REPORTS OF SOCIETIES.

MEDICAL SOCIETY OF LONDON.

C. A. BALLANCE, M.V.O., M.S., F.R.C.S., President, in the Chair.

Monday, February 18th, 1907.

DIAGNOSIS AND LOCALIZATION OF CEREBRAL TUMOURS.

DR. CHARLES E. BEEVOR delivered the second of the three Lettsomian Lectures on the diagnosis and localization of cerebral tumours. He described a tumour which grew from the left orbital plate and compressed the brain upwards and outwards. It did not grow into the brain substance, and there was no destruction of brain tissue. The general diagnosis of tumour was made from the symptoms of headache, vomiting, and double optic neuritis. The localization to the left frontal region was made by the following symptoms: The pain in the head was in the frontal region; there was a mental condition of stupidity and dullness; there were attacks of coma from which the patient could not be awakened, and there was a condition of want of interest in the interval between these attacks; there was incontinence of urine. There was impairment of smell on the left side as compared with the right; there was weakness of the right side of the face and slight paresis of right arm and leg; there was increase of the deep reflexes (wrist tap, knee-jerk) in the arm and leg on the right side, as compared with the left, and diminution of the superficial reflexes, abdominal and epigastric; on the right side the plantar reflex gave a doubtful extension of the big toe as compared with the definite flexion of the left toe. There was a fine rapid tremor of the left hand, when both arms were extended in front. Dr. Beevor then described six cases of tumour involving the second or middle frontal convolution, and in all of them there were attacks of some kind which differed according to whether the tumour was situated close to the ascending frontal convolution, or nearer towards the frontal pole of the brain. In three of these cases, where the tumour was near to the ascending frontal convolution, the fits affected first either the fingers, or the conjugate movement of the eyes, or the angle of the mouth, while in two cases where the tumours were in the anterior part of the second frontal gyrus, there were attacks of giddiness or fainting without convulsions, more like *petit mal.* In one case the attack was merely transient aphasia. In all six cases the mental condition was described as dull, stupid, slow, inattentive, with bad memory, except one case, but in none of these cases were the sphincters affected. In all of the cases there was slight weakness, either defective movement of the eyes to one side or upwards or some weakness of the opposite face, arm, or leg, with, in some cases, increase of the deep reflexes and diminution of the superficial on that side. These symptoms were probably due to pressure on the ascending frontal convolution. Sensation was either not affected, or there was temporary anaesthesia to slight touches after the fits, but stereognosis—the recognition of objects by the touch—was not affected. Affections of the sense of smell did not assist the diagnosis. In four cases of the six in which it was looked for, fine tremor in the fingers was observed in all on the same side as the tumour. It therefore appeared that the presence of fits, either faints or attacks beginning with spasm of conjugate movement of the eyes, or of the hand or face, followed by weakness but not by permanent anaesthesia, and also of mental symptoms and fine tremor on the side opposite to that affected by the fits and the weakness, were the diagnostic signs of tumour of the outer surface of the cortex of the frontal lobe anterior to the ascending frontal convolution. The lecturer then detailed six cases of tumour of the interior of the frontal lobe in which there was severe headache, vomiting (except one case), double optic neuritis, mental obtuseness, want of memory and attention, and with incontinence of urine in most of the cases, but no difference in the sense of smell on the two sides: a gradual hemiplegia without any anaesthesia, but with increase of the deep reflexes, diminution of the superficial reflexes with extensor plantar response on the paralysed side. In three of the cases there was a fine rapid tremor of the hand on the same side as the tumour, and also a tendency to fall backwards in one case. Those cases of tumour of the interior of the frontal lobe were exceedingly difficult to diagnose, and especially before there was any hemiplegia from the growth having extended backwards. The headache was often frontal, but it might be on both sides. Smell was not affected on one side as it was in extramedullary tumours. The deep and superficial reflexes might not be altered, though they were usually diminished, and in the cases where the tumour had not extended backwards there was no hemiplegia. Mental dullness was often a prominent symptom, and also involuntary micturition, but that did not help them as to which frontal lobe was involved. They must rely on the tremor occurring on the same side as the tumour. In two of the cases where the tumour was on the left side the patient was not able to speak properly, and there was some aphasia. When the tumour extended backwards, so as to compress the motor fibres of the corona radiata or internal capsule, gradual weakness of the face and limbs on the side opposite to the tumour came on with increased deep reflexes and diminished abdominal and epigastric reflexes with extensor plantar reflex, but without any affection of sensation. As soon as those symptoms appeared they pointed to which side of the brain was affected, and that taken with the mental symptoms and involuntary micturition and the fine tremor on the same side as the tumour would enable a diagnosis of a frontal tumour to be made. It must be remembered that a gradual hemiplegia might be caused by a tumour in the corpus striatum pressing on the internal capsule, but in those cases there was probably not so much mental change, and the tremor on the same side as the lesion was not observed. Dr. Beevor concluded by considering tumours of the temporo-sphenoidal lobe.

