contain a large quantity of pus, and on one occasion blood. His symptoms not improving, he was admitted on October 16th, 1889, when he presented the following conditions:—Patient weighs 4 stone; is very emaciated, anæmic, and delicate-looking; is restless, and sleeps badly; complains of pain, sometimes in his back, sometimes in the lumbar region; this pain, which is of a dull aching character, does not extend from the above positions; tongue is clean, transversely fissured; he takes food well, and does not complain of thirst; his bowels are constipated; temperature normal. Urine: He passes daily from 40 to 46 ounces, from 2 to 6 ounces being voided about every two hours, which froths when passed. Micturition is not now painful. Examination: Urine very pale; reaction neutral; specific gravity, 1009; deposits a thick white precipitate containing large quantities of pus with a little mucus. Albumen is not more than to be accounted for by the amount of pus present; chlorides $\frac{1}{10}$th of normal quantity; urea 1.1 per cent.; microscope shows pus corpuscles; large flattened epithelial cells, single and in masses of from twenty to thirty; a few epithelial tube casts—a specimen was examined for bacillus tuberculosis, but without success. The patient's abdomen appears normal, but becomes very rigid on palpation, when a rounded tumour is to be felt immediately below the costal arch on the left side, which moves with diaphragmatic respiration, and presents a distinct rounded margin. On deep pressure, a second tumour is to be felt below the former; pain is complained of on pressure over the anterior aspect of the abdomen in the position of these tumours, but not posteriorly.

The patient was detained under observation until October 31st without any appreciable change in his condition, when Dr. Heuston made the usual oblique incision for kidney exploration in the left lumbar region, and found the kidney much enlarged, with several opaque spots visible on its surface, which, on being punctured with a needle, gave a sense of resistance, but no solid substance was to be felt. An incision was then made into the kidney, when some pus and urine escaped from a large abscess sac, which was found to contain a quantity of caseous material, it being now seen that the organ was studded with caseous patches; the kidney was carefully separated from surrounding structures and the hilum exposed; the ureter being separated from the vessels was ligatured some distance below the pelvis and divided. The vessels were ligatured in two places with silk and divided, the ligatures being then cut short; the wound was closed with deep and superficial sutures, a drainage tube was introduced, and antiseptic dressing applied; the entire operation occupied a little over an hour.

Subsequent examination of the kidney showed it was all in a diseased condition, containing, in addition to the large cavity already described, a number of small abscesses, also numerous deposits of caseous material. Microscopic examination proved the presence of giant cells in large quantities.

November 1st. Patient did not sleep much, and vomited frequently during the night. Morning temperature, 102.6° F.; urine, 17 ounces; acid in reaction; specific gravity 1028, contains lithates, a few pus cells, and a number of granular casts.

November 2nd. Slept well; wound dressed and found healthy; urine, 60 ounces, pale, acid; specific gravity, 1016; temperature, 101.8° F.

November 4th. Slept well; bowels moved three times; urine, 46 ounces; specific gravity, 1024, acid; temperature, 100°F.; wound nearly healed.

November 5th. Passed urine three times during the night, 36 ounces acid; specific gravity, 1022, high coloured, contained pus, mucus, and tube casts, with some albumen; chlorides $\frac{1}{10}$th normal; urea, 2.5 per cent.; temperature, 100° F.

From this date patient progressed favourably, and on November 18th the urine was as follows: 27 ounces, acid, normal colour, specific gravity 1018, urea 2.3 per cent., chlorides $\frac{1}{4}$ normal, pus small quantity.

November 23rd. Allowed out of bed, and on January 18th, 1890, he was discharged from hospital, being then 4 stone 7 pounds in weight; sleeping and eating well, and did not complain of pain, or frequency of micturition.

Remarks.—In publishing the above careful notes so fully, I am induced to do so as the case may prove of interest to the members of the profession, owing to the uncertainty which exists as to the diagnosis of such cases, and the advisability of operative procedure. The success of this operation being so dependent on the limitation of the disease to one kidney, it is of the utmost importance to form a correct diagnosis. The devices recommended by such authorities as Silbermann, Sands, Glück, Pawlik, etc., must be placed on one side as impracticable, the only reliable method, in my opinion, being that of Mr. Greig Smith, who depends upon the characters of the urine, as to quantity, percentage of solids (especially urea), and the presence of no more albumen than is to be accounted for by the pus in the urine. The above, taken in conjunction with the signs and symptoms of the case, should generally enable a tolerably accurate opinion to be formed as to the condition of the kidneys. As to the advisability and advantage of such an operation, it will suffice for me to state that this patient called to show himself to me about a month after his discharge from the hospital, when the improvement in his general appearance was most marked. He looked strong and healthy, and had gained considerably in weight. He stated that he did not suffer in any way, and felt quite well.

REPORTS OF SOCIETIES.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Tuesday, January 13th, 1891.

Timothy Holmes, M.A.Cantab., President, in the Chair.

A Case of Nephrolithotomy (following Nephrectomy) for Total Suppression of Urine Lasting Five Days; Complete Recovery and Good Health Five Years after the Operation.—Mr. R. Clement Lucas read notes of this case, which was mentioned by the medical journals at the date of the operation, in 1885, as a case of exceptional interest, but the author had delayed publishing it until sufficient time had elapsed for a judgment to be formed as to the permanence of the cure. The patient was still enjoying the best of health and freedom from pain, discomfort, and hæmaturia, which, for seventeen years before her right kidney was removed, were almost constantly present. The operation for total suppression of urine was one that the author had long considered justifiable, and he had on more than one occasion previously publicly advocated its performance. The patient had been under the care of Mr. F. D. Atkins, of Sutton, Surrey, to whom much credit was due both for the original diagnosis and for the prompitude with which he acted when total suppression occurred. F. F., aged 37, was first admitted into Guy's Hospital on June 22nd, 1885. There was a strong family history of consumption. For seventeen years she had suffered from hæmaturia at intervals, and for nine or ten years this had been accompanied by pain on the right side of the abdomen, and for seven years a tumour, diagnosed as a floating kidney, had been felt on this side. On July 14th the right kidney was removed by lumbar incision. It was a mere shell containing masses of stone and weighing 21 ounces. The wound healed completely, and she left the hospital convalescent on August 10th, just within a month of the operation. All went well for three months. She had returned to her household duties, was free from pain and hæmaturia, and much satisfied with the result of the operation. On Sunday, October 24th, 1885, she was suddenly seized, between 7 and 8 A.M., with agonising pain in the back and left loin. The pain passed through the loin to the front of the abdomen and groin. About 8 o'clock she passed a little urine, but from that time all secretion stopped. Vomiting commenced about half-past 8 on the same morning, and was continued at intervals and whenever anything was taken. Mr. Atkins was called to see her, and found the bladder empty. Vomiting and anuria continued throughout Sunday, Monday, and Tuesday. On Tuesday Mr. Lucas met Mr. Atkins in consultation, and advised operation. The symptoms continued without cessation on Wednesday, when she was brought to London, but Mr. Lucas's medical colleagues still advised him to postpone operation till a further trial had been given to diuretics, and in deference to their opinion he waited another day. On the afternoon of Thursday, the fifth day of anuria, the patient became drowsy and weaker, so that it was difficult to rouse her to obtain answers to questions. Her pulse was weak, her tem-

perature 99°, and she had become less sensitive to pain and indifferent to what was passing around. Ether was given, and Mr. Lucas cut down on her remaining kidney and discovered a conical stone acting as a ball-valve to the top of the ureter. The stone was rather more than three-quarters of an inch in length, and from three-eighths to five-eighths in diameter. Urine began to drip away out of the wound as soon as the pelvis of the kidney was opened, but the pelvis was not found much dilated. For twelve days all urine was passed by the wound in the loin. Then an ounce and a half was passed with great pain from the bladder, and the quantity gradually increased. After the nineteenth day all the urine was passed naturally. The wound ran an aseptic course, and the patient's temperature scarcely rose above normal. Healing was complete ten weeks after the operation. During the last five years she had been employed in household duties and had enjoyed good health. The patient was exhibited, together with her right kidney, which was excised, and the stone removed from the left kidney for total suppression of urine.

