REPORTS OF SOCIETIES.
ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Sir ANDREW CLARK, Bart., M.D., F.R.S., President, in the Chair.
Tuesday, March 29th, 1893.

Resection of the Intestine and Immediate Suture in Gangrenous Hernia.

Mr. Kendal Frankes related the case of a woman, aged 30, who had an umbilical hernia of three months’ duration. It became strangulated on September 22nd, 1891. Thirty hours and a quarter later, the abdomen was found to be full of a gelatinous fluid associated with an ovarian tumour. The loop of intestine proved to be gangrenous. Nine inches and a quarter were excised, and the ends of the intestine immediately united by means of Gely’s suture. The abdominal cavity was closed and a glass drainage tube inserted, which was removed on the fourth day. The bowels acted regularly after the fifth day, and recovery was complete. Five weeks later the abdomen was again opened, and the umbilical multilocular semisolid cyst was removed. The sutured intestine was ununited. It was felt that the line of union could not be thickened; the principles. The treatment of the cases, with careful removal of strangulated hernia. The various methods of treatment were reviewed, and the following were some of the conclusions arrived at: Gangrenous hernia might be treated on one of the following principles: either by resection and immediate suture, or by the formation of an artificial anus. The latter necessitated a secondary operation for its cure by the use of Dupuytren’s enterotome, or by secondary resection and suture. To estimate the relative merits of these two methods of treatment, the death-rate of immediate resection and suture must be compared with the death-rate following the formation of an artificial anus. The death-rate of secondary operation required for its cure. The death-rate in cases of gangrenous hernia treated by the formation of an artificial anus was 80.7 per cent. The death-rate of secondary resection and suture for the cure of artificial anus was 38.2 per cent. The death-rate following the use of the enterotome was 7.3 per cent. The mortality which attended resection and immediate suture in gangrenous hernia was shown, in a table of 220 published cases presented to the Society, to be 48 per cent. The author concluded that the death-rate of immediate resection and suture should be the operation of choice in gangrenous hernia, and that simple enterotomy, followed by the formation of an artificial anus should be reserved for absolutely special cases, and should be considered as an exceptional procedure.

Mr. Jonat. BOWLEY, mentioned a case of a woman, aged 40, who had had a strangulated hernia for three days. On opening the sac he found the included portion of the gut gangrenous, and there was commencing peritonitis. He then opened the abdomen in the middle line and removed altogether 12 centimetres of the intestine, having taken care to be well away from any damaged portion. The piece removed was shown to the Society, and exhibited clearly where the gut had been gripped in the strangulation and some 2 inches on either side. He had not found clamps of much use, and preferred the fingers of an assistant for this purpose. He had used a continuous suture for the mucous membrane and Lambert’s suture for the rest of the wall in joining the ends of the intestine together. The sac was removed at the first operation, and a radiolar cure was performed. The patient made an uninterrupted recovery. In this case, although no taxis had been attempted, inflammatory changes above the seat of the stricture had set in. The mesenteric membrane was ulcerated quite through, and there was commencing peritonitis. One question in these cases was whether the section through the intestine should be oblique, in order to prevent stricture. In his opinion this was not necessary. Another question was, should the resection be performed at the site of the hold through a secondary incision in the middle line? He was in favour of the latter plan, as, after suture, the thickness of the gut was increased, and it might be difficult, or even impossible, to return it through a femoral or even through an inguinal ring.

Mr. Lockwood said that surgeons up to the present appeared to have been averse to accept resection, their objection being based on statistical grounds. He agreed with the author that resection was a rational operation. He preferred resecting the intestine through the original wound and cutting through Poupart’s ligament, if there was any difficulty in replacing the sutured gut. He considered that method of suture the best which the surgeon was most conversant with.

Mr. A. E. Bailey emphasised the importance of removing enough mesentery and intestine to ensure having healthy tissues to suture together. He preferred to resect through a median incision, for greater freedom of the hand and intestine was allowed. The plan that he advocated was to remove all the gangrenous and dangerous parts through the hernial wound and to close temporarily with ligatures the ends of the intestine, and then resect them in a median incision. With reference to statistics, he suggested that when an artificial anus was made the cases were very desperate, enterectomy being performed in the more favourable ones.