EDINBURGH OBSTETRICAL SOCIETY.

J. W. BALLANTYNE, M.D., President, in the Chair.

Wednesday, February 13th, 1907.

HYSTERECTOMY FOR CERVICAL FIBROIDS.

DR. HAULTAIN communicated a clinical and anatomical study of 30 cervical fibroid tumours removed by abdominal hysterectomy. Of his total number of cases the cervix alone was involved in 22. Cervical and corporeal fibroid tumours occurred in 7 cases, and in 1 the cervical tumour was complicated by pregnancy. Of the 22 cases in which the cervix alone was involved, in 4 the supravaginal portion was the seat of tumour formation, 3 developing on the posterior, and 1 on the anterior wall; 6 were found on the supra- and inter-vaginal portions, 4 on the posterior, and 2 on the anterior walls; 12 were found to involve supra-, inter-, and intra-vaginal portions of the cervix; of those, 8 occurred posteriorly, and 4 anteriorly. The supravaginal tumours were of the subperitoneal type, and embedded themselves in the recto-vaginal septum. The free portion of the cervix was not affected, except that it was displaced upwards, and was difficult to reach. In the 6 cases where both supravaginal and intervaginal portions were involved, the os externum was in no way affected, and was found as a small projection on the base of the tumour. This resulted from non-involvement of the intravaginal portion of the cervix. All those tumours filled the brim of the pelvis, and grew upwards and downwards, assuming an ovoid shape. In all cases the bladder was displaced upwards into the abdomen, and all gave rise to well-marked pressure symptoms. In the cases where the entire cervical wall, anterior or posterior, was involved the os externum was much dilated, and easily admitted a finger. This was due to the stretching and thinning out of the uninvolved wall. Dr. Haultain described the changes in the disposition of the pelvic peritoneum which resulted from those cervical growths. When situated on the anterior wall, the retro-uterine pouch was not interfered with, and the peritoneum extended downwards over the upper third of the posterior vaginal wall. Tumours of the posterior wall, on the other hand, lifted the peritoneum upwards, and lay in close apposition to the rectum. This was a point of considerable importance in relation to operative interference. In all Dr. Haultain's cases except one the tumours were uninodular. Cervical fibroid tumours, in his experience, manifested themselves by symptoms arising from pressure on the bladder and rectum, and not by pain. Haemorrhage occurred in 10 of the 22 cases

Br Med J: first published as 10.1136/bmj.1.2408.437 on 23 February 1907. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.

where the cervix was alone involved. In two cases the tumours were oedematous and gangrenous. Dr. Haultain then described the methods which he employed in removing those tumours. Absence of the usual landmarks, the relations of the ureters to the tumours, and the elongation of the uterine arteries rendered hysterectomy difficult. When the fibroid tumour was situated on the posterior wall of the cervix in close relation to the rectum, infection of the bed of the tumour by the *Bacteria coli communis* might follow enucleation. If a distinct capsule surrounded the growth, it was therefore safer to enucleate the latter and leave the capsule.

The PRESIDENT was of opinion that Dr. Haultain's paper would be of great value in establishing the true topography of cervical fibroid tumours, which up to now was in a chaotic state.

Dr. BARBOUR commented on the fact that notwithstanding the great pressure on the ureters which existed in those cases, the urine remained free from albumen.

Dr. BREWIS had found that in such cases the only symptom which might be present was repression of urine. Haemorrhage occurred in the submucous type of his cases. He had found that frequently panhysterectomy performed for such growths was much simplified by splitting the uterus.

FORCEPS DELIVERY IN OCCIPITO-POSTERIOR PRESENTATION.

Dr. ROBERTSON DOBIE (Crieff) described a method of delivery by forceps in some difficult occipito posterior cases. He had found that by reversing the forceps, so that when applied the sacral curve looked forward, flexion was promoted, and the head was delivered with less difficulty than when the instrument was employed in the usual method.

HYSTERECTOMY FOR FIBROIDS IN PREGNANCY.

