in the following way. The opening in the alveolus was made just large enough to hold comfortably the gold-plated antrum tube, and the rectangular silver cannula was made to fit exactly into the antrum tube, and long enough to project into the antrum, so that the stream of fluid subsequently injected might be readily scattered within the cavity itself. The rectangular silver cannula was provided with a movable platform, carrying a rubber washer, which, when pushed up against the alveolus, completely closed the opening, and prevented any regurgitation of fluid.

When in use the cannula was run up into the gold-plated antrum tube, the platform was raised until the rubber washer completely closed the alveolar opening, and the whole apparatus was kept *in situ* by means of the patient closing the jaws upon the instrument. In order to irrigate the cavity, a long rubber tube was attached to the cannula, and a siphon action established. In this way thorough irrigation could be obtained with very little trouble to the patient, and with very satisfactory results. The gold-plated tube was attached to a dental plate, and kept closed by means of a small screw plug.

In the treatment of suppuration of both anterior and posterior ethmoidal cells, of which he had seen a few cases, the diagnosis had been established by carefully watching the flow of pus, while at the same time disease of the frontal sinus and of the antrum could be excluded. The treatment had consisted in breaking down the cells with a small Volkmann's spoon, converting the whole into one large cavity, and packing loosely with iodoform gauze.

A CASE OF SANGUINEOUS CYST CONNECTED WITH THE PANCREAS.

By THEODORE FISHER, M.D.LOND.,
Registrar to the Bristol General Hospital.

SINCE there are many points that need elucidation in connection with pancreatic cysts, nearly every case is worthy of record. Although this example presents nothing particularly striking, there are one or two features of interest. The following are noteworthy: (1) A long history of epigastric pain preceded the appearance of the tumour; (2) the swelling appeared suddenly, within the course of a few hours; (3) the cyst contents proved to be sanguineous; and (4) since the cure of the cyst, the patient's health has been better than for several years previous to its appearance. It may be mentioned that a similar case was admitted into the Bristol General Hospital under the care of Dr. Markham Skerritt during the early part of last year. The cyst contained altered blood, and, as in the following case, its appearance was preceded by several attacks of epigastric pain. In the *Guy's Hospital Reports* for 1892 (Peritoneal Sanguineous Cysts and their Relation to Cysts of the Pancreas) I have given reasons for believing that all so-called pancreatic cysts may be due to hæmorrhagic effusions either arising in the gland or in its neighbourhood, and that the cause of such hæmorrhage is probably a lesion of the sympathetic system that at first manifests its presence by intermittent attacks of epigastric pain. This case is published with the kind permission of Mr. R. Poole Lansdown, under whose care the patient was admitted.

C. M., aged 38, a cabinet maker, was admitted into the Bristol General Hospital on July 3rd, 1893, complaining of abdominal pain. Twenty-two years before he had contracted syphilis, and had been attending as an out-patient during two or three months previous to admission for syphilitic testis. When last seen by Mr. Lansdown, June 17th, he appeared to be in perfectly good health. On admission he stated that on June 19th he was seized while at work with severe vomiting and abdominal pain. The pain, which was most marked on the left side of the abdomen, about the level of the umbilicus, continued for several hours, when he discovered a lump about the size of a closed fist. This swelling disappeared in a day or two, but he noticed that he could not lie upon either side with comfort; when on the right side something in the abdomen seemed to "fall over," and when on the left side to "press up." He had kept his bed since the onset of the abdominal pain. This attack of pain, however, was not the first. During the past six years he had suffered from severe epigastric pain, so severe at times that he had been obliged to leave work. His appetite had been bad, he had suffered from constipation, and for the last few months previous to admission he thought that he had wasted. There was no history of abdominal injury, but he attributed the attacks of pain to a strain produced by lifting a very heavy dining table. He said that the first attack followed three days after. A year before the strain he had fallen backwards and fractured his ankle, but was certain that his abdomen had not been struck.