Mr. Bowley agreed with the position that the author had taken up, though he thought that he had perhaps taken a too rosy view of the operation. From statistics gathered from the three large London hospitals by Mr. Berry over a period of ten years, it appeared that the mortality for all cases of strangulated hernia operated upon was 44 per cent. The St. Bartholomew’s Hospital, which he had himself collected, showed a mortality of a little over 40 per cent. The author’s statistics for resection were almost as good. The explanation of this was probably that unfavourable cases had not all been recorded. It was the fault of many of the surgeons mentioned by the author that he had performed this operation of resection, as out of the enormous number of cases of hernia admitted into St. Bartholomew’s Hospital in the last ten years, in only forty-two was the whole or gangrenous. It might be inferred, therefore, that resection had occasionally been performed in cases in which the intestine was not gangrenous.

Mr. Thomas Smith agreed with Mr. Bowley that the term “gangrenous” had a different meaning to different operators. The great object to the operation was the depressed condition of so many of the patients, which rendered them unsuitable subjects for so prolonged an operation. He did not approve of the use of Sen’s plates.

Mr. Clement Lucas said that in resection in cases of femoral hernia, one question, which would have to be settled sooner or later, was whether the operation should be completed at the seat of the hernia or through a median incision.

Mr. Smith added to his remarks that in every case of artificial anus a further operation was always needed, as occasionally they tended to recover of themselves.

Mr. Frankes, in reply, stated that he had found the fingers of a capable assistant to be the best form of clamp; that an oblique section was the proper one, and that more should be taken from the convexity than from the concavity; that if the condition of the intestine was doubtful, it was better to remove the doubtful portion rather than to risk returning a gangrenous portion into the abdomen. A plan adopted by German surgeons was to fasten the doubtful portion to the abdominal wall and to watch it for twenty-four hours, and then resect or return it according to circumstances. He said that apparently large pieces of intestine could be removed without doing any harm to the patient, and without increasing the risk, but that it would appear from the case that it was dangerous to leave or suture any unhealthy tissue. In cases of femoral hernia he preferred to open the sac and to clean the parts, and then to resect them through a median incision. With regard to sutures, he had always adopted Gely’s plan. He could see no objection to the continuous method. The mortality was perhaps about 50 per cent., which was much lower than in cases of artificial anus. He referred to a case of colectomy for malignant growth, published in the Society’s Transactions for 1889, and stated that the patient was at the time alive and well.

The President observed that the duration of time needed for the operation of resection had not been, he thought, adequately discussed, and that from a physician’s point of view it was a very important one.
CLINICAL SOCIETY OF LONDON.

SIR DYCQ DUCKWORTH, M.D., LL.D., F.R.C.P., President, in the Chair.

Friday, March 24th, 1883.

PERIPHERAL NEURITIS.

DR. HALF WHITE described two exceptional cases. One was septicemic: the other was due to lead, and presented unilateral, palatal, and fausal paralysis, and other rare symptoms. Case 1: A man, aged 33, came into the hospital suffering from mitral regurgitation, great edema of the lower extremities, and an ulcer on the left leg. Towards the ulcer had doubled in size, it was very foul, and the patient had a high temperature. He complained that he could not bend his hands, and it was found that he had wrist-drop on both sides. The weakness of the extensors increased, so that three days afterwards flexion and extension of the hand, wrist, and elbow on both sides were paralysed, supination was very weak, and pronation was completely paralysed. The movements of the shoulders were weak. The supinator longus on both sides was paralysed. The ulnar and ulnar-spiral nerves were extremely tender. Two days after this, as the ulceration was rapidly spreading, the leg was amputated at the knee; the symptoms of neuritis were worse. Case 2: A man, aged 45, who had lead colic twice, who worked in lead works, was suddenly taken ill with very acute pains in his limbs and body, especially the lumbar region. On admission, he was found to be suffering from intense abdominal pain, with severe pain and degeneration in some of the muscles. The peripheral circulation was considered to be restricted. On the right side the arch of the soft palate was much lower than on the left. The right posterior pillar of the fauces projected inwards more than the left. The uvula was not deflected. The taste was impaired. Food did not return through the nose. The left wrist was slightly swollen. The muscles of the limbs and the accessible nerves were all extremely tender to pressure. There was marked double wrist drop. The flexors were weak. Inspiration was normal. The lower extremities were in all movements almost completely paralysed. The pupils were equal. There was early optic neuritis. The bowels were confined, and there was vomiting. The knee-jerks and plantar reflexes were lively. He remained under observation six weeks, and was discharged well. During his stay in hospital, the ulnar and ulnar-spiral symptoms were observed: Painful swelling of various joints with subsequent grating in some; numbness, coldness, paresthesia, and loss of temperature sense in various parts of the body. The muscle sense in the hands was also impaired.

