of the abdomen, to the left of the middle line of the body, and in the region where the coeliac axis artery leaves the aorta; this tumour seemed to me to be about the size of a crown piece, and also to be both expansile and pulsatile; there was no pain on pressure, and the patient did not seem to experience any discomfort by manipulations. On auscultation over the tumour I thought a systolic bruit was audible; the pulses at the ankles were equal; no further signs nor symptoms were ascertained. The patient died on September 2nd, aged 75 years.

Post-mortem Examination.

At the *sectio*, which I conducted, a most interesting condition was found; lying over the region where the coeliac axis artery leaves the aorta was a rounded piece of liver tissue about the size of a crown piece or rather larger, and about half an inch in thickness; this rounded piece of liver tissue was quite distinct from the liver, was enclosed in a capsule similar to that of the liver, and was connected to the left extremity of the liver by a mesentery of 1 in. to 2 in. in length; no distension of the gall bladder was found, nor were gall stones present. The liver was not more enlarged than was due to its congestion owing to the cardio-vascular disease from which the patient suffered.

Remarks.

This, then, was the tumour which in life was palpable. The situation over an artery accounted for its being pulsatile; pressure on the aorta, with slight consequent constriction of the lumen of that part of the vessel over which this tumour lay, may account for the "systolic bruit"; and the nature of the tumour—namely, liver tissue—accounted for the absence of any marked signs and symptoms. In vol. iii, p. 321, of the *Medical Review*, Sir Frederick Treves describes a condition of floating lobe of the liver. He states that floating lobe is associated with a distended gall bladder, that the tumour is palpable in the right side of the abdomen or in the right flank, and that there are marked symptoms—pain in the back, nausea, constipation, and neurotic manifestations; the tumour is also tender on pressure. Sir Frederick Treves points out that such cases are usually erroneously diagnosed—such as movable kidney, omental tumour, hydatid cyst, new growth, abscess, distended gall bladder being mistaken for this condition. Riedel assumes that a distended gall bladder as it enlarges draws a tongue of liver tissue with it, and hence the floating lobe. Riedel and Terrier have shown that where exploratory operations have been performed, and a condition of floating lobe with associated distension of the gall bladder found, if cholecystotomy be done, the floating lobe with its consequent symptoms disappears. It would seem, then, that this condition of "floating lobe" is acquired, due to distension of the gall bladder, and, in cases where accurate diagnosis has been made, curable by the operation of cholecystotomy. The condition in the patient at Caterham does not seem to me in any way to be an acquired condition; the tumour was discrete from the organ of the liver, was not associated with marked symptoms nor with a distended gall bladder, was palpable to the left of the middle line of the body in contrast to the floating lobe, and had a definite capsule and mesentery. In my opinion the condition found *post mortem* in the patient at Caterham was that of a congenital malformation.

My sincere thanks are due to my chief, Dr. P. E. Campbell, whose permission I have to publish these few notes.

A MEETING of patients, both old and new, of the Pendyffryn Hall Sanatorium, Penmaenmawr, was held on January 7th, when a sundial was unveiled to perpetuate the memory of the late Dr. Morton Wilson, who founded this sanatorium, one of the first to be established on the Nordrach system in this kingdom. Dr. Dobson, the present Medical Superintendent, officiated at the unveiling, and said a few appropriate words.

DEATHS IN THE PROFESSION ABROAD.—Among the members of the medical profession in foreign countries who have recently died are Surgeon-General Hieronymus Laub, for many years Director-General of the Medical Service of the Danish army; Dr. Hans Goldschmidt, of Berlin, specialist in urinary diseases, aged 58; Dr. F. A. Suter, Professor of Surgery in the University of Lima; and Dr. Profeta, Professor of Dermatology at Genoa.

British Medical Association.

CLINICAL AND SCIENTIFIC PROCEEDINGS.

BIRMINGHAM BRANCH:

CLINICAL AND PATHOLOGICAL SECTION.

November 25th, 1910.

Dr. MELSON in the Chair.

Chorion-epithelioma.

DR. EDGE showed a specimen of chorion-epithelioma from a woman aged 45. The uterus was enlarged. There was a mass on the right side, which was thought to be an inflamed appendage. The uterus was curetted, causing perforation of the uterus; an immediate laparotomy was performed; free abdominal haemorrhage was found; subtotal hysterectomy was done. Several brown masses in iliac fossa and peritoneum, evidently secondary growths, were found. The patient remained well at the date of the report, two months after operation.

Grape-like Tumour of Cervix.

