evacuation on the following day (February 20th). On February 21st the pain became more severe, and she began to vomit, which she described as "bilious, watery, and yellow." Menstruation began on this day. The symptoms continued till the morning of February 22nd, when she saw a doctor, who gave her some medicine, which relieved the pain and the vomiting, but both returned on February 23rd, the day of her admission to the infirmary. She had pain in the left hypochondriac and lumbar regions posteriorly; it did not shoot down the thighs. The pain which she had originally described as situated in the hypogastric region was now described as being in the umbilicus, and tumid. On percussion it was tympanitic all over, even in the hypogastric region; tenderness was not marked. Examination of the usual sites for hermetism and per rectum gave a negative result. The urine was drawn off by a catheter; specific gravity 1020, appearance normal, no albuminuria. The urine was of a yellow color. No smell, no gas. The examination did not reveal a trace of albumen, but no blood. A simple emesis, followed by one of glycerine, produced no result. An hour after admission she vomited; it was then found that the vomit was fecal.

Mr. Steer, Medical Superintendent, then saw the case with me, and he agreed that laparotomy was the only course open. He therefore opened the peritoneal cavity by a median incision below the umbilicus. A faecal odour was at once noticeable. Inspection in the wound, which was distended; this did not obtain in the large intestine. There was a small amount of fluid in the peritoneal cavity, having a distinct faecal odour. The hernial sites were examined without result. The small intestine was traced into the right side of the pelvis, where it was adherent to the peritoneum of the right parietal. A loop of bowels 5 inches in length was released from the band, and was found covered by lymph, ecchymosed but not perforated. It was returned, and the abdominal cavity well washed. A glass drainage tube was left in the lower incision. Eight hours subsequent to the operation she became suddenly collapsed, after having appeared much better. She did not respond to stimulants, and died a few minutes after I was called. She had been having nutrient enemata containing 5j of brandy every three hours.

At the post-mortem examination no less than three parts of the small intestine were found in the same condition—namely, covered with lymph, intensely injected, black, but not perforated. Each place stood the pressure of the water-tap, each part was from 4 to 7 inches long, and each had at least a foot of circumference. Examination of the pelvis showed the broad ligaments to be tightly stretched across the pelvis, inclining slightly backwards, and adherent to the pelvic wall on either side. The appendix was adherent to the right broad ligament, but, beyond the adhesive peritonitis, was normal. The uterus was from two to three times its normal size, and the "band" previously mentioned was undoubtedly the upper border of the right broad ligament, which with the brim of the pelvis behind formed the opening of a pocket from which the loops of striated bowel were withdrawn. In the pocket so formed there was a small amount of faecal-smelling fluid. The pelvic organs were removed en masse. There was a slight laceration in the peritoneum at the junction of the uterus and Fallopian tube, possibly made by releasing the bowel. The cervix uteri was exposed by sifting up the bag. It was bound inflamed, with new growth, very soft, and breaking down under the gloved finger. The uterus contained a few blood clots and strands of membrane; the wall was much hypertrophied, and contained a small interstitial fibroid. The new growth infiltrated seemed limited to the cervix.

Remarks.—The explanation of the condition seems to be that the new growth set up a local peritonitis in the broad ligaments, which in consequence became adherent to the pelvic wall. The bowel became incarcerated in the pocket so formed, and the acute condition was brought about by the increase in size of the uterus at the menstrual period.