The President asked for fuller evidence respecting the septicemic origin of the first case, and thought that some of the arthritic cases were probably due to trophic changes, not essentially gouty.

Dr. Hadden was not a great believer in joint affections due to trophic changes. He had not seen a case of neuritis due to septicemia, but thought Dr. White's case was undoubtedly due to that cause.

Dr. White replied.

SEVERE SHOCK TREATED BY (TRANSFUSION OR) INFUSION OF NORMAL SALINE SOLUTION.

Mr. MAYO ROBSON described two cases in detail, and mentioned others in which he had found the infusion of several pints of normal saline solution into the circulation ward off imminent death in cases of shock after operation. The cases specially described were, one of enucleation of a large fibromyoma of the uterus, and another of amputation at the hip-joint in a young adult, for sarcoma of the upper part of the thigh. In neither case had there been any material loss of blood, but death was apparently imminent from shock. Both patients were saved by the means adopted. After quoting from several authorities to show the similarity in the symptoms of syncope and collapse, Mr. Robson pointed out that he had been clearly shown that shock was naturally due to paralytic changes in the heart and arteries, and not due to the vessels in the extremities. In these cases, the sudden dilatation of which might simulate sudden hemorrhage. He said in cases of shock without serious hemorrhage, the blood was driven into the large abdominal veins where, for the time being, it was useless, leaving the head and extremities in a state of anemia. If by injecting several pints of blood fluid into the vessels the blood could be forced into circulation again the effect should be at once manifest by a filling of the vessels in the head and extremities, and an increase in the temperature. In the ease of the uterus, three to four pints, would be sufficient to fill the dilated and partially paralyzed abdominal vessels as well as the vessels supplying the parts essential to life. Moreover, we would be able to simulate the state of the blood being driven into it. The case he had related seemed to bear out these suggestions. His own conviction, from personal experience, was so distinct, that it had become his practice, whenever he went to perform a capital operation, to include among his instruments a transfusion apparatus and a packet of salt sufficient to make four pints of normal saline solution.

Dr. L. REMFRY mentioned a case of ovariotomy at the Great Northern Hospital, in which the situation became collapsed three hours after the operation. The saline solution was at once injected, and the patient recovered.

Mr. R. W. PARKER said the cases in which after operation there was no loss of blood would be the cases least likely to be benefited by transfusion. German surgeons had injected the solution into the cellular tissue. He had tried that method in the case of a baby, but the patient was so far advanced towards death that no absorption of the solution from the cellular tissue took place.

Mr. BERNARD said that the cases of shock were due to the accumulation of blood in the abdominal vessels, and its consequent withdrawal from other parts.

Mr. BRIGHARD had seen six or seven cases treated by injection. Two were cases of shock not complicated with hemorrhage. The first was a case of amputation through the hip-joint. When collapse ensued, transfusion was done. Two pints were injected, but without improvement; then two pints more, when the pulse improved. After a time, however, it failed again, and after two transfusions the patient died. In the second case there was temporary benefit after transfusion, but the patient died in the same way 2½ hours afterwards. He thought the fluid poured in went simply to increase the dilatation of the abdominal vessels. He asked if Mr. Robson had seen any peculiar results from transfusion. In one case, where a movable kidney was being stitched, collapse came on; ½ pint was injected, and great dyspnea followed. In some thirty other cases of transfusion which he had seen there was no such dyspnea, but great benefit resulted.

Mr. DIDWELL had, in a case of Ceasarian section, where there was extreme collapse with no pulse in the radial artery, cut down upon the femoral vein, inserted into it the nozzle of a Higginson's syringe (threaded hand), and injected 5 pints of fluid, with very satisfactory results, though the patient died some days after from peritonitis.

