lasting for two days, and disappearing on the forming of the bleb. On admission, he had a bleb on the outer side of the right leg, which had not yet broken. He was injected hypodermically with the perchloride solution in five places around the bleb, where the worm was supposed to be. This was followed by slight œdema, and a little pus formed near the ankle on the third day after the injection, but, when this was opened, the swelling rapidly disappeared, and he was fit for duty on August 16th. Cured in fourteen days.

Both my cases were rather more advanced than those included in Dr. Emily's first, and would appear to come between his second and third categories. There was very slight suppuration in both cases. It was very different from the intense suppuration which commonly follows rupture of the worm during its extraction, and may keep a patient in hospital for months, and often results in stiffened and impaired joints. Both cases were fit for duty within a fortnight of admission.

Vesey Davoren,
Surgeon-Captain, Army Medical Staff.

Sirdarpore, Central India.

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

STATION HOSPITAL, AHMEDABAD, INDIA.

GUNSHOT INJURIES FROM THE NEW LEE-METFORD RIFLE.

(By Kenneth S. Wallis, Surgeon-Major Army Medical Staff.)

On the night of February 20th three non-commissioned officers were shot by Private O'H. in the regimental canteen. The first, Lance-corporal D., received two bullets through the right arm, the first taking effect in front of the arm, 4 inches below the shoulder-joint. The wound was ½ inch in length and ¼ inch broad. Passing upwards and backwards through the deltoid muscle, the bullet had made its exit at the posterior part of the shoulder, 3 inches below the acromion process. This wound had a ragged and everted edge, and was slightly larger than the wound of entrance. The second missile had entered the forearm at the inner side of the wrist, just below the lower end of the ulna, and passing upwards and outwards below the superficial flexors in front of the joint, had made its exit 1 inch above the lower end of the radius; the radial artery and deep flexor tendons were injured. The wounds were treated with carbolic oil and iodoform, and a well-adjusted pad stopped the hæmorrhage. The after-treatment of this case was continued for some time owing to the flexor tendons being injured, the movement of both wrist and fingers being interfered with.

The second case was Corporal D., who had received a bullet injury in the left side. In spite of my immediate arrival I found he was already dead. The wound of entrance was between the seventh and eighth ribs, being 2 inches external to the margin of the costal cartilages, 4 inches below and ½ inch external to nipple line. Entering the chest the bullet contused the lower border of the left lung, then passing downwards, inwards, and backwards, perforated the diaphragm close to the attachment of the pericardium; passing close to the posterior surface of the stomach, it pierced the spleen at the outer and lower third, splitting it in a star-shaped manner, and also the kidney in its upper portion. Then leaving the abdomen near the left of the spine, between the eleventh and twelfth dorsal vertebræ, the bullet splintered the spinous processes, and finally made its exit from the body I inch to the right of the spine. The wound of entrance was circular, ½ inch in diameter; the wound of exit was slightly jagged, with everted edges, ¾ inch in length, and ½ inch in width. Death was due to hæmorrhage.

The third man was Lance-corporal R., who was also shot in the left side, the bullet entering the abdomen just below the ribs on a line with the nipple. Its course through the abdomen was almost in a straight line backwards and slightly inwards; it severed almost completely a coil of the small intestine, and had also perforated the descending colon, and slightly contused the lower portion of the left kidney, then, leaving the abdomen just above the crest of the ilium, made its exit from the body 2 inches to the left of the spinal column. This man soon rallied from shock after a morphine injection, and the pulse remained fairly good till the morning, when, as he was getting weaker, I made an exploratory incision through the abdominal wall. Upon the removal of blood clots the severed small intestine was found and secured. However, as symptoms of collapse came on, I did not continue the operation, and he shortly afterwards sank, death being due to peritonitis.

Remarks.—The Lee-Metford new magazine rifle is a bolt-system gun, with a range from 1,600 to 2,900 yards. The bullet is a compound one, consisting of a core containing 98 per cent. of lead and 2 per cent. of antimony, and an envelope 80 per cent. copper and 20 per cent. nickel; weight 215 grains. The muzzle velocity of black powder is 1,850 feet per second, and with cordite 2,000 feet per second, with a penetration in earth parapet of 24 inches. Other cases of injury by this rifle were reported in the British Medical Journal, vol. ii, 1893.

REPORTS OF SOCIETIES.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Warrington Haward, F.R.C.S., Vice-President, in the Chair.

Tuesday, October 23rd, 1894.

The Surgical Treatment of Diffuse Septic Peritonitis, with Successful Cases.