Dr. F. Warner read this paper, the purpose of which was to show, as the result of extended observation among children, that: (1) Points of abnormal development in the body were very common and had important signification. (2) Abnormal nerve signs or posture of the body and its tissues; (3) Mental dullness and backwardness. (3) Some explanations of the relations among the classes of defect might be offered. After referring to his paper on Postures of the Hand as Indicative of the Condition of the Brain, read before the Society in 1882, the author said that investigation was continued, and in connection with the work of a committee he was enabled to examine, between 1888-94, 100,000 children individually, in conjunction with other cases, the results of which are published in the recent report; notes of 13,127 cases in some respect below normal were taken, and formed a basis of facts presented in the tables appended. After briefly describing the method of statistical examination of facts, the author passed on to describe four main facts observed. (1) There was in small proportion of children in the form, proportion of parts of the body, principally in cranium, palate, ears, and features, as well as more gross deformities; such signs were disproportions in ratios of growth. (2) Abnormal nerve signs in balance and action or reaction in movement and co-ordination as seen in the face and eye, the upper extremities, the hands, digits, and balance of the body. (c) Low nutrition; cases pale, thin, or delicate. (d) Cases dull or backward mentally, as reported by the teachers. The developmental signs were disproportions in growth; the abnormal nerve signs were abnormal signs of the brain, or in the ratios of action among the nerve centres. Movements were classified as: (1) Uniformly repeated series of movements; the same parts moving in similar combinations and series of acts on successive occasions. Athetosis, and adhesions of the frontal and cerebellar muscles, with grinning, were types of this class. (2) Augmenting series of movements; the area of movement spreading from part to part. The expression of mental excitement and emotion, awaking from deep sleep to activity, the extra movements of restlessness, the march of the spasm in epilepsy and convulsions may afford illustrations. (3) Diminishing series of movements, as seen when excitement subsides, or sleepiness comes on; as the convulsion subsides or chorea passes away. (4) Co-ordinated movements, such as were adapted in their relations in time and in quantity of action by the environment, and therefore in harmony with it. It was shown that in each class the character of the movement dependent upon the attributes time and quantity of the nerve centres. The observed correlation of development defect with abnormal nerve signs was that when proportional growth in body was abnormal, as a sequence of inheritance or otherwise, the nerve centres were commonly so built up that in subsequent action they did not work in the normal relations of time and quantity under the influence of the environment. It was shown that disproportion in growth and development of the body was
commonly accompanied by a status of the tissues prone to atrophy under adverse circumstances. This was specially the case with girls, who might therefore fall into permanent ill-health with neuroses. Inco-ordinated nerve action, such as fidgeting and habit of rubbing hands, was associated with a lowered status of nutrition, and suggested the hypothesis of a reversion of spontaneity in action, which was characteristic of the normal infant brain (microkinesis). The author proceeded to adduce evidence upon the following propositions. Disproportionate bodily development was very common; it was correlated with low nutrition of body and inco-ordinated brain action. Facts in evidence were given in tables. The correlation with low nutrition was highest with girls of all ages, and was especially marked among the children of 7 years and under; it was much lower at 1 years and over. The correlation with nerve signs increased with age for girls, less so with boys. Finally, the proportion of the developmental cases that had not acquired either low nutrition or nerve signs was highest for boys in the oldest group, while for girls it remained about the same in each age group. It seemed that the environment was apt to produce more harm and less good in girls than in boys of imperfect development. (2) Inco-ordinated brain action was much associated with malnutrition, and the nerve signs of defective development were strongly correlated with the causes of mental dullness than were the signs of defective development. The tables showed the correlation of nerve signs with maldevelopment as highest for children aged 7 and under, and lowest in the oldest group; while the correlation of nerve signs that had survived without low nutrition was highest with the oldest group. The environment appeared to favour the occurrence of simple cases of nerve inco-ordination and weakness, which in many instances might be removed by training; such signs were much associated with mental defect. There were no other constant variations in the body. With regard to the correlation of abnormal nerve signs with physical defects, he doubted whether abnormal gestures were necessarily a proof of mental defect, and partly ascribed it to Samuel Johnson as a case in point. He did not attach much value to the opinion of dull teachers as to the mental ability of their pupils; in Sir D. Brewster's Life of Newton it was stated that some of his teachers were half inclined to regard him as an idiot. He doubted whether the mere fact of the ears standing out pointed to any mental deficiency. He inquired what evidence the author's statement that bodily variation was more frequent in the male than in the female was based on; his experience in the post-mortem room did not support this, and he referred to variations in the arrangement of chordae tendineae and muscular papillares of the mitral and tricuspid valves. With reference to the stress laid upon uniformly repeated series of events, he thought that adult habit with not a sign of mental defect, and that sufficient attention had not been paid to the occurrence of habit. Variations in function had been described at length, while there was not, he thought, sufficient anatomical evidence brought forward. The after-history of childhood defects in adults was not established. He thought that the treatment, in any event, could only have a very limited field of application, and required close supervision. Dr. Luff insisted on the fact that there was no difference between strain and reaction of tissue metabolism, and he reiterated his arguments against the view that uric acid was introduced ready made in meat. He contrasted various statements made by Dr. Haig, and pointed out that
the reaction which he had used admittedly did not prove the existence of uric acid in meat, and could not show the presence of xanthin. He urged, therefore, that Dr. Haig had not only not proved the presence of uric acid, but that he could not possibly have detected the presence of xanthin by that means. He agreed that the author's treatment would be dangerous in patients with renal disease.

Mr. Freyer repeated his demand for an explanation of the reason why the case of a patient who lived on an exclusively vegetable diet, frequently suffered from stone, gout, and rheumatism, and concluded by advocating the disregard of all dietetic restrictions.

Dr. Maugain thought it was merely a question of vitality. When a man had a very healthy constitution he reverted to the condition of the lower animals, who excrete uric acid. He insisted on the fact that the treatment was not one that could be persisted in, a return to the ordinary diet being imperative.

Mr. Armstrong, in reply, challenged Dr. Haig's view that the red meat acted merely as a stimulant, clearing the blood of uric acid which was deposited in the joints. In his own cases the joint troubles had improved under the diet, and some of the patients had been under observation for as long as seven years, but the case of one patient who adopted Dr. Haig's dietary for six months; yet any worry or ill health was immediately followed by the copious excretion of uric acid, and he asked where it came from. He pointed out, in conclusion, that the diagnosis of the case was long enough, the patients then returning to ordinary diet. He added that not more than 3 per cent. of the cases were suitable for the treatment.

FOURTEEN CASES OF KRASKE’S OPERATION FOR HIGH LIVING CANCER OF THE RECTUM.

Mr. Swinford Edwards read a paper which is published on page 1210.

Dr. H. Snow raised the question whether it was possible to remove these growths without interfering with any structures, a proceeding which added materially to the danger of the operation. He related a case of cancer of the rectum, high up, in which he had succeeded in effecting complete removal by making a longitudinal incision through the growth; then, passing his left forefinger inside, he had cut away the growth from above.

Mr. Bidwell thought the high mortality of foreign statistics was due to the practice of performing resection. He suggested that in view of the possibility of obtaining a complete cure, patients would be willing to submit to the operation, even if the mortality were higher than it was.

Mr. Swinford Edwards, in reply, criticised Dr. Snow's plan of cutting through the growth itself.

ELECTION OF OFFICERS AND COUNCIL.


OBSTETRICAL SOCIETY OF LONDON.

C. J. Cullingworth, M.D., President, in the Chair.

Wednesday, May 5th, 1897.

SPECIMENS.

Mr. Bland Sutton: A lantern demonstration on Mycoma of the Cervix Uteri.—Mr. Targett: A lantern demonstration on Accessory Adrenal Bodies in the Broad Ligaments.

CHRONIC AXIAL ROTATION OF OVARIAN CYST.

