PERISCOPE

BLADDER SYMPTOMS FROM CONGENITAL DEFORMITIES WITH ASSOCIATED NERVE LESIONS.

Three cases are described presenting urological symptoms due to congenital deformities with associated nerve lesions.

The first case was that of a man of 37 years of age, who had no urinary symptoms till he was 24 years, when he developed difficulty in micturition. The symptoms became progressively worse, and patient had to use the catheter frequently. There was some bowel difficulty—constipation and faulty sphincter control, which was getting progressively worse. Radiograph showed a spina bifida occulta of the upper part of the sacrum. It was through that the sacral root fibres at the level of the 1st sacral vertebræ were mechanically affected by a slowly progressing lesion. There were slight changes in the leg reflexes, and a small area of diminished sensation over the sacrum. An operation was carried out, and the defect in the sacrum was exposed by removing the spinous process of 5th lumbar vertebræ. A mass of fat investing a swollen sac of dura was revealed. The lower fibres of the cauda equina were adherent to the fatty mass and were dissected free. The mass of fat was removed, and the wound closed. Patient was catheterised at regular intervals for four weeks, when he began to void naturally and has continued to do so.

The second case was a girl of 25 years, with a history of chronic invalidism since birth. She had had an amputation through the left thigh and a partial amputation of the right foot, for extensive ulcerations involving the bones. She always had had urgent urination and difficulty of controlling both the sphincters of bladder and bowel. She was admitted to hospital with a distended bladder containing 500 c.c. of infected urine. Bilateral pyelitis was present. Radiograph showed spina bifida occulta with absence of arches of 4th and 5th lumbar vertebræ. Cystoscopy revealed a trabeculated and infected bladder. Symptoms had always been present, but became much aggravated by addition of infection.

The third case was a male student of 17 years, who had been born with an imperforate anus, which had been successfully treated. Cystoscopy revealed a slight congenital deformity of the posterior urethra, and the presence of a unilateral fused kidney on the left side. Radiograph showed the presence of six lumbar vertebræ, and no coccyx present, the sacrum terminating in an irregular mass of bone. Attacks of pyelitis frequently followed respiratory infections, and weakness of sphincter control of bowel had always been present.

The first case was the only one in which operative treatment was carried out.

Periscope

[The successful result obtained in the first case emphasises the value operative treatment may have in a few select cases. The cases most likely to furnish good results are those where the onset of symptoms has been late.]

F. H. COLBY, Boston (*The Boston Medical and Surgical Journal*, November 1926). A. J. C. H.

VOLVULUS OF SIGMOID FLEXURE.

Twelve cases of volvulus of the sigmoid flexure, acute and chronic, are studied. Three types are recognised: (1) The acute type with sharp attacks, (2) the recurrent type with short sharp attacks continuously recurring, and (3) the chronic type with atypical moderate attacks of abdominal pain, often of daily occurrence.

In children with congenital megasigmoidium the author believes that depending on the degree of stasis and subsequent obstruction, either Hirschsprung's disease or chronic volvulus may develop. In stasis cases chronic mesosigmoiditis with fibrosis causes shrinking of the base of the mesosigmoid, which tends to volvulus or double-barrelled flexure formation. In diagnosis the barium enema is the most satisfactory means. In treatment removal of the flexure is advocated and the technique is described in detail.

B. FERNSTROIM, "Volvulus of the Colon and its Treatment," (*Acta Chirurgica Scandinavica*, lxi. (ii.-iii.) 213).

D. B.

PARAPLEGIA IN CHONDRODYSPLASIA.

A male achondroplastic, aged 46, developed at the age of 40 trouble with his sphincters. There then occurred an incomplete spasmodic paraplegia with hyperæsthesia and spinal reflexes. Lumbar puncture was negative and radiography showed nothing abnormal. The lesion, however, was located at the 12th thoracic segment, and laminectomy from 9th to 12th thoracic was carried out with a little difficulty on account of the thickness of the laminae. At the level of the 12th thoracic there was a distinct diminution of the dural sacs with meningeal adhesions and an encysted serous meningitis. A slow and gradual amelioration followed the operation, and three years later he was able to walk a little, and the trouble with his sphincters had disappeared as had his sensory phenomena. The author suggests that compression of the cord was the result of narrowing due to premature ossification of the vertebræ and the intervertebral discs. Besides this one might have an osteophytic spondylitis which would increase or cause pressure on the cord.

O. ALBRECHT and E. RANZI, "Kompressionsmyelitis bei Chondrodystrophie" (*Wiener klin. Wochenschr.*, 1926, xxxix., 1241).