Dr. BARBOUR commented on two cases where he had performed hysterectomy for fibroid tumours associated with pregnancy: (1) After five normal pregnancies and labours the patient became pregnant, and had repeated haemorrhages during pregnancy, followed by natural labour at term. Eighteen months later she had an abortion at the sixth month; haemorrhage, from which she suffered, prevented her from recognizing her condition. A year later, after four months' amenorrhoea, a tumour the size of a fetal head was discovered in the pelvis, growing from the posterior lip of the cervix, and displacing the uterus upwards. Panhysterectomy was performed, and the patient made a good recovery. (2) A year after marriage a three-month abortion occurred. Eight months later pregnancy again occurred, and after four and a half months' amenorrhoea a fibroid tumour measuring 4 in. in diameter was discovered. The tumour grew from the posterior wall of the uterus, had a broad base of attachment, and rotated the uterus so that the right appendages lay anteriorly. Subtotal hysterectomy was performed, and the patient made a good recovery. Immediate operation was decided on in the first case, as part of the tumour presented at the vulva, and was undergoing infection. In the second case Dr. Barbour was influenced by the strongly expressed wish of the patient and her husband for immediate operative interference.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

CLINICAL MEETING.

R. W. DOYNE, F.R.C.S., Vice-President, in the Chair.

Thursday, February 14th, 1907.

PARALYSIS OF VERTICAL MOVEMENTS OF EYES.

MR. LUDFORD COOPER showed a case of paralysis of the vertical movements of both eyes. The patient was a man in whom there was complete paralysis of the vertical movements of both eyes, which had come on suddenly, and for which no explanation could be found.

Mr. J. H. FISHER had seen two similar cases, one in a girl who was found one morning unconscious with this paralysis. She recovered consciousness rapidly, but the paralysis persisted for a long time. The explanation he then gave was an embolism of one of the small arteries of the corpus quadrigeminum. The other case showed hemianopic pupil reaction, without a hemianopic field, a condition never before recorded, and *post mortem* a diffuse growth of the lamina quadrigemina was found.

EFFECTS OF STEEL FOREIGN BODY IN EYE.

Mr. A. STANFORD MORTON showed a case of a man, aged 54, who two years previously received a steel foreign body in his right eye. The sight of this was immediately affected. About a month later the sight of the left eye began to fail, and within three months was almost completely blind. Now the right eye showed typical siderosis, with atrophy of the nerve. The left eye showed a similar condition of the disc, the atrophy being of the post-neuritic type. There was marked arterial sclerosis in both eyes. The left pupil showed the Argyll-Robertson reaction. No other sign of central nervous disease could be found.

POLYCORIA WITH CHRONIC GLAUCOMA.

Mr. MALCOLM L. HEPBURN showed a case of a man, aged 61, with polycoria associated with chronic glaucoma. The sight of the right eye had become dim recently, though for the last three years he had noticed coloured rings around the lamps. He had had no pain. The left eye was normal in every respect. The right eye showed an unusual appearance of the iris, which he stated had been present from birth. There was a complete pupil placed down and in, which reacted to light, while the part between the pupil and the periphery was made up of five triangular-shaped bands of pigmented iris tissue, with their bases towards the angle. These bands enclosed clear spaces, through any of which the details of the fundus could be plainly seen. In addition to these bands, an almost complete circular stump of pigmented tissue was visible at the angle of the anterior chamber, in which the bases of the different bands were lost. The patient stated that the pupil used to be in the centre of the eyeball, but of late years it had gradually come to occupy its present position. The fundus showed glaucomatous cupping of the disc. The case was interesting from a developmental point of view, and two explanations were possible: one that the iris was originally complete, and by subsequent atrophy, as the result of inflammatory action or otherwise, had partially disappeared; the other was a faulty development, which was difficult to understand, since the pupil was perfectly formed.

Mr. TREACHER COLLINS suggested as a possible explanation the failure of the formation of some of the loops of vessels which go to form the iris.

TUBERCULOSIS OF EYE.

Mr. WAREN TAY showed a drawing of an eye from a case of tuberculosis which was only diagnosed after an ophthalmoscopic examination had been made. This occurred 22 years ago. He showed this in order to disprove the statement of an eminent physician, who stated that this had never been done.

CASES, ETC.

Mr. J. H. TOMLINSON showed a retinoscopy longarm to facilitate the practice of retinoscopy in children.—Mr. HALLIBURTON MCMULLEN showed a case of detachment of the retina cured by two scleral punctures.—Other cases were shown by Messrs. G. W. THOMPSON and G. H. POOLEY.

PATHOLOGICAL SOCIETY OF LONDON.

DR. P. H. PYE-SMITH, F.R.S., President, in the Chair.

Tuesday, February 19th, 1907.

THE PARATHYROID GLANDS IN MAN.