Dr. Thomas Wilson read a paper entitled Chronic Axial Rotation of an Ovarian Cyst giving rise to Extreme Twisting of the Omentum. The uterus was a multipara, aged 55, whose abdomen had been increasing in size for four years; for two years there had been frequent attacks of pain and vomiting, many of which were caused by lifting a heavy invalid husband. A tumour was removed after tapping, by Mr. W. Turner, who advised the pedicle to be excised and the ovary resected. The pedicle was a short one, and the ovary was a strawberry-sized growth, and the pedicle was 2 inches long. The tumour was a strangulated, multilocular glandular cyst of the left ovary, weighing about 5 lbs. To the lower part of the cyst was attached the fundus uterus and the right ovary, tube, and broad ligament, all strangulated. The latter was carried up to the left side of the uterus, and the latter organ had been twisted almost through in a direction from right to left. Both tubes were occluded and adherent, the right forming a distinct hydrocele, the left was 6 inches long. The patient made an excellent recovery, and has remained well.

Dr. Peter Horrocks pointed out that in most cases of axial rotation there had been effort or exertion whilst in a bent position. He quoted a case where it occurred suddenly whilst the lady was sitting on a chair, which was rather a tight one. He thought that great force must be exerted upon a tumour in the direction of axial rotation when effort was made in a bent position of the body.

Mr. Doban was surprised to hear that in Dr. Wilson's case the entire uterus was involved in the rotation, the cyst was of a multilocular, glandular type. In twisting of the pedicle alone the tumour was dermoid in a considerable proportion of cases. Much remained to be learnt about axial rotation. Mr. Doran had operated on ovary with all the clamps on it, and twisted the pedicle, yet nothing was found except soft parietal and perhaps omental adhesions. He had found the pedicle short and slightly twisted in cases where the patient had nothing to complain of except the presence of an abdominal tumour. On the other hand, he had found a long pedicle moderately twisted in cases where there were typical symptoms, including severe pain.

Dr. Wilson replied.

OPERATIVE TREATMENT OF ABDOMINAL PREGNANCY.

Mr. John W. Taylor read a paper entitled Second Case illustrating the Treatment of (so-called) Abdominal or Ventral Pregnancy at full Term by the Operative Removal of Child and Placenta; Operation at Fifth Month; Recovery. He gave a detailed account of the previous history of the case, and of the condition of the abdomen and pelvis at the time of examination. The patient believed she became pregnant twelve months before operation. She felt earlier pains from the former pregnancies, but the movements of the child were unusually distinct and painful. Except for an attack of haematemesis, she was up and about during the whole time. At no period was there any acute pain, sudden illness, or fainting. A description was given of the operation of abdominal section for the removal of the child and placenta. The placenta was of ordinary size, and covered the pelvic inlet, "like the lid of a saucepan incompletely closed." The edge of the placenta being exposed and free on the left side of the pelvis, but closely applied to the abdominal wall on the right side, where the cord was situated; its attachments were first a thick band or rope of omentum firmly attached to the upper or serous edge of a placenta on the left side; secondly, several thin attachments or adhesions of small intestine to the same surface; thirdly, the deep pelvic attachments of the under surface of the placenta. The author described his bloodless method of removing the placenta. The paper concluded with a short commentary on the origin, growth, and history of the case.

Her remarks by Dr. L. M. Dr. Haywood Smith asked whether the medical man who first saw the case when labour pains came on had made any examination, as the condition might have been recognised and the child's life saved by an earlier operation.

Mr. Alban Doran thought this case seemed an argument in favour of postponing operation when ectopic gestation was advanced till some time after term. The removal or the leaving behind of a nine months' placenta was a more serious
mater than the removal of the degenerate structure which represented it several months later. Operation seemed more urgent at term, but when it was first distinguished by Freud, where continuous intestinal catarrh denoted the intimate attachment of placenta to intestine. This histological union involved immediate danger from sepsis as well as from hemorrhage.

Remarks were also made by Mr. B. Bland Sutton, Dr. A. M. Rout, Dr. Wilson, and the President.

Mr. Taylor said in reply that the attachments of the placentas were very vascular, and that the vessels could be felt pulsating before the forceps were applied. The main point, however, was that as each vascular connection was controlled before separation, the same operation might have been performed at any previous period of the pregnancy; and if the patient had come to the hospital at the time of the supposed labour it might have been quite possible to save the life of the child as well as that of the mother. The collection of caseous masses found below the placenta was at the extreme lower pole of the pregnancy sac. This reached to the bottom of the pelvis on the right side, and the reflection of the sac could be traced periphery to the peritoneum. Mr. Ch. de L. Emmett showed a case of Retinitis Punctata Albescens. A man, aged 48, had had night blindness all his life; his parents were first cousins; one sister had a similar condition, V = 5/6, colour vision was normal; the O.D. was pale and waxy; the central retina showed the typical retinal changes, with pigmented changes at the border. The patient said that the point about these cases was that they did not get worse, as the pigmented ones did.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

E. Nettleship, F.R.S., President, in the Chair.

Clinical Evening.

Thursday, May 6th, 1897.

Specimens and Cases.