Mr. C. B. Lockwood read this paper. He began with the remark that the term "diffuse septic peritonitis" probably included several kinds of disease. In the variety referred to by the author the inflammation was acute, and had no definite limits; the serous membrane was smeared with lymph, which was either transparent and oil-like, or collected in ashen-grey fibrinous flakes; adhesions were absent or very slight; the peritoneal cavity contained thin purulent fluid, which often had a fæcal odour, or it might be full of gas; the intestines were distended and paralysed, and the disease ran a rapid and fatal course. Although cases coming within this definition were numerous, surgical literature contained few records of recovery after operative intervention. Authorities were quoted to support this statement, and it was said that there had hitherto been no successful case in St. Bartholomew's or the Great Northern Hospitals. It was proposed to include in an appendix the successful cases which others had recorded. Hitherto the author had operated on cases of diffuse septic peritonitis more because he was afraid of overlooking a mechanical obstruction than in the hope of curing the peritonitis. A case was described to illustrate the importance of intestinal paralysis and distension in causing the fatal ending. Stress was also laid upon exhaustion and collapse as factors. In the author's successful cases a systematic attempt was made to meet exhaustion and collapse by stimulating the patient temporarily before the operation with strychnine and brandy, by the systematic application of warmth during the operation, and by rapid and methodical operating; and by warmth, stimulants, and nutrient enemata afterwards. The organisation of the operation was described, and the treatment of the distended intestines. To empty them the gas was drawn from each coil by puncturing it with a fine trocar and cannula; the fæces were let out by an incision, which was afterwards closed. The abdomen was afterwards irrigated, and closed after the insertion of a drain. Two cases of diffuse septic peritonitis were described in which the treatment was successful. In the first there was a perforation of the ileum. The peritonitis was of not less than forty-eight hours' standing. In the second case the peritonitis had probably been in progress fifty-two hours. The abdomen was full of free gas, with the usual lymph and purulent fluid. The cause was thought to have been a septic inflammation of the left Fallopian tube. The patient was now convalescent, the operation having been done more than five weeks ago. A third case was described, in which the peritonitis was diffuse but different in type. In this the recovery was mainly attributed to an accidental fæcal fistula, which discharged and prevented distension and paralysis after the laparotomy.

Mr. Hulke thought that this paper was of very considerable value as regards the surgical treatment of this class of cases, which previously were looked upon as most hopeless. The novelty was in the methodical evacuation of the intestines by the combined use of trocar and incision. In his own experience, and in that of others, puncture had not always been carried out with impunity, as in some cases the gut walls were so soft that the puncture continued to leak, and when an endeavour was made to close it by suture the opening was only made larger, leaving a ragged aperture of some size. No one would hesitate to enlarge a perforation by incision.

Mr. Knowsley Thornton said that these cases were most encouraging, and furnished hope for the future. Detail was the essence of good surgery, and in this respect the paper was a most valuable one. He could have wished that the author had gone even more minutely into detail, and had shown them the kind of trocar he used, and had mentioned the dose of strychnine he had subcutaneously injected. For many years he had been accustomed to puncture by trocar, and to make incisions into distended gut, but he had not performed these measures in a detailed method. Looking back on his previous work, in none of his cases had he been sufficiently careful to protect the patient from chill, shock, and prolonged exposure. The combination of puncture with incision, with the protection of the patient from shock, were the essential features of the treatment recommended. He had long recog-

nised that the distension of the intestine was the most dangerous feature. Septic material spread over the surface of the gut rendered thorough irrigation absolutely necessary. When free evacuation of the intestine by incision followed puncture, the collapse of the intestine which followed such evacuation would render the puncture non-dangerous, even if the intestinal walls were softened.

Mr. HARRISON CRIPPS said that he would rather have called such cases as had been related simple diffuse peritonitis, and he proceeded to give some illustrations of what he meant by this term. He divided diffuse peritonitis into two great classes: first, the mechanical, such as resulted from a twisted ovarian pedicle; and the second, diffuse septic peritonitis, such as followed childbirth, erysipelas, etc. In the latter class of cases he did not believe that any good could be done by operation, for the cause of death was the actual poison which had been absorbed into the system, and which had gone beyond the reach of surgery. He congratulated the author upon his paper and upon his success with cases which had been the bane of abdominal surgery, and thought that he was conferring a great boon upon the profession and upon humanity.

Mr. ALBAN DORAN went even further than Mr. Cripps, and divided up cases of diffuse peritonitis into three classes: the first the rapidly fatal; the second those that came on in about three days and were those with which the paper was concerned; and the third the truly pyæmic cases which came on in about the third week. In this third class the excretory viscera were almost always affected with pyæmic deposits, and he would like to ask the author if he thought it justifiable to operate upon such cases, or whether they should be considered hopeless.

Dr. NORMAN MOORE thought that collapse did not always depend on septic absorption, but might be due to the size of the ulcer, etc. He quoted the case of a man whom he had seen collapsed within two hours of the bursting of a gastric ulcer. Death occurred seven hours later, and at the *post-mortem* examination there were very few signs of peritonitis.

Mr. MARMADUKE SHEILD had punctured the gut through the abdominal wall on many occasions for chronic intestinal obstruction, but such punctures frequently leaked and had set up peritonitis. It was of immense importance to use a very fine trocar and cannula, which should be passed obliquely through the muscular coat so as to produce a valve-like opening, and thus render leakage almost impossible. He suggested that the peritoneum should be treated like other foul septic cavities by continuous irrigation or by multiple flushings.