Removal of large Calculi, first from one Kidney and afterwards from the Other: Death from Hæmorrhage after the Second Operation.—Mr. RICKMAN J. GODLEE read a paper on this subject. A gentleman, aged 37, first complained of renal symptoms in 1886. In the autumn of 1888 a diagnosis of left renal calculus and left pyelitis was made, but mischief on the right side was also suspected. In November, 1888, a large quantity of stone —uric acid and phosphatic—was removed from the left kidney. The patient made a rapid recovery, but the closure of the wound was not permanent, and after several febrile attacks it was found best for the patient to wear a plug permanently in the fistula, to prevent periodical accumulations of pus and urine in the kidney. At one time the ureter became completely blocked, and an operation was undertaken to remove a stone which was supposed to be obstructing it. None was found, but the ureter became again patent after the operation, and the state of the kidney very much improved. The patient now became convinced that he had stone in the right kidney. The risks of an operation were explained, but he was recommended to submit to it, and on November 19th, 1890, large masses of uric acid stone were removed. No bleeding followed the first incision into the kidney, but the laceration that was caused by the removal of the stones gave rise to very free venous hæmorrhage, which was easily controlled by pressure. At the completion of the operation there was little or no bleeding, but it was thought safer to plug the pelvis of the kidney. The patient remained in fair condition for an hour and a half after the operation, and then suddenly died, as the result of fresh hæmorrhage from the kidney. The rarity of the accident was dwelt upon, and attempts were made to suggest means of combating it if it arose. Mr. Godlee read a letter from Mr. Mayo Robson, in which it was related that three years ago after making a small incision into the cortex of a kidney violent hæmorrhage occurred, and in order to avoid a fatal result Mr. Robson had found it necessary to remove the kidney. On examination a large abnormal vein existed in the kidney near the surface, and from this, which had been wounded during the operation, the blood had escaped; and Mr. Robson mentioned in his letter a second case of hæmorrhage from the kidney, which had happened in the practice of another gentleman, and in which the result had been fatal. Neither of these cases had been published, but the first had been shown at a meeting of the Leeds Medical Society.—Mr. ARBUTHNOT LANE had experienced violent hæmorrhage from a kidney, which, after passing big sutures into the kidney substance in the neighbourhood of the bleeding, stopped at once when the sutures were firmly tied.—Dr. G. HARLEY, after complimenting the authors on their papers, spoke of the duty of physicians of endeavouring to remove calculi when small by chemical means, and stated that this could almost certainly be done. The difficulty was in diagnosing cases sufficiently early, as cases were likely to be mistaken for cancer, gallstones, Bright's disease, or lumbago. He showed a specimen of a large calculus, which had been removed from the body of a man after death, who had been considered for seven years previously to be suffering from lumbago, and whose urine when examined had never been found amiss. He also brought twelve specimens of small calculi to show that calculi had not always merely a local, but also a constitutional, cause, and that calculous disease had been traced through three generations. Such a family history was that of a London physician who had passed a renal calculus when 37 years of age. His uncle had had a calculus removed by Liston, and the physician had found a certificate of a *post-mortem* examination on an ancestor who died in 1620, aged 71, of gout, in whom a stone was found which weighed 16 ounces. He next stated that the amount of disturbance in the organism was not directly due to the size of the calculus, and showed two stones, the first of which was only passed after severe colic, whereas the second, though much larger, came away comparatively easily. He next showed some calculi removed after death from the kidney of a child of 10 months. He then related a case of a patient who, after having passed a uric acid calculus, was treated with alkalies for a year, when he passed a calculus of oxalate of lime; after this the patient took lactic acid, and later passed a phosphatic calculus; these stones were all of nearly the same size and shape. From this he concluded that, if it was possible to produce calculi in a patient by chemical means, it should be possible also to remove them.—Mr. G. R. TURNER related the case of a woman who had been under Dr. Whipham's care in St. George's Hospital with two large renal tumours and with well-marked symptoms of renal calculi. He had cut down on both kidneys and removed a calculus from each kidney. The patient died thirteen days later of asthenia. There had been no suppression of urine. He then gave an epitome of forty-three cases from the St. George's Hospital *post-mortem* records in which renal calculi had been found. He summed up by saying that the prognosis seemed to depend in part on the amount of suppuration of and destruction of kidney substance that had occurred before the operation.—Mr. T. SMITH asked Dr. Harley how it was possible to differentially diagnose between scrofulous kidney and renal calculus. He asked Mr. Godlee what part of the kidney he had opened in his case and what dressing had been used, as he was acquainted with a rash which sometimes followed the use of iodoform dressings. He agreed with Mr. Turner that the condition of the kidney affected the prognosis, and mentioned the case of a delicate lady from whom he removed a kidney for calculus without first cutting it open; and he was glad that he had done so, as, after removal, he had found it contained mortar-like material as well as calculus, and he suspected that the former, if left *in situ*, would probably have prevented the healing up of the sinus.—Dr. HARLEY said that he did not know how to distinguish between scrofulous kidney and renal calculus.—The PRESIDENT congratulated both authors on their papers, and thought that Mr. Lucas's was a unique case. He considered that the discussion had not sufficiently turned upon the treatment of hæmorrhage.—Mr. LUCAS, in reply, felt that his success had been partly due to the ample time afforded for thinking over the case. The frequency with which renal calculus was unilateral, as shown by Mr. Turner's statistics, was, he felt, an important fact. If there was much degeneration of the kidney, he agreed that it was preferable to remove it with the stone. Dr. Harley was, he believed, too sanguine in hoping that surgical interference would not be needed in future, and advised physicians not to delay too long before calling in surgical help. One easy and by no means formidable method of determining whether the symptoms in any given case were due to the presence of a calculus or to tubercular disease was to get a surgeon to explore.—Mr. GODLEE was still uncertain as to whether it was best to plug the wound or not, as if bleeding went on behind a plug, a cavity was formed into which the hæmorrhage continued, and prevented contraction of the tissues, and pointed out how in hæmorrhage into the bladder, the bleeding could not be stopped until the clots were removed and the bladder able to contract. He thought Mr. Lane's plan of suture a very good one. With reference to Mr. Turner's case, he should have been disposed to try for recovery from the operation on one kidney before attacking the other. He informed Mr. T. Smith that he had incised the outer part of the kidney, and he believed that this was the proper rule to follow unless a stone was very small, aud could be easily felt. The only objection was that if the stone could not be detected by feeling the outside of the kidney, it was somewhat difficult to find the way into the pelvis. In his case the dressing used had not been iodoform, but either carbolic gauze

or boracic acid. In his case it would have been impossible to remove the first kidney operated on, as disease of the opposite one was even then suspected. He thought the best plan was first to remove the stones, and later, when the other kidney had been ascertained to be healthy, to remove the kidney if necessary.