Mr. Priestley Smith showed specimens illustrating a new method of Mounting in Formol.—Mr. Ernest Clarke showed three specimens of Detachment of Retina in different stages: in the first there was a small tear, the vitreous body thickened, and there was a hemorrhage under the retina; in the second, there had been an inflammation, and in one there had been a formation of cysts in the detached retina.—Mr. Hartidge showed Unequal Refraction produced by a Corneal Opacity; refraction through the centre of the cornea H. 6 D.; through peripheral anisometropia.—Mr. C. D. Chambers showed a case of Sarcoma of the Iris. There was a solid unpigmented growth occupying the position of the lens growing from the posterior surface of the iris; it was a small round and spindle-celled sarcoma.—Dr. Barron showed examples of Symmetrical Hardness of the Yellow Spot in both eyes of a mother and a daughter, and in one of her nephews there had been a similar case with the symptoms of a dissecting aneurysm of the aorta in each eye. The appearances were symmetrical in the two eyes of each brother, and showed disturbance of pigment at the yellow spot; the failure of sight had been gradual. There was evidence of hereditary syphilis. Mr. Jessou had had a similar case, in which the failure came on at the age of 21; it began with oedema at the macula, followed by pigmented change.—Mr. Lawford had a similar case, under care at the present time, in which the sight had suddenly failed from 10 to 5.—Mr. F. Eve and Mr. F. J. Smith showed a case of Obstruction of the Cavernous Sinus. After rheumatic fever, three years before, proptosis and double papillitis had come on with headache and vomiting. There was also tenderness of the scalp, and pulsation of the temporal vessels. The pupils were slightly constricted, and the visual fields contracted. The case was either sarcoma or carcinoma of the pituitary gland or tubercle in the same region, or thrombosis in the cavernous sinus. There was no evidence of syphilis.—Mr. Dyne showed: (1) Result of Cavernous Aneurysm of Comical Corners. The aneurysm had been used deeply three times, but the resulting nebulæ was very faint. (2) Congenital Absence of Puncta Lacrymalia.—Mr. Lang showed a case of Enophthalmos with Proptosis on Stooping or Compressing the Jugular Vein. There was now a post-necrotic atrophy. The proptosis was easily produced without pain by the patient herself on compressing the jugular vein; sometimes the proptosis came on by itself, the eye was then very painful. Mr. Priestley Smith had seen the same condition dating from childhood in an elderly man. Mr. Treacher Collins had shown a similar case at the Society in a young man in whom the eye came forward, the lid dropped, and the sight went on stooping. Dr. Habershon did not think that the periodic swelling was due to a cavernous angioma, obstruction to a vessel might cause tenderness and proptosis.—Mr. C. H. Walker showed a case of Retrobulbar Neuritis in a middle-aged man in whom the sight had been found defective two months ago; there had been no change since. Vision was fingers at 30 inches; there was a central scotoma, but no peripheral contraction of the field. The swelling was distinctly raised above the discus and in the fundus; it might be a new growth, or inflammatory or cystic. Mr. Adams Frost thought the case was a form of central serous choroiditis. Mr. Holmes Spicer suggested that the doubt as to the cystic nature of the swelling might be set aside by a puncture of the growth under ophthalmoscopic observation. The President thought it was a form of central serous choroiditis. It would be interesting to know the further development of the case if this were so, as the ultimate result in such cases was not known.—Mr. John Griffith showed a case of Retinitis Punctata Alzescens. A man, aged 48, had had night blindness all his life; his parents were first cousins; one sister had a similar condition, V = 5/6, colour vision was normal; the O.D. was pale and waxy; the central retina showed the typical retinal changes, with pigmented changes at the border. The patient said that the point about these cases was that they did not get worse, as the pigmented ones did.

LEEDS AND WEST-RIDING MEDICO-CHIRURGICAL SOCIETY.

James Braithwaite, M.D., President, in the Chair.

Friday, April 9th.

Adherent Pericardium Diagnosed during Life.

Dr. Churton showed a specimen from a case of adherent pericardium diagnosed during life by the presence of Sir W. Broadbent's sign. The heart weighed 14 ozs., from a child aged 16 weeks. Old adhesions existed between the lower part of the left ventricle and the diaphragm; death had followed recent pericarditis over the right ventricle, etc. The eleventh rib on the left side had been very clearly felt to be drawn in and out a few days before the heart was opened. How long this sign had existed could not be ascertained.

Multiple Aneurysm of Pulmonary Artery.

Dr. Churton showed the lungs from a boy aged 12 years, in whom there had been a loud roaring in the chest, and very highly accentuated second sound were present during life, with hemoptysis, epistaxis, and dyspnoea. Four of the secondary branches in one lung, and three in the other, led into aneurysma as large as walnuts, filled with blood clot. The boy had been ill for 4 years. He had never been strong: had bronchitis at the age of 4 years, and again at 6; pleuritic effusion in July, 1895, and was subsequently said to have Bright's disease. In April or May, 1896, he had three attacks of hemoptysis; ascites appeared; and he became swollen after this. He died in July. There were several wart-like growths, firm and smooth, on the tricuspid valve and the endocardium near it.

Myxoma of Vermiform Appendix Simulating Recurrent Appendicitis.

Dr. Churton showed an appendix from a girl, aged 23, admitted with a history of two attacks of (supposed) appendicitis, and complaining of inability to work, with account of constipation and other symptoms. For a fortnight in bed caused no improvement. She was transferred to Mr. Mayo Robson for operation. After removal the appendix was found to be thickened at the end, and upon being opened showed a pellucid shining tumour, sessile, of the size of a small bean, obstructing the lumen 1/2 inch from the distal end, which was
slightly distended by clear mucus and thickened. In water the growth swelled up to nearly three times its original size. There were no peritoneal adhesions or other signs of peripendicitis. No record of a similar specimen had been found.

PERFORATION OF NASAL SEPTUM.

Mr. R. H. Hall showed an unmarried woman, aged 50, with a perforation of the nasal septum the site of a two-shilling piece. The perforation was first noticed four years ago when the size of a sixpence, and had steadily increased to the present size. The mucous membrane lining the alae of the nose had also become involved, having a rough-pitted appearance; there was no history of syphilis. Epistaxis invariably occurred once or twice a week, and seriously impaired her health. The perforation was a clean-cut round circular hole without discharge or fever. No sloughs were formed, and the tissue appeared to slowly melt away. Her general health was poor, but no disease beyond the nasal one had been discovered. She had been treated generally—with iodide of potassium, mercury, iron, strychnine, and tonics, and locally with the electric cautery, nitric acid, carbolic acid, yellow oxide of mercury, hazeline, boracic acid without any benefit. Mr. Hall had previously formed the opinion that the case belonged to the class of cases "simple perforating ulcer" (non-scuticulitic) reported completely cured by Hutchinson, Hajek, Jessop, and others, but as there was no improvement with local treatment as there had invariably been in the reported cases, he was losing faith in his diagnosis. He did not think the ulcer was syphilitic or tuberculous, but thought it might possibly be a rodent ulcer.

