REPORTS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

FRIDAY, DECEMBER 13TH, 1889.

CHRISTOPHER HEATH, F.R.C.S., President, in the Chair.

Living Specimens.—Mr. SILCOCK showed a case of acromegaly in a woman, aged 53. He noticed her fingers begin to enlarge six years ago. Her features were large, and the lower jaw was massive and projecting. The cartilages of the nose were enlarged, as was also the tongue. The feet were large, but less markedly so than the hands.—Other cases of acromegaly were shown by Messrs. PERCY FLEMING and K. CAMPBELL.—Mr. CHARTERS SYMONDS showed two patients from whom thyroid cysts had been removed, one of whom had a sympathetic paralysis of the eye.—Mr. SPENCER showed a man suffering from ataxia, on whom he had operated for suppuration of the left shoulder joint beginning as an ordinary case of Charcot's disease.—Mr. JOHN MORGAN showed a case of what he described as inflamed nævus associated with subcutaneous hæmorrhages in an infant.—Mr. MORGAN also showed a lad, aged 11, the subject of an enlargement of the left frontal bone of doubtful nature, which began five years ago. —Dr. ANGEL MONEY showed a girl, the subject of symmetrical enlargements, probably rheumatic in origin, in front of both elbows. She had had rheumatism, which had left a mitral murmur. She had also had erythema nodosum.

Eight Cases of Cysts and Adenomata of the Thyroid treated by Extirpation of the Growth—Six in Women, Two in Men; One, a Woman, being Fifty-four Years Old, the Others being under Thirty. —Mr. CHARTERS SYMONDS read notes of these cases. He sketched the other methods of treatment by injection and incision, and the method used by Professor Hahn, who ligatured masses of fascia and gland as he removed the cyst. In the cases recorded, in one the entire thyroid was removed with a tumour that lay partly beneath the sternum. The lobes were empty, and Mr. Symonds regretted that he had removed them. The operation was undertaken early in 1883, before the cachexia following removal of the whole gland was generally known, and the wide oozing surface left after removal of the growth seemed to promise hæmorrhage. In the next case of a solid tumour behind the right lobe, causing dysphagia so complete that the patient had to be fed with a tube, the lobe and tumour were removed by an incision to one side of the median line over the growth. Some difficulty was experienced in obtaining sufficient room, owing to the incision being lateral. On dissecting this tumour it was found to be encapsuled, and to be situated behind the gland, and might easily have been enucleated. Consequently, in subsequent operations, Mr. Symonds decided first to search for the capsule and then to enucleate. In four subsequent cases this was done, and the growths (in one case solid, in the others partly cystic) were removed without the loss of any blood, and with great facility. As a rule, at most these small vessels required ligature. In one the lobe had to be raised up before the cyst could be reached. In the remaining case the lobe was removed because it appeared to be blended with the cyst; this turned out subsequently not to be the case. All the patients recovered with primary union, and most required but one dressing subsequently to that made at the operation. The method employed might be thus summarised. To make in every case, no matter where the tumour was situated, a median incision, which gave more room and left less scar, and, when the deep fascia was opened, the largest growth could be brought to the median line. To expose certainly and definitely the cyst or adenoma—that is, its fibrous wall, and then to dissect off the gland. If the wall were followed closely no bleeding or trouble was encountered. If the white, glistening wall of a solid tumour or the bluish wall of a cystic were not seen at once, then the edge of the gland must be sought and raised up till the capsule was seen. If a dissection were commenced outside this severe bleeding would be encountered. In the case of a cyst Mr. Symonds advocated opening it early, after sufficient of the wall had been exposed to secure with forceps, and dissecting back the thyroid. By this means the operation could be performed through a smaller opening, and the resulting scar was slight. The similarity in anatomy between these cysts and adenomata and those of the breast was pointed out, to explain why the growths could so easily be turned out. All the cysts contained in the wall a variable amount of gelatinous glandular material which showed the usual veins lined by cortical or columnar epithelium, and this structure was exactly the same as in the solid forms. As to diagnosis, it was pointed out that the cases suitable for operation were those in which the growth was localised, well defined, and limited to one side. In no case were there two tumours, though multiplicity was not considered to negative operation, there being no reason why two or more localised encapsuled growths should not be extirpated at the same time. It was impossible to decide between cystic and solid forms without exploration. It was held that excision gave more speedy recovery, and was more free from danger than any other method, while the small scar resulting from injection seemed to the author to be counterbalanced by the prolonged treatment and the often severe hectic that followed. Mr. Symonds also pointed out the necessity of the strictest antiseptic precautions in these cases. He had employed the spray except in four cases, where the wound was kept full of sublimate solution. But more particularly he called attention to the necessity of surrounding the neighbourhood of the wound with towels wrung out of lotion, and of operating with the arms of the assistant as well as the surgeon bare, and of wearing a clean linen apron or a towel pinned over the waistcoat from the neck downwards. These subsidiary precautions he considered of far more importance than the spray. He further added that in all the cases except one there were symptoms sufficiently important to demand operation. The one was that of a lady who requested that the growth might be removed. He deprecated operation where symptoms were absent. Two patients were exhibited. One from whom an adenocystoma, measuring three by two inches, was removed through an incision one inch and a half long, presented only a very small scar. The other still exhibited the ocular symptoms of sympathetic paralysis, which had antedated the operation performed nearly three years previously.—The PRESIDENT had not removed cysts from the thyroid, but had injected them with solution of perchloride of iron; and had seen cures thereby effected in cases of simple cysts without solid growth, without any inflammation supervening. Fever was sometimes caused, but he had not seen any disastrous result.—Mr. SILCOCK described a case of the disease. The enlarged lobe was to the right of the middle line, but he made a median incision, and being unable to delimit the cyst wall, he removed the right lobe. There was probably not an ounce of blood lost. He had ligatured the veins as well as the arteries in that case. In another case, that of a lady, the cyst was injected with perchloride of iron, and acute cellulitis of the neck and of the anterior mediastinum supervened. Mr. Silcock evacuated the abscess, and that patient recovered.—Mr. G. SPENCER related a case in which a silk ligature caused much trouble until it came away. He asked whether, after partial removal of the thyroid, the remaining lobes continued to decrease as they did after division of the isthmus of that body?—Mr. PARKER said that years ago he was performing tracheotomy for a child with urgent symptoms, and with a big thyroid, when he divided the isthmus in order to introduce the tracheotomy tube. Some months afterwards there was found to be a considerable diminution of the thyroid in that case.—Mr. BLACK said that Mr. Sidney Jones divided the isthmus of the thyroid as a definite plan of treatment for urgent dyspnœa due to enlarged thyroid, after the plan first advocated by Sir Duncan Gibb. He placed two ligatures upon it, and divided the isthmus between them.—Mr. BATTLE asked whether Mr. Symonds had come across any case in which a large vessel communicated with the gland. He recollected the case of a lady with a cyst, which he had first emptied and then packed with gauze, the hæmorrhage having been free.—Mr. BERRY remarked that in one case, three years after division of the isthmus, the gland (which had at first diminished) had grown again to its usual size. It was also, he thought, a common experience that if one lobe were removed, the other at first diminished, and then grew again to its original size before the operation. There was generally no hæmorrhage when the isthmus was cut across, contrary to the opinion generally entertained by surgeons in this country. He had seen three cases of such division of the isthmus without hæmorrhage, such bleeding being almost entirely from the vessels at the upper and lower borders of the isthmus. If they were tied at first, there was not generally hæmorrhage from the division of the isthmus.—Mr. GODLEE described a plan for the removal of parts of the gland for goître, carried out by Sir Joseph Lister. Opening the gland, he scooped out part of it. There was hæmorrhage only if the large veins underneath the fibrous covering of the gland were interfered with. In a case of sarcoma, however, the hæmorrhage was severe, and almost endangered the patient's life. He thought the plan advocated by Mr. Symonds, with its healing in three or

four days without rise of temperature, better than that of the injection of iron, with its attendant dangers, rise of temperature, etc.—Mr. BERRY added that in the last ten years Socin, of Basle, had successfully removed the tumour in sixty-six cases, the results of which had been published in a pamphlet which Dr. Keser had translated.—Mr. SYMONDS, in reply, said that he had not yet encountered one of the hæmorrhagic cysts. He had divided an isthmus an inch and a half wide, using much care, by tying only one vessel. If the surgeon kept free of the fibrous capsule, there was very little hæmorrhage. He still thought that Mr. Silcock might have removed the cyst in his case without cutting away any of the body of the thyroid.

