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TRANSPLANTATION OF URETERS INTO RECTUM BY AN EXTRAPERITONEAL METHOD FOR EXSTROPHY OF BLADDER,

AND A NEW OPERATION FOR PROCIDENTIA RECTI IN THE SAME PATIENT.

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EITHER of the two surgical conditions—ectopia vesicæ and procidentia recti—is serious enough in itself, but the occurrence of both in one subject makes the sufferer's life so unutterably miserable, and renders him so repulsive to his friends, that life without relief is well-nigh intolerable.

B. S. G., aged 2 years 7 months, came under my care at the Victoria Hospital for Sick Children on September 29th, 1896.

History and State on Examination.—His parents were healthy and robust, as were also his four brothers and one sister. At birth the patient was found to present a healthy and well-developed appearance in all respects, except that there was an ectopia vesicæ or exstrophy of the bladder. He did not thrive, however, and was of a markedly constipated habit. This was doubtless the determining cause of a prolapsus ani (to which of course the absence of the pubic bone was contributory) that commenced when he was about 19 months old, and rapidly developed into an enormous procidentia recti. At first the protrusion was easily reduced, and remained in position until the next evacuation, but in a few weeks the act of reduction seemed to excite expulsive efforts so that it recurred immediately with violent tenesmus. At the time of admission the procidentia had been down continuously for nearly a year.

The Procidentia Recti.—As the child lay quiet the protrusion was about 4½ inches long, but during crying or straining at stool its apex reached 8 inches below the anal ring. The mass had the shape of a truncated cone, the larger circumference being adjacent to the sphincter, and the apical portion presenting an elongated depression flattened from side to side, which corresponded to the lumen of the bowel. The mucous membrane covering the cylindrical mass presented a somewhat undulating surface, the folds running transversely. These circumferential folds were, however, very much less distinctly marked than I had observed in similar conditions in adults. The colour of the surface varied greatly, being bright pink in the quiet state, but purplish during straining or when exposed to cold air. There were a few spots of granular ulceration which bled freely and also some patches of sloughing ulceration. For the most part, however, the mucous membrane appeared to be healthy. Some shreds of mucus were usually to be seen upon the surface.

The finger could be passed into a shallow sulcus surrounding the base, as if the outer fold of the protrusion had its origin just within the external sphincter. On passing the finger into the depression at the apex of the mass, the mucous membrane felt healthy. Under anæsthesia reduction was easily effected, and so far as could be made out no herniated intestine