CLINICAL SOCIETY OF LONDON.

FRIDAY, JANUARY 9TH, 1891.

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

Intussusception and Volvulus in Two Places of the Small Intestine.—Mr. TURNER read for himself and Dr. WHIPHAM the particulars of this case. E. H., aged 29, cook, was admitted into St. George's Hospital, under the care of Dr. Whipham, January 29th, 1890. She had suffered many years from "indigestion." Three weeks before admission she suffered from influenza, and soon after the onset of the disease experienced sudden acute pain at the umbilicus for about ten minutes; uncontrollable vomiting followed this. The attack passed off, and it was not until January 28th, during the act of defæcation, that she again felt intense umbilical and lumbar pain. There was a doubtful history of blood in the motions. She vomited and had hiccough. The symptoms were somewhat relieved by morphine before admission. The catamenia were irregular. On admission she was restless, with an abdominal aspect, distended belly, quick pulse, and a pelvic tumour. An enema brought away some foul-smelling blood-stained fæcal matter. Abdominal section was performed by Mr. Turner. The pelvic tumour proved to be the uterus enlarged to the size of the third month of pregnancy. Volvulus of the small intestine in two places was found, consisting at the lower place (the upper ileum) of one coil of bowel round another, and, higher up, of a twist of the jejunum on its mesenteric axis. These were unravelled, and then in the right hypogastric region an intussusception involving the jejunum (some five feet from the pylorus) was discovered. There was no difficulty in relieving this, but the intussusception, though not entirely lustreless, was deeply congested and on the verge of gangrene. The question of excision of this portion of the intestine was considered, but the state of the patient was evidently such as to forbid the attempt. The peritoneum was flushed and drained by one of Keith's tubes, and the wound united in the usual way. The patient had no further vomiting, but died some twenty-four hours after the operation. *Post-mortem* examination showed the intussusception to have been caused by a polypoid growth of the small intestine; all causes of the obstruction had been removed by the operation. The uterus was filled with blood clot, and was about the size of the third month of pregnancy; there was a true corpus luteum in the right ovary. It was suggested that the volvulus was secondary to the intussusception. Some remarks were made as to the diagnosis and rarity of the case, and as to the necessity in cases of obstruction requiring abdominal section for the operator to be quite certain that all the possible causes of obstruction had been removed. In this case they were no fewer than three, and in many there were more than one.

Acute Intussusception in a Child aged 4 years: Resection: Death from Shock Twenty Hours after Operation.—Mr. C. B. LOCKWOOD described a case in which resection of an intussusception had to be practised under these circumstances. The patient, who was a strong and healthy female aged 4 years, had been seized with purging and vomiting five days previously, but no blood or slime was passed with the motions. The sickness continued, and the abdomen became distended, but, nevertheless, a tumour about three inches long could be felt in the right iliac fossa. An intussusception was diagnosed, and the abdomen opened by an incision in the right linea semilunaris with the faint hope of being able to withdraw the invaginated bowel. There was slight peritonitis, and the invaginated bowel, which was part of the ileum, was firmly adherent to its ensheathing intestine (which was also ileum), and the peritoneum split at every attempt at withdrawal. It was therefore decided to resect the intussusception, and, with this end in view, the peritoneal sac in the neighbourhood of the wound was washed with sponges, and the intestines above and below the diseased part were controlled with an elastic band. The intussusception and a wedge of mesentery were removed, and, after the distended intestines had been emptied of gas and fæces, suturing was done by the Czerny-Lembert method. The abdomen was closed after having been irrigated with hot water, but this increased the shock instead of diminishing it. There was exhaustion before the operation, and considerable collapse after it was finished, and from the latter the child never rallied, and died twenty hours after the operation. The examination showed that the lumen of the bowel was quite pervious, and that the line of sutures was quite secure. In commenting upon this case, the fatal result was attributed mainly to the time occupied in the operation. The resection of a portion of mesentery had much to do with this, as it caused troublesome bleeding and seemed unnecessary. The emptying of the distended bowel was of great importance, both as an aid to the performance of the operation and as adding to the subsequent security of the stitches and relief from obstruction. The literature of the subject seemed to show that out of fifteen cases of resection of intussusceptions three had recovered. However, a distinction should be made between acute and chronic cases. Finally the desirability of adopting other methods of operating, with the view of saving time and diminishing shock, was alluded to.—Dr. ORMSBY (Dublin) related a case of obstruction of the bowels which he had treated in August, 1889. The patient was a woman who had been confined about six weeks previously. She then had trouble about the pelvis and her bowels had remained unrelieved for forty days. She was in a moribund condition when she came under the speaker's care. He at once opened the abdomen, when the intestines, which were greatly distended, protruded. He punctured them in three or four places and could then find his way about in the abdomen. He found the seat of obstruction at the middle of the descending colon. It was a band of lymph crossing in front of the bowel, and was soon broken down with the finger. The abdomen was closed, the patient being much collapsed. However, at the end of thirty hours she had a good motion, and finally recovered.—The PRESIDENT considered that Mr. Turner's case of intussusception accompanied by volvulus of the small intestine was very rare indeed.—Mr. H. CRIPPS said that, as to the question of dealing with a case of irreducible intussusception, he thought that resection gave the best chance of recovery. He mentioned a case at St. Bartholomew's Hospital, in which the ileo-cæcal valve was found protruding at the anus. It could be reduced for some two or three inches. Laparotomy was performed, when, with a finger and thumb pushing from below, Mr. Cripps was able to pass the intussuscepted part up to the situation of the ileo-cæcal valve. Then came a difficulty. The child lived some time afterwards; and at the *post-mortem* examination all was found reduced except the ileo-cæcal valve itself, which jutted into the cæcum, and formed a swelling as large as a champagne cork. If one were unable to push the piece back, what would have to be done in such a case? He himself should leave the intussusception, and make an artificial anus above the ileo-cæcal valve. The surgeon should see these cases early enough, in order to be able to do them good. He also related a remarkable case that occurred at St. Bartholomew's Hospital about ten years ago. A child was brought in with a substance that looked like a "leathern strap" protruding from the anus. About six inches of it were pulled out and cut off; the child was then admitted. Pieces of bowel were gradually removed, and the child recovered. Six months afterwards, when it died from measles, nearly the whole of the large bowel was found to have gone.—Mr. HOWSE said that when the ileo-cæcal valve protruded, the adhesion was at the valve, which was so tightly fixed that it was impossible to reduce it without tearing the bowel. He did not think abdominal section was the proper line of treatment, but that the better method was to cut away the protruding ileo-cæcal valve from the anus. The two cut ends of the bowel might then be sewn together, and if this procedure were conjoined with abdominal section, the whole protrusion might then be reduced into the abdomen. He was led to this line of treatment by an Italian case in which the ileo-cæcal valve was cut off by mistake, and the bowel returned, the patient afterwards recovering. He thought that was the most successful way of treating the most serious cases. Where there was great gaseous distension of the bowels he objected