Diffuse Aneurysm in the Calf of the Leg simulating Abscess. Recovery after Removal of Arteries.—Mr. W. H. BATTLE described this case. The patient, a labourer, aged 28, was admitted into St. Thomas's Hospital on December 27th, 1887, and came under Mr. Battle's care. Five weeks before admission the man was descending a ladder, when his foot slipped. Next day the left leg was painful, and the calf slightly swollen. He was able to do his work for a few days, but at the end of a fortnight the swelling began to increase rapidly, and the pain became very acute, preventing rest. The family and previous history of the patient were good. He was a slightly-built man, marked with scars of small-pox, and had an anxious appearance. The affected leg was much swollen, measuring about a third more than the right, and almost circular in shape. It was both very painful and tender. About five inches from the ankle-joint on the inner side was an area of marked redness; here there was fluctuation; œdema extended all round the ankle and for some distance up the leg. There was no pulsation in the swelling, and none in the arteries below. The swelling extended from the upper end of the tibia to within four inches of the ankle-joint, and was remarkably tense and hard. It occupied the deep calf and spread from side to side. The temperature was high; the tongue was furred; the pulse full and rapid. It was difficult to get any history of the swelling. The patient did not at first recollect the sprain. It appeared to Mr. Battle that the swelling was probably due to the formation of an abscess in the deep calf, and that its excessive hardness was the consequence of extravasation of blood into it from the giving way of a vessel of some size. The same evening antiseptic incision was carefully made into the most fluctuating part, and Esmarch's band applied above the knee. The large cavity was then emptied of its contents (which consisted only of blood partly in clots, without a trace of pus), plugged with strips of oiled lint, carefully bandaged, the elastic band removed, and the limb placed on a splint. Next day ether was again administered, Esmarch's band was applied above the knee, and, after removal of the plugs, which had effectually prevented any bleeding, the incision was prolonged upwards along the side of the leg; this incision divided the tibial origin of the soleus, and subsequently the inner head of the gastrocnemius, and upon the removal of the elastic band a spurt of blood came from an opening in the posterior tibial artery just below the origin of the anterior tibial. The popliteal artery was then tied just above its bifurcation, the posterior tibial just below the opening, and the anterior tibial at its commencement, after which the artery between the ligatures was dissected out and removed. The opening from which the blood had escaped was situated in the posterior aspect of the vessel, the margin of which showed fine granulations but no atheromatous change, nor was any found in the part removed. There was no sac other than that formed by the condensed tissues, the surface of which was shreddy, whilst the interosseous membrane had lost its firmness. Antiseptic dressing was applied, and three drainage-tubes inserted, the wound, which was about eight inches long, being closed with interrupted sutures, the limb enveloped in cotton-wool, and again placed in the splint. Further examination of the patient showed no evidence of disease of the heart, arteries, kidneys, or any of the internal organs. For some days there was sharp fever. The foot was at first cold, waxy in appearance, and retained the marks of the finger when pressure was made, but the circulation gradually improved until, on January 20th, 1888, anastomosing vessels could be felt around the knee and the upper end of the tibia. For nearly six weeks sloughs, some of them of large size, continued to come away, and although the temperature had fallen, suppuration was present in the wound. On March 18th a sharp attack of erysipelas affected the limb, and the temperature rose as high as 104.6°. This attack lasted a fortnight, and on the fourth day the knee-joint was aspirated, suppuration having taken place in it. The aspiration was repeated on the eighteenth day; the joint afterwards perfectly recovered. The wound was very slow in healing, progress being frequently interrupted by breaking down of the scar tissue. On June 5th it was examined under ether, opened up, and the surface scraped. The remainder of the cavity healed from the bottom, after relaxation of the calf muscles had been assisted by the division of the tendo Achillis. The breaking down of the scar tissue was always accompanied by fever, and preceded for some hours by enlargement of the femoral glands. The patient left St. Thomas's Hospital on October 27th, 1888, with the wound closed, but similar breakings down of newly formed tissue occurred on several occasions. However, when shown to the Society in May last he could walk with the assistance of a stick, and had perfect movements in both knee- and ankle-joints. The difficulty in diagnosing some cases in which blood had been diffused after the subcutaneous rupture of an artery had seldom been more fully exemplified than in this case. The great hardness and excessive tension of the part were so unusual that Mr. Battle thought they must be due to hæmorrhage into an abscess cavity. The extent and tension of the swelling made the absence of pulsation in the vessels below easily explicable on the supposition of pressure higher up, whilst the œdema of the limb made accurate examination difficult. This suggestion of hæmorrhage, in addition to the supposed presence of pus in the swelling, made him cautious in opening the cavity, and he was prepared to act should there be unusual bleeding. The increase in the swelling for the three weeks preceding admission probably allowed of the development of the anastomosing circulation, which at the time of operation was sufficiently established to maintain the vitality of the limb. It was suggested that the anterior tibial took a high origin, and so carried on the circulation, and that the vessel which appeared to be the anterior tibial was really the peroneal. Against this view was the point at which it arose from the popliteal, at the lower margin of the popliteus muscle; its size, which was little smaller than the posterior tibial; the fact that the anterior tibial could not be felt then at the ankle, nor for weeks later, though it could be felt to pulsate now; also the extreme anæmia of the part after operation, and the slowness with which circulation in the part became re-established. The portion of artery removed measured at least two inches in length, and presented no evidence of atheroma or of softening. The posterior tibial below the opening was pervious, as evidenced by passing a probe into it. The amount of clot was comparatively small, whilst the shreddy condition of the walls of the cavity made it a matter of no surprise that extensive separation of sloughs followed, with a failure of the antiseptic treatment employed. After the operation the course of the case might be divided into three periods: The first comprising the time during the re-establishment of the circulation, separation of sloughs, and partial healing of the wound. The second, the attack of erysipelas, complicated by suppuration in the knee-joint and the formation of a slough over the heel. The third, the continued healing of the wound and contraction of the extensive cicatrix, so often interrupted by breakings down of the newly-formed scar tissue. Mr. Battle gave in an appendix a short record of cases of a similar kind. Guthrie had a patient under his care with a rupture of a posterior tibial aneurysm. In the JOURNAL for 1878 was recorded a case of aneurysm of the posterior tibial, resulting from a wound of the calf of the leg seven months previously. Gross recorded[1] a case of aneurysm of the posterior tibial artery, which formed a pulsating tumour in the middle of the calf; there was a well-marked *bruit*. Gross ligatured the posterior tibial through an incision four inches in length, and the man recovered. A postman, under the care of Spence, had received a wound from a knife in the upper and inner part of the left leg, five weeks before admission.[2] The posterior tibial had been injured close to the popliteal, and also one of the venæ comites. A ligature was applied above and below the wound in both artery and vein, and another upon the anterior tibial, just below the bifurcation of the popliteal. The ligatures separated in eight days, and the man recovered.—Mr. BLACK thought that probably the anterior tibial artery had a high origin, and that the arteries tied were the posterior tibial and the peroneal, the anterior tibial carrying on the circulation.—The PRESIDENT said that cases of diffused aneurysm were often very difficult of diagnosis. In a case of popliteal aneurysm he had, within the last three months, seen a poultice removed when the case came before him for his opinion, the swelling being mistaken for an abscess.

[1] *Phil. Med. Times*, vol. ii, p. 374, 1871.
[2] *Med. Times and Gaz.*, 1872.

In another case he and another practitioner had been at variance as to the nature of the tumour.—Mr. BERRY related a case in which the anterior tibial, the peroneal, and the posterior tibial had been tied a week before, and yet the foot still remained warm.—Mr. BATTLE, in reply, was surprised that the circulation had been maintained, and mentioned Spence's case, in which there was extravasation in the limb. The same three arteries were there ligatured, and the patient recovered with a good limb.

PATHOLOGICAL SOCIETY OF LONDON.

TUESDAY, DECEMBER 17TH, 1889.

W. H. DICKINSON, M.D., F.R.C.P., President, in the Chair.

Cyst of Cerebellum.—Dr. HADDEN exhibited a simple serous cyst involving the right lobe of the cerebellum. It was imbedded in the white matter, and there was no sign of growth, hydatid membrane, staining or softening, in the neighbourhood. The cyst measured an inch and a half from side to side, and one inch from before backwards. The symptoms were those of cerebellar tumour. Two cases had been reported, one by Dr. Sharkey in vol. xxxiii of the Society's *Transactions*, the other by Dr. Pye-Smith in vol. xxxvi. The exhibitor referred to another case which he had published, and to one recently described by Dr. Major before the Bradford Medico-Chirurgical Society. The origin of these cysts was obscure; possibly they were due to the dilatation of lymph spaces. The explanation given by Mr. Shattock of Dr. Major's case was very doubtful. This gentleman had suggested that the cyst might be a fœtal remnant, and had alluded to the presence of a ventricle in the cerebellum of some birds.—Dr. GULLIVER then described a simple smooth-lined cyst of the right lobe of the cerebellum, which had contained semisolid material. The case was in every way very similar to the one just described by Dr. Hadden.—Mr. BOWLBY asked if the walls of the cysts had been examined microscopically.—The PRESIDENT asked Dr. Hadden whether there had been any loss of power in the lower limbs in his case. He recalled several cases of tumours in the lateral lobes of the cerebellum in which there had been loss of power in both lower extremities, but without any loss of sensation.—Dr. HALE WHITE referred to a paper that he had written, in conjunction with Dr. Savage, in which he had described the appearances of the organs of two lunatics, several of which contained cysts as well as the brain, yet these would hardly all be considered congenital.—Dr. HADDEN replied that there was no staggering or paralysis in the case that he had described, and that the cyst wall had not been microscopically examined.—Dr. GULLIVER replied that no microscopical examination had been made in the cyst wall in his case.—Dr. W. S. COLMAN then described a simple cyst of the cerebellum which had involved the middle lobe, and had also excavated the white matter of the left lateral lobe. Symptoms had existed for two years before death. These were paroxysmal left occipital headache, reeling gait, with tendency to fall to the left, occasional vertigo with sensation of falling backwards, slowly progressive impairment of power in right arm and leg, prominence of both eyes, sluggish pupils, slight nystagmus, and double optic neuritis. Great improvement occurred for a month or two after the patient first came under observation. Death had occurred suddenly from paralysis of the muscles of respiration. On microscopical examination, the wall of the cyst was found to be composed of layers of neuroglia. There was no trace of malignant disease, nor were there any other cysts in the cerebellum.

Alveolar Carcinoma of Breast following Eczema (Chronic Papillary Dermatitis) of Nipple.—Mr. BARLING described a specimen which had been removed from a lady, aged 58, who had suffered from the so-called eczema for six months. The nipple only was involved, and from it an indurated cord extended inwards on the equator of the breast for an inch and a half to a firm nodule, the size of a horse-bean. The skin over the whole breast was movable and free from puckering, and the axillary glands were free from enlargement. Only the middle third of the breast was removed, including the skin over it and the pectoral fascia and muscle beneath. The patient had continued well up to the present time, twenty months after the operation. A series of sections from the nipple through the indurated cord and the little tumour showed that there was overgrowth of the rete mucosum, with abundant small-celled infiltration. The lacteal ducts could be traced from the nipple to the growth. They were enlarged and distended with epithelium, whilst in places they were surrounded by small-celled growth. The small tumour was made up chiefly of alveolar carcinoma, with traces here and there of duct carcinoma. Mr. Barling commented on the short time which had intervened between the origin of the eczema and the development of the carcinoma, and upon the general absence of squamous-celled carcinoma in these cases.—Mr. BOWLBY alluded to a paper of Mr. Butlin's, which was read before the Medico-Chirurgical Society, in which the subject of the connection between eczema of the nipple and mammary cancer had been very exhaustively considered. Dr. Thin, a year or two later, brought a paper before this Society, in which he suggested that the eczema was secondary to the cancer. Mr. Bowlby then related the course of events in those cases which he had seen, and in which the eczema had undoubtedly preceded the cancer; and he said that he considered the relation between the two conditions was one of cause and effect. In all the six cases that he had seen the cancer had in each case been a round-celled scirrhous growth, and between the nipple and the breast tumour there had intervened a zone of healthy tissue, so that there was no direct extension of disease from the nipple inwards.—Mr. R. W. PARKER had examined one case of eczema of the nipple in which there was no tumour present, but the breast was not healthy, and on section the disease was continuous from the nipple to the breast, which led him to agree with Dr. Thin's view.—Mr. BOWLBY added that in none of the cases that he had seen had there at any time been any discharge from the nipples. The breasts had, however, undergone ordinary retrogressive changes, as the patients had been past the prime of life.—Mr. BARLING, in reply, said that the ducts were not healthy, being distended with a small-celled infiltration round them. He thought that Dr. Thin had been misled by the fact that in duct carcinoma cysts were frequently present, from which the patients were able to squeeze out a milk-like fluid.

Psorospermiæ in Ureter.—Mr. BLAND SUTTON exhibited a kidney and ureter, from the Middlesex Hospital Museum, affected with psorosperm saccules. These had previously been described as mucous cysts of the ureter. When sections were prepared by the celloidin process the saccules contained oval-shaped bodies identical with coccidium oviforme, a parasite which was the cause of a destructive liver disease of rabbits. The saccules were situated immediately beneath the mucous membrane of the ureter, and did not invade the muscular coat. The subject of psorosperms had attracted little attention in this country. It was curious that the disease, though so common in rabbits, seemed to be extremely rare in man. It was a comfort to know that eating infected rabbits was attended with no risk of infection, for the coccidia, after passing through certain stages of development, came to a standstill until they left their host. The channel of infection for man and rabbit was equally unknown as well as the condition of the parasite when it entered a mammal, as its complete life history was unknown. In cases of general psorospermia occurring in man the symptoms were much the same as those seen in rabbits. Darier had recently attempted to show that some skin affections, such as molluscum contagiosum, chronic eczema of the nipple, and the like, were due to these parasites. The evidence was as yet far from being conclusive.—Mr. SILCOCK related a case of parasitism by psorosperms. The patient was a woman, aged 53, who was admitted into St. Mary's Hospital seven days before death. She was thought to be possibly suffering from typhoid fever. The illness dated from a "chill," taken six weeks before admission into hospital. The symptoms consisted of pains in the limbs, nausea, and occasional sickness, tenderness over the liver and spleen, fever of remittent type, the temperature reaching 103° F., and slight diarrhœa. The urine was albuminous. The areas of splenic and liver dulness were increased. The tongue was coated with brown fur, which became dry. The breath was foul. Death resulted from cardiac failure. The *post-mortem* examination was made eighteen hours after death in the middle of July. The liver was much enlarged, and weighed 83 ounces; in its substance were a number of aggregations of caseous foci, for the most part near the surface, there being generally a well marked red ring of congestion or capillary hæmorrhage round each caseous area. The spleen was enlarged, and weighed 16 ounces, and exhibited sundry caseous foci varying in size from a pin's head to that of a pea. They were aggregated together with a red inflammatory zone around each nodule. In the ileum were found six papule-like elevations, with red bases and a circumferential inflammatory zone. Also in the large intestine, as well as in the ileum, there were red patches of injected mucous membrane, from one to three inches square. There was a small pneu-

monic area in the anterior border of the left lung. The other organs and tissues presented no interesting changes, except those associated with fever. The naked-eye *post-mortem* appearances to a certain extent resembled those of tuberculosis, but differed in the character, situation, and limited generalisation of the lesions. On examination of the caseous nodules, coccidia were found, which corresponded in every respect with those described by Leuchart. The psorosperms did not appear to develop within the body—a fact noticed by that author—but they were obtained by keeping the coccidia at an equable temperature, in a warm room or incubator. It was a very remarkable fact that the development of the psorosperms went on in a weak solution of bichromate of potash, such as was used for hardening purposes. The resistance and toughness of the coccidium capsule probably explained this occurrence, as also the difficulty in getting the organisms to stain with any of the reagents in ordinary use. The histological characters of the hepatic and splenic lesions were admirably given by Leuchart, and to his descriptions there was at present nothing to add. That the coccidia were present in the bile duct, and that this topographical distribution was regulated by the latter, was also obvious from an inspection of the specimens, but it was noteworthy that the only intestinal lesions found were far away from the duodenum. Their presence in the spleen could only be accounted for on the supposition that they had been carried there in the blood stream. This was the first case of the kind which, so far as he knew, had come under his notice; but from the marked *primâ facie* resemblances of the disease to tuberculosis, he could not doubt that it was much more common than was generally imagined. Mr. Silcock expressed his indebtedness to Mr. Rogers, of St. Mary's Hospital, for the specimens which were before the Society, and for the assistance he had given him in the preparation of this paper.