Mr. BATTLE said that in a case of intestine ruptured in three places he had found profound shock, without hemorrhage into the peritoneal cavity. Four pints of solution were injected, and the patient recovered for six days, but then died from perforation due to ulceration caused by one of the stitches. In another case of rupture of the spleen, in which the abdomen was filled with blood, the patient seemed too prostrate to undergo an operation. An injection of 5 pints brought him into a condition in which an operation could be done. Afterwards he again became collapsed; 4 pints more were injected, and the patient recovered.

After some remarks from Mr. SOLOMON SMIRN, Mr. ROBSON, in reply, said if the saline fluid was forced into the heart, surely that organ would force it on into the system through the lungs. The blood was retained in the large vessels of the abdomen, and not, he thought, in the right heart. A stethoscope's diaphragm, to which an India-rubber tube, with a glass pipette were attached, made a capital syringe. The patient should always be watched for some hours after transfusion, so that if the pulse again failed the transfusion should be repeated. Very rare, a second transfusion was required; but in some cases it was wanted, and a third transfusion, the transfusion should be repeated. The largest amount he had transfused was five pints, and that only in one case. Often he had used four pints, sometimes only three. In cholera the
condition of the blood was not on a parallel with that of the cases he had brought forward. He had done good with transfusion into the abdominal cavity when operating for rupture of extraneous gestation in three cases accompanied by extreme collapse. The abdomen was filled with the saline solution; the patients directly had a better pulse, and recovered.

LEAVING SPECIMENS.

Dr. NEWTON Pitt showed a man the subject of Pseudo-Bulbar Paralysis, probably of cerebral origin.—Mr. A. E. BARKER showed a man with Epithelioma of the Lips. He was a great chewer of tobacco, and his tongue showed patches of leukoplakia. He had systhile. Mr. Barker also showed a man on whom he had performed Le Fort's Modification of Pirogoff's Operation. The man could bear his weight on the stump seven weeks after the operation.—Mr. BATTLE showed a female patient who presented a Polypoid Exultration at the Umbilicus, from which there was a slight escape of feces. It formed the end of a Meckel's diverticulum. The bowels acted normally.—Mr. F. C. WALLIS showed a lad who had recovered without a bad symptom from a very severe Compound Comminuted Fracture of the Skull.

MEDICAL SOCIETY OF LONDON.

F. DE HAVILLAND HALL, M.D., Vice-President, in the Chair.

Wednesday, March 27th, 1893.

APHASIA FROM A FALL ON THE HEAD.

Dr. BIRDVOR related the case of a carpenter, aged 50, who fell off a scaffold 14 feet, alighting on the left side of his head. He remained unconscious for several hours; then he walked home. On arriving there he complained of pain in the head, constantly reiterating the sentence, "There is a fall." The next day he was drowsy, and could not answer questions. There was no definite paralysis. When he came under observation three days later, he could speak voluntarily but imperfectly, and talked a good deal of nonsense. He could understand spoken orders, and write spontaneously. He could not, however, understand written commands nor repeat spoken words. He could not pick out objects named to him, nor write from dictation, nor copy printed characters into writing. He was also unable to name objects shown to him, though he could recognise the use of the objects. The patient recovered in about three weeks. The nature of the lesion was probably meningeal hemorrhage or simple concussion, and, if the former, was probably situated over the visual word centre in the supra-marginal angular gyri.

In reply to the President, Mr. SPENCER WATSON, and Dr. WALTER CASE, Dr. Birdvor said attempts had been made to test the sense of smell, but without any result. The peculiar difficulties of making sure that the questions were understood by the patient were satisfactorily overcome. He had not complained of parosmia, though the optic discs showed the existence of a hemorrhage. Recovery was probably consequent on his absorption. In his case it could not be said that treatment had much done with it.

CHUBOSS PNEUMONIA IN CHILDREN.