OPERATION FOR VARICOCELE WITH UNUSUAL COMPLICATIONS.

Mr. W. H. Brown read this paper. A man, aged 42, consulted him two weeks before he had steadily increased pain in the left testicle. He had a large varicocele and a shrunken testicle, and was much distressed mentally about his condition. A suspensory bandage was ordered, but in a short time, as the patient worried himself very much about his varicocele, Mr. Brown excised the enlarged veins. The patient passed a restless night, was slightly delirious, and got out of bed and walked about. Next morning there was a large scrotal haemorrhage, temperature 103°; and he was quite insane. In a few days pneumonia attacked the right lung, and a rough-pitted rash covered the body. The scrotum and a large part of the testicle sloughed. Later the mental condition cleared up, and eventually the patient became quite rational, but some plastic operation would be required to close the exposed testicle. Mr. Brown suggested for discussion the connection between the dread of the varicocele and insanity, the absence of pain during destruction of the testis, the indifference with which the patient viewed the destruction of the testicle contrasted with his former anxiety; a patient repeatedly sick and severely ill by two previous confinements. The varicocele showed at its periphery a complete broad belt of fibroid and fatty tissue which appeared to be due to previous hemorrhages. The following were also shown:—Dr. A. BROXNER: Case of Cerebral Abscess opened and drained through the tegmen tympani. —Dr. TENNYSON: (1) An Injected and Dried Brain, showing the distribution of the middle cerebral artery; (2) Cultivation of a case from Secondary Cerebro-spinal Meningitis. Mr. LITTLEWOOD: (3) Case of Multiple Osteomata; (4) Sublingual Dermalgia; (5) Intussusception. —Dr. MAY: (4) Parts from a case of Intestinal Obstruction due to a gall stone. —The Resident: (1) Cancer of Ovary; (2) Two Ovaries removed for disease. —Mr. R. TROTT: (1) Carious Ossicles removed from the middle ear on account of chronic suppuration; (2) Case of Detached Retina. —Mr. WARD: Specimens of Miliary Tuberculosis of Hip and Knee-joints.

Dr. Johnstone reported a case of Ectopic Gestation.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

WILLIAM CRAIG, M.D., Vice-President, in the Chair.

Wednesday, May 5th, 1897.

CASES.

Mr. ALEXIS THOMSON showed (1) a patient after Resection of the Intestine, for Stricture, caused by Strangulation of a Hernia; (2) a patient with Lumbar Hernia.
Specimens.
Mr. C. W. CATHCART described and illustrated a method of examining Caustic and Silk in Balls to obviate the useless operation. Dr. C. W. CATHCART showed a specimen of Duodenal Ulcer. Dr. W. G. SYM showed a Melanotic Sarcoma of the Eye which had penetrated the globe and was growing in the orbit. Dr. SHERMAN showed the Bacillus of Plague and a Culture.

Renal Tumour.
Mr. F. M. CAILD read a brief note on this subject. He reported the case of a patient, aged 56, who suffered from a large malignant tumour of the left kidney. The symptoms were mainly those of pressure on the urinary and intestinal tracts. The patient was markedly anemic. Access was obtained by a lumbar incision prolonged forwards. Enucleation of the mass presented much difficulty, and it was found necessary to incise and evacuate the growth with one hand, while with the other an attempt was made to congregate it. In this manner the tumour, which weighed over 23 lbs., was successfully removed.

The paper was discussed by Dr. LOVELL GULLAND and by Messrs. SHAW MCLAREN, and C. W. CATHCART; and Mr. CAILD replied.

Congenital Gastric Spasm.
Dr. JOHN THOMSON read a paper on this subject. By the term "congenital gastric spasm" he proposed to designate the disease usually occurring in the newborn or infancy and terminating in a spasm of the pylorus. After giving details of another case he passed in review the clinical features and morbid anatomy as recorded in 15 published cases. The main clinical facts were as follows: The children affected were born at full term, and in a state of apparently perfect health and development; and they remained so until seemingly causeless vomiting set in. This might begin within a few days of birth, or only after several weeks. The vomiting rapidly increased in urgency, although there were usually no other signs of dyspepsia. It was brought on by the amount of food given, and the ordinary means of allaying it were without effect. When the fluids swallowed were not vomited they remained for an abnormally long time in the stomach. The hypertrophied pylorus could sometimes be felt through the epigastrium. The children lived from three weeks to six months, and died of exhaustion following the vomiting. At the necropsy the stomach was found hypertrophied and dilated, and the pylorus enormously thickened, its enlargement being mainly due to hypertrophy of the muscular tissue. There was no fibrous structure, and the mucous and serous coats were normal. The other organs of the body were practically quite healthy. With regard to the pathology of the condition, it was asserted that in the cases in which were found post mortem were secondary to the muscular hypertrophy, the muscular hypertrophy itself was obviously not a primary condition, but merely the result of increased action. The malady consequently was not to be regarded as a muscular, but as a nervous, one—a functional disorder of the nerves of the stomach and pylorus leading to ill-co-ordinated and therefore antagonistic action of the muscular arrangements of these parts in utero. It would, therefore, be better to speak of this condition as congenital idiopathic vomiting or congenital gastric spasm, rather than to give it a name merely denoting the anatomical results of the original malady. While the cause of the muscular spasm could not be ascertained for certain, it was probably to be attributed to an interference with the process of development.