Psorospermiæ in Rabbit's Liver.—Dr. DELÉPINE read the following paper on this subject. He said that the presence of psorospermiæ in the livers of rabbits was a fact of such common occurrence that it hardly attracted the notice of the histologist, notwithstanding the use which was made of rabbits for experimental purposes. He had had lately to examine a large number of rabbits for special purposes, and wishing to avoid as much as possible sources of error, had made a point to note carefully the amount of psorospermic nodules found in each case. This was done chiefly with the view of discovering whether the diseased livers would react to various agents as well as those which were little or not diseased; and whether the presence of psorospermiæ diminished in any marked degree the vitality, and whether it was so serious a pathological state as to render them unfit for the carrying out of comparative experiments. Out of 50 rabbits of which the necropsy had been made during the last few months, only 4 were found apparently, and 2 certainly, free from the lesions produced by psorospermiæ. Thus, 92 per cent. were certainly affected, and possibly 96. Some of these rabbits were obtained in London; the greater number were, however, of Swiss origin, and obtained from various farms. All these animals were young, but varied considerably in size, the smallest weighing 688 grammes, the largest 1,675 grammes. He had examined in Geneva a large litter of young rabbits, and found that the animals were of different sizes. But, contrary to his expectation, he found that some of the small rabbits had very few psorospermiæ in their livers, whilst some large individuals were infested to a considerable extent. However, these animals having all been submitted at the same time to a rather long preliminary fast, two of them died, and these were very small. In one of them the liver was almost entirely replaced by psorospermic nodules. In the other, the gall-bladder was distended with a clot, resulting from hæmorrhage caused by ulceration of the roof of the gall bladder; the rest of the organ was comparatively free from lesions. Of those that remained one other got very ill, and psorospermiæ were also extremely abundant. Out of the six that remained, it was found on opening their bodies that the largest and the one that had been the most active was also the one in which psorospermiæ were most abundant. From this it would seem that in very young rabbits psorospermiæ might multiply to such an extent as to be a serious danger to the life of the animal, but that after the first few months the presence of even a large number of psorospermiæ did interfere much with the nutrition of the animal. He then continued the investigation on another line. He weighed carefully the whole bodies and the livers of all the rabbits which he had to dissect; 32 rabbits were thus examined. Out of that number 2 were found free from psorospermiæ, in 9 psorospermiæ could be found here and there in the liver, in 8 the parasites were scattered all through the substance of that organ, in 10 the psorospermiæ were abundant, in 3 they were so abundant that it was almost impossible to find a single cubic centimètre of liver tissue free from them. The average weight of the animals belonging to these various groups was as follows: Psorospermiæ absent or nearly absent, 979 grammes; psorospermiæ pretty abundant, 871 grammes; psorospermiæ abundant, 1,010; psorospermiæ very abundant, 790. Thus it appeared that so long as the psorospermiæ were not very abundant the nutrition of the body was not much interfered with. The average weight of the liver in these various groups gave more interesting results. In order to render that weight comparable, the average weight having been found, it was reduced to what it would be in rabbits weighing 1,000 grammes in each case. The liver would, when so reduced, weigh, in animals in which the psorospermiæ were few or absent, 29 grammes; in animals in which the psorospermiæ were moderately abundant, 35 grammes; in animals in which the psorospermiæ were extremely abundant, 35 grammes. Thus it appeared that although the general nutrition was not much affected, yet the liver was distinctly diseased, as its weight showed. The nature of the changes found next attracted attention, and he found that the parasite crept along the bile channels, then the contents, after becoming full of very large highly refracting bodies, escaped from their envelope, and the granules then probably penetrated into the protoplasm of the epithelial cells, and in this way a large number of those cells were invaded at the same time. The small mass then developed into a larger protoplasmic mass, which at first was nucleated and nucleolated, and finally escaped from the cell. In some of these cells a long coiled filament was produced. He was not able to make sure of the nature of this filament, but it might be the pseudo-filaria of Van Beneden, in which case there could remain no doubt as to the relation between gregarinæ and psorospermiæ. The lesions produced were at first limited to the infested epithelium, remarkably fine specimens of papilliferous cysts being thus produced, but after a time the epithelium was destroyed and proliferation of connective tissue took place. Ultimately a kind of biliary cirrhosis was produced.—Dr. HADDEN gave an account of the clinical history and *post-mortem* appearances of a case which had already been described in the Society's *Transactions*, vol. xxxiv.—Mr. TARGETT described a case which occurred in Guy's Hospital fifty-three years ago, whose kidneys and ureters were now found to contain several psorospermial cysts. He thought, owing to the variations in size of the organisms found in different cases, that possibly there was more than one variety or species parasitical in man.—Mr. SPENCER said the experience at the Brown Institution was that rabbits infested with psorospermiæ showed evidences of distinct wasting, that in different animals they were to be found in the liver and kidneys, but as far as his experience went not in the spleen, and undoubtedly they acted as irritants, causing proliferation and infiltration of the organs which they infested.—Mr. BRODIE had found similar cysts to those described by Mr. Bland Sutton in a subject in the dissecting room at Middlesex Hospital, and referred to some fatal cases in rabbits which he had examined.—Dr. PAYNE had never seen any specimens inside human bodies. It was Professor Bollinger, of Munich, who first considered that the peculiar bodies found in molluscum contagiosum were low forms of animal life. Dr. Payne said that he had examined several specimens of this disease, but had been unable to satisfy himself that these bodies were of an animal nature, and commented on the difficulty of determining the animal nature of such bodies.—Mr. SHATTOCK asked Dr. Delépine if he had noticed any intestinal lesions in the rabbits that he had dissected, and whether he considered that they got into the bile ducts from the portal system.—Mr. BLAND SUTTON, in reply, thought that great caution must be exercised in determining the nature of these cysts. They might turn out to be the eggs of some unknown parasites, and mentioned that he had found appearances in monkeys which he had at first taken to be psorospermiæ, but which ultimately were found to be the eggs of entozoa.—Mr. SILCOCK thought Mr. Shattock's suggestion, that they were originally in the blood, was probable, as in his case they had been present in the spleen.—Dr. DELÉPINE had found that when very numerous they were injurious to rabbits, as the livers had been found enlarged with a form of biliary cirrhosis. He thought there could be no doubt that irritation caused proliferation of cells, and that this was one way in which the formation of tumours could be traced. At present the

observations of Continental authors tended to show that the organisms under discussion belonged to the protozoa, though they might turn out ultimately to be immature forms of some higher animals.

Card Specimens.—Dr. HADDEN: Cast of Œsophagus, expelled during life.—Mr. SPENCER: (1) Cystic Kidney from a horse; (2) Sebaceous horn on a mouse.—Mr. JACKSON: Subdural Hæmatoma.

MEDICAL SOCIETY OF LONDON.

MONDAY, DECEMBER 16TH, 1889.

C. THEODORE WILLIAMS, M.D., F.R.C.P., President, in the Chair.

CLINICAL EVENING.