Mr. HULKE added that he was under the impression that Billroth had fifteen years ago advocated continuous drainage.

Mr. BARKER had found by experience that a very convenient method of flushing the abdomen was to use a can with three taps to which tubes of large calibre were attached, and thus the abdomen could be flushed from several points at once, the fluid flowing out through the original incision. He used fluids for flushing at 105° F. He was in favour of free incisions into the intestine rather than punctures, on account of the immediate relief to the distended intestine, and said that it was almost as easy to stitch up an incision three-quarters inch in length as one of only a quarter of an inch. He entirely agreed with Mr. Lockwood that the best way to secure the patients from chill was to wrap them up in cotton wool.

Mr. A. BOWLBY dealt with the best means of washing out the peritoneal cavity. An incision below the umbilicus would not necessarily empty the peritoneal sac. In one case, after incising and flushing out through an incision below the umbilicus, he had found a large quantity of gas as well as fluid remaining in the peritoneal sac above. He considered that when the peritonitis was due to duodenal or stomach mischief, two incisions, one above and one below the umbilicus, were necessary to ensure complete flushing.

Mr. LOCKWOOD, in reply, said that if odour was a test of septicity, then his cases possessed that attribute in a remarkable degree. He agreed that there were almost as many different kinds of peritonitis as there were different kinds of organisms that could get inside the peritoneal cavity. He remarked that all recent researches on this subject had been done by cultures, but this was a fallacious method, as some of the organisms might not grow in the cultivating media used. He had been in the habit of using a trocar of the size of a large Southey's tube with a diameter of 1½ to 2 millimetres. He agreed that the bayonet puncture, as suggested by Mr. Sheild, was the best. He flushed out the peritoneum in a methodical manner with a large single tube. He agreed that in cases of perforation high up a second incision lower down should be made. The object of his paper was not to bring forward anything new, but to advocate the methodical use of known methods

MEDICAL SOCIETY OF LONDON.

Sir WILLIAM DALBY, M.B., F.R.C.S., President, in the Chair.

Monday, October 22nd, 1894.

LAPAROTOMY IN ULCERATION OF THE DUODENUM.

MR. MARMADUKE SHEILD read a paper on ulceration of the duodenum with special reference to the latent perforating ulcer of that part of the intestine. He related two cases where he had performed laparotomy for acute abdominal symptoms in young men for this affection. Other cases were referred to, especially those by Mr. Lockwood in last year's *Transactions of the Medical Society of London*. The literature of the subject was reviewed, and the author attempted to show that ulceration of the duodenum after burns was due to septic infarction of the vessels of the duodenum, the gastric juice then acting upon the parts cut off from the vascular supply. He pointed out that duodenal ulcer after burns was rare in the present day on account of the care with which antiseptics and cleanliness were employed. The predisposing causes of ulceration of the duodenum, especially chronic albuminuria, tuberculosis, and malignant disease, were reviewed. Latent ulcer of the duodenum was shown to be more common in men than in women, and generally to be situated on the anterior surface of the first part of the duodenum. No explanation could be offered of this fact beyond the possibility that when ulcers occurred on the back of the duodenum they might heal, but when they occurred on the unsupported front aspect of the gut they usually perforated. Mr. Arthur Latham had added an important mass of information to this paper by reviewing, in conjunction with the author, the cases of perforation of the intestine at St. George's Hospital during the last thirty-one years. In 8,192 *post-mortem* examinations there were 116 cases of death from perforation of the intestines, and 12 of these were due to perforation of the duodenum; 10 of these occurred in males and 2 only in females. In 9 out of the 12 cases the ulcer was on the anterior surface of the duodenum. Ulcerations of the duodenum which had not perforated were found as follows: Burns, with slight ulceration or congestion, 7 cases; associated with renal disease, 6 cases; tuberculosis, 2 cases; malignant ulceration, 1 case; in association with scirrhus of the pancreas, 2 cases; and 5 cases without obvious cause. The symptoms and diagnosis were next considered, and cases were quoted to show the similarity of the affection to lead colic and intestinal obstruction, while the sudden collapse and death which had marked some of the cases had led to suspicion of death from poison. Great stress was laid upon the symptoms being previously epigastric, and on the fluid and gas in the peritoneal cavity being devoid of fæcal odour. The reaction to litmus should be acid, but this was not always the case, since the peritoneal exudation might neutralise the contents of the duodenum or stomach. The situation of an exploratory incision was finally considered, and the methods of Senn for finding a perforation were mentioned and criticised. Stress was laid upon a method used by the author in abdominal surgery of passing stout silk loops through the abdominal opening on either side, and holding them asunder. This gave freer access to the cavity of the abdomen than any other method, while traction upon the loops greatly facilitated the return of distended intestine. The following conclusions were arrived at: (1) Perforating ulcer of the duodenum is a rare affection, and far more common in young adult males than in females. (2) In a considerable number of cases the symptoms are primarily epigastric, or referred to the right hypochondrium, or there is a previous history of epigastric troubles. (3) In perforative peritonitis occurring suddenly in a male, if the symptoms are not very typical of implication of the vermiform appendix, the surgeon should turn his attention to the duodenum, where the lesion will most generally be found. The absence of fæcal gas or odour in the abdominal contents pointed to implication of the duodenum or stomach. Acidity of abdominal contents pointed to the same conclusion. A small incision below the umbilicus would clear up the nature of the abdominal contents. (4) The success of the future lies in cleansing the peritoneum by repeated hot-water flushings and drainage of the pelvic *cul-de-sac*.

