a green will be called red; this shows how many of the colour blind are able to escape detection when methods of comparison are used. Again, why should a colour-blind person guess or attempt to guess that a red light is visible when he can see nothing, or call a light which appears to him definitely white, green. In cases where he is on the border line of uncertainty, he may guess, but does so in such a hesitating manner that his difficulty is quite obvious to the examiner. When, however, a red light is shown to him which has all the characteristics which he has associated with green, or a green light which has all the characteristics he has associated with red, he names the colour shown without doubt or hesitation. The colour names which I refer to in this paper are those which are clearly distinguished by the normal sighted—red, yellow, green, and blue—and with the use of one or more of these colour names with black and white, all colours can be sufficiently described.

Reports
ON
MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

TAUNTON AND SOMERSET HOSPITAL.

UTERINE FIBROID WITH CHRONIC SALPINGITIS.

(Under the care of Mr. L. H. C. BIRKBECK.)

[Reported by A. CLOUSTON RUSSELL, M.B., Ch.B., Senior House-Surgeon.]

THE following case is interesting, as it illustrates how few symptoms may be present notwithstanding extensive pathological change in the body.

E. M. A., single, a spare woman, aged 45, was admitted to the Taunton and Somerset Hospital on October 28th, 1911, complaining of slight enlargement of the abdomen.

She said she had enjoyed the best of health up to three weeks before admission, when she noticed a slight enlargement of the abdomen and began to worry about it; there were no other symptoms whatever. Menstruation was normal.

The abdomen was found to be slightly distended, due to the presence of fluid; it moved freely with respiration, and there was no tenderness anywhere. A small hard mass could be felt situated deeply on the right side of the pelvis. It was diagnosed as fibroid of the uterus. On vaginal examination extensive parametritis was found, the uterus being adherent both to the bladder and to the rectum. The heart beat was rather feeble but regular; there was slight sclerosis of the radial arteries. The pulse was 94 and the temperature 97.2°.

As there was some difficulty about consent to an operation she was simply kept in bed under observation. On November 2nd she suddenly cried out, and her face became ashen. She died in a few minutes, the attack having all the appearance of angina pectoris.

After her death her brother told me that for the past two years she had always slept best when propped up in bed; also that she had been a great walker, covering twenty miles one day within a fortnight of her admission to hospital; she had never complained of any cardiac symptoms. A *post-mortem* examination was made by Dr. Egan and myself, with the following results: The heart wall was flabby and thinned; there was slight sclerosis of the coronary arteries, but no valvular disease. About 1½ pints of ascitic fluid were found in the abdomen. There were small reddish deposits scattered all over the parietal peritoneum, mesentery, intestines, and uterus; slides of these were obtained from the Clinical Research Association, and proved to be of a chronic inflammatory nature; no evidence of tuberculosis could be found. The uterus and appendages, with the bladder and rectum, were bound together in one mass. A fibroid projected from the fundus of the uterus on the right side. The right Fallopian tube was greatly thickened, evidently from chronic inflammation, and widened out into a hydrosalpinx near its fimbriated extremity; the ovary on that side was entirely transformed into a blood cyst the size of a hen's egg. The left tube was chronically thickened and full of caseous material breaking down into pus; a somewhat larger blood cyst represented the left ovary. Both tubes were ulcerated on their external surface, while deposits were numerous upon them and upon the ovaries.

Memoranda:
MEDICAL, SURGICAL, OBSTETRICAL.

FRACTURE IN UTERO.

ON May 13th I was sent for to attend a primipara. I found a footling presentation and the cord prolapsed. After prolonged labour a male child was delivered dead. The right leg was bent at almost right angles half way down the shin. The tibia had been fractured and united. Bony union seems to have been good as the bone was quite firm. Over the fracture was a well healed cicatrix of about 1 in. in length. The four smaller toes on the same foot were united into one. There were no other developmental abnormalities. The evidence of fracture and cicatrix was so plain that I cannot think of any other explanation, especially as there was a confirmatory history of the mother having fallen against the edge of a large tub when six and a half months pregnant.

Lisburn. J. L. RENTOUL, M.B.

WIRING THE PATELLA TWICE IN EIGHT WEEKS.

THE case of rewiring the same patella twice in eight months, reported by Mr. Thos. North in the BRITISH MEDICAL JOURNAL for May 25th, and the evident rareness of the incident, make me wish to record a somewhat similar case.

J. S., aged 21 years on the day of the accident, injured his left leg while playing football on December 9th, 1911. I saw him at his home some time after the accident, and found him suffering from a transverse fracture of the left patella, with separation of about ¾ in.; the lower fragment felt very small. As I was unable to persuade his people to have the fracture wired, he was put up in a back splint, with over-extension of the leg, and the fragments approximated by a figure of 8 bandage. On December 17th permission was got to operate; he was removed to the Royal Albert Edward Infirmary, Wigan, and the operation was performed on December 20th. After clearing out some clots the pieces were wired, the lower piece being very small indeed, and the capsule sutured. He did very well, and left the infirmary a fortnight later, wearing a plaster-of-Paris case. About the last week in January the case was removed; union seemed to be good; there was a fair amount of flexion, and he was allowed to go about with a stick.

Early in February, while out walking after a sharp fall of snow, he slipped, and in attempting to recover himself felt the knee give way. He was removed at once to the infirmary, and on February 19th the knee-joint was again opened, the former scar being dissected out. The wires had torn clean through the lower fragment, and this was so injured that it was found impossible to pass further sutures through it; a thick silver wire was therefore passed through the ligamentum patellae below and the muscle above, and brought out at the outer aspect of the joint. This enabled the two fragments to be brought fairly well together, and by carefully tightening the wire the position was maintained.

He was sent home a month later with a back splint and footpiece on, and in April I put on another plaster case, which he still wears. We were much interested as to the condition of the bone on reopening the joint at an interval of eight weeks from the first operation, and were much surprised to find, so far as we could see, no attempt at union, either bony or cartilaginous—in fact, the fragments seem to have been kept together solely by the wire sutures, and yet the man was young, healthy, and vigorous. Several of the members of the staff were present at the second operation, and all agreed that there seemed no sign of attempted repair.

The fractures, as in Mr. North's case, were both the result of indirect violence, and I have been unable to find any record of a similar occurrence in any medical literature to which I have had access.

JOHN BLAIR, M.D.,
Honorary Surgeon, Royal Albert Edward Infirmary, Wigan.

Br Med J: first published as 10.1136/bmj.2.2688.13 on 6 July 1912. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.