Dr. FRANCIS HAWKINS read a paper based on 230 cases, and the conclusions at which he arrived were fully illustrated by diagrams. He showed that most cases occurred during March, May, and July; the fewest in January, August, and December. They occurred, as a rule, independently of antecedent disease, and in a great majority the onset could not be attributed to any definite cause. Fifty of the cases occurred under the age of 5 years, 120 between 5 and 10, and 50 between 10 and 14. The disease was most frequent at the ages of 5 and 9 respectively. Connecting his table with a further series of over 700 cases compiled by Drs. Hadden, Mackenzie, and Ord, he found that the frequency of the affected gradually rose from the fifth to the twentieth year. Its onset was usually sudden, and the chief symptoms of invasion were vomiting, cough, and pain, while rigors and convulsions were very infrequent, and hemoptysis extremely rare. Arrangements of groups showed that the nervous system was the one most variously affected. The average daily temperature before crisis was 103° to 104° F., and in about one-seventh of the cases the fever was of a hectic type, though in only three was such associated with pus in the pleural cavity. The sixth was the commonest day of crisis, it being very frequent also on the seventh and eighth days. In basic pneumonia it was rather later than in apical. A dull tympanitic note was often present before any differentiation was detected in the character of the breath sounds. In 146 cases the base of the lung was attacked in 68, the apex in 46; in the remainder the seat of the disease was in other parts. The most rapid respiration noticed was 68. Typical rusty expectoration was present in 7 cases, the youngest being 6. Pleurisy coexisted in 16 cases, pus being formed in three. Gangrene of the lung occurred once. A soft syphilitic murmur was detected as arising during the course of the disease in 6 cases. Pericarditis was noted in one case, the patient having rheumatic fever previously. Albuminuria was discovered during the disease in 7 cases, and herpes in 36, being in one case on the wrist as well as at the angle of the mouth. Delirium was more frequent during the course of the disease than at the onset, and more in apical than in basal cases. In the treatment ice should be used with great caution when the pneumonia was on the left side, as the heart might become slowed and dangerous symptoms arise. With regard to alcohol, discretion was required to select those cases in which it was needed.

EPIDEMIOLOGICAL SOCIETY.

J. F. PAYNE, M.D., F.R.C.P., President, in the Chair.

Wednesday, March 16th, 1893.

AFRICAN HEMOGLOBINURIC FEVER.

Dr. PATRICK MANSON read a paper on this subject, which we propose to publish.

Dr. BATTEN, speaking from a considerable experience of African fever, observed that the characteristic nature of hemoglobinuric fever, but maintained that all African fevers differed from the corresponding types of Asiatic in absence of periodicity, etc. He had had seven consecutive monthly attacks of common malarial fever during his first residence in Africa, and a subsequently four of hemoglobinuric fever either there or on his return to England, with mean intervals of three months, one of the attacks apparently excited by a chill. He doubted whether it differed essentially from other African fevers, except in the hemoglobinuria, which could not be deemed a specific symptom.

Dr. K. MACLEOD and Dr. LAWSON having referred to the fevers of India,

Dr. COPEMAN stated that though he had never been in the tropics he had worked with Dr. BRISTOWE at hemoglobinuria, which he considered to be, whether here or in Africa, the direct effect of chills on persons in whom an excessive susceptibility was natural or acquired. None of their patients, adults, and children had ever been out of England, but their attacks were essentially the same as those described by Dr. Manson. The attacks, which lasted about six hours, could always be induced experimentally by exposure to the free heat of the sun. Treatment in hot water, etc., was found necessary. The children were all subjects of congenital syphilis, and in them the attacks recurred whenever the day was cold and wet. None of the adults had had syphilis, but one ague. He was an omnibus driver, and was liable when at work to almost daily attacks; his spleen only was enlarged. The very best method of microscopic examination failed to reveal any micro-organisms. Paroxysmal hemoglobinuria was not infrequent among horses, especially in Scotland, where it was sometimes fatal. It appeared from the paper and discussion that quinine was the only drug that had been tried, though Dr. Manson himself had no confidence in it. He (Dr. Copeman) would suggest arsenic, which had proved of undoubted service, also in pernicious anemia; experiment showed that it restrained hemolysis, and increased the hemoglobin.

After some remarks by the President, Dr. MANSON replied.

HARVEIAN SOCIETY OF LONDON.

MALCOLM MORRIS, F.R.C.S. EDIN., President, in the Chair.

Thursday, March 2nd, 1893.

SPECIMENS.

Mr. ROUGHTON showed the excised Bones of an Elbow-joint in which Osseous Ankylosis had taken place without previous suppuration.—Mr. J. JACKSON CLARKE showed the Brain and
Spinal Cord of a boy who died of Chronic Hydrocephalus, the result of a general tuberculosis in which recovery had taken place. Mr. Clarke discussed the treatment of such cases by operation.