Mr. C. B. LOCKWOOD remarked that many additions to our knowledge were required before this strange malady could be treated with success. Therefore it was desirable to record every case, especially those in which laparotomy was performed. In the first case there was acute intestinal obstruction due to septic peritonitis, with the accumulation of pus in the pelvis. The symptoms had come on suddenly, and there was nothing whatever pointing to the duodenum or stomach. At the operation all the peritonitis seemed confined to the lower part of the abdomen. So far as could be seen through the incision the upper part of the serous membrane was normal. At the necropsy there was a zone of peritonitis beneath the liver caused by a perforating ulcer of the duodenum, a zone of peritonitis in the pelvis, and a zone of normal peritoneum between them. It could not be discovered how the upper zone had communicated with the lower. An exploratory incision into the upper abdomen would have revealed the ulcer, which could have been closed. In a second case a perforating ulcer was diagnosed close to the pylorus. Laparotomy was performed, and the ulcer found in the duodenum was sutured. The operation prolonged the patient's life and relieved his pain, but at the end of fifty-seven hours he suddenly vomited bright blood, and died. This patient was 61 years of age. At the necropsy a good deal of purulent fluid was found behind the liver and in the pelvis. A third case was mentioned in which a perforating ulcer of the duodenum had not been discovered. It also might have been closed by sutures. In future cases it seemed advisable to drain the pelvis, and in doubtful cases of diffuse septic peritonitis to examine the stomach and duodenum. It was not desirable to prolong the incision upwards, this being a formidable proceeding, likely to leave a weak abdominal wall. A small incision some two or three inches long would be sufficient to enable them to ascertain whether or not the lesion was in the upper part of the cavity.

Dr. HECTOR MACKENZIE had looked up the cases at St. Thomas's Hospital during the last few years, and in none of them did the symptoms allow of a diagnosis. The very latency of the symptoms in ulcer of the duodenum might serve to indicate the fact of the duodenum being implicated.

Dr. ROUTH suggested the use of a current of positive electricity as a means of diagnosing the exact site of the lesion, the pain being increased when the current passed through the injured part.

Dr. AMAND ROUTH pointed out that even in rupture of a duodenal ulcer fæcal matter might be extravasated as the result of reversed peristalsis forcing fæculent matter high up the intestines.

After some remarks from Mr. HOWARD BARRETT, Mr. SHEILD, in reply, admitted the suggestion of Dr. Amand Routh, but he doubted whether any assistance would be derived from the procedure advocated by Dr. Routh, the patients being too ill and the inflammation being general. He agreed that the incision ought not to be prolonged, but a fresh incision made above the umbilicus.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

D. ARGYLL ROBERTSON, M.D., F.R.S.E., President, in the Chair.

Thursday, October 18th, 1894.

CASE OF FILARIA LOA IN WHICH THE PARASITE WAS REMOVED FROM UNDER THE CONJUNCTIVA.

THE PRESIDENT read notes of this case. The patient, who was a woman aged 32, came to him in September complaining of the presence of a worm in her eye. She had resided in Old Calabar, on the West Coast of Africa, for some years, but had been obliged to return home on account of intermittent fever and dysentery. She had first felt the worm in her eye last February. It gave her a sensation of pricking or quivering, and she was quite conscious of its movements; it wandered over the eye

beneath the conjunctiva, and raised the conjunctiva into a small ridge as it moved; it sometimes left one eye, and could be felt travelling beneath the skin over the bridge of the nose, and reappeared in the other eye; lately it had kept to the left eye. Sometimes the eye was tender and a little bloodshot after the appearance of the worm. The influence of cold on the behaviour of the worm was very curious. In the warm climate of Africa it appeared frequently, and, as after her return to England the patient was confined to the house and to her bed, the worm frequently appeared beneath the conjunctiva; warm rooms increased its activity. As she began to leave her room and went out, the worm disappeared into the deeper parts, and was seen only rarely. During the summer its visits were very few, but in September, as soon as the house was warmed, the worm reappeared. When seen the eye appeared normal, except for a small vesicle at the outer part of the conjunctival *cul-de-sac*. The patient was instructed to come again when the worm was active. On September 12th the worm was felt moving again; she applied hot cloths to the eye and immediately went to the infirmary, where she was seen by Dr. Argyll Robertson. The worm could then be seen moving tortuously beneath the conjunctiva; the finger was applied to it and the worm kept in position while the eye was cocainised. The conjunctiva was grasped, an incision was made, and the worm withdrawn. The worm looked much like a piece of fishing gut; it wriggled at first, but when placed in a weak solution of boracic acid it died at once. It was 25 mm. long, and 0.5 mm. wide, its head tapered slightly but its tail tapered very much. There was a fine filament wound round the worm which appeared to be its alimentary canal, forcibly squeezed out by the grasp of the forceps. From its size it was probably the male animal. It was difficult to determine how the parasite had gained entrance to the body; the drinking water had always been boiled, and in washing her face she was always careful to use the boiled water; she had not eaten uncooked vegetables; mosquitoes abounded. No filaria were found in the patient's blood, but the worm was probably a male one. Several other cases were narrated of this filaria being present beneath the conjunctiva; the patients were all members of the Old Calabar Mission; it was a very common occurrence among the negroes. It was probable that the parasite gained admission to the body through the water in some way; the embryos were sucked up in the blood by mosquitoes, who played the part of intermediate hosts; thence they found their way to water again. They were limited strictly to this small part of Africa.