The Diagnosis and Treatment of Aortic Aneurysm.—The PRESIDENT, in resuming the adjourned discussion on this subject, congratulated Dr. R. Douglas Powell on the practical character of his propositions, and specially on his attaching more importance to the pressure phenomena than to the cardio-vascular signs in the diagnosis of aneurysm. With reference to the relation which fusiform aneurysm bore to saccular, it must be remembered that both sometimes co-existed in the same patient. He had never heard the diastolic shock sound, except in cases of aortic aneurysm, but it was not always to be detected in these, and, as for murmurs, they were quite as often absent as present. The relative importance of auscultatory phenomena and pressure signs depended principally on the portion of the aortic arch involved, aneurysm of the first portion usually presenting some physical signs in the shape of pulsation, dulness, shock, or murmur, and it was generally with this form that cases of aortic regurgitant disease with retracted lung were confused. Dr. Williams, however, thought that the position of the heart, the presence or absence of cardiac hypertrophy, and the results of measuring the two sides of the chest were generally distinguishing features. In many cases of aneurysm of the transverse and descending portions of the arch the evidence of auscultation was often wanting, and that of pressure signs most important, and the variations in this pressure in aneurysm from changes in the size of the vascular swelling often proved of assistance in the diagnosis. In these cases the presence of stridor, of metallic cough and dysphagia, with fixation of the left vocal cord, with dilatation of the left pupil, and weakening of the left pulse generally, signified aortic aneurysm, but Dr. Williams had published a case in the *Proceedings* where all these phenomena were present, and were, after death, proved to have been due to a lympho-sarcomatous tumour in the mediastinum, which was detected during life by the rapid extension of the dulness in more than one direction. Syphilitic glands might give rise to nearly all the characteristic pressure signs of aneurysm, for in one well-marked syphilitic patient of Dr. Williams's, with enlarged cervical and axillary glands, stridor of voice and breath were present, with fixing of the left vocal cord, and tubular sounds were heard above both scapulæ, with sternal dulness and accentuation of the second sound of the heart. Under large doses of iodide of potassium the symptoms entirely disappeared, which was the result in a similar case, where, in addition, dilatation of the left pupil was noted. Nevertheless, stridor was of great diagnostic value, and sometimes the only means of detecting the presence of aneurysm. A man, aged 32, was admitted into the Brompton Hospital with a history of emphysema and asthma, and during one of the asthmatic attacks stridor was noted. The spasms subsided under chloroform, and he was free for weeks, but he died suddenly in an attack from syncope, and *post-mortem* examination revealed an aneurysm the size of a Seville orange springing from the back of the transverse portion of the aortic arch, and involving the posterior pulmonary plexus. The presence of markedly tubular breathing above one or both scapulæ was one of the most valuable signs in obscure cases, but no sign or symptom could be absolutely relied on; they should only trust to a combination of the various phenomena to guide us to the right conclusion. Dr. Williams often experienced great difficulty in persuading the patient to adopt Tufnell's method long enough for a complete trial, but he obtained excellent results from the iodide of potassium treatment, while restricting the patient's liquids, and confining him to one floor of his house, or to the gallery of the hospital; in other words, limiting his exertions without keeping him in bed, and he thought this was sufficient for most cases of aneurysm. Consolidation of aneurysms sometimes took place under conditions the very reverse of those of rest, as Dr. Williams had witnessed in a shoemaker suffering from aneurysm of the ascending aorta apparently pointing in the second intercostal space on the right side, and who, in spite of rest being enjoined, pursued his heavy labours at his last, with the result that six months later the tumour had sufficiently consolidated to withstand a blow from the patient's hand, apparently without injury. With regard to abdominal aortic aneurysm many cases of vasomotor paresis of the aorta were mistaken for it, and Dr. Williams well remembered one instance where what had been described as saccular aneurysm of the abdominal aorta disappeared after the removal of an ill-fitting truss, which had compressed both iliac arteries.—Dr. QUAIN recalled the well-known case of the eminent surgeon Liston, the diagnosis of whose affection baffled the most eminent authorities of his time, though he was found *post mortem* to have a tumour as big as a Seville orange under the clavicle pressing on the trachea. The presence of the tumour had been suspected before death, but it had been thought to be tubercular. He said that he did not think that a similar failure in diagnosis was likely to happen in these days, the means of diagnosing aneurysm having immensely improved since that time. With regard to treatment he said he could recall to mind many cases in which iodide of potassium had saved life, or at least rendered it tolerable, and he mentioned several such. He concluded by calling attention to the importance of noticing even slight symptoms, in support of which he alluded to a case in which very slight stridor had alone saved him from giving an unguardedly favourable prognosis in the case of a man who died shortly afterwards from rupture of an aortic aneurysm.—Dr. FELIX SEMON dwelt more particularly on the cases in which there were no audible laryngeal symptoms, notwithstanding paralysis of the abductor fibres. He mentioned incidentally that the idea that the cords in man moved rhythmically during respiration was quite erroneous, and must have been derived from observations on animals. He recalled that nine years ago he had laid it down as a scientific law that while the adductors of the cords had a proclivity to become involved in functional affections, the abductors were more likely to be affected in cases of progressive organic disease, and he pointed out the bearing of this law on the subject then under discussion. He showed by means of diagrams how, if the abductor fibres were alone pressed upon, no very obvious effect was produced on phonation, at any rate during the initial stages. It was only on the supervention of paralytic contractures that attention was directed to the larynx. On this ground he urged the routine examination of the larynx by means of the laryngoscope in all cases in which aneurysm was suspected, even in the absence of laryngeal symptoms, the discovery of the paralysis of an abductor being of the utmost importance to the diagnosis.—Dr. F. DE HAVILLAND HALL said that it was not convenient to discuss aneurysm of the abdominal aorta at the same time as thoracic aneurysm. He mentioned cases showing the difficulty of distinguishing between pulsating empyema and aneurysm, and insisted upon the diagnostic importance of the steady downward progress in malignant growth simulating aneurysm, the progress of cases of aneurysm being more fluctuating. Alluding to the difficult cases in which there was direct pressure upon the trachea with bilateral paralysis of the crico-arytenoidei postici, he mentioned two cases in which, in spite of urgent dyspnœa, he had declined to advise tracheotomy, and in which the *post-mortem* examination justified his abstention by showing that the obstruction would not have been relieved by the operation. In reference to the iodide of potassium treatment, he said that Dr. Balfour's plan was to keep the patient in bed for a few days, in order to ascertain the normal pulse rate and then to commence the iodide, keeping it up until there was acceleration of the pulse, which he regarded as a sign that the limit had been reached. In one case of his the greatest benefit had followed the continuous application of ice over the tumour. He deprecated the administration of digitalis, and preferred aconite when a cardiac depressant was indicated.—Dr. MITCHELL BRUCE urged a thorough and systematic examination of every patient suspected of aneurysm, especially by means of the simpler methods of physical examination. He said that the neglect to observe the patient closely before passing on to auscultation, was one of the reasons for the affection escaping notice. He mentioned five cases treated by a combination of the Tufnell and the iodide of potassium treatments, and observed that in many cases the urgency of the symptoms precluded following Dr. Bristowe's suggestion to send the patients back to their work. Of his five cases the first remained 207 days on his back. He pointed out that if this

method were decided upon it should be thoroughly carried out with due discrimination as to the ability of the patient to support its rigour, and with the most scrupulous attention to detail, the patient retaining the most complete immobility. He showed a specimen from a case in which Mr. Barwell and Dr. Murray had introduced a bright steel wire into the sac, through which was passed a current of electricity, with the result of causing a very beautiful deposit of laminated fibrin around the wire, and on the walls of the sac.—Dr. KINGSTON FOWLER associated a diastolic murmur rather with aortic regurgitation than with aneurysm, and he thought that one cause of aneurysms being overlooked was that sufficient importance was not attached to the symptom pain. With regard to the prognosis, he was of opinion that it was not so unfavourable as was generally thought so far as duration of life was concerned. In support of this view, he mentioned several cases in which the patients had gone on for periods of as long as five and eight years. Passing on to discuss the value of treatment, he urged that the Tufnell treatment consisted of two parts, rest and diet, the relative importance of which two factors had, he maintained, not as yet been established. He quoted several passages from Tufnell's writings, to show that he attached most importance to rest, and under these circumstances the speaker urged that it was cruel and unnecessary to reduce the amount of fluids and solids below the limit consistent with comfort to the patient. He regarded aortic regurgitation as a formal contraindication of the Tufnell treatment. With reference to the treatment by surgical procedures, he mentioned Dr. Cayley's case, which had been regarded as a successful instance of the application of the ligature for the cure of thoracic aneurysm, but in which, when the patient ultimately died, the source of the symptoms was found to have been pulmonary stenosis, no aneurysm having been present.—Dr. SEYMOUR TAYLOR pointed out that in small aneurysms death most frequently resulted from bursting, whereas in large aneurysms the cause of death was pressure. He thought that the *rôle* of syphilis in the production of aneurysm had been much overrated and with regard to the influence of heredity he quoted an instance in which members of four generations of the same family had died of aneurysm.—Dr. MAGUIRE briefly alluded to five cases of aneurysm which he exhibited, and insisted upon the value of the sphygmograph in such cases. One of the cases illustrated the presence of physical signs in lieu of pressure symptoms in aneurysm of the second part of the arch, and another showed the importance of paying attention to coincident signs, individually insignificant; and he concluded with a striking example of the fact that a large aneurysm may be present and yet give rise to only trivial discomfort.—Dr. EWART gave the history of the cases exhibited by him, and expressed his concurrence in the views as to treatment put forward by Dr. Mitchell Bruce.—Dr. BRISTOWE protested against being credited with the views ascribed to him by Dr. Mitchell Bruce. He said that he never intended to intimate that patients should be sent back to their work no matter what their condition.—Dr. DOUGLAS POWELL, in reply, expressed himself as gratified with the discussion to which his paper had given rise. He explained that he did not say that fusiform aneurysm called for no treatment, but that its treatment was not that of aneurysm proper. He explained also that in saying a laryngoscopic examination was not necessary to the diagnosis in certain cases, he did not wish to detract from the extreme value of that instrument in the general diagnosis of this affection. He concurred in Dr. Hall's view that stridor was usually caused by pressure on the trachea or bronchus, and was therefore not to be relieved by tracheotomy, which was rarely of service in the dyspnœa due to the presence of aneurysm. He agreed as to the necessity of a careful choice of the cases to be submitted to the Tufnell treatment. With regard to the use of ergot, he confessed himself somewhat sceptical, and said that in any case twenty-minim doses were not likely to have much effect on the circulation. He pointed out that in a given series of cases a certain proportion of them would be sure to prove unsuccessful whatever was done, and he had only endeavoured to show which cases were most likely to be benefited by particular methods of treatment.—A large number of patients suffering from aortic aneurysm were exhibited.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

THURSDAY, DECEMBER 12TH, 1889.

J. HUGHLINGS JACKSON, M.D., F.R.S., President, in the Chair.

Note on a Case of Hereditary Tendency to Cataract in Early Childhood.—Dr. TATHAM THOMPSON (Cardiff) gave a description of well-marked heredity of cataract through four generations. The cataract developed when the individuals were from 3 to 5 years of age, and in all the cases quoted, except one, affected both eyes. There was at first a finely granular opacity of the entire lens, which rapidly increased in density till vision was reduced to mere light-perception. The cataracts were much harder than those of the ordinary congenital or the lamellar type. One peculiar feature was that the tendency was transmitted, in two generations, only through the male line, thus differing from the somewhat similar cases recorded by Mr. Berry in the *Ophthalmic Review* for January, 1888, but agreeing with the observations of Hosch and others. The heredity was more marked in the early childbearing period; this was also noted by Mr. Berry in his patients. In reply to questions by the PRESIDENT, Mr. ROCKLIFFE, Mr. GUNN, and Mr. S. J. TAYLOR, Dr. THOMPSON said that his patients were in all other respects healthy, and there was no evidence of further disease of the eyes. He was unable to obtain any information which explained the curious inheritance. There was no consanguinity in the parents of the affected children.

The Operative Treatment of Cicatricial Ectropion of the Lower Eyelid.—Mr. TWEEDY described a method by which he had obtained very satisfactory results. He showed a patient upon whom he had operated, and a drawing of the same patient previous to operation. He made a doubly curved incision from the outer canthus, downwards and outwards over the malar prominence, and a second parallel incision about 6 to 8 millimètres to its inner side, carried through the whole thickness of the everted lid. The flap thus formed was dissected up, remaining attached only at the lower end. He then made a single straight incision obliquely across the cicatrix, nearly parallel to the lid margin; the outer end of this reached to the innermost of the two curved incisions. The lid and adjoining skin were then separated from the subjacent tissues. This allowed the cut surfaces at the sides of the flap to be brought closely together and united by sutures, and the eversion of the lid was thus corrected. The gap left by the drawing up of the lower lid was filled by the flap previously made, which was turned inwards towards the nose, and secured in position by a few stitches.—Mr. MACKINLAY asked if the depressed cicatrix so usual in these cases was filled up by this plan of operating. In the case shown there was still a rather deep depression.—Mr. SPENCER WATSON fully appreciated the ingenuity of Mr. Tweedy's method, but thought that for most cases a simpler operation would suffice.—Mr. TWEEDY replied that the operation he had described was designed for the cure of the ectropion. In the particular case exhibited to the meeting there was a large osteophytic mass at the lower orbital margin, covered by a very thin cicatrix, and but little could be done to remedy the depression at the site of the scar.

The Operative Treatment of Symblepharon.—Mr. TWEEDY gave a description of a procedure which he had adopted in cases of extensive symblepharon following burns. It was most suitable for those instances in which there was a prolongation of the cicatrix on to the cornea. His plan was freely to separate the lid from the cornea and globe, making a sulcus rather deeper than that of the normal conjunctiva; then having attached two or three fine doubled silk threads to what had been the uppermost margin of the symblepharon, to pass these by means of curved needles through the lid from the bottom of the sulcus, bringing them out on the skin surface as near the lower orbital margin as possible. These threads were then tied over a piece of drainage tube, and allowed to remain in position for four or five days. By this means the cutaneous surface of the corneal portion of the symblepharon was folded inwards and became the lining membrane of the lid. The patient should be kept under observation during the process of repair, so that any adhesions which formed between the lid and the globe could be broken down. If the lower lid were much incurved by the folding of the flap, its position could be restored by buttonholing the flap near the margin of the lid.

