On Saturday morning, 2nd July, the following short papers were read and films shown:—

Paper: "Testicular Tumours and Late Results of Radical Orchidectomy." Mr A. W. Adams (Bristol).

Paper: "Function in the Hydronephrotic Kidney." Mr A. I. L. Maitland (Glasgow).

Film: "Congenital Abnormalities of the Urinary Tract." Mr T. L. Chapman (Glasgow).

Paper: "Some Observations on the Different Types of Bladder Neck Obstructions." Mr H. P. Winsbury-White (London).

Paper: "Investigation of the Male in the Subfertile Marriage." Mr W. Selby Tulloch (Edinburgh).

Paper: "Hypernephroma and Prognosis." Mr I. H. Griffiths and Dr A. C. Thackray (London).

Social Activities.—A Supper Dance was held in the ballroom suite of the Dorchester Hotel on Thursday evening, 30th June. It was attended by 128 members and guests. Dancing continued until 1.30 A.M. During the evening the President, Mr Clifford Morson, made a speech of welcome to the guests. Among the visitors from overseas were Professor De La Pena from Madrid, Mr Schunk from Montevideo, Uruguay, Mr Scher from Cape Town, M. Bertrand from Ghent, M. Croisier from Lausanne, M. Just, also from Lausanne, and Dr Curt Franksson from Stockholm.

On Saturday afternoon, 2nd July, seventy-one members and guests were able to pay a visit to the Houses of Parliament through the courtesy of Dr Stephen Taylor, M.P., Parliamentary Private Secretary to Mr Herbert Morrison. His lucid explanation of parliamentary procedure and conducted tour to the various parts of the building were of outstanding interest. The visit was followed by a tea, served in the Students' Club of St Thomas's Hospital Medical School, which had been kindly lent by the authorities. At the conclusion, the President proposed a very hearty vote of thanks to Dr Taylor for his kindness in setting aside his Saturday afternoon for this purpose.

On Sunday, 3rd July, forty-two members and guests embarked at Westminster Pier at 10.30 A.M., and proceeded upstream to Hampton Court. The weather was such that the river appeared the only place tolerable in the tropical heat. Lunch was served on board, and Hampton Court, where the party disembarked, was reached at 2 P.M. Some time was then spent in viewing the gardens and palace. At Richmond, on the return journey, an interesting diversion was provided by a magnificent view of an air battle over London, part of the Anglo-American exercises. Westminster was reached at 8.15 P.M. after a most interesting and pleasurable excursion.

At a meeting of the Council held at 45 Lincoln's Inn Fields, London, W.C.2, on Wednesday, 29th June 1949, the following were elected Associate Members of the Association: Dr R. B. Watson, Capetown; Mr J. F. R. Withycombe, Cambridge; and Mr Murray T. Pheils, London.

OPERATING SESSIONS AND DEMONSTRATIONS

The Middlesex Hospital. Mr E. W. RICHES.

1. *Retropubic Prostatectomy.*—After a preliminary cystoscopy a transverse incision was made just above the symphysis pubis, the skin flaps were reflected to give a good view of the rectus sheath, which was opened through a vertical incision in the median raphe thus exposing the retropubic space. The veins in front of the prostatic capsule were ligatured, using a boomerang needle, and three stay sutures were then placed in the prostatic capsule to act as retractors. A vertical incision was then made through the prostatic capsule in the mid-line from the bladder down to the urethra, using the diathermy knife. The prostate was thus exposed, and beginning at the apex it was removed by digital enucleation and scissor dissection. Diathermy was used to seal bleeding points and to excise a wedge of the trigone. A whistle-tipped catheter (No. 20 French) was passed and kept in position by means of a silk-worm gut suture through the tip of the catheter, and traversed the bladder to emerge through the anterior abdominal wall well above the incision, where it was fixed with a button. The prostatic capsule was sutured with chromic catgut, using a continuous suture and one or two interrupted ones. Penicillin powder was blown into the prevesical space, and the bladder was washed out with sodium citrate solution through the catheter by means of a 2 oz. urethral pipette. A corrugated rubber drain was placed in the space of Retzius and the wound closed with interrupted sutures. Bilateral vasectomy was carried out and the penis wrapped in a flavine dressing.