to puncture for its treatment. Paralysis of the muscular coat of the bowel supervened, and fæculent matter was apt to escape however fine the trocar employed. Even if stitches were put in the peritoneum was so rotten that they would not hold. He thought puncturing for the treatment of flatus was often fatal.—Mr. PARKER said that in a case in which he had found great difficulty in returning the bowel into the abdomen he had passed a long tube into the bowel from the anus, and then by manipulation of the bowel at the abdominal wound he had found the flatus pass away by the long tube. In another case of a child in which an acute was engrafted upon a chronic intussusception, he found the acute could be reduced whilst the chronic malposition could not be returned. He consequently put back the bowel into the abdomen with the chronic intussusception unreduced, and thought the child would die. But he happily recovered. The bowels acted, and there was a hard mass in the groin for months afterwards. But the child was now quite well, and the mass in the groin had quite disappeared.—Dr. WHIPHAM thought great care should be exercised in the administration of opium in such cases. It was right to use it at an early stage of the disease. It relieved pain and spasm and peristaltic action, but after a time, when constipation had been established and vomiting was occurring, it masked the symptoms, and great caution should at such time be exercised in its use. Opium then led to a deceptive calm, often simply disastrous, since it encouraged delay in operative proceedings. The disease went on in the belly, and the patient being quiet and comfortable, one at last drifted into that worst form of surgery, "too late" surgery.—Mr. BARKER spoke of cases in which the intussusception could not be reduced by any ordinary amount of traction. For these he some years ago suggested a plan of treatment. If the portion of intussuscepted bowel was too swollen and solid to be reduced, he suggested the making of a longitudinal incision through the intussuscipiens, the removal of the intussusceptum by a cut across it, stitching of the two edges of the circular wounds in the intussusceptum together; with special care to secure them most carefully at the mesenteric edge; finally, washing of the edges of the longitudinal incision and stitching of it up. Some bleeding from the cut surface would be rather beneficial. He threw out the suggestion some four years ago, but had not yet had an opportunity of carrying it out. He had since then had three cases in which he had reduced the intussusception. As to the distension of the bowels, he had thrust his scalpel into the gut, and let gas and fæces come away; had then stitched up the wound and reduced the bowel into the abdomen. He thought it safer to deal with an incision than with a puncture. In considering the treatment, the question arose, When ought one to operate? He believed as soon as injections had failed, if the diseased returned, the time for operation had come. *Per se*, the operation was not a very severe one. His last cases were 4 or 6 months and 4 years old respectively, and both recovered.—Dr. KINGSTON FOWLER mentioned the case of a patient who had been in the Middlesex Hospital. She had pain in the abdomen which increased until obstruction supervened. Abdominal section was advised by the surgeon, but the patient refused. A few days afterwards the patient passed by the anus a portion of bowel, to which was attached a melano-sarcomatous tumour. As soon as an intussusception of the bowel was detected in the Middlesex Hospital, the injection of air, etc., was first tried, and if this failed the surgeon was called in; but the relief afforded by the surgeon was too often not successful, whilst cases which were almost *in articulo* did sometimes recover if left alone.—Mr. TURNER, in his reply, said that he believed his case was almost unique in its complications.—Mr. LOCKWOOD said that, in his case, he had removed a portion of the mesentery, which caused some bleeding and increased the time occupied in the operation, and the gravity of the operation for the patient. In his paper he had collected nine cases in which an aperture was made into the bowel above the intussuscepted portion, all of which had died. As to the suggestion of Mr. Barker, he would remind his hearers that the bowel that had to be sutured longitudinally was soft, and could not well be expected to heal. For simple great distension he had made an incision with the scalpel, and then closed it with a ligature.

ANNUAL MEETING.

The remainder of the sitting was occupied with the business of the annual meeting.

Report of Council.—The retiring Honorary Secretary (Dr. T. BARLOW) read the report of the Council, which stated that the past year had been unusually prosperous. The members now numbered 518. Two distinguished foreign honorary members, Dr. Bigelow and Professor von Nussbaum had died, and seven ordinary members, including Sir W. W. Gull, Bart. The question of the incubation period of certain infectious diseases was still under the consideration of the committee appointed to investigate the subject. The rules of the Society had been revised, and would be submitted to the meeting for adoption. The treasurer's financial statement showed that the balance in hand in January, 1890, was £58; in January, 1891, it had increased to £119, after payment of all the year's expenses.—The President, Mr. C. HEATH, moved, from the chair, the adoption of the Council's report, and the satisfactory financial statement of Dr. Ord, the Treasurer; and the resolution was carried.

Votes of Thanks: New Rules.—Mr. HOWSE proposed a vote of thanks to the retiring President, which was felicitously seconded by Dr. WHIPHAM.—Mr. C. HEATH returned thanks for the vote, and proposed that the meeting should adopt the new rules. The chief change effected in them was that the annual meeting would for the future be held at the end of the session, that is at the second meeting in May, instead of at the first meeting in January.—Votes of thanks to the retiring Vice-presidents and members of Council were cordially adopted; and Brigade-Surgeon MYERS and Mr. PARKER proposed a very hearty vote of thanks to the retiring Secretary, Dr. Barlow, after three years of office. This was carried with much applause, and Dr. BARLOW replied in feeling terms.

Election of Officers.—The result of the ballot for officers and council for the year 1891, was then declared, and was found to be the same as the list proposed by the outgoing Council. The following is that list. The gentlemen whose names are marked with an asterisk were not on the Council, or did not hold the same office, during 1890. *President:* *Sir Dyce Duckworth, M.D., LL.D. *Vice-Presidents:* C. Bastian, M.D., F.R.S.; *A. B. Duffin, M.D.; H. G. Howse, M.S.; *H. G. Sutton, M.B.; *B. Hill, M.B.; S. Sibley. *Treasurer:* W. M. Ord, M.D. *Council:* J. Abercrombie, M.D.; *T. Barlow, M.D.; C. E. Beevor, M.D.; R. L. Bowles, M.D.; T. Churton, M.D.; E. Diver, M.D.; *D. W. C. Hood, M.D.; *P. Kidd, M.D.; A. E. T. Longhurst, M.D.; T. J. Maclagan, M.D.; *W. Pasteur, M.D.; P. H. Pye-Smith, M.D.; W. H. A. Jacobson, M.Ch.; *W. Anderson; *A. A. Bowlby; *G. Buckston Browne; J. R. Lunn; Malcolm Morris; R. W. Parker; J. K. Thornton. *Honorary Secretaries:* *D. W. Finlay, M.D; W. H. Bennett.

MEDICAL SOCIETY OF LONDON.

MONDAY, JANUARY 12TH, 1891.