Primary Tuberculosis of the Iris.—Dr. HILL GRIFFITH related particulars, and showed specimens and drawings from a case of tubercle of iris, which occurred in a 7 months old female child. The eye had been affected for one month, and the child subject for three months to attacks of bronchitis and diarrhœa; there was an enlarged gland in the neck on the same side, but there were no other physical signs of tubercle. The parents were healthy, and there was no family history of phthisis. A yellowish nodule grew from the periphery of the iris of the right eye, and numerous millet-seed bodies from its surface; the pupil was closed, but

there was no acute inflammation. The nodule grew rapidly, and the smaller deposits multiplied day by day. The eye was enucleated after three weeks' treatment. The disease was found to be confined to the iris and ciliary body. The new growth exhibited the histological characters of tubercle; but Professor Dreschfeld failed to detect the bacillus tuberculosis. In 32 recorded cases in which microscopic and other tests left no doubt as to the tubercular nature of the disease, one eye only was affected in 29; the average age of the patients was 12, youngest 4 months, oldest 51 years. In 10 cases bacilli were searched for, but only found in 4; in one of the remaining 6 cases however, the inoculation test was successful. Three cases in which no operation was undertaken terminated fatally from tuberculosis. Of the 27 cases in which enucleation was performed, 2 died with brain symptoms, but several others showed signs of tubercle subsequently to the operation. Dr. Griffith thought enucleation was on the whole satisfactory, cases being reported well five or more years afterwards. Iridectomy could not be recommended. In view of the fact that it was impossible to be quite certain if the disease were primary, and that some of the milder cases got well, he would enucleate only if the sight was destroyed or the eye becoming rapidly disorganised in spite of treatment, as in his own case.—Mr. LAWFORD mentioned two cases of supposed primary tubercle of the eyeball in young children. In both of these enucleation was performed, and the general condition of the patients improved markedly: one was known to be alive and well three years afterwards. In these and in many of the recorded cases there was strong heredity of tubercle. His own feeling was in favour of enucleating in cases of intraocular tubercle, as soon as there was moderate certainty that the eye was irremediably damaged; he thought the after-history of published cases justified this opinion; in a fair proportion the disease seemed to have been eradicated.—Mr. MCHARDY referred to a case of localised choroidal tubercle, which he had brought before the Society last session, and in which he had removed the eyeball. The child was still in fair health, though delicate. In cases of tubercular disease of the cornea recovery sometimes occurred even when the affection was very severe. In localised choroidal tubercle enucleation should, he thought, be performed; but in cases of tubercle of the iris he was often doubtful what treatment to adopt.—Mr. TWEEDY spoke of a young man who had been under his care at Moorfields for twelve or eighteen months, and in whom both irides were studded with little tubercular bodies. The eyes were slowly degenerating in spite of all treatment. There was no family or personal history of tubercle or syphilis.—Dr. TATHAM THOMPSON referred to a case of tuberculosis of the eye, in which enucleation was followed by tubercular meningitis and death.

Tealeaf Conjunctivitis.—Mr. CHARLES WRAY (introduced) read a paper describing a form of conjunctivitis observed by him after the application of tealeaf poultices to the eyelids. In a typical case there was swelling and congestion of the lid margins, with congestion of the palpebral and ocular conjunctiva, the latter being most affected in the line of the palpebral fissure. The caruncle and plica semilunaris were swollen, and presented a peculiar glistening, translucent appearance. There was sero-purulent discharge. Mr. Wray considered it most probable that the affection was caused by micro-organisms.

Living and Card Specimens.—Mr. TREACHER COLLINS: Microscopic section of Human Lens with Epithelium on the inner surface of the Posterior Capsule, and showing other structural peculiarities.—Mr. JESSOP: (1) Aniridia with Dislocation of Lenses; (2) Punctate Appearance of Anterior Capsule of Lens.—Mr. SILCOCK: A case of Symblepharon treated by Snellen's operation (modified).—Mr. SPENCER WATSON: Osteoma of infrasuperciliary Region.

BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, NOVEMBER 13TH, 1889.

FANCOURT BARNES, M.D., Vice-President, in the Chair.

Nephrolithotomy.—Mr. SPANTON showed renal calculi removed from a woman who had complained of pain in the left loin for three years. When she came under his care a tumour had developed reaching from the umbilicus to the iliac crest. He cut down in the left loin, and on aspiration removed half a pint of urine. A calculus weighing 180 grains was found impacted in the ureter. For several days the patient did well, passing urine freely by the bladder and from the wound; but subsequently she died. Although when under chloroform careful examination could detect nothing wrong at the right side, at the *post-mortem* examination the right kidney was found to be practically gone, consisting of a mere shell, and the ureter was completely blocked with calculi rounded off at their edges.—Remarks were made by Dr. HEYWOOD SMITH, Mr. BOWREMAN JESSETT, and Dr. OLIVER, and Mr. SPANTON replied.

Gall-stones.—Mr. LAWSON TAIT exhibited some gall-stones, removed from an American physician.[1]

Hysterectomy for Cancer.—Dr. BEDFORD FENWICK showed a pregnant uterus at about the third month, removed by hysterectomy for cancer of the cervix. Two years previously the cervix had been cauterised because of suspicious pouting points. Six months later malignancy had declared itself more by friability and other signs, and the cervix was amputated. Six months afterwards the patient was found to be two months pregnant. The uterus was found drawn up and the vault of the pelvis very tense. It was decided to induce abortion in the usual way, but it was found impossible to discover any trace of cervical canal in the hardened remnant of the cervix, which to the sight was perfectly healthy, not a trace of a soft or bleeding point being visible. The patient had made an uninterrupted recovery.—The case was discussed by Dr. EDIS, Dr. OLIVER, Mr. LAWSON TAIT, Dr. JAPP SINCLAIR, Dr. HEYWOOD SMITH, the PRESIDENT (Dr. Barnes), Dr. GRIGG, Dr. BURFORD, and Dr. RUTHERFOORD.—Dr. FENWICK replied that the *serre-nœud* was applied, as far as could be judged, at the junction of the lowest and middle thirds of the uterus. The embryo escaped complete.

Extra-uterine Gestation.—Dr. INGLEBY MACKENZIE read an interesting case of protracted extra-uterine gestation, on which the PRESIDENT made some remarks as to its bearing on the question of legitimacy.

Four Hundred Cases of Ovariotomy.—Dr. BANTOCK'S paper on this subject was discussed.—Dr. EDIS referred to some of the practical suggestions which the author had given as the result of his extensive experience, and which were an encouragement to other workers.—Dr. BARNES agreed with what had been said with regard to Listerism. As regards the ligature, he reminded the Society that Dr. Tyler Smith had adopted that plan of treating the pedicle. He strongly condemned the use of carbolic solutions in the peritoneum, and also the use of ice for thirst.—Dr. JAPP SINCLAIR said he was not convinced of the uselessness of antiseptics. Everyone was willing to give up the use of the spray, but it was impossible to overlook the good results of antiseptic midwifery. Nor did he agree with the condemnation of opium, and he thought it was downright cruelty to refuse it after some of the severe operations. Its use required judgment, but he had never seen any bad results follow. The question of purgatives in peritonitis he thought needed a great deal of consideration, and at present rested purely on Mr. Tait's authority.—After some remarks by Dr. GRIGG and Dr. LYCETT, Dr. BANTOCK replied.

EPIDEMIOLOGICAL SOCIETY OF LONDON.

MONDAY, NOVEMBER 11TH, 1889.

SIR T. CRAWFORD, K.C.B., M.D., President, in the Chair.

Malaria.—Sir WILLIAM MOORE remarked it had been stated that malaria caused more human misery than any other known cause of disease. Many theories had been originated as to the nature of malaria, but hitherto he considered we were ignorant of what malaria really was. He did not believe that the bacillus malariæ of Crudeli and Klebs was the true malaria germ, any more than he admitted that the spores of algoid plants of the palmetta species, stigmatised as such years ago by Salisbury, was the true malaria germ. He mentioned what had been advanced by Klebs, Crudeli, Marchiafava, Laveran, and others, on the subject of the bacillus malariæ. But there were fatal objections. The bacillus had not been found everywhere where paroxysmal fevers prevailed. Neither was it reasonable to suppose that every kind of surface on which paroxysmal fever occurred would produce the same kind of bacillus. It was said to require heat and moist earth. But malarious fevers prevailed in sandy deserts, where water was hundreds of feet from the surface; and on bare rocks, where there was no earth, although plenty of moisture in the form of dew at some seasons of the year. Moreover, credible authorities had stated that malarious fever might occur in half an hour after exposure; and was it to be supposed that in that short time the bacillus malariæ entered the spleen and marrow of the bones

[1] See report of meeting of Birmingham and Midland Counties Branch, JOURNAL, December 14th, p. 1341.

(where they were supposed to reside until coming into action), increased and multiplied, and then sallied forth to excite fever? Moreover, he would ask what became of the bacilli when a person recovered? Evidently they did not pass into the atmosphere, or malarious fever would be infectious. Then it was also well known that a person might have an attack of ague months, or even years, after the primary seizure. Was it to be supposed that the bacilli remained in the system all that time? Curious things were found in the blood of human beings in different parts of the world. Manson had theorised that the filaria sanguinis hominis was the cause of elephantiasis, but filariæ were found in the blood of persons who were not suffering from elephantiasis. Indeed, it had been stated that 10 per cent. of the Chinese had filariæ in their blood. Again, the spirillum which Carter thought distinctive of relapsing fever had been found in the blood of persons not so affected. Sir William Moore considered that a more rational and a more recognisable cause for paroxysmal fevers and malarious diseases generally could be found. Dr. Maclean had said that the heat-generative powers of all victims of malaria were impaired; but he (Sir Wm. Moore) said the heat-generative powers of all victims of heat were impaired, and their skin, in consequence of the excitation and consequent debility from heat, became so sensitive that they were specially liable to all changes of temperature. The effects of heat on the human system were referred to at some length. It was formerly taught that congestions and inflammations were originated by the rush of blood to internal organs consequent on a chilled surface, and probably this teaching was not altogether incorrect. Others had regarded chill as acting by a depressant effect on the nervous system. It was more recently advanced that chill indicated disturbance of protoplasmic molecular correlations, or, in chemical language, that new bodies were evolved in the protoplasm, which acted as veritable poisons. With regard to the periodicity which was supposed to characterise maladies produced by malaria, periodicity was a characteristic of all Nature, more or less; but there was no periodicity in enlarged spleen supposed to arise from malaria, and even ague sometimes became so irregular that it lost all claim to be considered a periodic malady. When ague presented in temperate climates, it did so in the autumnal season, when changes of temperature were greatest, and it did so in marshy localities where damp was added to cold, damp cold having the greatest power of abstracting heat. His position was, that so-called malarious fevers were caused by the sudden abstraction of heat, or chill, under the influence of cold, and especially of damp cold; and that the characteristic effects of chill were most marked in hot climates, because of the antecedent exposure to great solar heat and disregard of suitable precautions. He thought if they could wash in the waters of Lethe, so as to emerge fresh to the subject, the contradictions involved in the theory of malaria would lead to the abandonment of the belief. It was the heat, and not the malaria of tropical climates, which produced anæmia and blood degeneration, as well as fevers.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

FRIDAY, NOVEMBER 29TH, 1889.

E. H. BENNETT, M.D., President, in the Chair.

Renal Calculus.—Mr. KENDAL FRANKS read a paper on renal calculus, describing a case in which the nucleus was an ordinary sewing needle, swallowed many years previously.—The PRESIDENT said it was not merely the presence of phosphate of calcium but the predominance of carbonate of calcium that characterised calculi in suppurating kidneys. But calculi of this character passing away in the urine were suggestive of suppuration rather around the kidney than originating in it. They knew that calculi originating in the kidney, apart from suppuration, were more likely to consist of oxalate of calcium or lithic acid. A noteworthy point in Mr. Franks's case was that the urine appeared to have been normal. He did not know whether the slow process of oxidisation was likely to take place in any needle introduced into the body, because as soon as the needle was introduced into any tissue it would, in a few hours, become covered with a gloss which was not very easy to describe—a kind of composition like varnish which perfectly prevented oxidisation.—Mr. FRANKS, in reply, said it was remarkable that all the stones which had come surgically under his notice in connection with the kidneys had the same composition, namely, phosphate of calcium mixed with small quantities of carbonate of calcium. In the present case the phosphatic compound formed 90 per cent. of the entire calculus. The present specimen was the more interesting because formerly they found it stated in textbooks and used to be taught that stones in the bladder were chiefly composed of oxalates and urates, and that renal calculi, which were formed in the kidney and had a phosphatic deposit, received it from the bladder.