**DIAGNOSIS AND TREATMENT OF PERNICIOUS ANAEMIA.**

Dr. William Hunter read a paper on this subject, up till recently it was customary to arrive at the diagnosis of this disease by a process of exclusion. It was held that no anaemia could be termed "pernicious" unless it could be proved not to belong to any of the other and better known forms of simple or complex anaemia. This rule has been found so far as I can gather, was only meant to enable the diagnosis to be made on positive evidence. He, however, accustomed to resist his diagnosis almost entirely, although not exclusively, on a consideration of the changes in the blood, the character of the urine, and certain associated changes pointing to disturbance of liver function. Unlike the other severe forms of anaemia, most of which were the result of impaired formation of blood, blood destruction being, if anything, less than in health, pernicious anaemia was due to an excessive destruction of blood, the chief features of which were that it was intermittent in its character, was limited to the portal division of the circulation, all the products of this destruction necessarily passing through the liver, and that it was occasioned by substances foreign to the healthy body introduced into the system by absorption from the gastro-intestinal tract. The chief clinical features of this destruction were: (1) As regards the blood a much higher percentage of hemoglobin as compared with the percentage of corpuscles was found, their presence being noted particularly in chlorosis, and in the anaemia from loss of blood. Another change which he had recently found in the blood in pernicious anaemia was a greatly diminished alkalinity of the blood. (2) As regards the urine, the chief character in pernicious anaemia was its dark colour, either absolutely or relatively to the condition of the blood. In this respect it contrasted greatly with the pale, watery urine of simple anaemia. In some cases, as he had shown, blood pigment proper was found and done microscopic examination of the urine, lying within renal cells and resembling all respects that found so abundantly within the cells of the convoluted tubules after death. (3) As regards the liver, he was accustomed to attach considerable confirmatory importance to the occurrence periodically of a slight degree of icterus of the conjunctive, or other evidence of liver disturbance. The chief work in disposing of the large excess of hemoglobin set free within the portal area fell upon the liver; and he found that the extent of the destruction taking place at any time could only be gauged by the amount of blood pigment in the urine and the associated disturbances of liver function. These facts suggested certain lines of treatment. Regarding the disease as he did it as an infective one, localised to the gastro-intestinal tract, he thought that the treatment should be directed to that tract. Regimen must be imposed in the use of antiseptics, the best being beta-naphthol and salol, with arsenic when that could be borne.

Dr. Barlow believed with Dr. Hunter that under the term "pernicious anaemia" were probably comprised several diseases characterised by anaemia but due to different causes, and which, therefore, though resembling one another in many important features, were yet fundamentally distinct.

**SOCIETY OF MEDICAL OFFICERS OF HEALTH.**

Shirley F. Murphy, M.R.C.S., L.R.C.P., President, in the Chair.

**Monday, March 20th, 1893.**

**THE PREVENTION OF CONSUMPTION.**

Dr. Niven having laid before the Society a memorandum issued by the North of Scotland Board of Health, referred to the now almost universal recognition of the communicability of tuberculosis. After reference to the work of Villemin and others, he said Koch had proved by pure cultures the identity and intercommunicability of human, bovine, and, indeed, of all mammalian tuberculosis, but the non-identity, original or acquired, of that of birds, the two requiring for their development the different temperatures of the mammalian and avian bloods. Cornet had shown that the great source of infection was the dust deposited on the dead organic matter, the bacilli could generally be grown from the dust of rooms occupied by consumptives, unless great care were given to the disposal of spouts, but elsewhere, and in streets, only negative results were obtained. Among cattle farmers, the novices who had to sweep the floors frequently succumbed within four years. Dr. Niven had rarely failed to trace opportunities for infection, and considered that the greater frequency with which wives seemed to contract the disease from their husbands than vice versa, which Dr. Longstaff deemed evidence of mere coincidence, to be easily explained by their greater exposure in nursing the invalid. Between the ages of 20 and 30 half the deaths of women were from tuberculosis. The dilution of milk from tuberculous cows with that of healthy cows had not, as the milk had been handled, removed its purchased, for the bacilli sank to the bottom. He advocated the establishment of isolation hospitals in healthy open country sites as a boon to the suffering poor and a means of checking the extension of the disease. He would have it made notifiable, as at Oldham, with precautions against multiple notification; and he showed by statistical tables that the cost would not be any difficulty. Tuberculosis in cattle should be brought under the Contagious Diseases (Animals) Acts, and county veterinary inspectors should be empowered to order the slaughter, with reasonable compensation, of obviously diseased animals.