Dr. Patrick Manson said he had paid great attention to the parasites of Africa, and especially of Old Calabar. The blood of 50 per cent. of the negroes contained embryos of filaria. The filaria diurna was a form which appeared in the blood during the day and disappeared during the night; in his opinion it was identical with filaria loa; it could not be distinguished microscopically. He thought it very improbable that this filaria was the only one in the body in this case; the embryos existing in the body pass out probably by means of mosquitoes. The duration of life of a filaria was ten years or more. They varied in length from 17 to 70 mm.; the smaller ones were the males. He agreed with the President that the size of the one he had shown indicated that it was probably a male.

Filaria Oculi Humani.

Dr. Drake-Brockman read notes of a case of filaria oculi humani. The patient was a young Madras woman. When first seen there was a patch of redness at the edge of the cornea; soon the whole eye became red, but there was no pain. The cornea was dull, the aqueous muddy, the pupil had been dilated by atropine; the tension was +1. A small worm could be seen in the anterior chamber, twisting about. The eye was cocainised, an incision made with a keratome; the aqueous flowed away, but the worm could not be found. There was some reaction after, but the eye eventually quieted down.

Card Specimens.

The following were the card specimens: Messrs. Hartridge and Griffith: Microscopic Sections of Tuberculous Keratitis.—Mr. Kenneth Campbell: Equatorial Rupture of the Choroid.—Mr. Marcus Gunn: Case of Lamellar Cataract of Unusual Form.—Dr. R. McIntosh: A Case of Leuticonus Posterior; and a Case of Associated Movements of the Left Levator Palpebræ and Internal Pterygoid Muscles.

BRITISH GYNÆCOLOGICAL SOCIETY.

Professor Thomas Savage, M.D., President, in the Chair.

Thursday, October 11th, 1894.

Specimens.

Dr. Elder (Nottingham) showed: (1) Two Myomata, removed by supravaginal hysterectomy; in one on account of alarming hæmorrhage, in the other because it had become wedged into the pelvis, and gave rise to pressure symptoms; (2) a Papillomatous Ovary.—Dr. Purcell showed a Sarcomatous Ovary removed from a girl of 18, and narrated some further cases of Cancer of the Uterus treated by chloride of zinc, with specimens and casts.

Treatment of Uterine Myomata.

Mr. Bowreman Jessett read a paper on the treatment of myomata of the uterus complicated with pregnancy, illustrated by two cases, in which he pointed out that this complication was of comparatively rare occurrence, owing to the infrequency of women suffering from myomata becoming pregnant. After giving details of the cases, and discussing the literature of the subject, Mr. Jessett came to the following conclusions: (1) That it would be justifiable in these cases of subperitoneal myomata, if growing rapidly and causing great pain, to open the abdomen and enucleate the growths; (2) in cases of subperitoneal and interstitial myomata of considerable size, and surrounding the uterus, it would be wise to remove the whole organ; (3) in cases of interstitial or submucous myomata complicating pregnancy statistics seem to show that the risk to the patient is greater if left to go the full period, than if abortion is produced or the organ removed; (4) cases in which the growths are limited to the cervix may be allowed to go their full term, as the growth, if presenting in the vagina, may be either enucleated or removed *morcellement* at the end of the period.

Dr. Routh dissented from the opinion held by many that conception was rare when fibroids were present, especially when those fibroids were extrauterine. Miscarriage must occur if fibroids were multiple and scattered throughout the uterus. He commented also on the frequency with which fibroids disappeared after pregnancy.

Dr. Heywood Smith thought the amount of danger was relative to the proportionate development of fibroid and pregnancy. He classified such cases into three groups: (1) where the tumour greatly preponderated so as to prevent growth of the uterus; (2) where the tumour, though large, did not entirely hamper the development of uterus; (3) where the tumour was not of such size or position as to interfere with natural labour. In the first only would operative interference be imperative, while the second would require careful watching.