United Fracture of the Base of the Skull.—The PRESIDENT exhibited a united fracture of the base of the skull involving the anterior and middle fossæ. The injury which caused the fracture was a fall from a car during an epileptic fit. Having detailed the symptoms observed during the fatal illness, which resembled those of Jacksonian epilepsy, the President stated the grounds on which he had declined to interfere surgically with the patient. The *post-mortem* examination disclosed a united fracture of the frontal region radiating to the base along the middle line, and the changes observed in connection with it were clearly seen to have no causal relation to the epilepsy. The man had albuminuria. Referring to the details of the fracture, the President noted the great rarity of such specimens. This, he stated, was due to the amount of force necessary to produce fractured base, which inflicted great injury on the brain, and to the fact that almost all such fractures were compound, either by external wound, or more frequently by opening the nasal and aural cavities, and so were specially prone to be complicated by inflammation.—A discussion followed, in which Dr. MYLES, Mr. FRANKS, and the PRESIDENT took part.

A Contribution to the Pathology of Joint Bodies.—Dr. R. G. PATTESON read a paper on this subject. The conclusions arrived at were summarised as follows:—1. In the majority of cases loose bodies of mixed bony and cartilaginous nature are wandering osteophytes, and are evidences of a latent rheumatic arthritis. 2. This form of chronic rheumatic arthritis is insidious and latent in character, occurs in young persons as well as in those more advanced in years, and is chiefly manifested in "lipping" of the articular margins, and in the formation of enchondroses and osteophytes which, while attached, cause no symptoms. 3. These bodies, after liberation in the joint, may, and do often, undergo considerable increase in size, their nutriment being derived from the synovial fluid. This fact points to the necessity of their early removal by operative interference.—The PRESIDENT said he was glad to find the opinion of the late Mr. Adams, that foreign bodies in joints were mostly of rheumatic origin, was now being confirmed by the elaborate microscopical researches of the day.—Mr. FRANKS said there had recently been great discussion in London as to whether it was not possible for bodies of this sort to be formed by the chipping off of little pieces from the articular cartilages. The body shown bore a strong family resemblance to the articular cartilage, having regard to the arrangement of the cells.—Dr. MYLES said he found difficulty in understanding how the synovial fluid could have afforded pabulum enough not only for the maintenance of the cartilage, but for the development of this piece of bone.—Dr. PATTESON, in reply, said his attention had been directed to the subject by a paper of Dr. Humphry, of Cambridge, and after examining the records of the cases he came to the conclusion that what had, in a great many instances, been regarded as fragments of articular cartilage or bone, chipped off by injury, or exfoliated by a process of necrosis, were in reality detached osteophytes. The matter was concluded by the experiments of two French writers, who had examined these bodies, and had found that the mode of production in all was similar. First, there was an excessive development of the articular cartilage in a localised spot; secondly, a development of bone took place which was connected by slender trabeculæ with the cancellous tissue of the shaft; and then when a fracture occurred they had a loose osteophyte. He did not attempt to explain the growth of such bodies in the synovial fluid.

LEEDS AND WEST RIDING MEDICO-CHIRURGICAL SOCIETY.

FRIDAY, DECEMBER 6TH, 1889.

A. F. MCGILL, F.R.C.S., President, in the Chair.

Polygraph.—Professor BROCK showed a projection polygraph by which the recording of muscle curves, pulse tracings, etc., could be rendered visible on a screen.

Diseases of the Thorax simulating Empyema.—Dr. EDDISON described three cases. CASE I. A patient was admitted to the Infirmary with a large swelling over the right hepatic region after three weeks of intense pain. There was resonance over part of the swelling, and signs of right pneumothorax. The swelling

suddenly disappeared, and the patient became collapsed. On exploration of the right chest in front pus was obtained, and an opening was made into the right pleural cavity and also into the abscess, the latter being found to be below the diaphragm. The necropsy showed a large subdiaphragmatic abscess, with an opening into the stomach near the pylorus and another opening into the right pleural cavity. Dr. Eddison thought the abscess was probably the beginning of the case, and that the ulceration was from it into the stomach. CASE II. A man, aged 48, had dulness in the upper part of the left chest in August, 1888, and pus was found on exploration. It did not appear to be an ordinary empyema, and the patient left the hospital after some months. In June, 1889, he was readmitted, and 70 ounces of clear fluid drawn from the lower part of the same side of the chest. There followed œdema of the chest wall, dysphagia, and collapse. The necropsy showed malignant disease of the upper part of the chest, involving specially the root of the left lung. CASE III. The patient was admitted with œdema, dulness, and other signs of fluid in the chest, and pus was obtained on exploration at various points, clear fluid being withdrawn at others. The case proved to be one of malignant disease of the right lung. Dr. Eddison thought these cases, and others like them to which he referred, instructive as bearing on the necessity of a guarded prognosis in cases of what seemed in their early stages to be cases of empyema, and he pointed out how difficult an exact diagnosis sometimes was in the beginning of the cases.—Dr. BARRS, who had made the necropsy in Case I, thought the primary disease was not in the liver, but the stomach, possibly from an ulcer bursting into the space between the liver and diaphragm. The stomach showed a very remarkable condition of purulent infiltration of the mucous layer. On the question of the diagnosis of empyema, he thought the liver was never displaced downwards by fluid in the pleura, but that displacement signified an abscess between the lungs and liver, which was not uncommon in cases of pleurisy, and had been described by Leyden as "pneumothorax subphrenicus."—Mr. N. PORRITT referred to a lecture by Dr. Allbutt in which a stomach ulcer was mentioned as the cause of pleurisy. He had seen the liver displaced downwards in pleurisy.—Dr. CHURTON referred to a case of Mr. M. Robson's, where in a patient from whom a colloid ovarian growth had been removed, pus and blood were found in the chest. The question arose as to its malignancy, and to the advisability of operating, owing to the risk of hæmorrhage.—Mr. LITTLEWOOD said that the case referred to by Dr. Churton had been tapped twice, and two pints of fluid removed without any effect. Referring to the difficulty in opening the chest he had experienced in Dr. Eddison's first case, he said the diaphragm was closely applied to the chest wall, so that the exploring trocar passed through it, but when he inserted his finger he pushed the diaphragm down, so that the drainage tube was inserted into the pleura, above the diaphragm.—Dr. GRIFFITH thought, considering the anatomical relations, it was possible that the liver might be pushed down in cases of pleurisy, though displacement would take place in the cardiac direction first.

Notes on the Recent Epidemic of Pneumonia in Leeds and Neighbourhood.—Dr. CHURTON read a paper on this subject.—Dr. EDDISON agreed that there had been a great epidemic of pneumonia in that neighbourhood recently. He thought the disease was clinically akin to erysipelas. Infection was difficult to prove, but he related the following: Patient No. 1 was suffering from a pulmonary attack (? broncho-pneumonia), and recovered. At the time her husband was ailing with a "cold." In a few days he developed symptoms of pneumonia, and died. His medical attendant, who slept one night in the house, developed in a few days symptoms of pneumonia, and died in eight days. A few days later his assistant succumbed in a precisely similar manner. Had this sequence occurred in a disease of acknowledged infectiousness it would certainly be said to have been communicated. The severity of cases of pneumonia, as a rule, did not bear a constant relation to the extent of pulmonary consolidation. He thought all treatment was disappointing, and that as yet we knew of no specific remedy.—Dr. BARRS related a series of cases bearing on the question of infection. 1. A man (over 50 years old), suffering from acute pneumonia, died. 2. His brother, who attended him, before the funeral of the first was taken ill in the same way, and died, the physical signs being very trifling. The wife of the last patient fell ill in similar fashion, but he did not know the sequel of this case. The mortality of acute pneumonia in hospital practice was about 20 per cent.—The PRESIDENT said there were many fallacies in the method of "collective investigation." In one locality he had heard from a medical health officer that in one-half his district there were many cases of pneumonia reported, in the other half none. He thought there was great difference of opinion as to what should be called acute pneumonia, and that the diagnosis was rather a "function" of the mind of the medical attendant than of the body of the patient.

Cases.—Mr. GODFBEY CARTER: Case of Myxœdema in a Man.—Dr. WARDROP GRIFFITH: Case of Sporadic Cretinism.—Mr. E. ATKINSON: (1) Case of Myositis Ossificans; (2) Case of Ectopia Vesicæ.—Mr. MCGILL: Patient on whom Prostatectomy had been Performed by the Transverse Method (Trendelenburg's incision).—Dr. CHURTON: Two Cases of Peripheral Neuritis (recovering).

Specimens.—Dr. ALLAN: (1) Hæmatoma of Dura Mater; (2) Tibia showing Chronic Ostitis, etc.; (3) Syphilitic Caries of Skull.—Mr. MCGILL: Tubercular Mass in Pons, Tubercular Elbow-joint, Acute Necrosis of Tibia.—Dr. EDDISON: Hæmorrhage into Pons, Subdiaphragmatic Abscess communicating to Stomach and Pleura.—Dr. CHURTON: (1) Pulsating Sarcoma of Rib; (2) Small White Kidney.—Dr. BRAITHWAITE: Ovaries Removed for Dysmenorrhœa.—Mr. LITTLEWOOD: Ulcer in the Stomach of a Rat.—Mr. WARD: Malignant Disease of the Sigmoid Flexure in Man aged 22.—Mr. NUNNELEY: Tubercular Tumour of Optic Thalamus and Cerebellum (There was optic neuritis two years before death).

PATHOLOGICAL SOCIETY OF MANCHESTER.

WEDNESDAY, DECEMBER 11TH, 1889.

J. DIXON MANN, M.D., M.R.C.P., President, in the Chair.

Multiple Deformities.—Mr. C. E. RICHMOND exhibited the photograph of a child, aged 1 year, in whom many deformities were present. There was a large cavernous nævus in the pterygoid region, and a cutaneous one on the abdomen. There were also intrauterine amputations of several fingers and toes, and annular constrictions on those which remained, and also on the legs. Mr. Richmond enumerated the theories of origin of these amputations, and stated that the present case exhibited fleshy cords which could be picked out of the constrictions, thus confirming the theory of intra-amniotic bands as causing them.

Case of Elephantiasis following Injury.—Mr. C. E. RICHMOND exhibited a hand in which elephantiasis had arisen after very serious burns of the forearm, where skin and muscles were extensively destroyed. He also showed a microscopic section of the part, demonstrating the areolar hyperplasia (particularly marked round the small blood vessels), and dilated lymph spaces characteristic of the development. It was incidentally mentioned that in this case the antipyretic action of quinine had been found far superior to that of antifebrin.

Abscess of the Cerebellum.—Dr. MILLIGAN exhibited a specimen showing an abscess cavity in the right lobe of the cerebellum. The patient, a boy, aged 14, had suffered from scarlet fever six years previously, and there had since been an occasional discharge from both ears. The discharge had suddenly stopped a week before seeking advice, during which time he had suffered from severe headache. The pain radiated over the right side of the head, but was most intense in the neighbourhood of the right coronal suture. He was quite unable to sleep although very drowsy. Pulse 80, feeble and intermittent. Nausea, but no actual vomiting. Marked optic neuritis on right side, very slight on left side. Paralysis of the right side of soft palate and uvula. When standing with his eyes closed he showed a tendency to fall forwards. Mr. Hare trephined over the right cerebellar lobe, and after introducing a trocar into the substance of the brain drew off about two drachms of dark-coloured and very fœtid pus. A drainage tube was placed in the abscess cavity, and the wound dressed with antiseptic precautions. The boy died rather suddenly about twenty-four hours after the operation. There was no other lesion found at the necropsy. The petrous bone was quite healthy. No meningitis, no sinus phlebitis.