Dr. THOMAS WILSON showed a grape-like tumour of the cervix, from a single girl aged 24. At the age of 19 a mucous polypus was removed from the patient, but was not microscopically examined. She remained well for three years. For the last two years she had had a blood-stained discharge, with menorrhagia, and occasional lower abdominal pain. She had lost 20 lb. in weight. She was admitted to the General Hospital February 25th, 1910. Wertheim's abdominal hysterectomy was performed. The specimen showed polypoid grape-like masses from the cervix, and in the cervical canal, similar masses upon back of uterus, left broad ligament, and left ovary. Coley's fluid was injected every second day for two months after discharge. The patient still remained well. Microscopically the growth was a mixture of gland acini of simple type and a rich stroma of spindle cells.

Carcinoma of Colon.

Mr. GILBERT BARLING showed three specimens of carcinoma of the colon, all columnar celled.

1. From a man aged 70. Constipation eighteen months; hemipiegia two years ago; loose, blood-stained motions at intervals; two attacks of incomplete obstruction in January and March, 1910. Doughy abdominal mass. Laparotomy in March, 1910. Large intussusception from caecum to middle of transverse colon, reduced; malignant growth at the caecal valve. Six inches of ileum and first 12 in. of colon excised. Ends closed and lateral anastomosis made. Good recovery.
2. A woman, aged 78, had partial obstruction in May, 1910. Movable tumour in abdomen. Laparotomy May 15th, 1910, in left semilunar line. Had two malignant structures, one just below the splenic flexure, a second 3½ in. lower down; glands in mesentery enlarged; 8 in. of colon removed, ends closed; lateral anastomosis made. Patient made a good recovery after some suppuration of wound.
3. From a man aged 66. Had lost 2 st. in six months; loose motions, but no obstruction; mobile growth to right of umbilicus. Laparotomy July 8th, 1910; intussusception of ascending colon into transverse colon; glands in mesentery enlarged; whole of ascending colon excised, ends closed; lateral anastomosis between ileum and transverse colon; faecal fistula formed, now gradually closing. Good recovery.

Myoma removed by Morcellement and Enucleation.

Dr. PURSLOW showed a specimen of a large myoma removed by morcellement and enucleation from a married woman aged 45. She was sterile. For two years menstruation had been irregular and scanty, followed by amenorrhoea for six months; then she had a severe flooding one week before her admission to hospital. The cervix was dilated about 3 in., and protruding through it was a hard tumour. There was an abdominal mass continuous with the cervix, reaching well above the umbilicus. The physical signs very much resembled, on first impressions, those of a woman in labour. A paravaginal incision was made. The cervix was split, and a large myoma was removed by morcellement and enucleation. The patient was discharged in two weeks.

Carcinoma of Jejunum.

Mr. HEATON showed a specimen of carcinoma of the jejunum, removed two weeks before from a man aged 41, who had suffered from occasional attacks of colic with rapid wasting during the past six months. By inspection about every twenty minutes a tumour appeared in the left iliac fossa which slowly rolled across the abdomen to the right iliac fossa, with visible peristalsis. The stomach was enormously dilated; there was marked stasis and copious vomiting from time to time. Median laparotomy revealed a movable tumour high up in the jejunum, with enlarged glands in the mesentery. The stomach and all the small intestine proximal to the growth was dilated. Six inches of the jejunum was excised, the ends closed, and a lateral anastomosis was made. Microscopically the growth was a columnar-celled carcinoma; the enlarged glands showed hypertrophy, but no malignant invasion. The patient was doing well.

Specimens.

Mr. FURNEAUX JORDAN showed two specimens:

1. Red degeneration in a myoma from a single girl aged 26, who thought that she was pregnant. She gave a history of three weeks abdominal tumour. Some instrument had been passed into the uterus previous to her admission to hospital, followed four or five days later by severe lower abdominal pain, accompanied by a temperature of 103°. A supravaginal hysterectomy was performed early in November, 1910. The tumour, which was an interstitial myoma about 6 in. in diameter, showed early red degeneration. Dr. Mackey took cultures from the centre of the growth, and found organisms resembling *Bacillus xerosis* and *Micrococcus catarrhalis*. The tumour showed the usual appearances, histologically, of red degeneration. No abrasion could be found upon the mucous membrane of the uterus to account for the infection.

2. Sarcoma of the uterus, from a woman aged 27, married two years, no children. Severe menorrhagia with dysmenorrhoea for eight months. No loss of flesh; tumour reached to umbilicus; movable. Supravaginal hysterectomy in November, 1909. The patient remained well one year later. The tumour was an imperfectly circumscribed tumour in the anterior uterine wall 4½ in. in diameter. The greater part of it was oedematous, joining small cysts in places. The uterine cavity was elongated and the tumour bulged partly into it. Microscopically the tumour was a spindle-celled sarcoma undergoing myxomatous degeneration.

Reports of Societies.

MEDICAL SOCIETY OF LONDON.

Monday, January 9th, 1911.

Mr. CHARTERS J. SYMONDS, President, in the Chair.