Dr. DAVID FORSYTH discussed the anatomy of these glands, in the first place referring to the original observations of Sandström and others, up to those of Welch. Although the glands were commonly two on each side, they might reach a total of twelve. They never lay upon the superficial aspect of the muscles. Furthermore, they might occur within the thyroid itself. For identification, microscopic examination was essential. With the parathyroid tissue there might be bound up thymus, or accessory thyroidal. In infancy the parathyroid glands were small; in the adult their bulk varied. Arguing from the fact that the number of parathyroids was greater in infancy, and the number of accessory thyroids greater in adults, the speaker thought that the one class became transformed into the other. The presence of colloid in parathyroid tissue had been noticed by Sandström. Welch described eosinophile or oxyphile cells amongst clear, "principal" cells. The author's observations showed that the oxyphile granules

Br Med J: first published as 10.1136/bmj.1.2408.437 on 23 February 1907. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.

were discharged and could be found in the lymph capillaries as granules, or coalesced into droplets of colloid. The colloid in parathyroid and thyroid appeared identical; it was oxyphile as a rule in both. In the infant the cells were usually in the resting stage; colloid appeared later.

Mr. W. L. HARNETT read a communication upon the same subject. After describing the two types of cell met with, he advanced the view that they were merely phases of the same, the "oxyphile" cell representing the resting, the "principal," the discharged stage. The frequent occurrence of colloid in the gland was remarked upon, as was also the fact that these colloid-containing glands showed evidence of great activity in the large numbers of oxyphile cells present. Fat was normally present in the parathyroids, more especially in the more active glands. After describing the appearances of sections of the glands at various periods of life, the speaker inferred that the tissue began to show signs of activity in early childhood, and became steadily more active as age advanced, reaching the height of its activity late in life. As a result of the examination of a series of parathyroids from subjects dead from various diseases it was found that there was no feature in which these differed from normal glands at the corresponding period of life. The parathyroid from a case of parenchymatous goître in a girl aged 18, showed signs of activity unusual at that age, and contained a considerable quantity of colloid. There were no grounds for supposing that the parathyroids were affected in Graves's disease or in tetany.

Dr. H. BAYON did not hold that colloid was formed in true parathyroid tissue; the presence of colloid would show, he thought, that the tissue was thyroidal—that is, an isolated lobule of the proper thyroid. He did not think that the parathyroids took on the function of the thyroid, and he exhibited a section through the goître of a cretin, showing the parathyroid; in the latter there was no trace of colloid.

MANCHESTER MEDICAL SOCIETY.

S. MORITZ, M.D., President, in the Chair.

Wednesday, February 6th, 1907.

CONGENITAL PYLORIC STENOSIS.

DR. H. ASHBY showed nine specimens illustrating congenital pyloric stenosis in infants. The ages of the infants at death varied from 32 days to 4 months. The times at which the vomiting commenced varied from seven days to twenty days. They all showed hypertrophy of the circular fibres of the pyloric sphincter, hypertrophy of the walls of the stomach, dilatation, and marked gastric catarrh. They were treated during life with stomach washing, with either whey or peptonized milk and small doses of tr. opii. In only one case was operation performed (by Mr. Telford)—a posterior gastro-enterostomy; death occurred in twelve days. A septic abscess had formed between the spleen and the stomach, and there was also a septic pneumonia. Death occurred suddenly and unexpectedly in two cases which were apparently doing well.

ACUTE INFECTIVE BONE DISEASE WITHOUT NECROSIS.

Mr. W. THORBURN communicated two cases of acute infective bone disease unassociated with necrosis. The first, which was an example of serous or albuminous periostitis involving the whole of a metacarpal bone, and appearing as a sequel to active suppurative osteomyelitis of the femur, was brought forward as an example of attenuation. The second was a case of acute suppurative periostitis of the femur in a boy aged 11, in which the periosteum was stripped off almost the whole of the shaft by a large collection of pus. The shaft remained bare and exposed at the bottom of the large incision made for drainage for a period of many weeks, but eventually the wound healed without the formation of any sequestrum. In the latter case convalescence was complicated by the development of suppurative epiphysitis at the lower end of each tibia, small abscesses being there formed, and small sequestra being produced. It was suggested that the original infection of the femur was probably an example of true periostitis in which there had been no interference with the intraosseous blood supply, whereas in the subsequent and less active foci inflammation had commenced in the usual position (the ossifying plane), and had thus more seriously affected the bone.

TREATMENT OF VESICAL CALCULUS.