Mr. F. B. Young testified to the good effect of several Lancashire towns by voluntary or municipal disinfection. Dr. Hamilton said previous researches had not only extended those of Quincke on the accumulation of iron in the viscera, but had added much to our knowledge in other respects, particularly as to the reaction of the blood—a point of great interest, since that disease was probably of chemical rather than of histological origin.

Dr. Hale White showed a patient suffering from splenic leucocytosis in whom the administration of arsenic had brought back the blood to its normal state; but the liver and spleen continued to enlarge, and the patient remained very ill. Dr. Hale White remarked that on the whole the evidence he had accumulated bore out Dr. Hunter's contention, for out of 29 cases of pernicious anaemia he found that 41 per cent., gave a history of icterus, but 31.5 per cent. gave a history of diarrhoea before admission. After admission 55 per cent. suffered from vomiting, and 41 per cent. from diarrhoea; but at the post-mortem examination it was nearly always found that the gastro-intestinal tract was healthy; when any changes were discovered they were slight and unimportant. While the urine was undoubtedly often dark, in some cases it was not, and he considered that for theoretical reasons it was only probable that sometimes the kidneys should be absent. Cases had occurred at Guy's Hospital in which the liver had shown an excess of iron. Speaking of prognosis, Dr. Hale White related the case of a man who was cured by arsenic, but he gave statistics from the records of Guy's Hospital to show that the usual cause was for the patients to recover twice, or even thrice upon arsenic, but finally succumbed to the disease.

After some remarks from Sir Hugh Bervor, Dr. William Hunter replied.
ferers. If infection, etc., were avoided, any so-called hereditary tendency might be disregarded.

Dr. WILLOUGHBY, SYERS, and ARMSTRONG having taken part in the discussion, Dr. NIVEN replied.

Dr. ARMSTRONG then moved a resolution on the sale of tuberculous and inoperable disease, and which, at the suggestion of the PRESIDENT, was passed as a provisional expression of opinion only pending the report of the Royal Commission.

MIDLAND MEDICAL SOCIETY.

HENRY EALES, M.R.C.S., President, in the Chair.

Wednesday, February 8th, 1883.

CASE.

Mr. WOOD WHITE showed a woman, aged 30, who had a tumour growing from the peritoneum of the inner wall of the orbit and the side of the nose.

Dr. PEBBSLOW showed a Multilocular Ovarian Cyst which he had removed by abdominal section from a woman, aged 46. No flushing or drainage tube was used, and the patient made an excellent recovery.—Dr. MALINS showed (1) a Large Hematocelepinx, and (2) Dermoid Cyst of Ovary.

PAPERS.

Mr. HASLAM read a paper on the Value of the Ligature of the Lingual Arteries in Malignant Disease of the Tongue.

Wednesday, February 22nd, 1883.

HENRY EALES, M.R.C.S., President, in the Chair.

UNUNITED FRACTURE OF THE CLAVICLE.

Mr. THOMAS exhibited a boy, aged 12, who had an ununited fracture of the right clavicle. When about a year and a half old he had an accident, in consequence of which his clavicle was fractured. The following was the present condition: The right clavicle had been fractured a little external to the centre. The fractured ends could be readily separated and moved. The shaft of the clavicle was atrophied, but the muscles of the shoulder, and especially the deltoid, were much hypertrophied. Any kind of movement of the upper extremity could be performed with ease and quickness.

THYROIDECTOMY.

Mr. MARSH showed a youth, aged 20, the right lobe of whose thyroid, with the central part, he had excised three weeks before for acute bronchocele, causing dyspnea. The right lobe was larger than the left, and the central part dipped down beneath the manubrium sterni. There were no cardiac symptoms or ophthalmos, but the veins on the right side of the neck were distended. A median incision was made, and as Mr. Marsh explained the central portion, with a small piece of the two lateral lobes, which showed marked lateral flattening. The patient made a rapid recovery, and the remaining piece of thyroid had already considerably diminished in size.