2. *Retropubic Sling Operation.*—The second case was that of a woman suffering from stress incontinence for which the sling operation was performed through a long crescentic transverse incision: Two strips of fascia were separated from the abdominal wall and used as a sling to support

the urethra at the neck of the bladder according to Millin's method. They were secured to each other in the usual way with unabsorbable suture material.

3. *Cystoscopy.*—The third case was a woman of middle age with stones in her bladder and cystitis. She was cystoscoped to find out if there was any underlying cause for this unusual condition, and cystoscopy showed an underlying carcinoma. A portion of tissue was taken for biopsy, using Lowsley's punch forceps.

King's College Hospital.

1. Mr HARLAND REES. *An Operation for Stress Incontinence in a Woman of* 31.—The principle of this operation, first introduced by Mr Everard Williams, is a simple hitching of the neck of the bladder to Cooper's ligament on each side. The operation appeared to be neat and was much simpler to do than a sling operation.

2. Mr YATES BELL. *Retropubic Prostatectomy.*—A very large prostate was removed. The special points in technique were the use of the Wilson-Hey diathermy forceps, a general V-excision of the bladder neck, careful hæmostasis, the introduction of a partially distended Foley catheter, and the use of prevesical drainage for five days.

3. *Demonstration of Cases.* (*a*) Mr HARLAND REES.—A man, aged 20 years, was presented with a soft swelling in the left loin, probably a chronic perinephric abscess associated with tuberculosis in the left epididymis.

(*b*) Mr YATES BELL.—A series of cases of urinary tuberculosis was demonstrated to show the beneficial effects of streptomycin, particularly in the post-operative treatment.

The last patient was a child of 2 years suffering from chronic retention with bilateral ureterocele and bladder neck obstruction. Mr Yates Bell demonstrated a thick bladder wall. Diathermy of each ureteric orifice was done, followed by a wedge resection of the tight internal meatus to increase its calibre.

Post-graduate Medical School.

Mr H. K. VERNON. *Transplantation of the Ureters.*—A bilateral transperitoneal ureterocolic anastomosis was carried out on a male patient aged 43 years. This man was suffering from an intrinsic carcinoma of the bladder. There was no evidence of metastases. The technique followed was that of Grey Turner. Particular attention was paid to planning the anastomosis so that the colon was secured to the parietal peritoneum, the site of the anastomosis was extraperitoneal, and kinking or torsion of the ureter was avoided.

Mr R. D. WILKINS. *Demonstration of Cases.*—1. A series of seven renal tumours was shown, five being papillomas of the renal pelvis and two being hypernephromatous. All the papilliferous tumours were treated by total nephro-ureterectomy, and the two hypernephromatous tumours were treated by nephrectomy.

2. A case of chronic retention of urine was demonstrated as an ambulatory patient treated by an indwelling Foley catheter.

3. A series of polarographic readings was shown, demonstrating the value of this test in the diagnosis of carcinoma of the prostate.

Visit to the Surgical Research Laboratories.—An exhibition had been set out to show some of the current investigations going on in the laboratories. Mr R. SHACKMAN introduced the laboratory staff and then summarised the main studies in the department.

The techniques of cardiac catheterisation, renal vein catheterisation, and hepatic vein catheterisation were explained, and the results of completed investigations were demonstrated and discussed. Oxygen consumption studies of patients before, during, and after operation were also demonstrated. The rise of blood pressure during some operations under pentothal, curare, and cyclopropane anæsthesia was being investigated, and studies were in progress to follow changes in cardiac output during and after operation. Stress was put on the value of the cardiac catheter for recording right auricular pressure and for rapid replacement of blood when necessary.

Dr D. MELROSE showed an apparatus for perfusing isolated human and animal organs. A Dale-Schuster pump was used to deliver blood. Between the inflow and outflow tubes a shunt mechanism was inserted, which allowed excess blood not required by the organ to be returned directly to the circuit. Flow was measured by a flowmeter based on a modification of the rotameter and recorded on a kymograph. Diastolic pressure was maintained by a simple elastic cuff adjusted by air pressure. An oxygenator was not included in the circuit. During the demonstration 10 ml. of urine were produced by a pig's kidney attached to the perfusion apparatus.