Mr. E. STANMORE BISHOP read a paper on vesical calculus and the methods in use for its removal. He remarked that although litholapaxy had many advantages the choice of this method must always depend upon the absolute certainty or otherwise of total removal of all fragments, however small; it was no wonder, therefore, that surgeons were once more reverting in some cases to cutting operations; of these, he professed a preference for the perineal route if septic cystitis were present; otherwise for the suprapubic operation. For purposes of diagnosis he claimed that the time had arrived for total abandonment of the sound; skiagraphy was extremely useful, but the cystoscope had two great advantages over even this method; stones impacted in the vesical end of the ureter, or embedded in a diverticulum would be shown by a skiagraph, but not their relation to the vesical cavity; besides this, small growths at or near the internal urethral opening might give rise to symptoms which could only be satisfactorily differentiated from those of calculus by the aid of sight. In describing the technique of suprapubic cystotomy he showed certain forceps for securing the edges of the divided bladder, which gripped without crushing them; others for the removal of the stone, the blades of which protected the raw surfaces through which the calculus had to be withdrawn; Cathcart's instrument, by which the vesical interior might be more clearly examined, and a bougie with bulbous tip for lifting up the anterior wall previous to its division. He spoke strongly in favour of immediate suture of the bladder in all clean cases, as avoiding the well-known drawbacks of the old suprapubic operation: the dribbling of urine over the skin, possible secondary abscesses behind the pubic bone, urinary fistulae, the avoidance of an open wound, especially in children, and similar sources of disgust and disappointment. He pointed out that it is not now so necessary to insist upon asepsis, since that may be taken as a matter of course, but that the obstacles to the primary union of such a wound would now be found to be, first, the escape of fluid from the bladder over the wound when that viscus had been distended with boric solution before division; secondly, the opening up of the cavum Retzii and the formation there of a haematoma; and, thirdly, the bruising of the edges of the wound, either in the bladder or the tissues of the abdominal wall. He showed several calculi, ureteric and vesical, also a patient with his temperature chart, to demonstrate the small amount of local or constitutional disturbance produced.

NORTH OF ENGLAND OBSTETRICAL AND GYNAECOLOGICAL SOCIETY.

E. O. CROFT (Leeds), M.D., President, in the Chair.

Liverpool, Friday, February 15th, 1907.

CARD SPECIMEN.

DR. A. STOOKES (Liverpool) showed a mixed adenoma and dermoid of the ovary, weighing 9 lb., co-existing with a small dermoid of the opposite ovary.

SPECIMENS.

DRS. BRIGGS and EMRYS-ROBERTS exhibited (1) the Fallopian tubes and ovaries from a case of acute gonorrhoeal salpingitis occurring in a woman aged 25 years, who had suffered from repeated attacks of pelvic pain since marriage five years ago; (2) cancer of the cervix uteri coincident with unilocular cyst of one ovary and fibroma of the opposite ovary, removed from a patient aged 67 years, 4-para, who had suffered from a sanious vaginal discharge for two years. Abdominal hysterectomy was performed. Microscopically the growth was an epithelioma.

Dr. GEMMELL showed a double pyosalpinx. The tubes were each 4 in. long and 1 in. in diameter. There were only a few peritoneal adhesions. The ovaries were unaffected.

Dr. A. STOOKES (Liverpool) exhibited an ovarian cyst with the adherent vermiform appendix successfully removed by abdominal section from a nulliparous woman, aged 41, who had suffered from pain in the right side and menorrhagia for six to seven years. The Fallopian tube was thickened by chronic salpingitis, and was stretched over a thin-walled cyst of apparently inflammatory origin. Beneath this lay the cystic ovary, the size of an orange. The adherent vermiform appendix was also removed.

Br Med J: first published as 10.1136/bmj.1.2408.437 on 23 February 1907. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.

Br Med J: first published as 10.1136/bmj.1.2408.437 on 23 February 1907. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.

Dr. F. W. BAKER YOUNG (Liverpool) showed a safety-pin removed from the vagina of a girl aged 8 years. It had been there for two years, and had caused continuous haemorrhage.

Drs. GEMMELL and LEITH MURRAY showed a tumour of the right ovarian ligament weighing 2 lb. and the size and shape of a cocoanut. There was a double twist of the pedicle, and the surface and substance of the tumour was deeply mottled with haemorrhage. Microscopic section proved it to be a pure fibroma.

ECTOPIC COEXISTING WITH UTERINE PREGNANCY.

Dr. DONALDSON (Manchester) described a case of ectopic pregnancy coexisting with uterine pregnancy in a woman aged 40, 4-para. Previous to this pregnancy menstruation had been regular every four weeks, lasting one to fourteen days. She was delivered of a seven-months living child eight weeks prior to admission to hospital. Three days after the confinement her doctor noticed an abdominal swelling which increased in size and was accompanied by intermittent cutting pain in the left side. During the eight weeks following delivery there were two menstrual periods lasting seven and fourteen days respectively, the latter accompanied by the passage of two large, stringy lumps. There were no symptoms of severe pain, fainting, or other signs of haemorrhage. An irregular swelling occupied the hypogastric and both iliac regions, and per vaginam was found to be distinct from the uterus. Abdominal section revealed a sac composed of the left Fallopian tube containing a decomposing fetus measuring 13 in. and weighing nearly 3 lb. The sac was adherent to intestine, and was therefore stitched to the edges of the abdominal wound and packed with gauze. The patient was discharged convalescent at the end of six weeks. The extrauterine was probably synchronous with the uterine pregnancy, death of the fetus occurring when the uterine fetus was born.

