lower end of the incision. There was a slight rise of temperature for three days, the highest being 101° on the evening of the second day. Urine came both through the catheter and the large drainage tube, by far the most from the drainage tube.

On the 2nd day, the bladder was washed out by boracic solution through the catheter, and twice daily, and subsequently for ten days.

The large drainage tube was removed on the 10th day, the india-rubber catheter still being retained, and being removed occasionally for clearing purposes.

There was comparatively little trouble with the abdominal wound, which healed at the end of the 6th week. The india-rubber catheter was removed finally in the 6th week. The weight of the calculus on removal, was 1206 grains, over $2\frac{1}{2}$ ounces.

The Hon. Secretary then exhibited the calculus.

Exhibit by Dr. Hinchcliff.

Dr. Hinchcliff then exhibited a beautiful specimen of the mulberry calculus, and read notes of the case.

The following paper was then read:

NOTES OF A CASE OF DISLOCATION OF THE GREAT TOE.

By J. P. Ryan, Chevalier of the Legion of Honour.

M. S., a strong, healthy young man, had his left foot injured on the 28th of October last, by a horse rearing and falling over on him. He attempted to get up, for he was uninjured elsewhere, but was unable to rest any weight on the foot, and he was carried to a hotel in the neighbourhood.

I was called to see him about an hour afterwards, when there was already considerable swelling about the instep and ankle, and there was so much eversion of the foot that at first I took it for an ordinary case of Potts' fracture. However, on closer examination, I discovered that the fibula was not broken, but that the internal lateral ligament had given way. The foot was easily restored to its normal position, but without some support, eversion again took place.