Dr. Godson believed that small fibroids frequently coexisted with pregnancy and were never discovered. Subperitoneal fibroids, when found occupying the pelvis, even during labour, could sometimes be pushed up so as to allow of the application of forceps. When, however, a fibroid was known to exist and be fixed in the pelvis, he considered the production of an early abortion to be the only right treatment.

Dr. Bantock quite agreed that fibroids did not prevent pregnancy, and laid stress on the fact of the frequency with which fibroids disappeared after pregnancy. He did not consider the matter of the position of the fibroid, as regards the uterus, important.

Remarks were also made by Dr. Macnaughton Jones, Dr. W. Armstrong (Buxton), Dr. T. B. Grimsdale (Liverpool), and Dr. Leith Napier; and Mr. Jessett replied.

LARYNGOLOGICAL SOCIETY OF LONDON.

Felix Semon, M.D., F.R.C.P., President, in the Chair.

Wednesday, October 10th, 1894.

Adenoma of the Tongue.

Mr. Cresswell Baber showed a girl, aged 16, who for nine months previous to July, 1894, had suffered from adenoma of the tongue. The tumour was removed by means of a snare. The tumour had reappeared, but was now an irregular flat growth, only seen on depressing the tongue. The case seemed to resemble those described by Mr. Butlin in the *Transactions of the Clinical Society* for 1890, vol. xxiii, p. 118, under the head of glandular tumours of the tongue. The microscopic examination made by Mr. H. H. Taylor showed that the growth closely resembled thyroid tissue, and might well be connected with some fœtal remains of the lingual ducts. There were no cysts and no tubular structure. The case therefore seemed to support the theory advocated by Bernays and Bland Sutton that these tumours were of the nature of accessory thyroid glands.

Mr. Lake gave details of a somewhat similar case.

Immobility of the Left Vocal Cord.

Dr. Bennett showed a case in a woman, aged 47. Onset about two years. Loss of voice had been progressive, but more rapid since influenza some ten months ago. First seen three months ago. No congestion, no ulceration, and no symptoms pointing to any other affection. No certain signs of chest mischief either in the lungs or in the vessels. No dysphagia. At first a sensation of aching over the larynx, but this soon disappeared. Iodide of potassium did no good. No suspicion of syphilis.

Dr. Dundas Grant could find no evident cause for the fixation of the cord. He suggested the possibility of a deep-seated gland, exercising pressure.

Dr. Tilley suggested that it might be the first indication of tabes.

The President observed that cases of fixation of one cord were met with, and were quite compatible with perfect health. In twelve cases of tabes he had met with laryngeal paralysis no less than seven times, but in another series of fifty or sixty not another case occurred. Hence the frequent discrepancy in the accounts given as to its frequency.

Cystic Fibroma of the Left Vocal Cord.

Dr. Bronner (Bradford) showed microscopic specimens of a tumour removed from the left vocal cord of a clergyman, aged 76. The veins were very distended and numerous, and there were several large cavities lined with endothelium. Drawings of similar growths were shown, as demonstrated by Professor Chiari in *Archiv für Laryngologie*, ii, 1. The growth was situated on the upper surface of the cord, and had been first noticed three years ago. Such cases were rare in old age.

Epithelioma of the Epiglottis.

Dr. Bronner also showed a specimen of a tumour removed from the epiglottis by cutting forceps. The patient could now eat and speak without any difficulty. The growth had been of three years' duration, and there were unmistakable signs of secondary affections of the liver and lungs.

Chronic Tuberculosis of Larynx (?).

Dr. de Havilland Hall showed a patient, aged 51, the subject of syphilis of twenty-six years' standing, who had been troubled with throat symptoms for ten years. These had become more serious during the last three years. First seen in May, 1894. The epiglottis, ary-epiglottic folds, and arytenoids were found to be greatly tumefied, the glottis reduced to a chink, the vocal cords not visible. The posterior pharyngeal wall was cicatrised, the nasal septum completely destroyed. There were physical signs of infiltration at the apex of the left lung. Tracheotomy had to be performed. The patient was now being treated with carbonate of guaiacol, and the galvano-cautery was being applied in the larynx. Marked relief had followed the use of the cautery. Dr. Hall regarded the case as one of chronic tuberculosis, preceded by a syphilitic lesion.

Dr. Beale mentioned a somewhat similar case, previously shown to the Society, which had been under observation for the last year, and had remained quiescent under the use of iodide of potassium. From the history of the case and the general appearance he thought that the condition was one of combined syphilis and tubercle.

Tonsillar Mycosis.

Mr. R. Lake showed two cases. The question which he wished to raise was whether there was any more rapid and successful method of dealing with such cases than the galvano-cautery?

Dr. DE HAVILLAND HALL advised continuance with the cautery, as that treatment certainly gave relief.

The PRESIDENT thought that such cases might well be left alone if the condition gave rise to no distress.

Mr. CRESSWELL BABER had seen good results from the local application of absolute alcohol.

Dr. SPICER preferred to destroy the crypts by means of a cutting operation.