Ulcerative Aortitis.—Dr. DRESCHFELD related the case of a girl, aged 14, in whom during life there had been symptoms of aortic stenosis and embolism of the right middle cerebral artery. During the last few months persistent pyrexia pointed to the existence of ulcerative endocarditis. A fortnight before death the patient complained of intense and persistent pain in the head, occupying only the right half of the head. At the *post-mortem* examination the valves were found normal, but the heart was much hypertrophied, and the aorta showed a marked congenital

narrowing and chronic thickening of the intima, and a large quantity of small vegetations, which had ulcerated. The right middle cerebral artery was blocked by an embolus, and below the embolus a small embolic aneurysm was found, which had burst, causing extensive extravasation. Scrapings from the vegetations showed diplococci and streptococci, and plate cultivations made from growths, obtained by inserting portions of the vegetations in gelatine, showed similar organisms. Further observations with the pure cultivations were reserved.

Fracture of the Coracoid Process.—Mr. A. H. YOUNG showed a specimen of fracture of the coracoid process of the scapula obtained in the dissecting room. The fracture, which was somewhat oblique, had resulted in the separation to the extent of three-eighths of an inch of the free end of the process, carrying with it the attachments of the coraco-brachialis and biceps and the greater part of the pectoralis minor, but firm fibrous union had taken place.

Tuberculous Affections of the Eye.—Dr. HILL GRIFFITH showed microscopical sections from cases of tuberculosis of the conjunctiva and of the iris. The latter case was shown to the Ophthalmological Society.[1] The former was briefly summarised as follows: A boy, aged 4, showed in the right eye uniform thickening of the entire ocular conjunctiva, which was pale, waxy, doughy to the touch, and studded over with yellowish-white, pin-head, follicular (?) infiltrations; there was an absence of discharge or pain, the changes did not spread to the palpebral conjunctiva, there was great enlargement of the lymphatic glands of the same side of the neck. The diagnosis was only made some five months later, when a patch of lupus appeared on the skin near the eye and the glands had suppurated, leaving fistulous openings. The eye recovered without operative interference. The sections showed well-marked giant cells, with reticulum, and slight caseation; no bacilli were found by Dr. H. G. Brooke, but there were only some half-dozen sections.

STAFFORDSHIRE BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THURSDAY, NOVEMBER 28TH, 1889.

T. VINCENT JACKSON, F.R.C.S.Ed., President, in the Chair.

Cases.—Mr. FOLKER exhibited a girl, aged 18, who was admitted on September 3rd into the North Stafford Infirmary, suffering from an enlarged thyroid of five or six years' standing, and which during the last month had increased rapidly in size, causing great dyspnœa. Mr. Folker divided the isthmus (having tied it in two places), with immediate relief to the dyspnœa.—Mr. FOLKER also exhibited a girl, aged 14, on whom he had performed osteotomy in June last. Six years previously the patient fractured her leg, and union had followed, but the limb was greatly deformed, the patient walking on the external malleolus. The operation consisted in removing a wedge-shaped portion of the tibia and fracturing the fibula. The position was now excellent, and the patient walked well on the sole of the foot.—Mr. ALCOCK exhibited a child, aged 8, suffering from ossification of the deltoid muscle. The ossification, which had started at birth, now involved the entire muscle.—Dr. MCALDOWIE showed a patient suffering from nasal hemiopia of the left eye, the result of embolism of the arteria centralis retinæ. The patient was a perfectly healthy man, aged 59, and no exciting cause could be discovered. The attack occurred in April, 1887, and the disease had remained stationary till the present time.—Dr. MCALDOWIE also showed a boy, aged 13, suffering from Friedreich's disease. He was the youngest of nine children, but was the only one who showed any signs of nervous disease. He was undergoing the suspension treatment with considerable benefit.—Dr. HIND showed a young man who had suffered from a large number of scrofulous glands of the neck, both arms, and one leg. The glands had broken down, and were cured by scraping and the application of strong nitric acid.—Dr. HIND also showed a young man, a stoker on the railway, who had suffered from nodes on the tibia the result of a fall over a rail. Superficial treatment had been adopted without result, and afterwards the nodes were opened and scraped, and nitric acid was applied with complete success.

Specimens.—Mr. ALCOCK exhibited a specimen of intestine removed from a patient who had suffered from obstruction, the result of a portion of gut being twisted round a diverticulum. The strangulated bowel had been liberated, but the patient died from previous peritonitis.—Mr. FALKNER exhibited a fœtus which presented the following extraordinary deformities: the umbilicus in the middle of the back; the right side of the body undeveloped, with the liver and the whole of the intestines outside the body; the penis and scrotum on the lower side of the back. There was no anus. Besides other deformities, there was double hare-lip and cleft palate extending into the orbits.—Dr. HIND exhibited an ovary and tube removed from a patient. It was prolapsed into Douglas's pouch. Although the pain was always on the left side, it was the right ovary that was diseased and removed, it having passed across to the opposite side. Previous to the operation the patient had suffered from hystero-epilepsy, but not since.—The PRESIDENT exhibited multiple extra-peritoneal fibroid tumours weighing 13 ounces, which he had four days previously removed by abdominal section from a married woman, aged 38, who had never been pregnant, and whose family history indicated a strong tendency to cancer. After the tumours had been brought outside the abdomen, their base was surrounded by the wire of a *serre-nœud*, and after proper precautions they were cut away. Mr. Jackson referred to the value of using an anæsthetic to perfect the diagnosis when it was not distinctly evident whether the tumour was solid or fluid; also to the fact that the removal of uterine fibroid tumour was a distinctly different operation from ovariotomy, it being more dangerous and fatal. He further said it was unwise, at an early period after operation, to be too hopeful of recovery.

Papers.—Two papers promised by Dr. HIND and Dr. MCALDOWIE were postponed on account of the late hour.

MANCHESTER MEDICAL SOCIETY.

WEDNESDAY, DECEMBER 4TH, 1889.

JAMES ROSS, M.D., LL.D., President, in the Chair

Hypertrophy of the Bones of the Face and of the Hyoid Bone.—Dr. JOHN BROWN showed a mule-piecer, aged 29, who had enormous hypertrophy of the bones of the face and hyoid bone. The enlargement was first noticed when about 9 years of age, and commenced in the lower jaw when 14. The upper jaw was also hypertrophied. Its course had been slow and painless; it was symmetrical, but rather more on the left side. The deformity was very great. The orbital fossæ were encroached upon, causing exophthalmos, very marked on the left. There was obstruction of the duct, causing epiphora; obstruction of the nasal fossæ, causing loss of smell for five years. The oral cavity was diminished, owing to hypertrophy of the alveoli of the upper and lower jaw encroaching upon the roof and floor of the mouth; this caused a muffled condition of the voice. Mastication and swallowing and movement of the jaw were normal. Dr. Brown at first thought it was a case of acromegaly, but there was no hypertrophy of the hands or feet, nor overgrowth of the tissues over the bones of the face. In the *Transactions of the Pathological Society of London*, vol. xxii, there was a case reported by Mr. Bickersteth, of Liverpool, of hypertrophy of the bones of the face, cranium, and of the hyoid bone. It was similar to Dr. Brown's except that in his there was no hypertrophy of the cranial bones. There were two plates which illustrated several features in Dr. Brown's case. In Mr. Bickersteth's case the four wisdom teeth had never been developed. In Dr. Brown's case these teeth were also absent. He believed that the etiology of this condition might be explained by the suppression of the wisdom teeth and the diversion of the vascular supply to the development of the alveolar processes of the upper and lower jaw.

"All Wool" Wadding.—Dr. WILD showed a preparation of wool in the same form as ordinary cotton wadding, to be used as a substitute for cotton wool in cases of acute rheumatism and similar diseases; the "all wool" wadding was more elastic, a better absorber of moisture, and much warmer than the cotton wool.

Acute Non-Tubercular Phthisis.—Dr. THOMAS HARRIS described an unusual case of non-tubercular phthisis, which had developed in a girl aged 18 after the removal of the right lobe of an enlarged thyroid. There were, however, no signs of injury to the vagi or the recurrent laryngeal nerves, nor to the trachea. Death took place about eight weeks after the first onset of the pulmonary symptoms. The *post-mortem* examination revealed nearly complete consolidation, with small excavations, of the whole of the

[1] See JOURNAL, p. 1395.

left lung, and a less extensive, but also marked, change of a similar nature in the right lung. Microscopical examination proved the case to be a broncho-pneumonia with no signs of tubercle, and no tubercle bacilli could be found in sections taken from different parts of the lung. The case was one of non-tubercular broncho-pneumonia, which had produced small necrotic foci around and involving the small bronchi. One interesting clinical feature was that over the base of the left lung the respiration was not merely of the cavernous type but of almost perfect amphoric character. But, at the necropsy, there was found no cavity which exceeded a small horse bean in size. The character of the breath-sound must have depended upon the consolidation and not upon the excavations. So that the presence even of amphoric respiration could not be regarded as conclusive proof either of pneumothorax or of a cavity in the lung itself.

Unusual Case of Malignant Disease of the Œsophagus.—Dr. HARRIS also showed a specimen of a flat-cell epithelioma of the œsophagus, which had caused death by perforation into the lung and the production of pulmonary gangrene. The case was unusual in the sudden onset of dysphagia during a meal, at a time when the person thought he was in perfect health. This was ten months before his death. After the first onset of the dysphagia he did not again swallow solid food. The case presented a difficulty in diagnosis, in consequence of the ease with which a stomach tube could be passed on some occasions, even a few days before death, whilst on other occasions it could not be passed. At the necropsy there was found to be no stenosis of the œsophagus, but an ulceration, which extended all round the gullet and for a longitudinal distance of three inches and a half in the middle third of the passage. The edges of the ulcer were finger-like, not indurated, and not at all like a malignant affection. The base of the ulcer also was free from induration, but was very irregular, in consequence of being adherent to the adjoining lower lobe of the right lung, and to the presence of an aperture communicating with the gangrenous cavity in that lung. It was this condition of the base of the ulcer which apparently accounted for the occasional difficulty in passing the stomach tube. Although to the naked eye the ulcer appeared to be non-malignant, the microscopic examination proved it to be a flat-cell epithelioma.

Angina Pectoris and Pseudo-Angina.—Dr. DRESCHFELD read a paper on this subject. Of true angina there were, according to the prominence of a certain group of symptoms, several types: 1, the respiratory, which was a very rare form; 2, the neuralgic, which was the more common type, of which the gastralgic, owing to its resemblance to simple gastralgia with which it might easily be confounded, required special mention; and 3, the vasomotor type. The lesion most commonly found in true angina was some affection of the coronary arteries (atheroma, thromboses, embolism, syphilitic endarteritis), and it was to be noted that atheroma of the coronary arteries was often found before the other arteries showed any changes, and where even the opening of the coronary artery appeared healthy, patches of atheroma might be found on tracing out the course of the vessel. The cause of the anginal attack was in most cases an irritation of the peripheric portion of the cardiac sympathetic nerve—the katabolic nerve of the heart—and irritation of those spinal sensory nerves, which were embryologically associated with the cardiac sympathetic, explained the neuralgic pain in the shoulder and other parts. In those cases where no lesion of the heart or coronary vessels was found after death, the irritation of the sympathetic was probably due to spasm of the coronary artery. Gaskell's important researches on the innervation of the heart had thrown great light on the pathology of angina, and by their help many of the symptoms could be readily explained. The cardiac ganglia, though they had often been found affected in many various diseases, were in most cases of angina found healthy. Pseudo-anginal attacks might be due, 1, to central irritation of the sympathetic cardiac nerves, either by direct irritation of the vasomotor centre (as in hysteria, neurasthenia, etc.), or by some toxic agent circulating in the blood and causing irritation of the centre (gout, alcohol, tobacco, tea); and 2, to reflex irritation of the cardiac nerves, as in affections of the stomach, intestines, liver, etc. Dr. Dreschfeld gave the points of distinction between the anginal and pseudo-anginal attacks, amongst which were vasomotor disturbances, periodicity of the attacks, and great irregularity of the pulse, which often persisted for days, chiefly characterised the pseudo-anginal attacks. The paper was illustrated by numerous specimens and microscopic sections.