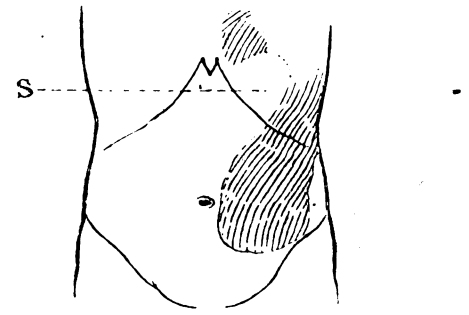

Diagram showing the position of the swelling; S, stomach resonance.

The patient was a well made but rather thin man of yellowish sallow complexion and lethargic expression. On inspecting the abdomen slight fulness was seen on the left side, and on palpation a tumour could be felt which gave the impression of an enlarged spleen extending as low as the anterior superior spine of the ilium and inwards to within an inch of the umbilicus. It was so hard as to feel solid, but differed from an enlarged spleen in the want of definition of its borders. Below it did not extend outwards into the left lumbar region and could not be palpated between the two hands, one being placed behind. There was little if any tenderness, and it did not move with respiration. The note over it was dull, absolutely so immediately below the costal margin, but becoming less marked towards the limits of the tumour. Marked out by percussion and palpation the border of the swelling extended along a line drawn obliquely inwards and downwards from the cartilages of the ninth rib, to a point 2 inches above and 1 inch internal to the umbilicus. From that point it passed downwards to the level of the anterior superior spine of the ilium, where it turned directly outwards until the spine was reached, and from there obliquely upwards to the tip of the twelfth rib, leaving an area of resonance in the left lumbar region. Above the margin of the ribs the dulness extended to the seventh intercostal space in the mid-axilla passing obliquely downwards and backwards from that point to the junction of the tenth rib with the spine, thus giving a small area of dulness at the base of the left side of the chest. Stomach resonance separated the dulness in front from that of the heart.

On July 10th a consultation was held by Mr. Lansdown with his surgical colleagues, when there was a general opinion that the tumour was solid. The history seemed, however, to give a clue to its real nature. After some deliberation, it was thought that the needle of an exploring syringe might be inserted. Dark reddish-brown fluid was drawn off, and 30 ounces of the same fluid afterwards aspirated. The fluid was strongly alkaline and highly albuminous, of specific gravity 1014. A dark brown sediment was quickly deposited, leaving a clear fluid of deep reddish-brown colour above, which proved to be altered blood. This deposit, under the microscope, showed numerous pigment granules, but no formed elements and by dialysis a fluid was obtained that gave peptone reactions. There was marked reduction of Fehling's solution after digestion with starch for ten minutes at the temperature of the body.

On the following day there was little of the tumour to be felt. About the site of the puncture there was a small area of dulness of about 2 inches diameter, separated from the splenic dulness by a band of resonance. The dulness at the left base of chest had disappeared.

On July 13th it was noticed that the cyst appeared to be refilling, and on the 22nd it had regained its former size.

On July 25th. Under chloroform Mr. Lansdown made an incision over the tumour about 2⅔ inches long in the line of the left linea semilunaris. On coming down upon the cyst it was found to be adherent to the abdominal wall. Little could, therefore, be learnt of the situation of the collection of fluid. The cyst was opened, and 26 ozs. of fluid of the colour of *café au lait* came away. Mr. Lansdown introduced his finger, and could reach the limits of the cyst. Above it reached to the point up to which dulness had been noted, and internally to the middle line. The spleen could be felt but not the left kidney. The fluid, which was of much lighter colour than that aspirated on July 10th, on standing deposited granular material of light greyish colour, leaving a clear, dark brown fluid above. It was strongly alkaline, highly albuminous, of specific gravity 1012, and amylolytic as before. The granular deposit showed transparent granules under the microscope, highly refracting spheroids of various sizes, and orange masses of pigment, with a few large round cells, some containing highly refracting granules.