FATAL VOMITING IN PREGNANCY.

Dr. STOOKES (Liverpool) also described a case of fatal vomiting in a woman, 2-para, who was seven months pregnant. From the second to the sixth month the vomiting was not excessive, but for the fortnight preceding admission to hospital it was continuous and "coffee-ground" in character. She was so ill that induction of premature labour was deemed inadvisable. Rectal salines were administered. Death occurred on the second day after admission, from cardiac failure. At the autopsy partly-digested blood was found in the stomach and small intestine; the kidneys were congested; the other organs were normal.

ROYAL ACADEMY OF MEDICINE IN IRELAND.—At a meeting of the Section of Anatomy and Physiology, held on January 25th, Professor A. F. DIXON, President, in the chair, Mr. F. O'B. ELLISON (introduced by the PRESIDENT) presented a note on the musculature of the villi. A number of microscopic sections of villi were shown in illustration of the points indicated, and one of the specimens showed compound villi. Professor W. H. THOMPSON said that the appearance of round spaces with transverse sections of muscle in the first section shown would come to some of them as a revelation of the amount of muscle that could be present in villi. Further facts that Mr. Ellison had made out made it exceedingly probable that there was far more muscle in the villi than came up from the muscularis mucosae. If so, it would make the working of the villi a mechanical process about which there would not be very much mystery. The investigation, however, was not complete. The PRESIDENT expressed the hope that research in the same direction would be continued.—Mr. WM. CALDWELL (introduced by the PRESIDENT) read a paper on the estimation of urea in urine, and the estimation of hydroxybutyric acid in urine. The PRESIDENT exhibited a series of sections and x-ray photographs of the upper end of the femur to illustrate the arrangement of the cancellous lamellae and of the structure known as the calcar femorale. Professor E. P. M'LOUGHLIN said that the communication threw a new light on the significance of the calcar, and the sections showed that structure to be very much more extensive than had been generally described.—Professor FRASER exhibited two adult male subjects cut in the long median plane. He referred to the varying relations of the ventral aorta to the sternum, to the presence of the embryonic cranial flexure in the adult, which did not cease with the bony dorsum sellae, but extended as soft supporting tissue to the roof of the fossa interpeduncularis, a point which had great significance in the numerous measurements of the skull. He also drew attention to the variations in the distance between the perineal skin covering and the posterior extension of the body cavity in both male and female, and more particularly in the young.

LEEDS AND WEST RIDING MEDICO-CHIRURGICAL SOCIETY.—At a meeting held on January 18th, Dr. BAMPTON in the chair, Dr. W. EDGECOMBE read a paper on metastatic pancreatitis in mumps. Mr. LAWFORD KNAGGS read a paper on punctured fractures of the base of the skull. Dr. A. F. DIMMOCK gave a demonstration of the uricmeter, designed for a rapid process for estimating uric acid in urine. The following are the details of the method: 100 c.cm. of urine are taken and placed in a conical flask (Erlenmeyer) of about 400 c.cm. capacity; to this is added 1 gram of lithium carbonate, and the whole boiled for three minutes. By this means practically the whole of the phosphates are precipitated, and free carbonic acid is eliminated. If frothing occurs it can be checked by simply blowing with the mouth on the upper portion of the outside of the flask. The liquid is filtered while hot, to remove precipitated earthy salts, etc., which are washed with a little distilled water until the filtrate measures 100 c.cm. This is now cooled down to 60° F., and to 50 c.cm. of the filtrate, which contains the uric acid as lithium urate, 5 gr. of ammonium chloride is added, shaking the flask until dissolved. After three minutes the contents of the flask are warmed to 120° F., so as to secure a uniform aggregation of the precipitated urate of ammonium. The whole is now poured into a tube graduated in parts per 100 of uric acid, and deposition allowed to take place, the reading being taken after twenty-four hours have elapsed. If the urine does not contain a high percentage of uric acid, the reading can be taken in four to six hours. Dr. Dimmock claimed that this rapid method proved sufficiently accurate for most clinical purposes. He had made a large number of estimations with it, controlled by estimations made by the more exact processes, and the close agreement between the two sets of results obtained had demonstrated that this method was useful for all ordinary clinical purposes where rapidity was desirable. The following cases and specimens were shown: Mr. W. THOMPSON: A specimen of intussusception of the vermiform appendix, removed by operation. Mr. H. LITTLEWOOD: A case of fracture of both patellae, wired December 13th, 1905. Mr. SECKER WALKER: A case of Mules's operation after perforating wound of the eye. Mr. J. F. DOBSON: A case of bilateral congenital dislocation of the hip, treated by Lorenz's method. There had been an entirely successful result on one side, and he proposed to repeat the operation on the other side. Dr. MAXWELL TELLING and Mr. DOBSON: A case of hydrocephalus treated by ligature of both internal carotid arteries, with considerable improvement. Dr. E. F. TREVELYAN: A case of Graves's disease in a man, aged 20, whose sister also suffered from the disease. Dr. TELLING: A case of framboesioid syphilis of the face. Cases and specimens were also shown by Mr. A. L. WHITEHEAD, Mr. O. GRUNER, Dr. J. B. HELLIER, Dr. WARDROP GRIFFITH, Mr. L. ROWDEN, Mr. R. G. HANN, Dr. T. CHURTON, and Mr. LAWFORD KNAGGS.