Ocular and Visual Conditions in Medical Cases.

MR. PERCY FLEMMING, in a paper on cases of medical interest met with in ophthalmic work, said, without denying the importance of hypermetropia and astigmatism as factors in the production of headache, his experience led him to think that such a causal connexion was apt to be too easily assumed. Headaches were common and hypermetropia very common in this country, and it was easier for a patient complaining of headaches to have his eyes seen to than to make an exhaustive examination to ascertain if there might be any general cause for the headaches. There were mixed cases, where a condition of debility made a slight error of refraction more potent to produce headache than if the individual were robust and strong. One should have clearly in mind the characteristics of a hypermetropic headache before coming to the conclusion that a headache was due to an error of refraction. Most commonly the headache was frontal, more particularly above each orbit, but it was not uncommon for the pain to be referred to the back of the head and neck. A very characteristic feature was that the patients waked up with headache, which improved after breakfast and might be absent during the day if the eyes were not much used, but would be increased or brought about by the use of the eyes for near work. Of those characteristics, perhaps the one that was least well known was the occurrence on waking, and it was frequently supposed that the eyes could not be the cause of a headache if the latter occurred after a good night's rest. The explanation was that the ciliary muscle had been relaxed during sleep, and the very act of waking was the act of looking at some near object. Unless the headache in question presented those features, one should hesitate about correcting a half or quarter D. of hypermetropia or astigmatism. On the other hand, if the headache was ocular in origin no error of refraction was too insignificant to correct. The crucial test as to whether a headache was truly ocular in origin was the use of atropine, which by paralysing the accommodation annulled the headache; but for obvious reasons one could not apply that test in all cases. Dr. JAMES TAYLOR, in a paper on the same general subject, said that inequality of pupils was not necessarily of grave significance. The sixth nerve frequently suffered from accident, probably because of its prolonged and exposed course—for example, fracture of the base. Third nerve paralysis, when isolated, was usually the result of syphilis, and was noted sometimes in tabes, sometimes as a precursor of general paralysis. It also occurred in the condition known as *migraine ophthalmoplégique*, probably as a result of an actual lesion of the nerve. Optic neuritis occurred most commonly as a result of intracranial tumour. In spite of assertions to the contrary it was frequently an early sign, and the impairment of vision which it caused might be the first thing to excite the attention of the patient. It also was said to occur in anaemia, and as a result of other toxic conditions such as influenza. The long subsequent life of many who had suffered from retinal thrombosis would seem to indicate that it did not necessarily imply a serious general condition. Embolism of the central artery of the retina occasionally occurred after diphtheria without any recognizable sign of heart disease. Bitemporal hemianopia was always the result of a lesion at the chiasma.

LIVERPOOL MEDICAL INSTITUTION.

Thursday, January 5th, 1911.

Dr. T. R. BRADSHAW, President, in the Chair.

Diagnosis of Subphrenic Abscess.

MR. FRANK JEANS, in a paper on subphrenic abscess, said he had operated with complete success upon three cases recently, one being probably pneumococcal in origin, one following appendicitis, and one possibly arising from an infection of the kidney. The diagnosis was often difficult and the etiology obscure. Appendicitis and gastro-duodenal ulcers accounted for more cases than other abdominal causes. In diagnosis he had derived great benefit from radiography. The transpleural operation, performed as far back as possible, was the best and most usually applicable. He used a very large rubber drainage tube at least 1¾ inches in diameter. The use of the aspirating needle was condemned. It was of great importance to obtain a vaccine from the material removed, since the case might become chronic. In the discussion which followed, the general opinion of the surgeons was that the exploring needle should not be used unless the patient was already prepared for an operation. The President and other physicians, however, maintained that its use in some cases was necessary. Dr. JOHN HAY thought that oedema of the chest wall was more likely to be present in subphrenic than in pleural collections of pus. Dr. WARRINGTON considered that, excluding those cases in which the pleura had become infected, the important guide was the recognition of normal, or exaggeration of normal, signs above a somewhat sharply-defined line of abnormal thoracic signs. Mr. LARKIN said that he had several cases in which a left subphrenic abscess had arisen from infection due to oesophageal injuries from foreign bodies.

Knee Injuries.

Mr. W. H. BROAD, in a note on the exercise treatment of knee injuries, advocated a much earlier resort to massage than was usually practised, even when considerable synovitis was present. Many of his patients had been persons suffering from severe football injuries.

Intestinal Fistulae.

Mr. G. P. NEWBOLT showed a patient whom he had observed for many years, and on whom he had performed many operations for intestinal fistulae, due to tuberculous peritonitis. A considerable amount of the intestine had now been resected from time to time, and the abdominal wall had become closed. Mr. R. W. MURRAY pointed out the danger of closing both ends of a piece of intestine.