Dr. BENNETT advocated forcible syringing with carbolic acid.

Dr. DUNDAS GRANT pointed out the distinction between pharyngomycosis and pharyngitis with accretions. He had used the galvanocautery with success, and also a lotion of iodine and carbonate of soda.

LUPUS TREATED WITH THYROID EXTRACT.

Mr. R. LAKE showed a boy with lupus of the soft palate and posterior pillars of the fauces, of fourteen months' duration. He had been taking 7½ grains of thyroid extract daily since July 14th, and was very much improved. A second case, a girl of 16, had been affected for three years, and was treated at the same time as the previous case. She was much improved, and was now taking 17½ grains daily. The cases would be shown again at a later stage of the treatment.

Dr. DUNDAS GRANT expressed some doubt as to the nature of the disease in the girl's case.

Dr. JESSOP related a case in which marked improvement had followed the use of 300 tablets, in a case of thirty years' duration.

TONSILLAR NEW GROWTH.

Dr. SCANES SPICER showed a man aged 70, who had a vascular tumour the size of a large walnut, spreading from the lower part of the right tonsil on to the base of the tongue. Tonsillar growths had been removed two years previously from both sides. Microscopically the tumour was made up of closely-packed round cells.

Dr. BRONNER referred to the great benefit sometimes afforded by arsenic in large doses.

After some remarks from Dr. TILLEY, Dr. HILL said he would not use the guillotine in such a case, but would prefer to enucleate.

Dr. PEGLER regarded the case as one of lympho-sarcoma, and not of ordinary hypertrophy.

The PRESIDENT observed that after the age of 40 such cases were generally either lympho-sarcoma or lymphadenoma.

Dr. DUNDAS GRANT thought that it would be best to snip round the mucous membrane, and clear the whole growth out behind it with the finger.

Mr. DE SANTI suggested removal by external incision, and mentioned two cases thus dealt with.

Dr. SPICER replied.

LARYNGEAL STENOSIS SUPERVENING ON TYPHOID FEVER.

Dr. SCANES SPICER showed a patient, aged 20, in whom acute stenosis of the larynx had supervened after typhoid fever. The patient could phonate, but a probe could not be got through the stricture after cocainisation. The case was shown preliminary to division of the stricture under a general anæsthetic by Whistler's dilator and the use of O'Dwyer's tubes.

The PRESIDENT agreed that it would be best to try and divide the stricture, and to use tubes, but he was not sanguine as to the result in such a case.

LIVERPOOL MEDICAL INSTITUTION.

CHAUNCY PUZEY, M.R.C.S., President, in the Chair.

Thursday, October 18th, 1894.

CYST OF THYROID.

MR. THELWALL THOMAS showed a woman, aged 30, from whom he had removed a cystic swelling in the isthmus and lateral lobe of the thyroid by a median excision. The cyst contained a brownish fluid, in which large flakes of cholesterin floated about.

Mr. PAUL said that the plan of removing thyroid tumours in their early stage should be generally adopted, as they shelled out so readily.

URETHRAL CALCULI.

Mr. THELWALL THOMAS read notes of the case of a man, aged 46, who had suffered from gonorrhœa and stricture twenty years previously. Ten years later internal urethrotomy was performed, but the stricture had returned, accompanied by great difficulty in micturition. Syme's staff sounded calculi behind the stricture. On incising the perineum a dilated membranous urethra was opened, which contained twenty-five calculi, varying in size from a mere speck to a pigeon's egg, and weighing in all 2 ozs. 50 grs. The stricture was divided and the bladder drained, but the patient succumbed to uncontrollable vomiting and diarrhœa on the fourteenth day. *Post-mortem* examination showed both kidneys suppurative, and an abscess surrounded the right one.

Mr. RAWDON suggested that in these advanced cases of chronic dysuria a safety valve might be afforded by ensuring a preliminary suprapubic free drainage of the bladder for a few days, or even weeks, before adopting the operative measures for permanent cure.

CEREBRAL ABSCESS.

Mr. MURRAY showed three children who had been operated upon for cerebral abscess. (1) Due to traumatism, and situated in the upper part of the right Rolandic area. Three and a-half years had elapsed since the operation, and the child was in good health, and showed no signs of mental impairment. (2) Operated on eleven months ago, where there had been a large abscess of the left tempero-sphenoidal lobe following middle ear disease. Here, too, the recovery had been complete. (3) Operated on four months ago for an abscess of the right lateral lobe of the cerebellum, and an extradural abscess over the sigmoid sinus, also due to middle ear disease. The result was entirely satisfactory.

Mr. RUSHTON PARKER pointed out how unnecessary it was, at least in children, to replant the trephined disc of bone. This had not been done in any of Mr. Murray's cases, yet the openings were firmly closed by bony growth.

Mr. HUGH E. JONES, who had been present at the operation on the third of Mr. Murray's cases, referred to the advantage in the method adopted for reaching the cerebellum, namely, to snip away the bone from the mastoid opening, rather than make a separate trephine hole over the cerebellum, which so often resulted in very troublesome bleeding.