CARDIFF MEDICAL SOCIETY.

THURSDAY, DECEMBER 5TH, 1889.

A. P. FIDDIAN, M.B. (in the absence of the President), in the Chair.

New Members.—Messrs. Marsh and J. T. Thomas, Newport, were elected members of the Society.

Periostitis as a Cause of Death in Children.—The CHAIRMAN read a paper on this subject. Two cases were described, in one of which the symptoms came on shortly after an accident, and ran so acute a course that the whole leg became swollen from the foot upwards as far as the hip, and death ensued in six days. At the *post-mortem* examination the tibia was found lying quite loose, bathed in pus, and the tissues of the thigh infiltrated with serum. In the other, a child of three, the illness began with convulsions, high temperature, and pain and swelling in the legs. It lived only fifty-six hours from the commencement of the seizure, and after death the shaft of the tibia was discovered to be bare, with a watery fluid around it.

Extrauterine Fœtation.—Dr. CAMPBELL gave the history of a case of extrauterine fœtation. Sixteen years ago, the patient, thinking herself pregnant for the third time (eighteen years having elapsed since the last confinement), engaged a nurse to attend her. Labour pains came on, but no progress was made, although a medical man who saw her pronounced her to be pregnant. After a week in bed, she got up, but continued ill more or less for the next three years; and, when Dr. Campbell saw her then for the first time, the signs of a large abdominal abscess pointing near the umbilicus were present. This discharged pus for a few months, but, after the sinuses had been closed for some time, a large pendulous ventral hernia made its appearance. A binder supported this efficiently, but the patient suffered at intervals from abdominal symptoms, and at length died in October of intestinal obstruction at the age of 58. At the *post-mortem* examination there was found in the pelvis a mass of stony hardness, about the size of a child's head, occupying the seat of the uterus and right broad ligament. It was attached only by a small pedicle in the situation of the uterine cervix, and was freely movable in all directions. On section with a saw, it contained an almost complete set of fœtal bones enclosed in a calcareous capsule. The immediate cause of death was the constriction of a knuckle of small intestine by a band of omentum.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

THURSDAY, DECEMBER 5TH, 1889.

C. N. GWYNNE, M.D., President, in the Chair.

Specimens.—Dr. HARGREAVES showed a specimen of Aneurysm of the Abdominal Aorta just above the bifurcation. The sac was posterior, resting on the vertebræ, and of the size of a small orange. The patient, a man aged 30, was a grinder, and the probable cause of the aneurysm was a strain in lifting a grinding stone. The cause of death was rupture of the sac into the abdominal cavity.—The PRESIDENT showed a specimen of Aneurysm of the First Part of the Descending Thoracic Aorta. The patient was a healthy woman, aged 36, married, but no family. There was no history of gout, rheumatism, or syphilis, nor of any injury. She complained chiefly of acute neuralgic pains shooting from the spine to the left inframammary region. She died about a year after the symptoms appeared. A *post-mortem* examination showed an enormous aneurysmal sac filling up the entire cavity of the left chest. The necks of three ribs were quite eaten into, and the bodies of the corresponding vertebræ were eroded so as almost to expose the cord. Beyond the pain referred to there were no other pressure symptoms.—Dr. PORTER showed a specimen of Aneurysm of the Ascending and Transverse Aortic Arch. The symptoms had been those due to pressure on the trachea at its bifurcation and on the root of the right lung. The patient, a man aged 48, died of asphyxia.—Dr. KEELING showed a specimen of Epithelial Cancer of the Vulva and Vagina, removed from an elderly single woman at the Jessop Hospital. An operation had been performed on the same patient twelve years before, the disease at that time occupying the clitoris and fore part of the vulva. The old cicatrix and neighbouring tissue had remained sound, the return of the disease being in the posterior half of the vulva, extending from this point up the vagina.

Strangulated Hernia.—Dr. KEELING read a paper on two unusual cases of strangulated hernia, operated on in the Public Hospital and Dispensary. One of the patients was a man aged

72, with double inguinal hernia, that on the left side being irreducible, and containing a coil of large intestine and a mass of fat, consisting of the hypertrophied appendices epiploïcæ. Amongst these a knuckle of small intestine had descended and become strangulated. After this had been reduced, some of the fat and sac were removed; the large bowel was then loosened from its bed and returned to the abdominal cavity, along with the fat and remnant of the sac, the hernia being thus radically cured. The patient made a good recovery. The other case was that of a boy, aged 2½, who had congenital hernia, with incomplete descent of testicle. Strangulation occurred three days after a hearty meal, at which some crab shell had been munched and swallowed. A long thin pouch of gangrenous intestine (believed to be a diverticulum) was found in the sac, and in the pouch there were about two teaspoonfuls of bits of crab shell. These and the gangrenous tissue were removed and a portion of the sac was cut away, the remainder being stitched to the skin, and a drainage tube passed into the external ring. A free discharge of fæcal matter took place by the wound during the first three weeks; after this the parts healed soundly, and complete recovery followed. A small phial containing the fragments of crab shell was shown. The patients had been shown at a previous meeting.

Joint Dislocation.—Mr. GARRARD read the notes of two cases of joint dislocation. In one, a man aged 44 had sustained a dislocation of the right femur on to the dorsum ilii, and of the left femur into the thyroid foramen, with other injuries, including fractured ribs and arm. The other case was one of subcoracoid dislocation of the humerus in a young man, of five weeks' duration, which he reduced with difficulty by Kocher's method after other means had failed. He asked whether it would not be justifiable, in the case of a young man, with a comparatively recent irreducible subcoracoid dislocation, to open the joint, with the minimum of damage to the circumflex nerve and deltoid muscle, between the two heads of the biceps, clear out the glenoid fossa, and restore the head of the bone to its right position rather than leave the case to Nature. He thought that a movable joint ought to be secured.

CORK MEDICAL AND SURGICAL SOCIETY.

WEDNESDAY, NOVEMBER 28TH, 1889.

FRANCIS WM. GREENE, M.B., President, in the Chair.

President's Address.—The PRESIDENT gave a short inaugural address, in which, after thanking the members for the honour conferred upon him in electing him their President for the ensuing year, he referred to the good work done by the Society, and to the great benefit such an Association was to the medical man engaged in private or country practice, enabling him by interchange of ideas with his fellow practitioners to keep abreast of the times, and keeping him from falling into narrow grooves. A still greater advantage to the ordinary practitioner was the meeting there of men who had devoted themselves to the study of some special branch of medicine or surgery. He next referred to the great progress and triumphs of modern surgical research, especially mentioning the operations on brain, spinal canal, and abdomen, dwelling particularly on those performed on the gastro-intestinal tract. The newest advances in antiseptics and their application were alluded to, and with a few well chosen words on the immediate benefits and preservation of life derived from surgery in general, the President closed his address.

Vote of Thanks.—A vote of thanks was proposed by Dr. W. JACKSON CUMMINGS, seconded by Dr. PEARSON, and carried unanimously.

Subperitoneal Fibromyoma of the Uterus.—Dr. GUISANI showed naked-eye and microscopic specimens of uterine tumour, which he had removed by abdominal section. The patient, aged 45, unmarried, had a history of prolonged dysmenorrhœa and gradual enlargement of the lower region of the abdomen. The nature of the tumour having been diagnosed, it was removed, and the pedicle (an unusually long one) ligatured in halves, with the precaution of a second ligature nearer the uterus. The wound was dressed, closed, and the pedicle enclosed in the cavity. Drainage was effected by a tube in Douglas's *cul-de-sac*. An antiseptic dressing of sal alembroth gauze was applied over the abdominal incision. The general treatment consisted of iced water for the first six hours, and next day milk, aqua calcis, and hot water to relieve flatus. Broths, etc., were administered from the third day, the patient making an uninterrupted recovery. The microscopic specimens were made by Dr. Cotter.

Urinary Calculi.—Surgeon-Major WALKER showed specimens of urinary stones, removed by him from natives in India. Some of the calculi were of unusually large size and weight, embracing all the varieties of stone.

REVIEWS AND NOTICES.

THE ANIMAL ALKALOIDS, CADAVERIC AND VITAL; or the Ptomaines and Leucomaines. By A. M. BROWN, M.D. With an Introduction by Professor A. GAUTIER. Second edition. London: Hirschfeld Brothers. 1889.

THIS book is the outcome of incomplete information. If it had been entitled a eulogy of M. Gautier it would have been a correct designation. In every chapter, almost on every page, the French chemist is spoken of as the eminent or gifted discoverer of the animal alkaloids, or his researches are alluded to with similar adjectives of admiration. Gautier is, no doubt, one who has contributed largely to our knowledge of these substances, particularly of the leucomaines, but to maintain that he is their discoverer, or even the chief worker in the field, is a mistake.

If we may judge by the English, or, rather, want of grammatical English, in which the book is written, we should say that the greater part of the first chapters, those which relate to the chemistry of the subject, are very free translations from French papers. Gautier is, however, only one, and not the first or the most correct, among many investigators in this field. The author is almost completely ignorant of the immense amount of work done by many German investigators, who, as a whole, are much more correct and exact in their researches. Beyond a few references to Brieger, the names quoted are almost exclusively French. We have a great sympathy with and respect for French workers, but here they suffer from misplaced admiration of their errors as well as their achievements. The French origin of most of the chemistry is evidenced by such expressions as "melange" for mixture, "groupment" for group, "resumed" for summed up, "dissolvents" for solvents, and by the placing of the adjectives after instead of before the nouns; we thus frequently read "anhydride carbonic," "alkaloid liquid," "formula of constitution," "kreatinine pure," "hydrochloric acid concentrated," and soon.

The sentences as a rule are not punctuated, very often either the nominative or the verb is absent; they are always difficult to understand, and sometimes quite unintelligible. The following are a few selected at random as illustrations:—On p. 21 we read: "The products responding to ordinary tests are reliable in physiological experimentation, still, it is to be observed that in separating the alkaloids from the extracts which they accompany by this method, it is only possible, and with the utmost care to obtain even impure bases, in quantity sufficient to admit of isolation and correct analysis." On p. 56: "An alkaloid liquid that smelled of mice-piss." On p. 47: "Sensibly, the free ptomaines smell virous or cadaveric." On p. 77: "In alkalinity adenine is neutral." This last quotation is evidently a conundrum. To go through the whole book pointing out all the mistakes would take more space than we care to give to its consideration. We will however select portions of two chapters, and enumerate those errors which we have noted in passing. On p. 37 we notice three words, "Schulze," "tungstic," and "cæphalopod," wrongly spelt. On p. 38 coniine is called "conicine," as throughout the rest of the book, and in the word "orthorhombic," the second *h* is omitted. On the next page there is a misprint in the word "cholesterin." Errors of a more serious nature, however, are committed on the same pages, for here we are told that putrescine and cadaverine are not toxic. We refer Dr. BROWN to papers by von Behring, Scheuerling, and by Fehleisen and Grawitz on this subject. Turning over the page we find the formula for water wrongly written, and on p. 41 that for silver oxide is also incorrect; the long word "trimethylhydroxethylene" is here also wrongly spelt; this of course would have been pardonable if the simpler words had been correctly given; we find the same carelessness, however, on the next page, where the author comes to grief over trimethylamine and neurine, and on p. 42 his mistakes culminate in the wrong spelling of the comparatively simple word chloride. On p. 44 he commits the very serious error of accepting the truth of Pouchet's experiments on alkaloids in urine, though we should have thought that the fallacies of Pouchet's method and results had been