

priests. The recent studies of insanity in the Malay races by Professor Kraepelin⁶ throws an interesting light on this question. A year ago he visited the State Asylum at Buitenzorg in Java. His inquiries and observations revealed to him the fact that patients of European birth born and reared in Java presented the same clinical pictures and types of mental disease as at home. (Senile dementia, however, was rare and exceptional, this fact, as in other colonies, being due to the character of the population). As to the abuse of stimulants and narcotics, the natives did not drink alcohol, and therefore cases of alcoholic insanity are not met with in the native population of the asylum. Opium-smoking and abuse of the drug is common in Java (Malays) as well as in Singapore (Chinese and Malays), yet in neither of the State asylums were there cases of insanity due to opium; of special interest also was the fact that out of 370 insane (Malay) natives there was not a single case of general paralysis, while among 50 European male inmates there were eight cases. There is no satisfactory explanation of this fact on the basis of the ordinarily accepted theory of the syphilitic causation of general paralysis, for the native of Java is not less the victim of syphilis than other similarly circumstanced people. For an explanation we must fall back upon such imperfectly understood questions as racial types and proclivities. Dementia præcox was found to be extremely frequent among the natives, and on the whole presented symptoms similar to those found in Europeans. On the other hand, mania—melancholia was rare. Hysterical and epileptic insanities, including the form known as psychical epilepsy were observed. We see then, says Dr. Macpherson, that statistical insanity in its fluctuations must depend upon the standard of intelligence of the people whose insanity is being considered, and upon their ethical and religious attitude towards disease of all kinds. The recognition of insanity as a disease by a community is very gradual, and older notions as to its supernatural origin linger for a long time even after the general acceptance of newer ideas. Like every other variation, insanity, says Dr. Macpherson, can only be held in check—"swamped out" to use a common expression—by extensive inter-crossing. New health of constitution can only be obtained if there are units to introduce new and healthy strains. There are, then, two reasons why a decreasing population favours a high lunacy rate:—(1) Because the normal age distribution of the population is greatly modified (as, e.g. by extensive emigration of the young and energetic males and females). (2) Because there is not sufficient compensatory introduction of new blood to check the increase of variation. This is illustrated by study of lunacy in Argyll, Caithness, and Inverness. (The marked and high lunacy ratio of Ireland points to the same conclusion.) It is necessary to point out that in dealing solely with the statistics of pauper lunacy an element of fallacy has to be reckoned with—namely, the difference in administration of the Poor-law, as well as the difference in custom in various divisions of Scotland. The fact has also to be borne in mind that when a country is being drained by emigration, the weak, the feeble-minded and insane, and the diseased are, as a rule, left behind, so that the

proportion of these to the general population is increased by arithmetical progression. Exactly the reverse is seen in large urban centres which are being constantly reinforced by the addition of young adults. There remains the question of the isolation of a community, as a favouring cause of insanity and other pathogenic variations, especially marriage isolation and in-breeding. Terrible examples of this have been afforded us in the cases of the village of Eycaux with its excessive inter-marriages (in France), of the Vale of Glamorgan "the blackest spot as regards insanity in Wales, whose inhabitants were nearly all related and constantly marrying amongst each other" until it was opened up by the railway, and the studies of Drs. Ireland⁷ and Brachet upon the insanities of the Royal families of Europe (Spain, Austria, and France) which from repeated inter-marriages throughout several centuries and numerous generations produced numerous classical examples of insanity and mental degeneracy.

⁴ Jour. of Mental Sci., July 1905. ⁵ Ibid. ⁶ Ibid. ⁷ The Clot upon the Brain (London, 1896).

GENITO-URINARY SURGERY.

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Conservative Operations for Hydronephrosis.—F. Gardner⁶ points out that cases of hydronephrosis not curable by nephropexy or by the external liberation of the ureter are due to a vicious implantation of the ureter into the renal pelvis, either because it is not implanted at the most dependent part, or it presents a stricture, or is bent or twisted or compressed by an abnormal renal artery. The methods of treatment available for these conditions are:—(1) Division of the spur when the ureter is implanted too high in the pelvis; (2) uretero-pyeloplasty in which the orifice of communication with the pelvis is divided longitudinally and sutured transversely; (3) uretero-pyeloneostomy, in which the ureter is divided and the end implanted into the lowest part of the pelvis; (4) pyeloplication, in which the size of the pelvis is diminished by infolding; (5) orthopædic resection, in which the greater part of the dilated pelvis and kidney is resected; (6) lateral anastomosis of the ureter; and (7) nephro-cysto-anastomosis, in which the dilated renal pelvis is directly anastomosed with the bladder. If infection is present (pyonephrosis) a preliminary nephrostomy is essential.

