movable. The resonance in this region varied, and a thrill, obtained by flicking the belly wall, was put down to the laxity of the parietes. There was no liver enlargement, and no other mass was felt in the abdomen, nor could glands be felt in the left posterior triangle of the neck. Per rectum, no mass felt bimanually; prostate considerably enlarged.

Diagnosis.—From the age of the patient and the nature of the mass felt it was decided to be a case of ileo-cæcal carcinoma, the alternative diagnosis being that of old appendix abscess.

Operation—22/2/10. *Mr Morison.*—Usual appendix incision; belly muscles divided. They showed marked œdema. On opening the abdomen there were present some omental adhesions to the anterior belly wall. The appendix was found wrapped round by, and buried in, inflamed omentum. On separating this the remains of an old abscess between the appendix, omentum, and mesentery of the ileum were exposed. The cæcal wall was thickened and œdematous, and showed a small hole, which, however, did not communicate with the lumen of the gut, but which was considered to be the seat of discharge of the abscess into the cæcum. The appendix exhibited a very bulbous tip, and the remainder of it, which was very long, was shelled out of a very thick œdematous peritoneal coat, and removed in the usual way. The thickened coat and omentum were sutured over the stump, and the abdominal wound closed in layers without drainage.

4/3/10.—Uninterrupted recovery; patient left hospital healed and quite well.

2. ENLARGED PROSTATE ASSOCIATED WITH VESICAL TUMOUR. NOTES OF SIX CASES

By DAVID WALLACE, C.M.G., F.R.C.S.,
Surgeon, Royal Infirmary, Edinburgh

As operative experience increases in cases of enlarged prostate, liability to error in diagnosis based on symptoms alone is necessarily more recognised. The fallacy of fibrous stenosis at the neck of the bladder as a cause of prostatism is now admitted, and the need for care in differentiating simple enlargement from malignant disease of the prostate is well known. Within the last two years I have seen six cases of enlargement of the prostate associated with the presence of a vesical neoplasm, in each of which

the symptoms were explicable from the enlargement of the prostate without any suggestion of the presence of a tumour, and it is to this possible association that I wish to direct attention. In all of these cases hæmaturia was a prominent symptom, but this did not necessarily indicate the presence of a tumour, as it is quite well known that profuse bleeding may be due to prostatic enlargement alone, this symptom of bleeding not infrequently being the first symptom seriously to direct a patient's thoughts to his condition, so that he consults his medical attendant. More especially is this the case when clots are passed and difficulty in micturition results, leading, it may be, to temporary retention. If a patient comes before us with a history of bleeding and he is well up in years, describes symptoms such as we are familiar with in prostatic cases, and we find on examination *per rectum* that the prostate is enlarged, it seems natural to take the simple explanation and diagnose hæmaturia a result of prostatic enlargement. In such a case as a routine we examine the kidneys by palpation, but unless we have definite evidence of something wrong, we are almost justified in believing that the prostate is the cause. We do not consider that it is necessarily a malign prostate, because we are more likely to have profuse bleeding in a simple case than in neoplasm of the prostate. At the present time prostatectomy is so often recommended, and its results are so beneficial in the majority of cases, that we are most likely, having made the diagnosis of enlarged prostate, to advise operation and give a very favourable prognosis. If, however, at the operation a vesical tumour is found, it must be very disconcerting to the surgeon and most disappointing to the patient. On the other hand, if the symptoms are not urgent and the bleeding not profuse, operation may be delayed, palliative measures adopted, and valuable time is lost. As an example of this I quote the following case :—

G. D., æt. 70, in April 1909 complained that he had to rise three or four times at night, and that for three weeks he had seen some blood in his urine. It came at the beginning, and the urine towards the end was clear. He had no pain in the lumbar regions and the kidneys were not palpable. *Per rectum* the prostate was not much enlarged, and there was no induration. He stated that the first bleeding was seven years previous to the present attack and lasted eight days. Since then bleeding had occurred three or four times and lasted for a day or two. I advised no operation, and wrote to his doctor that I thought the condition was prostatic,

but that if the bleeding continued he should be examined cystoscopically. In October 1910, that is about eighteen months later, he came to see me again. The bleeding had ceased for nearly a year, and then recurred. The frequency of micturition was as before, but he now stated that he had lost weight. Examination *per rectum* revealed practically no change. I examined him cystoscopically and detected a villous tumour just above the left ureteral orifice. I later removed this tumour and the patient made an excellent recovery.

One naturally asks the question in regard to the above case, Should an earlier diagnosis have been made of vesical growth? and I am satisfied that a similar history of bleeding in a man of about 50 would have at once suggested a vesical neoplasm; but in a man of 70 the symptoms were rather those of enlarged prostate, and had he had greater micturitory trouble I would probably at the first have advised prostatectomy without the use of the cystoscope as an aid to diagnosis.

Take another case—Mr A., æt. 69. I need not detail the symptoms further than to say he had frequency of micturition, and at the time I saw him, hæmaturia, the former of some years' duration, the latter, of much more recent origin, three months. The prostate was enlarged, firm, and rather fixed, so much so that I feared it might be malign, and it was certainly not a satisfactory one for removal. Again I attributed the symptoms to prostatic enlargement, with the *caveat* that the prostate might be malignant. I advised no operation, but said that if the symptoms got worse, or the bleeding increased, a cystoscopic examination should be done with a view to immediate operation if that proved feasible. In six months, his symptoms being worse and the bleeding more continuous and profuse, I made a cystoscopic examination, which revealed a large sessile papilloma, involving the bladder-wall so widely that removal was out of the question. I performed a suprapubic cystostomy, and he wore a tube for some months with much comfort.

In this case, again, if the patient had been a younger man I think the diagnosis of vesical tumour would have been arrived at from the symptoms, but at the patient's age these were quite explicable on the ground of an enlarged prostate, and a provisional diagnosis was made on that basis.

The other four patients were all over 65 years of age, and the symptoms in each were those of hæmaturia associated with

prostatic enlargement rather than caused by bladder tumours. In only one was there pain accompanying the bleeding, and in his case another surgeon had sounded him for stone three years previously, and failing to detect a stone pronounced the condition to be due to enlarged prostate. The bleeding ceased for months, but the frequency of micturition continued to give trouble, both during the day and at night. I saw him when the bleeding had continued for several months, and concluded that the condition was due to a tumour. This I verified by cystoscopy, when I detected a large villous growth. A palliative suprapubic cystostomy was performed, and the bleeding entirely ceased.

The conclusion of the matter may be summed up as follows :—

Hæmaturia is a symptom of prostatic enlargement and also of vesical tumour, and in a man with enlarged prostate it is often not possible to say it is due to the one rather than to the other. Short of operation there is only one means of diagnosis, and that is by cystoscopy.

When we have much bleeding, or when bleeding comes on without any aggravation of other symptoms in a case of enlarged prostate, no instrumentation having been used, it should be borne in mind that a neoplasm may be the cause. In such circumstances it is judicious to make a cystoscopic examination prior to opening the bladder. In some cases it may not be possible to pass the cystoscope, and then we must operate, but in such a guarded prognosis should invariably be given.

Meeting IX.—July 5, 1911

DR BYROM BRAMWELL, *President, in the Chair*

I. ELECTION OF MEMBER

George Fyfe, M.D., 24 Broughton Place, was elected an Ordinary Member of the Society.

II. EXHIBITION OF PATIENTS

1. *Dr Chalmers Watson* showed—

Case of MYASTHENIA GRAVIS.

Man, æt. 41, paraffin worker; pains throughout the body and