J. KNOWSLEY THORNTON, M.B., President, in the Chair.

On Chronic Disease of the Uterine Appendages.—Dr. W. DUNCAN read a paper on chronic disease of the uterine appendages. This paper will be found at page 101. (A few clinical notes have been omitted.)—Mr. ALBAN DORAN read a paper on the treatment of this class of affections, an abstract of which is published at p. 106.—The PRESIDENT asked Dr. Duncan whether the cases related by him were consecutive, and whether they comprised all the cases of the kind which had been thus treated by him. If not, what principle had been followed in the selection of the cases?—Dr. DUNCAN explained that the list did not purport to include all his cases treated by abdominal section. Years ago, before the Waterloo Road Hospital was placed in a condition of sanitary repair, his results in all cases of abdominal section had been so awful that he would not like to publish them. In other respects the cases were consecutive.—Professor SINCLAIR, of Manchester, pointed out that severe attacks of puerperal fever were a frequent cause of the affections for which these operations had subsequently to be undertaken, and as these had decreased of late years in consequence of greater care and skill in operations and instrumental labours, the number of cases of disease requiring operative interference had tended to

diminish. He observed that little had been said of gonorrhœa as a cause of severe forms of the disease. In relation to this subject he related an anecdote of a student of his, a man who knew his work well, who, on presenting himself for examination in London, had been asked the most frequent cause of ovaritis, in answer to which he had mentioned gonorrhœa. Thereupon the examiner retorted: "I am talking of respectable married women, and not of strumpets." He urged that strumpets were not the only people who suffered from severe attacks of gonorrhœa; on the contrary, they took care of themselves whereas the respectable married woman, not being warned, frequently fell a victim to infection at the hands of her husband. Another frequent cause of these diseased conditions was ill-advised treatment, especially at the hands of the younger men who had obtained a smattering of gynæcology, and were but too anxious to display their skill. He instanced the case of a weakly married woman who had applied to a newly fledged practitioner on account of a sore throat. The practitioner elicited the fact that, though married, she had never been pregnant, and thereupon he obtained permission to examine her, declared that the uterus was retroverted, and forthwith inserted a pessary. In the sequel the woman developed a hæmatocele, followed by abscess in the left broad ligament and Fallopian tube which burst into the rectum. He hoped someone would be bold enough to condemn this tendency to rash treatment on the part of general practitioners. He alluded *en passant* to cases of intermitting hæmatocele, and mentioned an example of this affection. The patient had been under his observation for seven years, but as the tumour invariably cleared up after treatment, he had been unable to ascertain the condition of the parts. He had operated for removal of the tubes during the last ten years but he had found it a difficult and dangerous operation. With regard to prognosis, he said there were operators who assured their patients that the operation was practically unattended with danger, and he mentioned a striking example of the folly of so doing. He urged that the Staffordshire knot ought to be abandoned as utterly unreliable, as much so, indeed, as Keith's clamp for ovariotomy. Lastly, he expressed unreserved approval of the practice of flushing the peritoneum, and expressed his surprise that Sir Spencer Wells should have obtained his results in view of the fact that he boasted of having resorted to flushing on only two occasions. In conclusion, he said that operators were disposed to regard the woman's escaping with her life as constituting *per se* a satisfactory result; but he urged that more attention should be paid to the ultimate effects upon the general health.—The PRESIDENT recalled that in his opening address before the Society he had denounced the tendency complained of by Dr. Sinclair.

The discussion was then adjourned until Monday, January 26th.

OBSTETRICAL SOCIETY OF LONDON.

WEDNESDAY, JANUARY 7TH, 1891.

A. L. GALABIN, M.D., F.R.C.P., President, in the Chair.

Specimens.—Dr. PHILLIPS: Genital Organs from a Fatal Case of Purpura Hæmorrhagica.—Dr. DAKIN: Tubercular Uterus and Appendages.—Dr. HAYES: (1) Distended Fallopian Tubes; (2) Fibroid Polypi.

On Removal of the Uterine Appendages in Cases of Functional Neurosis.—Dr. PLAYFAIR read a paper on this subject, in which he detailed several cases that had come under his observation:—1. A case of neurosis treated by removal of the appendages, without benefit, subsequently cured by systematic treatment. 2. A similar case in which the operation was recommended, and about to be performed, when the patient refused her consent, likewise cured by systematic treatment. 3. A case of neurosis, in which there was distinct evidence of structural disease of the appendages. In this instance the neurotic symptoms were first dealt with, in the hope that the patient would be sufficiently bettered to avoid the necessity of operation. 4. The subject of hystero-epilepsy and mania treated by removal of the uterine appendages was considered, and an illustrative case given. The general conclusions arrived at were:—1. That the removal of the appendages was not a legitimate procedure in cases of purely functional neurosis. 2. That when marked structural disease of the appendages coexisted with severe neurotic conditions, the latter should be treated in the first instance, in the hope that operation might be avoided. 3. That in hystero-epilepsy and hystero-mania the results of operation had been so unsatisfactory that it was a procedure of very doubtful expediency, and not to be recommended.—Sir SPENCER WELLS referred to a pamphlet by Dr. Ross, of Toronto, on "The failure of the removal of the tubes and ovaries to relieve symptoms." He says, "To operate on organs not diseased for the relief of indefinable pain symptoms, hysterical symptoms, cataleptic symptoms, epileptic symptoms, is to my mind unjustifiable. A craze seems to have taken hold of the profession. The axiom seems to have become, if a woman has indefinite pains and local symptoms, take out her ovaries. This axiom requires a radical change." Dr. Ross went on to say, "I have seen these unjustifiable operations done both in Europe and America.....Many cases in which ovaries and tubes are removed to relieve certain nervous symptoms remain unrelieved..... Many cases I hear of as cures are not cures.....From our many failures to remove nervous diseases, as hysteria and epilepsy, by castration, we can see that the ovaries play but a part in their causation; and I believe that we might as well hope for relief of these diseases by enucleation of both eyes as by removal of both ovaries, or both tubes, or both tubes and ovaries, or even tubes, ovaries, and uterus." Dr. Ross related a case where he removed the ovaries in 1886. In 1888 he was able to report that his patient had been in splendid health ever since operation, but in 1890 had to say "her mental condition is not what it was before. She seems lazy, indolent, and fat, and is not the bright little woman she was before the operation, even when she had her aches and pains. Sexual intercourse is only indulged in as a marital duty; it gives neither pain nor pleasure." Then Dr. Ross proceeded: "Many deaths from these operations have been recorded.....A girl's prospect of marriage, maternity, and a happy life are blasted for ever by such a procedure." He (Dr. Ross) then referred to a case where a lady of his acquaintance was operated on in the provinces, and her case was brought before the Gynæcological Society in December, 1888, very soon after the operation as a practical cure. He (Sir Spencer Wells) had seen that lady that day; she had never been well since the operation, but very much worse than before, and her case instead of being a cure was a deplorable and disastrous failure. He had seen other cases almost as unsatisfactory, and he fully concurred in all that Dr. Playfair and Dr. Ross had said against unnecessary and unjustifiable mutilation for transitory disease.—Dr. PRIESTLEY referred to the debate on the subject at the International Medical Congress held in Copenhagen six years ago. The preponderance of the best opinion was adverse to operation. His own experience was not favourable to it. It was not free from danger and was not easy, nor did it cure, proving that severe ovarian pain without disease is but the expression of a general neurosis. The proposal to remove the uterine appendages arose really from mistaken diagnosis, and was comparable to treating as the real ailment the pain in the knee associated with hip-joint disease in children, or the pain in the calf of the leg so often experienced by women who were the subjects of phlegmasia dolens. It was well known that neurotic cases often got better spontaneously. Alteration of surroundings, an engagement to marry, or other occurrence, was sufficient. Dr. Priestley said that neuralgia of the testicle was not treated by castration, therefore why was castration performed in women? He referred to the remark of the late Dr. Matthews Duncan about the dangerous precedent of allowing a patient to decide upon an operation. He contended that these cases were best treated by medical and moral treatment as recommended by Dr. Weir Mitchell. He would lay it down as a rule that the appendages should only be removed when there was distinct local disease, ascertainable by examination; and he would put still some further limit to this, for it was well known that both ovaries and tubes might be considerably enlarged and yet return to their natural size without operation. In those formidable diseases mania and epilepsy he did not venture to give an opinion.—Dr. GERVIS said he agreed with the first and third conclusions of Dr. Playfair, but in the second he should be influenced by the interpretation to be put on the word "marked." If it sig-