Renal Calculus.—G. E. Brewer, New York,⁷ recently opened a discussion on renal surgery at the New York Academy of Medicine. He alluded to 36 cases of renal trouble in which the presence of calculus was strongly suspected. In only 21 of these did subsequent operation reveal a stone. Of the remaining 15, nine showed other lesions, but in six no lesion could be found. Thus the diagnosis of stone in the kidney was wrongly made in 41 per cent. of the cases. Pain was the most constant symptom of calculus. It was either paroxysmal or constant, and in some mild, in others severe. Of cases with typical renal colic or constant pain not due to stone one had intermittent hydronephrosis, two had chronic interstitial nephritis, one had multiple

abscesses, four had no discoverable lesion, and two had suppurative disease of the kidney. Frequent or painful micturition was present in more than half the cases of stone, and tenderness was almost constantly present. Pyuria was present in 16 of the 21 cases, the kidney was palpable in a third of the cases. The writer considers *x*-ray examination to be the most valuable method of examination for the diagnosis of calculous disease of the kidney or ureter. In three cases shadows were given with the *x*-rays and yet no stones were found. In one of these the shadow was due to a calcareous appendix epiploica adherent to the peritoneum over the ureter. Possible sources of error in *x*-ray plates are shadows due to calcified lymph nodes, phleboliths, calcareous masses in the sacro-sciatic ligament, and calcified appendices epiploicæ. Dr. Cole recommends the rejection of all plates which do not show the outline of the psoas muscle and the transverse processes of the lumbar vertebræ, and that all shadows which have not well-defined edges be regarded with suspicion. That calculus often exists without pain is evidenced by the statement of Bruce Clark, who reported 24 autopsies upon calculous patients, in 13 of which there had been no subjective symptoms during life. H. A. Fowler,⁸ discussing the diagnosis of stone, alludes to the importance of taking a full and correct history. The patient never remembers to mention all his symptoms and valuable information is missed if the history is taken hurriedly. With respect to the state of the urine the cases fall into two groups—namely, (1) The infected, with pus in the urine; and (2) the non-infected. The urine in the latter cases may be absolutely normal. The cystoscope gives valuable information on the following points: (1) Presence or absence of vesical involvement—calculus, tumour, etc.; (2) difference in the two sides of the trigone, suggesting a lesion higher up, either calculous or tuberculous; (3) presence of ureteral calculus at the mouth of the ureter; and (4) in cases of pyuria or hæmaturia of renal origin the side of the disease may be recognised, if unilateral.

Tuberculosis of the Kidney.—Leopold Casper (Berlin),⁹ has discussed the diagnosis and treatment of this condition. He states that tuberculosis of the kidney is not an ascending infection but is due to infection through the blood-stream, and that tuberculosis of the genital tract must be dissociated from it. Usually one kidney only is affected, it being only in the late stages that the second kidney is attacked. The disease is commoner than has been thought and occurs much more often than it is diagnosed. Painful and frequent micturition and pain in the kidney are symptoms of little diagnostic value, for they are met with in almost any disease of the kidney. True attacks of renal colic are often present, and are due to the passage of caseous masses down the ureter. In the early stages the patients often appear to be in perfect health. The most important objective symptom is the altered condition of the urine. In a few cases the earliest sign is an attack of hæmaturia. Pus is almost always present in the urine and blood, albumen, casts and epithelial cells can frequently be found. Tubercle bacilli can be demonstrated in about 80 per cent. of the cases. Tuberculous urine, even with pus present, is often sterile. Similarly sterile pleural effusions are

nearly always tubercular. Convincing, but lengthy, is the diagnosis by the injection into guinea-pigs of the centrifuged sediment of the urine. The animals must first be tested with tuberculin to discover if they are free from tuberculosis. The reaction of a patient to the tuberculin test is not reliable, for in the majority of men small tuberculous nodules may be present in various parts and yield a reaction. Also an injection of tuberculin may light up the disease and render it dangerous to life. Küster and others, however, deny that the presence of tubercle bacilli in the urine proves that the patient has urinary tuberculosis. The bacilli may be in some distant organ and may be merely shed in the urine. This would not apply if the bacilli were present only in the urine of one ureter. Primary tuberculosis of the bladder is rare. The presence of an enlarged kidney on one side may lead to an error in diagnosis, because sometimes the diseased kidney is shrunken and the sound one enlarged from compensatory hypertrophy. The author has found that the prognosis of operable cases is much worse if they are not operated upon than if they are. Therefore all cases should be operated upon as soon as the diagnosis is established. The most important point to decide before operating is the sufficiency of the other kidney. He gives an interesting statistical table which shows that those surgeons who use the modern methods of ascertaining the sufficiency of the opposite kidney get much better results than those who do not use these methods.

⁶ Vide Abst. Med. Chron., April 1905, p. 33. ⁷ Med. Rec., Feb. 18, 1905, p. 243. ⁸ Ibid., Feb. 4, 1905, p. 171. ⁹ Vide Abst. Med. Chron., March 1905, p. 394.

DISEASES OF THE CIRCULATION. APOPLEXY.

The Causes of Apoplexy.—A great deal of work has recently been done on this subject, and the numerous discussions upon the causes of high tension have led to some useful results. Clifford Allbutt has in various papers taught us the necessity of recognising early stages of persistent high pressure, of measuring it by instruments more exact than the finger, of removing known causes, and of preventing a further rise when possible. He has shown, too, what is most important, that high pressures do often occur without granular kidneys, that arterio-sclerosis is not a cause but a result of such pressures, and that early treatment will often check the rise until the age when the tendency ceases.¹ It is true that many forms of "apoplexy" and hemiplegia are due not to cerebral hæmorrhage but to thrombosis and embolism. Unfortunately, little progress has of late been made in diagnosing and combating the conditions which lead to these disorders. We must here, therefore, confine ourselves to the papers on high tension and hæmorrhage. One of the most instructive is that by H. W. Cook of Johns Hopkins.² He lays down that "apoplexies" most frequently occur in vigorous men with nearly normal vessels, but with hypertension, while far older persons whose arteries feel like beaded pipe stems rarely suffer. From the