PARAPLEGIA SUPPLEMENTING UPON EXOPHTHALMIC GOITRE.

Mr. WHITE showed for Dr. Suckling a woman, aged 42, suffering from paraplegia supplementing upon exophthalmic goitre. Dr. Suckling considered that descending sclerosis of the motor tracts had followed upon a lesion in the region of the floor of the aqueduct of Sylvius.

TUMOUR OF ORBIT.

Mr. WOOD WHITE showed a boy, aged 6. A firm, elastic, and fairly movable tumour was growing from the upper part of his right orbit, and was bulging the upper eyelid. The growth was first noticed six months previously, and, three months before admission to the Eye Hospital, was removed at another institution. It occurred very rapidly, and at the present time the increase in the size of the tumour could be noticed daily. Mr. Wood White had no doubt that the tumour was a sarcoma, and he contemplated its removal at once, sparing if possible the eyeball.

GALL STONES.

Dr. SHORT showed a man, aged 62, who during the last six months had passed two large gall stones weighing respectively 309 and 214 grs., at an interval of eight months. A review of the symptoms made it most probable that the stones had ulcerated into the gall bladder into the hepatic flexure of the colon. The first calculus was perfectly smooth and the second was facetted at each end.

REVIEWS.

VARIOUS FORMS OF HYSTERICAL OR FUNCTIONAL PARALYSIS.

By H. CHARLTON BASTIAN, M.A., M.D., F.R.S., Professor of the Principles and Practice of Medicine in University College, London; Physician to University College Hospital, and to the National Hospital for the Paralysed and Epileptic. London: H. K. Lewis. 1883. (Post 8vo., pp. 212, 7s. 6d.)

The reader, whether he be a reviewer or the happier person who reads books only for the pleasure or advantage to be derived from their perusal, will lay down this small volume with the feeling that he has not been wasting his time, but that he has been presented with new ideas on a well-worn subject and new lights for the investigation of a form of disease which is among the most perplexing and least satisfactory which a physician can be called upon to treat. There are few diagnoses which are rendered with greater rapidity and with less certainty than that of hysterical. Dr. Bastian observes in his preface that "if we are to arrive at a fuller and more accurate knowledge of the various forms of functional paralysis, this can only be brought about by a continuous methodical investigation and record of all the minute details pertaining to such cases"—the very thing which the diagnosis of hysteria is commonly assumed to render unnecessary.

The main part of the volume is occupied by a study of the localisation of the lesion, that is, the site of the disordered function, in a series of cases which are rendered interesting by the care with which they have been examined. Dr. Bastian insists upon the difficulty of diagnosis as between functional paralysis and organic disease. The emotional weakness of certain nervous patients suffering from structural disease is especially liable to betray the incautious observer into "the facile but erroneous diagnosis of 'hysterical paralysis'". Even after this distinction has been made we are still far from a complete diagnosis; we have still to form "a notion as to the region of the nervous system that is at fault, and also as to the nature of the pathological condition which causes a failure of functional activity in the part in question". In the first place whether the functional failure is in the brain or the spinal cord is difficult to answer, and commonly is not answered. Secondly, as to the brain itself, any attempt at localisation must be limited, but Dr. Bastian thinks that a diagnosis may be made in three regions: (a) a region involving some part of the Rolandic convolutions; (b) a region involving the posterior third of the hinder segment of the internal capsule; (c) a region involving some of the outgoing fibres from these convolutions. Very careful clinical studies of cases illustrating each of these types are given and discussed. Function paralyses, of spinal type, are next treated in the same way; they are divided into two main types: (a) the spastic, due to functional perversion of, or defect in, the pyramidal system of fibres in the cord; and (b) the flaccid, due to functional diffuseness of the anterior horn cells in certain segments of the cord. The site of disordered function is determined by the same order of facts as would lead to a diagnosis of the site of a lesion in organic disease.

The conclusions arrived at are summarised in a convenient table on page 121. This table is, in fact, the clue to the main part of the book; it is accompanied by some observations on the nature of hysteria which are well worthy of study, though they do not altogether succeed in dissipating the obscurity which surrounds the subject. Dr. Bastian strongly condemns the practice of using the term "hysterical" as though it were synonymous with "functional." For him hysterical