BURNLEY AND DISTRICT MEDICO-ETHICAL ASSOCIATION.—At a meeting held on January 24th, J. S. WILSON, M.B., in the chair, Mr. A. MACGREGOR SINCLAIR, M.B., showed four tumours of ectopic gestation which he had recently removed from patients. He gave histories of each of the cases, and laid especial stress upon each woman having been sterile for several years and having had an offensive leucorrhoeal discharge during the period of sterility. He deduced from these facts that ectopic gestation was probably due to disease, either of the uterus or of the tubes. Each case was marked by the usual symptoms of abdominal pain and bloodlessness before operation and a well-marked pulsation in the fornix of the side upon which the tumour was situated. The fourth case differed from the first three, inasmuch as it was complicated by an inflamed adherent appendix, and the earlier abdominal symptoms were obscure. On operating, the right tube,

which contained a three to four months fetus, was twisted round behind the uterus and attached to the appendix, and, though it was ruptured, only a small amount of haemorrhage had taken place, because the tear in the tumour was filled by the protruding head of the fetus. The cases were all treated in the ordinary aseptic manner, and made uneventful recoveries. The discussion was introduced by Mr. H. J. SLANE, M.B., Dr. R. C. HOLT, followed by Mr. J. H. CARTER, F.R.C.V.S., who related a case which he had discovered of ectopic gestation in a Newfoundland bitch.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY.—At a meeting held on January 30th, Mr. H. SHIRLEY JONES, President (Droitwich), in the chair, Dr. C. W. BUCKLEY (Buxton) introduced a discussion on the influence of climate on gout and rheumatism. He said gout was affected by climate, so far as the functions of the liver and excretory system, comprising both kidneys and skin, were concerned. In patients who were fairly robust and without high arterial tension or arterio-sclerosis a bracing climate was desirable; humidity should be low and temperature fairly equable. Where there was high tension a more relaxing climate was best, and inland were generally better than marine climates. The south-eastern counties showed a remarkable excess of gout in comparison with other parts of the country, partly explained by the class of population, and perhaps partly by the chalky character of the water. Acute rheumatism was not affected by climate, except so far as unfavourable climatic conditions might lower the resistance of the system to infection. Muscular rheumatism and kindred conditions, which were best described as fibrositis, were unfavourably influenced by a high humidity and especially by a damp soil, but temperature was of less importance, equability being more essential than warmth. Free air access was important, and stuffy hollows to be avoided. For the foregoing diseases there did not appear to be any advantage in sending the patient abroad. In rheumatoid arthritis, however, the desirable combination of warmth, equability, and low humidity was hardly attainable in this country, though low humidity was still the most important factor. Probably the best climates in this disease were those of Grand Canary, Teneriffe, and Bermuda. Dr. GROVES (Isle of Wight) expressed general agreement with Dr. Buckley's views, and pointed out the unreliabilty of statistics in determining the effect of climate upon the diseases in question. For those of early middle and later life suffering from or having a tendency to rheumatic and gouty affections, an equable climate with a marine atmosphere, not too humid to admit of free diaphoresis in connexion with exercise in a locality sheltered from cold winds, was most suited. Dr. PERCY LEWIS (Folkestone) held strongly that chalk in drinking-water had nothing to do with the causation of gout. Gout and rheumatism were considerably more a matter of the habits of individuals than of the climate in which they happened to reside. Dr. BEGG (Bath) thought of climates as divided for clinical purposes into two classes—(1) the bracing, (2) the relaxing or sedative—and his principle of applying them to cases was that which governed his administration of stimulants. When he would use malt liquors and nourishing port, he advised a sedative climate to build up a reserve force; and when champagne and spirits, he recommended a bracing one to influence metabolism. Dr. LEONARD WILLIAMS did not believe in the existence of a disease which could be properly called chronic rheumatism. Most of the cases so described were chronic gout or some septic form of arthritis. Goutily-disposed people were better in bracing climates; those with definite gouty manifestations in kidneys or arteries ought never to be sent to bracing climates, but always to relaxing ones. The discussion was continued by Dr. TYSON (Folkestone), Dr. JOHN LEON (Southsea), Dr. F. THOMPSON (Bath) Dr. GEORGE THOMPSON (Buxton), and Dr. HEANEY (Blackpool); and Dr. BUCKLEY replied.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.—At a meeting on January 23rd, Dr. LESLIE ROBERTS, President, in the chair, Dr. A. EDDOWES showed a case of *Acrodermatitis hiemalis* in a young woman, aged 24, in whom the condition had lasted for nine years. The hands were somewhat swollen and congested, and here and there were small scars, the result of previous nodules which had appeared deeply, come towards the surface, and had ruptured. The patient also had a chronic swelling of the left knee-joint. The case was discussed by many of the members, and the resemblance of the condition to *folliclis* (Barthélemy) and also to *chilblain-lupus* (Hutchinson) was pointed out. Dr. J. H. STOWERS showed a boy, aged 9, with a small nodule upon the right cheek which was alleged to have resulted from a mosquito bite seven months before. The tuberculous nature of the lesion was regarded as "not proven."—Mr. G. W. DAWSON exhibited (1) a boy of 11 with *Tinea tonsurans* in order to demonstrate what a complete and rapid defluvium of the hair had occurred from only four exposures to the x rays; (2) a case of *Acute lichen planus* in a woman aged 45, in whom the eruption had appeared suddenly five months previously. The lesions were annular, widely distributed, and the irritation very severe. The patient's general health was much impaired at the onset of the disease. Dr. GRAHAM LITTLE showed, for diagnosis, a woman, aged 33, in whom a scaly, papular eruption had appeared three weeks previously. The skin was very dry and irritable. Among the suggestions offered were lichen planus, a drug eruption, and dermatitis exfoliativa.