nified organically and permanently affected, then he failed to see any object in hesitating at operation, unless the local conditions gave rise to no symptoms of importance. But if it meant only a condition which came within the limits of what was curable, then certainly systematic treatment should be tried before any idea of operation was entertained. He believed systematic treatment combined with massage was often of real value, not only in curing the general neurotic condition but the local malady.—Dr. HORROCKS said it was necessary to remember that a functional neurosis was a complaint without an organic lesion to account for the symptoms. It was always difficult to prove a universal negative. Hence, when a woman complained of pain in the ovarian region it was not easy to say that she had no disease in the pelvis to account for such pain. If no disease could be found and yet the patient complained persistently of pain and distress, which remained unrelieved by systematic treatment, it became a question whether it was not justifiable to open the abdomen and examine the pelvic viscera, with the object of discovering, if possible, the source of the pain and removing it. In such a case, if the ovaries and tubes were found to be healthy, ought they not to be dropped back into the pelvis and left alone? He mentioned a case now in Guy's Hospital, under his own care, which had been treated twelve months without benefit. She was waiting to have abdominal section performed to relieve her ovarian pain, although, on careful examination, no disease could be found in the pelvis. He did not think that healthy ovaries and tubes should be removed in cases of true functional neurosis. —Mr. ALBAN DORAN said there was a great difference between the removal of the appendages for disease and their removal for a neurosis. In the first case, even when the patient might have recovered without operation, structures absolutely diseased were removed, the ligatured pedicles remaining as relatively small sources of irritation. In removal of the appendages for neurosis, structures only assumedly morbid were cut away, whilst the ligatured pedicles remained as definite sources of irritation in these neurotic patients. Some believed the induction of the menopause cured the neurosis, but the menopause was always more or less of a shock, and a premature menopause was a still greater shock.—Dr. HEYWOOD SMITH said that in his experience many cases had been entirely relieved from intense neurosis of the ovaries by their removal. He mentioned a case of intermittent melancholia cured by removal of the uterine appendages. One ovary was beginning to undergo cystic degeneration. — Dr. HAYES thought neurotic symptoms were not usually present where there was disease of the appendages; and even if they were present they were not relieved by removing the diseased appendages. Where these organs were diseased, they should be removed for other reasons. He was led to believe that patients often submitted to these operations in order to escape from the inconveniences of menstruation and childbearing.—Dr. PLAYFAIR, in reply, said Dr. Heywood Smith had misunderstood him. His paper was not written with the view of opposing operation in suitable cases of structural diseases which he himself constantly practised, but to show its inefficiency in cases of purely functional nervous breakdown. He could only repeat his conviction that these cases had generally nothing to do with the reproductive organs. In mixed cases, operation should follow, not precede, the attempt to cure the neurotic symptoms.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

FRIDAY, NOVEMBER 19TH, 1890.

J. M. FINNY, M.D., President, in the Chair.

Left Hemiplegia with Aphasia.—Dr. BEATTY exhibited a young girl suffering from left hemiplegia with aphasia. There was complete loss of taste and smell on the left side, and left hemianopsia was present and symmetrical.—Dr. C. J. NIXON remarked that left hemiplegia was usually explained by a double lesion in the common situation; but the fact of the patient being left-handed explained all the phenomena that existed, assuming there was a single lesion. In place of the left hemisphere administering to the phenomena of speech, in this instance it was the right hemisphere that acted.—Dr. BEATTY, in reply, located the lesion in the angle and posterior segment of the internal capsule on the right side.

A Case of Scleroderma.—Dr. NIXON read the notes of a case of unilateral scleroderma, in which there was hemiatrophia facialis, atrophy of one side of the body, and alopecia confined to the side of the head corresponding to that of the body implicated. The patient was exhibited, and the existing features of the case were dwelt upon. Large patches of morphœa were engrafted upon the sclerodermatous skin. Dr. Nixon gave reasons why the affection should be regarded as a trophoneurosis. The treatment adopted was the administration of cod-liver oil and a mixture containing muriate of quinine, tincture of the perchloride of iron, and the liquor of the hydrochlorate of arsenic. The local treatment consisted in the use of warm baths, with shampooing, rubbing the indurated skin with lanolin. The patient was kept warmly covered, and warned to avoid wet or cold.—Remarks were made by Dr. TWEEDY, Dr. BEATTY, and the PRESIDENT; and Dr. C. J. NIXON replied.

Cystinuria.—Dr. WALTER G. SMITH read a paper on cystinuria. The condition was rare, scarcely 70 cases being on record. A boy, aged 8 years, was reported by his mother to have passed urine of a fragrant orris-root odour, and depositing a greenish sediment. His health was excellent in all respects, and there were no symptoms of urinary irritation. Out of six occasions upon which the urine was examined, once only was cystin found. The crystals were identified by their form, solubility in ammonia, and insolubility in acetic acid. The true formula of cystin was $(C_3H_6NSO_2)_2$. The following is a summary of Dr. Smith's review of the facts at present known concerning cystinuria: 1. Cystin, or a cystin-like body, occurs in small amount in human urine as a normal product of proteid metabolism. 2. No relationship exists between uric acid and cystin. 3. Associated with cystinuria, pathologically, is the occurrence, in the urine and fæces, of certain ptomaines, belonging to the class of diamines, namely, (*a*) Penta-methylene diamine (cadaverin), $C_5H_{11}N_2$; (*b*) Tetra-methylene-diamine (putrescin), $C_4H_{12}N_2$. 4. Normal urine and fæces never contain diamines, nor do they occur in cystin calculi. 5. The formation of diamines is due to the agency of specific bacteria in the intestine. 6. The exact nature of the correlation between cystinuria and diaminuria has not yet been determined. 7. Cystinuria may persist for years without apparent injury to the health of the patient. 8. The therapeutical indication is to disinfect the contents of the bowel. Dr. Smith exhibited some microscopic slides showing the characteristic crystals of cystin.

SECTION OF OBSTETRICS.

FRIDAY, JANUARY 2ND, 1891.

S. R. MASON, M.B., F.R.C.S.I., President, in the Chair.

Specimens.—Mr. M'ARDLE exhibited: (1) Subperitoneal Fibroid, removed from a patient aged 32 years; (2) Ruptured Ovarian Cyst, removed from a lady aged 24 years; (3) Large Ovarian Cyst.—Dr. W. J. SMYLY showed a Large Fibromyoma which he had removed on account of hæmorrhage. The pedicle was treated extraperitoneally, and the patient made a good recovery. He also showed Tubes and Ovaries removed for Gonorrhœal Salpingitis.—Dr. MACAN showed a Fibrous Tumour removed from a patient who had been two months married, and was about two months pregnant. The operation was not difficult, but the peritoneum became infected from the stump, and she died on the fifth day after operation.—Dr. MACAN also showed a Multiple Ovarian Cystoma removed from a patient.