The paper was discussed by Dr. A. JAMES, Dr. W. RUSSELL, Mr. SHAW MCLAREN, Mr. C. W. CATHCART; and Dr. JOHN THOMSON replied.

Removal of a Piece of Steel from the Vitreous.
Dr. W. G. SYM read remarks on a case in which a fragment of steel was removed from the vitreous humour. A marine engineer presented himself thirteen months after having been injured by a spark of steel broken off a drill entering the left eye. The whole tissues of the eye were stained of a rusty brown, and ripe cataract was present with slight restriction of the field of vision, but no signs of any sympathetic trouble. The patient had been strongly advised in another town that his only proper course was to submit to immediate removal of the globe. He was admitted to Leith Hospital, and after careful discussion of several possible methods of treatment Dr. Sym decided to extract the lens and at the same sitting to attempt to remove the foreign body by means of the electro-magnet. This was accomplished successfully without the loss of the smallest quantity of vitreous humour, and the patient thus relieved of cataract and all fear of loss of vision from sympathetic opthalmia.

The piece of steel, weighing 1 grain exactly, was shown at the meeting of the Society on May 7th, 1897.

Epidemiological Society.—At a meeting on April 30th, President Services, that is, Dr. Louis PARKES read a paper on the Infectivity of Diphtheria and the Relation of Diphtheria Prevalence to School Attendance. In Chelsea, with a nearly stationary population of 75,000, there had been from 130 to 200 cases annually from 1893 to 1899, but in the next fifteen months two epidemics occurred, of three and six months' duration respectively, in which 421 cases were notified. The distinguish these, not as primary and secondary, but as single and multiple, the latter including all occurring in a few years, the epidemic period was 135 days, of which 209 (18.1 per cent.) were multiple; but in the epidemic periods of nine months, of 421 cases, 168 (39.9 per cent.) were so. The deaths in the former period were 222 (19.3 per cent.) of the cases, and in the latter period 66 (22.8 per cent.) of the cases. The cases mortality was 18.6 and 22.0 per cent. in the non-epidemic, and 21.3 and 25.0 per cent. in the epidemic periods. In the two periods the cases under 10 years numbered 174.3 per 100,000, and in both periods mortality of those under 10 years was 9 per cent. lower in the epidemic period, though at other ages it was higher. In both periods the mortality of multiple cases was higher under 5 years and lower above that age than among single cases. The percentage of cases at schools was 48.9 per cent. in the school period 1893 to 66, 61, and 63 in 1894, 1895, and 1896. Diphtheria, unlike scarlatina, was most fatal when most prevalent, and its epidemics were more local, persisting for from three to four years in a district, and extending in the course of two years and a half from 1893 to 1895, when the disease was rapidly increasing in intensity. The conditions under which children "romped" in the playground were more conducive to infection than those under which they associated in the class room. The following methods were recommended for detecting suspicious cases and preventing the spread of the disease, medical inspection of children in schools, communication between the head masters of schools and the medical officer of health, and a system of inter-notification between the medical officers of different districts.

Mr. MURPHY criticised Dr. Parkes’s division of cases into single and multiple as likely to obscure important issues, and believed school closure to be most effective when an epidemic was increasing in intensity.—Dr. HAMER maintained that many of Dr. Parkes’s multiple cases were really primary, and derived from a common source with the first cases. In an outbreak at Lewisham he had no difficulty in distinguishing between primary and secondary cases, there having been an interval of over forty-eight hours between the two attacks, and to have substituted Dr. Parkes’s division would have deprived his inquiry of most of its value.—Dr. NEWSHOLME believed firmly in school closure, and said Dr. Parkes laid too great weight on personal intercommunication, ignoring the part played by fomites, and thus underestimating the greater importance of primary cases.—Dr. SYKES insisted on the importance of social conditions and of the dependence of the number of multiple or secondary cases on that of susceptible individuals in a house, and thought that the dust raised by the movements of children in a class room was a very probable source of infection wanting in the playground or street. He also demanded a change in the allocation of beds in the hospitals, since cases of one disease were often refused admission when
there were many vacancies among the beds set apart for another.—Dr. Dudfield said internotification was necessary, since children from one district often attended schools in another. The medical officer of the School Board was unfortunately in a similar position. The location of beds was already under the consideration of the Asylums Board.—The President considered that the aggregation of many persons in a house or room was more potent than any association in the open air. The fever was verified bacteriologically at Aldershot, though of a mild type.—Dr. Parkes, replying, adhered to his methods and conclusions, adding that the number of occupants in the affected houses was generally 7 to 12, though sometimes only 4 or 5 in small cottages for single families.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.—At a meeting held on May 7th, Mr. W. Bruce Clarke, President, in the chair, Mr. L. A. Bidwell read a paper on the Value and Safety of Abdominal Exploration in Observe Cases. He brought forward a series of thirty laparotomies for diseases of intestine, liver, stomach, and kidney. One patient (gastro-enterostomy) died on the tenth day from broncho-pneumonia, all the others recovered. He had excluded cases of acute obstruction in the abdomen, and the operation involved cases of chronic intestinal obstruction, nine cases of exploration of the stomach, in three of which gastro-enterostomy was performed, eight cases of exploration of the liver, and seven cases of exploration of the kidney, in five of which peritonitis resulted. Exploration was performed to the benefit which followed simple abdominal exploration in advanced malignant disease of the peritoneum where no curative operation was possible. Mr. Doran had found Langenbuch’s incision very useful for exploring doubtful swellings in the region of the abdomen. It allowed the operator to explore both kidneys, which was always advisable, so that the operator refrained from removing a tumour apparently omental. He pointed out the good results obtained by exploration in cases of malignant disease, ascribed to the method of suturing the abdominal incision adopted by Mr. Bidwell. Mr. McAdam Eccles dwelt on the occurrence of ventral hernia and intestinal adhesions following abdominal operations. Dr. Snow pointed out the occasional improvement which resulted after abdominal section in cases of malignant disease, even although the disease was not eradicated. He contrasted this with the recovery resulting from abdominal section in tuberculous peritonitis. Mr. Keating insisted on the importance of early diagnosis in abdominal cases, as so many were seen when the disease was too advanced for radical surgical treatment. Wholesale exploratory operations could not be advised. Many would be quite fruitless, as it was precisely in the cases where nothing was found that the operator was most disturbed in trying to find something. Although septic peritonitis ought never to follow abdominal sections, extreme illness without peritonitis might be observed in hypochondriacal patients after abdominal exploration. There were other obvious objections to thinking of the abdomen as of a laryngo-scopic examination. There were many methods of suturing the abdominal incision. He now generally united the peritoneum with a continuous silk suture, the remaining layers and skin being brought together by a single row of silk-knot gut sutures. He had observed improvement in two cases of malignant disease after laparotomy where radical treatment was impossible.—Dr. Herbert Snow read a paper on The Principle of Anticipatory Gland Excision in Cancer Surgery.

