

floor to the urethra by turning the mucous membrane of the rectum into this position. Two crescentic incisions were made, as shown at *A, A*, Fig. 2, being about parallel with the edges of the opening but approaching more closely at its upper and lower angles. These incisions went deep into the wall of the rectum and included the mucous and muscular layers. The two lateral flaps were dissected up the left to within an eighth of an inch of the edge of the opening; the right could not be carried so far on account of the pocket which undermined this side.

The flaps were now turned toward each other and their raw edges made to meet in the middle line, while the raw surfaces looked into the rectum and the mucous surfaces into the urethra (Fig. 3). Sutures of silk-worm gut were inserted, as

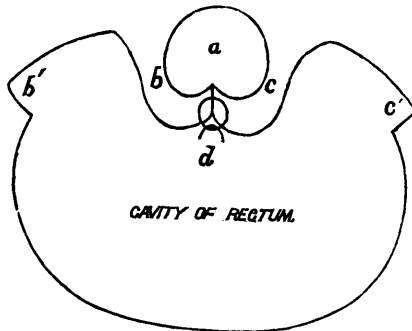


FIG. 3. (Schematic.) Transverse section through the urethra and rectum, showing the method by which the flaps were turned from the mucous membrane of the rectum to make the floor of the urethra. *a* Urethra. *b* The right flap dissected from *b*. *c* The left flap from *c'*. *d* The silk-worm gut suture in position (not entering the cavity of the urethra).

shown in Fig. 3, at *D*. These sutures were about three-sixteenths of an inch apart, and were so inserted that they did not penetrate to the cavity of the urethra. On account of the thinness of the flap at one point I was compelled to pass one suture into the urethra.

A Nelaton's catheter was carried through the meatus and urethra into the bladder, and through this the urine ran out at intervals. Whenever the urine accumulated enough to create a desire to expel it, about six ounces of Thiersch's solution were thrown in to dilute it, and when this with the normal contents of the bladder were evacuated, the same quantity was thrown in again and immediately expelled. In this way the wound was kept practically free from irritation by the

urine. Divulsion of the sphincter ani removed all danger or annoyance from spasm of this organ. The bowels were kept quiet for nine days, and liquid diet was enforced. The patient had been placed on liquid diet for ten days prior to the operation.

The sutures were left *in situ*. The wound healed promptly and the patient left for his home in three weeks after the operation. In April, 1888, seven months later, he returned complaining of slight irritation in the rectum, and said he thought at rare intervals a few drops of water escaped into the bowel. On examination three of the sutures were still in position, but no opening could by most careful search be discovered. The sutures were removed and in a few days the patient was discharged.

IDIOPATHIC GLOSSITIS.*

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It is generally conceded that Idiopathic Glossitis is a disease of very infrequent occurrence. During a practice of twenty years I have met but with one case, and in the current medical literature of that period I have not seen a single case recorded. Writers of medical and surgical works dismiss the subject after brief notice, but all agree that it is a rare though very formidable affliction. I have, therefore, considered that a report of my case might not be uninteresting to this Association.

The patient was a robust, florid looking farmer, thirty-five years of age, of good family history. He had taken cold and at first complained of soreness of the throat and root of the tongue. The first physician in attendance diagnosed quinsy, and treated him accordingly. In three or four days, as he was decidedly worse, he sent for another doctor whom an officious neighbour recommended as the possessor of a specific for quinsy. He came, he saw, he diagnosed, what by that time was very easily done, inflammation of the tongue, and promised speedy relief. On visiting the patient the following day he pronounced him to be dying. Said, alas! he was too late in being called in. That to open the windpipe was now useless, as his lungs had become too much congested to

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