Dr G. GRABER explained some laboratory aids now used to help to assess renal function in patients. He showed charts of measurements of effective renal blood flow, glomerular filtration, and tubular function.

Mr K. WILKINSON showed charts illustrating the results of fluid balance studies in a series of post-operative patients.

Mr J. Dempster summarised the experimental work of autotransplantation of kidneys in dogs, and showed X-ray films demonstrating results, using Blakemore-Lord vitallium tubes. He pointed out that the operation was technically easy if the external jugular vein and the carotid artery were used, but it had proved difficult to maintain a kidney in function for any length of time. Renal infarction and thrombosis of the renal vein—in spite of heparin—had been the main causes of failure.

Mr O. Daniel showed an injected specimen illustrating the blood supply of the human adult ureter, and discussed the importance of an adequate local circulation in safeguarding uretero-colic transplantation. His plan of study of this problem was available.

All Saints' Hospital. Mr TERENCE J. MILLIN and Mr MCALLISTER.

1. *Retropubic Prostatectomy;* 2. *Bilateral End-to-side Uretero-intestinal Anastomosis;* 3. *Total Cystectomy;* 4. *Case Demonstration.*—The operative surgery could be described only as brilliant. The stages of Mr Millin's retropubic prostatectomy and total cystectomy are sufficiently well known to members from recent publications. As was to be expected with Mr Millin as host, there was a viable, free and easy discussion during an enjoyable tea interval, and innumerable questions were asked.

St Peter's Hospital.

1. Mr MASINA gave a demonstration of specimens removed at operation for carcinoma of the bladder, and discussed the different varieties.

2. Mr E. I. WILLIAMS demonstrated radiographs illustrating the following conditions: (*a*) Nephrocalcinosis; (*b*) tumours of the kidney; (*c*) ureteral calculus and tuberculosis in the same kidney; (*d*) ureteric stricture resulting from tuberculosis.

3. Mr R. OGIER WARD. *Vesico-capsular Prostatectomy.*—A transverse abdominal incision was used. The bladder was opened for 1½ in. in the middle line immediately above the vesical neck. Two stay sutures were inserted with boomerang needle. The points of curved Mayo scissors were now passed into the plane between the anterior surface of the prostate and the layers of pelvic fasciæ which contain the venous plexus of the vesical neck and the veins in front of the prostate. This plane was cleared by separating the points of the scissors, and no veins were opened. A Bernard Ward bladder retractor was introduced, together with its smaller middle blade, then after the plane had been still further opened up one blade of a pair of straight Mayo scissors was put into the urethra and the other in front of the prostate, and thus the anterior commissure of the prostate was divided. The extent of such division varies according to the size of the gland; in this case it was 1½ in. The prostate was then enucleated. Vessels on the vesical neck and bleeding points on the trigonal margin were coagulated. As an overhang was present a wedge was cut out of the trigone. A 22 Charrière catheter was passed. The retractor was now rearranged, the short lateral blades replaced the long ones and were used to separate the abdominal wall, whilst the middle blade only was in the bladder and served to pull it upwards and to bring together the edges of the incision. Using the large boomerang needle, two obliterative sutures of No. 1 chromic catgut were inserted; each was passed from the right outer aspect of the prostatic capsule through this into the cavity anterior to the catheter, then out through the left side, and was tied anteriorly. The degree of the closure of the cavity was estimated by introducing a finger into the cavity. Then the bladder was closed with a continuous suture of No. 1 chromic catgut, beginning at the lowest point of the incision into the prostate, thence extending up to the top of the bladder incision and back to the same point on the prostate. The abdominal wall was closed with a small drainage tube in the prevesical space. Mr Ogier Ward said he used the retropubic operation for large prostates and periurethral resection for small ones. The vesico-capsular method was used for prostates of medium size and also whenever cystoscopy was unsatisfactory, or if for any other reason it was desired to inspect the bladder interior.