BRITISH ORTHOPAEDIC SOCIETY.—At a meeting on March 12th, Mr. C. B. Keetley in the chair, Dr. Jackson Clarke showed a case of Spontaneous Inward Displacement of the Saphoph Bone, uncomplicated by flat foot, but associated with a good deal of pain. There was also a distinct depression externally to the saphoph bone. The Chairman remarked that there was a valgoid condition in each ankle, which might have tended to squeeze the saphoph a little inward. Mr. Prew described a similar case in which he had, after failure of other means, chiselled off the prominence of the scaphoph. Mr. Muirhead Little thought that the condition was similar to that described by Schaffer under the title of non-deforming flat foot. Messrs. Noble Smith, Luke Freei and Robert Jones also discussed the case, and after a suggestion from the Chairman that the Roentgen rays might be of value in clearing up the difficulties of the case. Mr. Jackson Clarke replied.—Mr. Noble Smith drew attention to the accounts of Immediate Reduction of the Deformity arising from Fctt’s Disease, as practised by Dr. Calot. Mr. N. Smith was under the impression that this plan of treatment had been adopted by the Chairman and he questioned if it were possible that such a procedure had been followed by the results described. As showing the possibility of a very large gap in the spinal column becoming filled by bone, he alighted to show a similar saphoph which had been filled with small new bone. The Chairman remarked that he was not quite satisfied that in the specimen described by Mr. Noble Smith it was actually new bone that had been formed, and Mr. Robert Jones mentioned certain cases in which ignorant attempts at forcible straightening had been followed by disastrous results.—Mr. Luke Freei described a simple instrument for cases of Hallux Valgus.—The Chairman showed a girl, aged 13, on whom he operated for Congenital Dislocation of the Hip three months previously. After extension and division of the contracted muscles he had opened the capsule of the joint and gouged out a new acetabulum. There was now shortening of 1½ inch, with a good deal of flexion movement, but no upward displacement of the femur could be felt. Mr. Tennyson congratulated Mr. Keating on the successful result he had obtained, and suggested a collective investigation by the Society of these cases. Messrs. Robert Jones, Noble Smith, and Muirhead Little took part in the discussion.

BIRKENHEAD MEDICAL SOCIETY.—At a meeting on May 7th, Dr. R. Sydney Marsden, President, in the chair, the following clinical cases were shown:—Dr. Blood: Cases of Squint; Cataract Extractions; also Cases of Congenital Absence of Iris in mother and child.—Mr. Shears: 1. Two Cases of Interstitial Keratitis. 2. Case of Hereditary Optic Atrophy. 3. Case of Choroido-retinitis (specific). 4. Case of Extreme Hyperaemia of both Optic Discs due to hypermetropic astigmatism and closely simulating optic neuritis of disease.—Dr. Stansfield: 1. Ligature of Internal Saphenous Vein for Intractable Varicose Ulcer. 2. Skiagraph of Cranium. 3. Case of Umbilical Hernia.—Dr. Carlow Pearson: 1. Varicose Veins of Thorax. 2. Successful Case of Ligature of Innominate Artery for Subclavian Aneurysm.—Dr. Stewart: 1. Rodent Ulcer of Eyelid. 2. Case of Tonsil. 3. Case of Hydrocephalus in a boy aged 11 years.—Dr. Laird Pearson: Plastic Operation for repair of Harelip in a grown-up child.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.—At a meeting held at Owens College, Manchester, on April 23rd, H. Briggs, F.R.C.S., President, in the chair, it was decided, on account of the Royal visit to Sheffield, to postpone the Leeds meeting until May 28th.—Dr. Fawcett of Sheffield, showed a specimen of Pyosalpinx removed that morning.—Dr. T. B. Grimdale (Liverpool) narrated a case of Atresia Vagina resulting in Double Hæmatometra and Double Hematocolpos. The patient, aged 16, complained of pain in the lower abdomen and vaginal region. She had never menstruated. She had passed "yellow jelly" from the bowels. The girl was well nourished and well developed. The external genitals well formed. An opening, which had the appearance of the vaginal orifice, extended down into the bladder. This was really a cul-de-sac about 4 inch deep, into which the urethra opened. The condition was relieved by a central perineal incision. The condition found at the operation was atresia of the lower portion of vagina; about an inch and a half of vagina measured from the clitoris to the introitus. The vaginæ led into a separate uterus; all these cavities were distended with blood. At a subsequent date the condition was verified to be uterus didelphys and vagina duplex.—Dr. Gemmell (Liverpool) related a case of Fuerperal Septicaemia from an unknown cause. The patient had been in convalescence on the fourteenth day after confinement, with a history that she was a primipara who had had a prolonged labour,
the result of narrowness of the brim of the pelvis, and a dead child was born which was undergone with ease. The uterus was well doused with perchloride of mercury, and all went well until the ninth day, when the temperature went up to 104°, and she had been in a state of high fever since. When seen she was in the stage of collapse, and on examination per vaginam the cervix was patent, and the finger passed into the uterine cavity, which was quite clean and smooth; but in the posterior wall of the cervix, just at its junction with the uterus, was felt a hole leading into a cavity which was in the pouch of Douglas, and from which sloughs came away. As to the origin of this abscess cavity, it is open to question whether a rupture had taken place at the junction of body and cervix uteri, or prolonged pressure on the posterior lip of the cervix had given rise to a sloughing, and then formation of an abscess cavity. There was no pelvic cel-lititis.