Three Ovariotomies in one Patient.—Dr. MACAN read a paper on a case on which he had performed abdominal section three times, and removed an ovary each time. He drew attention to the fact that a great many similar cases to this had been explained by a separation of one ovary into two parts by some constricting band. Professor Winckel, in his work on the "Diseases of Women," said no case was absolutely proved to be one in which three ovaries were present unless the three ligaments of the ovaries were also found. As his case did not fulfil this condition, he was obliged to place it in the second class, where there was a greater or less probability of three ovaries being present. The chief points of interest in the case were:—First, the performance of laparotomy three times on

the same patient; secondly, the probability of three ovaries being present; thirdly, the occurrence of a hernia in the abdominal walls, which would, in any case, have called for operative interference.—Dr. F. KIDD thought that the title of the paper was based on an assumption, as no microscopical examination of the tumour had been made at the time, nor was any description given as to where or in what manner the pedicles of these various tumours had been ligatured with reference to their attachments to the uterus. He believed the presence of a third testicle had never been demonstrated, and there was a great analogy between the testicle in the male and the ovary in the female.—Dr. HORNE wished to know if both Fallopian tubes had been removed, and thought the occurrence of menorrhagia, subsequent to the removal of two ovarian tumours, very unique and difficult of explanation.—Dr. BAGOT said that Dr. Macan had stated that this was the first case in Ireland in which a third laparotomy had been performed. He thought that it must have escaped Dr. Macan's memory that he had previously performed a third laparotomy in the case in which he mentioned that he had operated for abscess of the bladder wall. As to the method of flap-splitting the abdominal walls in operating for hernia, he had seen patients operated on by this method by its originator, Dr. Hänger, in Leipzig; it was certainly the best method he knew of.

Fæcal Fistula.—Dr. W. J. SMYLY said this fistula was the result of coitus, and passed through the navicular fossa upwards and backwards into the rectum. The case was cured by dividing the perineum, and thus splitting flaps on the lateral walls and uniting them by continuous catgut suture.—Dr. MASON referred to another case in which injury to the vagina had been caused by forcible connection.

NOTTINGHAM MEDICO-CHIRURGICAL SOCIETY.

WEDNESDAY, JANUARY 7TH, 1891.

C. HAYDON WHITE, L.R.C.P.LOND, M.R.C.S., President, in the Chair.

Gastrostomy.—Mr. A. R. ANDERSON showed a man, aged 55, on whom gastrostomy had been performed on June 26th, 1890, for malignant stricture of the œsophagus. The disease was situated in its lower portion close to its termination in the stomach. The patient was then much emaciated, and could only swallow fluids in small quantity and with considerable difficulty. He spat up blood-stained mucus, and any attempt to pass a bougie caused bleeding. There was no history of syphilis or of injury to the gullet. After the operation he improved greatly in health and gained weight, but there had been some falling off during the last month.

Laparotomy for Abdominal Injury.—Mr. ANDERSON read notes of the case of a youth, aged 18, over whose abdomen the wheel of a heavy cart had passed, the injury being followed by symptoms closely resembling those of ruptured bowel. An exploratory laparotomy revealed nothing beyond considerable intraperitoneal hæmorrhage. The abdomen was washed out, and the patient made a good recovery.

Hysterical Lethargy.—Dr. HANDFORD read notes of the case of a young married woman, aged 37, who was first seen late on the evening of July 20th, in conjunction with her usual medical attendant. She was supposed to be suffering either from meningitis or uræmia. Her illness had begun three days previously with headache, delirium, and vomiting. She soon improved sufficiently to go about and take solid food. On July 20th she became unconscious, but at long intervals cried out, "I shall go mad." There was no alteration of the reflexes, no affection of the sphincters, no optic neuritis or ocular paralysis, and no albumen in the urine. The breathing was quiet, and the pulse soft and regular, speed 100. The temperature remained normal throughout. She could swallow a few spoonfuls of milk, but retained it a long time in her mouth. The limbs were flaccid, but there was no paralysis. The physical signs pointed to the absence of any serious organic disease, and hysterical lethargy—corresponding to one of the phases of hypnotism in which the unconsciousness was deepest—was suspected. Next day it was ascertained from some other friends that she had been subject to hystero-epileptic fits since childhood; and also that she had lately been overworked and underfed, and had helped to nurse a neighbour's child who died of tuberculous meningitis, and who had been accustomed to cry out, "I shall go mad." The patient gradually recovered consciousness and mental power, but it was a month or more before she talked readily. Dr. Handford also mentioned the case of a boy, aged 10, in whom, after a very trivial head injury, unconsciousness came on suddenly at the end of a week. The boy was supposed to be dying, but during examination sat up and began to laugh. He had previously shown some wilfulness. He soon got quite well.—The PRESIDENT, Messrs. ANDERSON, PRYCE, and CATTLE made remarks.

Specimen.—Dr. WILLIAM RANSOM showed the organs from a case of Ulcerative Endocarditis. The patient was a man, aged 24. There were large masses of vegetations on the wall of the left auricle and on the mitral valve, ruptured chordæ tendineæ, pneumonia, old infarcts in spleen and kidney, recent superficial hæmorrhage in pia mater over frontal lobe of right hemisphere. The vegetations were practically solid masses of micrococci.

Sterilisation of Milk for Infants.—Dr. WILLIAM RANSOM read a paper on this subject, in which attention was drawn to the probability of milk being a frequent agent in producing tuberculous disease in infants. Soxhlet's apparatus for sterilising milk was exhibited, and the possibility demonstrated of attaining the same object with the ordinary boat-shaped bottle and ordinary domestic utensils.

Examination of Sputum.—Dr. CATTLE read notes on this subject.

Demonstrations, etc.—Dr. HANDFORD demonstrated the Diazo Reaction in Ehrlich's Test for the Urine in Enteric Fever.—Dr. WM. RANSOM showed Micrococci in Ulcerative Endocarditis.—Mr. ANDERSON showed an Encysted Vesical Calculus.—Dr. CATTLE showed Tubercle Bacilli stained by different methods.

MIDLAND MEDICAL SOCIETY.

WEDNESDAY, DECEMBER 10TH, 1890.

M. A. MESSITER, M.R.C.S., President, in the Chair.

Hammer Palsy and Exhaustion Paralysis.—Dr. SUCKLING showed a toolmaker, aged 36, who had for twelve months suffered from weakness of the right arm and leg, with inability to follow his employment. In his work he used a little hammer, and for many years he had done ten hours' work daily, the movements required being very fine and precise. His illness began with inability to direct the strokes of the hammer, and cramp on using it. After a long walk he dragged his right leg, and after talking for a time speech became very difficult, the difficulty being purely motor. He had at these times pain in the left side of the head. There was no optic neuritis, and no alterations in the reflexes, or any signs of organic disease. He had much improved with rest, galvanism, and tonics. The occurrence of hemiplegia and aphasia after effort in a case of hammer cramp was of interest.

Intestinal Obstruction.—Mr. CHAVASSE exhibited a specimen taken from a woman, aged 45, in whom complete intestinal obstruction had existed for a fortnight previous to operation. An exploratory incision, made as for inguinal colotomy, revealed annular scirrhus at the junction of the descending colon and sigmoid flexure. Three inches and a half of the bowel, with the neoplasm, were resected, the lower opening was closed and dropped back into the peritoneal cavity, and an artificial anus established at the upper one. The operation lasted one hour. The patient, who was exhausted by her previous inability to take nourishment, subsequently had three copious evacuations of the contents of the bowels, each being accompanied by syncope. On the last occasion, fourteen hours after operation, restoratives failed to rally. Examination showed that the small opening left in the gut by the encroachment of the growth had become blocked by pieces of undigested apple skin, thus causing the final obstruction.