REMOVAL OF VERMIFORM APPENDIX.

Mr. MITCHELL BANKS showed a vermiform appendix which he had removed on the previous day. A man, aged 28, had had more or less abdominal pain for five years. Mr. Paul saw the case with Mr. Banks, and neither of them could discover anything by palpation, but the pain had become localised to the region of the cæcum. At the urgent request of the patient an abdominal section was made, and although the parts looked healthy from the outside, the appendix on section was found to be twisted, and to contain hard fæcal concretion.

ADMINISTRATION OF ARSENIC.

Dr. CARTER read a paper entitled "Facts, Legal and Medico-Legal, in the Administration of Arsenic." He referred to an important trial which took place in Liverpool some five years ago. The medical experts for the defence had positively stated that the administration of arsenic in medicinal doses would diminish the secretion of urine, and also that arsenic given medicinally could readily be detected in the urine if it were boiled for a minute or two with a little pure hydrochloric acid and a slip of copper foil introduced into it. Dr. Carter was much struck at the time by these statements, which were so contrary to his own experience and to the statements made by the leading authorities. Since the trial he had made many very careful experiments on these two points, and he now stated positively that in his experience the medicinal administration of arsenic almost invariably increased the secretion of urine, provided that there was no organic disease of the kidneys, and he also affirmed that the rough test with copper foil would fail to detect arsenic in the urine when it was given as a medicine.

Drs. WHITFORD and LOWNDES had also had the urine of patients who were taking arsenic carefully examined, and the copper foil test had failed to discover the presence of the metal.

Mr. PAUL and Dr. DAVIDSON took part in the discussion.

Card specimens were exhibited by Mr. PAUL.

NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

F. PAGE, M.D., President, in the Chair.

Thursday, October 11th, 1894.

CASES.

DR. GEORGE MURRAY and Mr. W. G. RICHARDSON showed a man after successful removal of a Sarcoma from the Brain. In February, 1894, he had an attack of Jacksonian epilepsy of the left arm; later there was nausea, vomiting, headache, and double optic neuritis, complete loss of power in the left arm, and considerable loss in the left leg. Operation July 1st; tumour easily separated from the brain substance and removed with part of the dura mater; power began to return within three days. The man could now walk five miles, and had fair power in the arm; headache, etc., had disappeared, and the neuritis was subsiding.—Dr. MURPHY showed: (1) A man seventeen weeks after Gastro-enterostomy for large Sarcoma at cardiac end of Stomach. Vomiting, previously severe, had ceased, and strength and flesh were rapidly being restored. (2) Man after Suture of Bladder produced by crush by a cab; constant drainage by a catheter was employed. (3) Man after Removal of Ruptured Appendix; patient arrived from sea with intense general peritonitis; median incision showed appendix lying loose, and a concretion; removal of appendix by an iliac incision. (4) Woman after operation for a Hydatid in the region of the Liver.—Dr. HUME: A man after intestinal anastomosis for Malignant Stricture of Colon. There had been absolute constipation and greatly distended abdomen. The growth lay at the splenic flexure, firmly fixed, and accompanied by enlarged glands. A loop of the sigmoid flexure was attached to the ascending colon by Senn's plates and circle of Lembert sutures. The bowels moved naturally two days later, and had done so regularly ever since. The man had recovered weight and strength to a surprising degree.—Dr. BRADLEY showed an infant with large depressed Fracture of the Skull in the frontal region produced during birth. A previous child had been affected in a similar way, but on the opposite side of the frontal region.—Dr. LIMONT showed (1) Boy with Band Morphœa extending from near the coracoid process to tips of thumb and index finger. A patch was present in the axilla, and the two vaccination marks formed two other patches. (2) Woman with Contracting Morphœa following course of one of the intercostals, and accompanied by great pigmentation. In each breast were two early patches, still violet, but beginning to turn white in the centre. (3) By photograph a girl with symmetrical patches of Morphœa behind each knee in which there was considerable loss of sensation. (4) Girl with localised Mycosis Fungoides of one leg.—The PRESIDENT showed a case of aggravated Club-foot in a young child, in which an excellent result had been obtained by Phelps's method of operating.

SPECIMENS.

Specimens were shown by Dr. MURPHY and Mr. RUTHERFORD MORISON.

"RECTO-VESICAL TUBERCULOUS FISTULA": A CORRECTION.

MR. E. HURRY FENWICK calls our attention to the fact that in the report of the discussion at the Pathological Society upon the above subject, published in the BRITISH MEDICAL JOURNAL of October 20th, page 868, certain statistics drawn from records by Dr. Soltau Fenwick at the Brompton Hospital were incorrectly recorded. Only 20 cases out of 1,000 consecutive cases of chronic phthisis which were examined *post mortem* are mentioned as having tuberculous deposits in the lower urinary or genital organs; 13 of these 20 are noticed as having tuberculous disease of the seminal vesicles, and Mr. Hurry Fenwick suggested that Mr. Paget's case fell into this category.