REVIEWS.


Dr. Galabin's book has established its place as an authoritative work—an account of the science and art of midwifery given by one of the most competent persons to expound it that could be found in England or in the world.

In the present edition the general character of the work is not altered. Only the changes which have taken place in obstetric matters are brought up to date. Thus in the chapter on the development of the placenta the author has availed himself of the researches of Webster and of Eden. The section on extrauterine gestation has been for the most part rewritten. Dr. Galabin, considering observers, accepts actualities, though rare, both ovarian and primary peritoneal pregnancy. In this edition there appears for the first time a section on decidua malignum, in which the literature of the subject is referred to, and the various opinions as to its pathology are summarised; but the reader may possibly wish for a more definite statement of Dr. Galabin's own opinion.

On one point we would respectfully find a little fault. At page 515 the author says that, in measuring the diagonal conjugate with two fingers in the vagina, the forefinger of the other hand being employed to mark the place where the fingers come into contact with the pubic arch, "it is rather difficult to mark the exact spot with the nail while the finger is closely pressed against the arch," and recommends to educate the perceptive faculty of the finger so that it may retain the impression of the exact spot where the pubic bone touched it; in other words, guess rather than measure. The difficulty in measurement which the author speaks of is explained when his illustration on page 514 is looked at. This represents the measurement being taken with two fingers of the right hand in the vagina, the palmar surface being upwards; the left forefinger, awkwardly held nearly at right angles to the symphysis, and almost parallel with the fingers in the brim, marking the point of contact. The left forefinger cannot easily do it in any other position, but when so held the measurement will vary according to how far the tip of the finger penetrates beneath the pubic arch. But if both forefingers of the hands are inserted into the vagina, the right forefinger can take the measurement held parallel with the symphysis, at right angles to the fingers in the brim; and the source of inaccuracy above pointed out does not exist.


This work professes to be the first attempt to deal with the English law of lunacy as a whole, by combining a systematic treatment of it under various headings, with a practical annotation of the numerous statutes in which a great part of that law is embodied. The scheme is a large one, and nece-

sarily makes the book bulky, but it cannot be said that the author has been unnecessarily diffuse. It is any considerable amount of the matter presented to his readers would have been omitted without the risk of leaving the treatment of the subject incomplete.

Insanity is first dealt with, apart from statute, in five chapters, and with one chapter, which deals with the matter bearing on contracts, marriage, wills, torts, and life insurances. Then follows the Lunacy Act, 1890, as amended by the Act of 1891, with copious explanatory notes; the rules of 1895 made under those Acts; the Criminal Lunatics Acts, 1881-89; and some other cases, occupying in all over 800 pages. The work concludes with an interesting chapter explanatory of the rules in Maunaghton's case, which are so frequently referred to as defining the criteria of responsibility for criminal acts, but are almost as often misused and misunderstood, or are interpreted in the subject should read this chapter, at any rate, carefully. The historical development of the doctrine of criminal irresponsibility is carefully traced, and rulings of the courts prior to the year 1843, when Maunaghton was tried for the murder of Dr. Drummond, are set forth with a history of the cases in which they were given. The opinions given to the House of Lords, after Maunaghton's acquittal on the ground of insanity, are usually quoted in medical and legal textbooks.

The opinions delivered by the judges in Maunaghton's case are not legally binding on any one. They were given in no legal proceeding, without the questions having been argued, and without direct reference to the facts of any particular case. But though not legally binding, they have been adopted and followed, more or less, by many judges since 1843, and must be considered as laying down the principles to be acted on now and until the law is altered by Parliament, if such an alteration should ever be made. Mr. Renton shows that, especially of late years, the summings up of individual judges have not always been in strict accordance with Maunaghton's case. He does not say whether these later rulings are of much or any authority. Perhaps, as the judges are still alive and are wiser to say nothing about them, the language they used has been recorded, and may have to be considered by those concerned in deciding how far other alleged lunatics are to be held criminally responsible for their actions.

All who have to consider such cases, and indeed all concerned in lunacy practice considered from its legal side, will find this book useful. The type used is good, and the index and table of cases cited seem to be full and accurate.


This book is not comprehensive as its title would imply, for it does not include syphilis, which, however, we learn from a preface contributed by M. Tenneson, one of the physicians to the St. Louis Hospital, is to follow later in another volume. Gonorrhoea and its complications in men, women, and children are considered, the considerable length, occupying indeed more than half the book. Then comes the soft or local chancre, and this in turn is succeeded by a long account of a parasitic form of balano-posthitis which we gather from the preface was first described by MM. Berdal and Bataille in 1885 under the name of balano-posthite érosive circinata, and which here occupies over forty pages. The remaining subjects are grouped under the barbarous title Affections Para-vénériennnes, and include herpes, warts, phimosis, and some other affections of the genital organs not nece-