Uterine Fibroid removed per Vaginam.—Dr. PURSLOW showed a fibroid tumour of the uterus taken from a patient, aged 53, who was admitted in a collapsed condition from uterine hæmorrhage. She was found to have a fibroid tumour, apparently in the anterior uterine wall. The bleeding was stopped by plugging and ergotin, but recurred, and a laminaria tent was introduced. Two days later the tumour began to slough, and the patient had very severe septicæmic symptoms and

purulent discharge. She was placed under an anæsthetic, and the tumour was removed piecemeal with the volsella, the uterus being plugged after operation. She had no further hæmorrhage, and gradually recovered after some further slight septicæmia.

Ovarian Cystoma.—Mr. JOHN W. TAYLOR showed this specimen removed from a young single woman who, during childhood, had suffered from hip-joint disease. She consulted Mr. Taylor with all the signs of ascitic fluid in the abdomen. Mr. Taylor supposed the case to be tuberculous peritonitis, but on opening the abdomen a large cyst of the broad ligament was found containing 10 pints of fluid. The patient made a good recovery.

Fibromyoma of Uterus.—Mr. CHRISTOPHER MARTIN showed a large solid tumour of the ovary removed by Mr. Lawson Tait from a lady, aged 32, single. It had been growing many years, and six years ago a very eminent London gynæcologist said it was hopeless to attempt to remove it. Microscopic sections showed it to be a fibromyoma undergoing calcareous degeneration. It weighed over 9 lbs. It had no connection with the uterus, the pedicle being formed by the elongated right broad ligament. The wound healed by first intention, and the patient returned home in perfect health.

Dermoid Cyst of Ovary.—Mr. CHRISTOPHER MARTIN also showed a dermoid ovarian cyst removed by Mr. Lawson Tait from a married lady, aged 28. It was glued to the posterior surface of the lower part of the uterus, and interfered with delivery, so that craniotomy had to be performed in the patient's first labour, and premature labour was induced when she again became pregnant. The patient made an easy recovery. The tumour was the size of a cocoanut, and was filled with dense masses of matted hair mixed with fatty matter.

Tarsectomy.—Mr. JORDAN LLOYD showed bones removed by tarsectomy from a boy, aged 9 years, with an exaggerated talipes equino-varus. The bones consisted of the whole astragalus, the anterior half of the os calcis, the cuboid, and a portion of the scaphoid. The foot came into good position, and the wound healed solidly by primary union within three weeks. The boy was still under treatment, and the sole of the foot was flat on the ground when the patient stood upright.

Sequestrum Removed from a Fistula in Ano.—Mr. JORDAN LLOYD showed a sequestrum, the size of half an adult finger, which he had removed through a perineal incision from a boy, aged 7 years. The boy had been sent to Mr. Lloyd as a case of ordinary fistula *in ano*, but at the time of operation a sinus was traced, running up the side of the bowel towards the pubes, the body of which in its right half was found to be necrosed. There was no history of an acute attack of any kind. An abscess formed gradually in the right ischio-rectal fossa, and opened about five months before coming under Mr. Lloyd's care. The patient made a good recovery.

Scrivener's Palsy in the Muscles of the Neck.—The PRESIDENT showed a man who had been in the habit of writing with a pen held in his mouth. He wrote in this way a good legible hand, and followed the occupation of a clerk, but latterly the muscles of his neck commenced to fail, and he had had to discontinue the practice.

Paper.—Dr. EUSTACE HILL read a paper on the Chemical Composition of Condensed Milk, and their Use as Food for Infants.

REVIEWS AND NOTICES.

HANDBOOK TO DR. KOCH'S TREATMENT IN TUBERCULAR DISEASE. By EDWARD F. GRÜN, M.R.C.S., L.R.C.P., and WALTER D. SEVERN, Assoc. Roy. Coll. Sci. London: J. and A. Churchill. 1890.

As the result of a most careful perusal of the *Handbook to Dr. Koch's Treatment in Tubercular Disease*, we feel compelled to state our conclusion that it would have been perhaps better for their own credit, and certainly more for the good of the profession, had the authors not rushed into print so precipitately on their return from Berlin, as it is evident that they have not prepared and thought out their work sufficiently well to enable them to render their book either very interesting or permanently valuable.

Koch's treatment is not a thing to be taken up lightly and unadvisedly, and we cannot help thinking that this so-called handbook, in the hands of even the best physicians—many of whom are necessarily comparatively ignorant of the fundamental principles of practical bacteriology and inoculation methods—might be the indirect cause of very serious accidents.

With the first chapter of the work it is scarcely necessary to deal beyond stating that it gives only one method of staining, and that method probably not the best, although it is generally used in the Charité, where the assistants are of course accustomed to the somewhat complicated method. It also gives a very incomplete account (which would have been better left out) of the method of cultivating the tubercle bacillus. The chapter commences with a misstatement, for Koch distinctly says that his method does not cause the death of the tubercle bacilli, but only of the tissues in which they are growing. Then follow omissions of points bearing on matters of fundamental importance; for example, in speaking of the sterilisation of the syringe, it is merely stated that "it suffices to rinse the glass part first with mercuric chloride solution 1 in 2,000, and then thoroughly with absolute alcohol." This is all that is said at this point about this sterilisation, though later, at the part giving the description of the method of inoculation, it is incidentally mentioned that "the tube of the needle must be cleansed before and after every operation with a silver wire and absolute alcohol." We are then told "that before use each time the solution should be heated up to kill any spores of bacteria which may have sprouted in the intervening time." As the conditions under which spores on the one hand and the organisms that result from this sprouting on the other are destroyed are very different, it would be well to know to which phase of the life of the organism reference is here made, as such a description as this may refer to either or both. We are also told that "the injections are preferably made early in the morning; 9 A.M. is the time adopted in Berlin, and would be a good hour at all times." How 9 A.M. can be a good hour at all times is almost as incomprehensible as how spores can be killed when they "have sprouted in the intervening time," especially as we are afterwards told that 8 o'clock in the morning may with advantage be one of the "all times" to which reference is made.

We speak thus strongly of this part of the book because we wish to deprecate, in the most forcible manner possible, this rushing into print on the part of those, who, not giving themselves time to think out a subject that involves the gravest issues, may do an incalculable amount of harm both to patients who may come under this method of treatment and to the method itself.

We are ready to believe that this work does not fairly represent the knowledge of the authors, for the clinical part of the work and the notes on the cases that they observed in Berlin are of a much higher order than the work in the first part. But here, again, the language is slipshod, and the proof-reading is far from perfect. Some sentences are incomprehensible; whilst in a book of fifty pages such a word as "supiginous" should not be allowed to occur. Everything, in fact, points to a somewhat hurried and careless writing, for which an apology may be accepted by most readers, who will feel, however, whilst accepting it, that the authors really owe such apology to themselves. They may have been first in the field; but this fact will bring them little credit—especially from those who read the first twenty pages only. From those who are not discouraged and read further, the authors will receive credit, no doubt, for their careful notes on some of the cases that they have observed, and for the fact that they have brought within reasonable compass a description of some of the more important cases that were treated in Berlin during their sojourn there, but we should strongly advise anyone who wishes to carry out Koch's treatment to go into the matter for himself much more carefully than he possibly can with only the help of the handbook before us.

It is to be hoped, indeed, for the sake of both authors and possible readers, that the edition is not large. The authors would, then, do well to reconsider the subject carefully, and, having thoroughly revised and extended their work, they might place it before the profession in a form more com-