HUNTERIAN SOCIETY.—At a meeting held on February 13th, Mr. JOHN POLAND, President, in the chair, Mr. LANGDON BROWN read a paper on acetonuria, its clinical significance and treatment. The presence of diacetic acid in the urine was more important than that of acetone, but this acid was unstable and broke down into acetone if not excreted very rapidly. It was found not only in diabetes, but in recurrent vomiting in children, pernicious vomiting of pregnancy, mountain sickness, delayed chloroform poisoning, and starvation. Acetonuria was a symptom of tissue degeneration, of acidosis with insufficiency of oxygen. It was possible that biliousness and migraine were both due to acetonuria. The most successful treatment consisted in the administration of large doses of sodium bicarbonate. Dr. Langdon Brown dwelt at some length on the question of delayed chloroform poisoning. Dr. LEWIS SMITH insisted on the importance of acetonuria in the differential diagnosis between diabetes and elementary glycosuria. He demonstrated the fact that the urine of a patient who in taking salicylates gave a reaction with a solution of perchloride of iron similar to that given by urine containing diacetic acid. He spoke of the marked changes seen in the epithelium of the renal tubules in some cases of diabetes. Dr. RUSSELL ANDREWS remarked on the fact that acetone was found sometimes in the urine after labour, particularly in cases where the labour had been prolonged and difficult, and asked whether prolonged administration of chloroform could be held responsible. The theory that acetonuria could be looked on as a sign of intrauterine death of the fetus had been disproved. In some cases of necrobiosis of uterine fibroids acetone was found in the urine. Dr. F. R. HUMPHREYS exhibited charts which he had compiled from the monograph of Dr. Schumann Leclercq on the variations brought about by dieting in the amount of acetone in his own urine. Dr. THEODORE FISHER spoke of recurrent vomiting in children, which seemed to be due sometimes to a recurrent febrile attack. He doubted whether the fatty condition of the liver found after chloroform poisoning was due so much to the administration of cod-liver oil as to prolonged sepsis. Dr. FORTESCUE FOX asked whether acetonuria occurred after administration of anaesthetics other than chloroform.

GLASGOW PATHOLOGICAL AND CLINICAL SOCIETY.—At a meeting held on February 11th, Dr. J. LINDSAY STEVEN, President, in the chair, in addition to other business of a private character, the following card specimens were shown: Professor MUIR: (*a*) Spinal cords from cases of cerebro-spinal meningitis; (*b*) specimens from a case of generalized melanotic sarcoma (primary tumour in the eye). Dr. JOHN ANDERSON: (*a*) Kidney with tumour invasion of the adrenal type; (*b*) brain with basal meningitis from a case of pneumonia. Dr. JOHN H. TEACHER: Specimens from two cases of abscesses in the liver secondary to septic cholangitis.

Br Med J: first published as 10.1136/bmj.1.2408.437 on 23 February 1907. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.