August 12th. Some of the fluid draining from the wound was collected in a sponge. It was of dirty brownish-white colour, depositing a grey sediment, alkaline, highly albuminous, and markedly amylolytic. Under the microscope the deposit showed masses of granular material, some colourless, some of faint yellow colour. There were also irregularly-shaped flakes of hyaline material of various sizes, but no formed elements could be seen. The skin round the edge of the wound was reddened and macerated, but not more than is common with discharges of other character, such as pus from an empyema.

On August 19th the patient left the hospital with a sinus still discharging, which, however, healed six weeks after.

He was seen eight months after leaving the hospital when he stated that he had enjoyed better health than for six years previous to the appearance of the cyst. He had been free from pain and was 4 lbs. heavier than when last weighed before his illness. His wife was more emphatic than the patient when speaking of the improvement in his general condition, and said that he could do more work than he had been capable of doing during the six years that preceded his admission to the hospital.

The history of pain, the sudden appearance of the tumour, and the sanguineous nature of its contents, have already been pointed out. The change in the colour of the fluid is also worthy of note. At first it was deep reddish-brown, afterwards the colour of *café au lait*. It seems possible that this change of colour may progress until the cyst contents fail to give evidence of their former sanguineous nature, and the origin of the pancreatic cyst in a hæmorrhagic effusion be thus overlooked. The cessation of pain after the appearance of the cyst is a curious feature that has occurred in other cases. The patient is cured of pain that may have existed for months or even years before the development of the swelling. A long-standing disease culminates in a severe manifestation that, instead of proving disastrous to the health of the patient, results in the removal of the distressing symptoms. This fact increases the obscurity of the origin of these cysts, but a discussion of its import is beyond the scope of this brief record; it may, however, be remarked that the great point of interest seems to be how far the pancreas is involved. In fatal cases of hæmorrhage in the region of the epigastrium the pancreas may be extensively affected, but we can hardly suppose that a patient would improve in health and gain in weight after destruction of that important gland.

OBSTRUCTION OF THE BOWELS CAUSED BY AN INCOMPLETELY REDUCED LEFT INGUINAL HERNIA.

LAPAROTOMY: DIVISION OF INTERNAL ABDOMINAL RING FROM WITHIN THE ABDOMEN: RECOVERY.

BY W. C. EVERLEY TAYLOR, F.R.C.P.EDIN., M.R.C.S.,
Surgeon to the Scarborough Hospital.

ON April 13th, 1893, I was asked by Dr. Wilkinson, of Cloughton, to see G. H., a man aged 53, living at Scalby. The patient had for many years suffered from hernia, which was kept in position by a well-fitting truss. On April 7th, after retiring to bed and taking off the truss, he sneezed violently, which caused the hernia to descend. He attempted to reduce it himself without success. On the following morning he sent for Dr. Wilkinson, who found a manifest left oblique inguinal hernia. With gentle manipulation the hernia seemed to be easily reduced, with apparent great relief of the pain. During the next two days there were no remarkable symptoms, save that no flatus passed. On the morning of April 11th the patient complained of wandering colicky pains, which during the day increased in intensity; obstinate vomiting set in, and the general condition became alarming.

I saw him on the afternoon of April 13th, at 4.30 P.M. The patient was much exhausted; the pulse was 120, rapid and running; the tongue small and red; the temperature 100° F. The abdomen was distended and tender; there was no dulness nor increased pain on pressure over the site of the hernial apertures. There was nothing to be felt in the inguinal canals. The patient's condition was desperate; the stercoraceous vomiting had existed for forty-eight hours, and there had been no action of the bowels or passage of flatus since April 7th. I was of opinion that either the gut had been incompletely returned or that there was strangulation by a band.

Ether having been administered, a median incision was made. The intestines were much distended. I passed my hand to the site of the left internal ring, and found a knuckle of the small intestine tightly grasped by the inner margin of the internal ring. A very slight incision liberated the gut; about two-thirds of the lumen of the gut had been involved in the constriction; it was dark chocolate colour, but shining; there was no evidence of any peritonitis. The abdominal contents were as little disturbed as possible, and no "toilet of the peritoneum" was attempted. The peritoneum and muscles were sutured separately with silk, and the skin wound with silkworm gut; three carbolised catgut sutures were unfortunately used in the superficial wound. The patient rallied well from the operation; flatus was passed within six hours; the vomiting ceased immediately; the progress to recovery was only retarded by some stitch abscesses set up by the carbolised catgut sutures, and the patient is now "as well as ever he was" in his life.

The remarkable points in the case are the abeyance of symptoms for forty-eight hours after the gut was thought to be returned, the desperate condition of the patient when operated upon, and the great ease with which the hernia was dealt with from within the abdomen.

REPORTS
ON
MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN, IRELAND, AND THE COLONIES.

LYING-IN HOSPITAL, MADRAS.[1]

A CASE OF SYMPHYSIOTOMY.

(By Surgeon-Lieutenant-Colonel A. M. BRANFOOT, M.B.)

THE patient, Velliammah, Hindu girl, 15 years of age, was admitted into the delivery ward on September 16th, 1893, in labour with her first child. It was stated that she had been in labour for eight hours previous to admission, but she had all the appearances of having been much longer than this. The uterus corresponded to full term of gestation, and was somewhat rigid. Fœtal heart audible on the left side below the umbilicus. Bladder was distended, and 20 ounces of urine drawn off by catheter. In general appearance the girl was small. *Per vaginam* head presenting in the brim with a large scalp tumour, membranes absent, and the rim of the cervix could just be felt. Pelvis markedly small, and of apparently infantile type. Chloroform was administered, Simpson's axis-traction forceps applied and traction made, but considerable traction force failed to move the head. It was therefore determined to perform symphysiotomy.

Operation.—The abdomen was washed with antiseptic lotion and the pubic hair shaved. An incision 2½ inches in length was made from above the symphysis downwards in the median line, dividing skin and tissues down to the top of the symphysis. Symphysis was exposed and a blunt-pointed bistoury pushed into the joint; but the separation of the pubic bones could not be completed, and it was found necessary to complete the division with a small Hey's saw, when the pubic bones separated to about half an inch, the hips being firmly supported by an assistant. Pressure from above failing to deliver, Simpson's ordinary forceps were applied and delivery readily effected. During delivery the bones separated to about 2½ inches. The head was delivered with the occiput posterior. The bones were then approximated by pressure and the periosteum united by two deep silk sutures. The wound was closed by silk sutures and a small drainage tube inserted at the lower angle. The placenta was expressed, the wound dressed with antiseptic gauze, and a firm bandage placed round the pelvis. The child, a male, weighed 212 *tolas*—just under 6 lbs.; length 18½ inches. It was alive and has since thriven well.

Convalescence after delivery was uneventful. The wound healed almost by first intention, except at the lower part, from which a little pus escaped. The patient was kept on her back until September 29th (twelfth day), when she was allowed to lie on her side. On October 1st the following note was taken: Temperature, normal; pulse, 88. Vaginal walls natural; the finger can be passed along both sides of the pubic arch, and the symphysis appears united. There is still a small sinus at the lower end of the wound externally. On October 9th patient sitting up. She has some cough. October 18th patient is able to walk by herself. No pain complained of over the symphysis. Slight rise of temperature due to bronchial catarrh. When walking there is slight incontinence of urine occasionally; this is apparently due to debility. When convalescent patient's height found to be 4ft. 6½ inches, and weight 65 lbs.

A careful examination of the pelvis was made. External measurements, A.S.S. 8¼ inches, Cr. Il., 8⅝ inches. External ante-posterior 5 inches. Promontory of sacrum reached by

[1] Communicated to the South Indian Branch